SFY 2026-27 Joint Legislative Budget Hearing—Health

Assembly Ways and Means, Assembly Health, Senate Finance, and Senate Health Committees

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GREATER NEW YORK HOSPITAL ASSOCIATION

Committee Chairs and Members, thank you for the opportunity to testify today. I am Elisabeth Wynn, Executive Vice President of Health Economics & Finance at the Greater New York Hospital Association (GNYHA). GNYHA represents not-for-profit and public hospitals, health systems, and continuing care providers around the tri-state region, including 170 hospitals and health systems and 54 continuing care facilities in New York State.

New York hospitals face unprecedented pressures from massive Federal health care cuts resulting from the One Big Beautiful Bill Act (HR 1), which was passed by Congressional Republicans and signed into law by President Trump. HR 1 enacts the largest health care cuts in history. The broad array of Medicaid eligibility and financing arrangements that HR 1 impacts includes New York's managed care organization (MCO) tax and State directed payments (SDPs) that financially distressed safety net and rural hospitals rely on. HR 1 also decimates the financing of the State's Essential Plan.

New York State estimates that the Federal law will strip health insurance coverage from an estimated 1.5 million New Yorkers, and a GNYHA/HANYS analysis estimates that it will reduce hospital revenues by more than $8 billion annually when fully implemented. HR 1 will ultimately cause a revenue reduction of a staggering $40-50 billion over the next eight years (2026-2033).

These massive Federal will slam an already incredibly fragile hospital system. In 2025, New York's hospitals collectively broke even, with 50% of them losing money[1] and 30% (about 75 hospitals) requiring extraordinary financial subsidies from the State to keep their doors open.[2] This is in a sector where a 3% operating margin is considered the minimum sustainable margin to reinvest in patient care services, technology, and capital infrastructure.

HR 1 uniquely harms New York hospitals given the law's SDP changes, the reliance on MCO tax revenues to support Medicaid rate enhancements, and the direct impact of increased uncompensated care from 1.5 million New Yorker's losing health coverage. As HR 1's devastating impacts are felt over the next few years, nearly all hospitals will lose money. That will force significant service reductions, and some hospitals may close their doors entirely.

While GNYHA will continue to advocate vigorously in Washington, DC, for changes to HR 1, it is an uphill battle. It is therefore essential that Albany step up to mitigate HR 1's severe impact. I want to thank Governor Hochul for continuing to dedicate MCO tax revenues to health care investments, including hospital and nursing home rate increases, and dedicating another $750 million ($500 million recurring) for new hospital and nursing home investments.

The Governor's proposed budget assumed that the MCO tax would sunset on March 31, 2026 (an assumption based on preliminary Federal guidance). But thanks in large part to GNYHA's relentless advocacy, the MCO tax has been extended to December 31, 2026. That will provide more than $1.25 billion in additional revenues above the levels assumed in the Executive budget. We support dedicating this

[1] Joint Association Financial Survey.

[2] New York State Division of Budget, SFY 2027 Executive Budget Briefing Book, pg. 70.

additional revenue to continuing the Health Care Stability Fund investments in State Fiscal Year (SFY) 2028 (these currently expire at the end of SFY 2027), including the hospital 10% outpatient rate increase, the Safety Net Transformation Fund investment, and the 4% nursing home investment. We also support restoring the $125 million (State share) hospital quality pool. The quality pool was programmed in the SFY 2026 budget but was administratively "swept" due to the MCO tax's uncertain sunset timeline. A minimum of $500 million should also be dedicated to the Vital Access Provider Assurance Program (VAPAP) for financially struggling hospitals.

The Executive budget's new $750 million investment and the additional MCO tax revenues must be used to sustain critical Medicaid rate investments and mitigate HR 1's devastating impacts. We urge the Governor and Legislature to collectively direct those funds to protect hospitals, nursing homes, New York's health care delivery system, and patients we serve. We share our more detailed thoughts on this funding below.

There is an opportunity to support safety net providers by adopting the proposed 340B Non-Discrimination Act (A.6222/S.1913). This bill would ensure that they have continued access to discounted pharmaceuticals. Pharmaceutical companies are implementing policies to limit patient access to 340B drugs by limiting the sites that are covered, imposing onerous administrative and logistical requirements to establish procedural barriers for providers, and imposing "back-end" rebates to delay and challenge claims. *Implementation of these policies threaten to cost New York's hospitals and other safety net providers hundreds of millions of dollars in savings.* GNYHA urges the Legislature to incorporate these protections in their one-house budgets and as part of the final negotiated SFY 2027 budget.

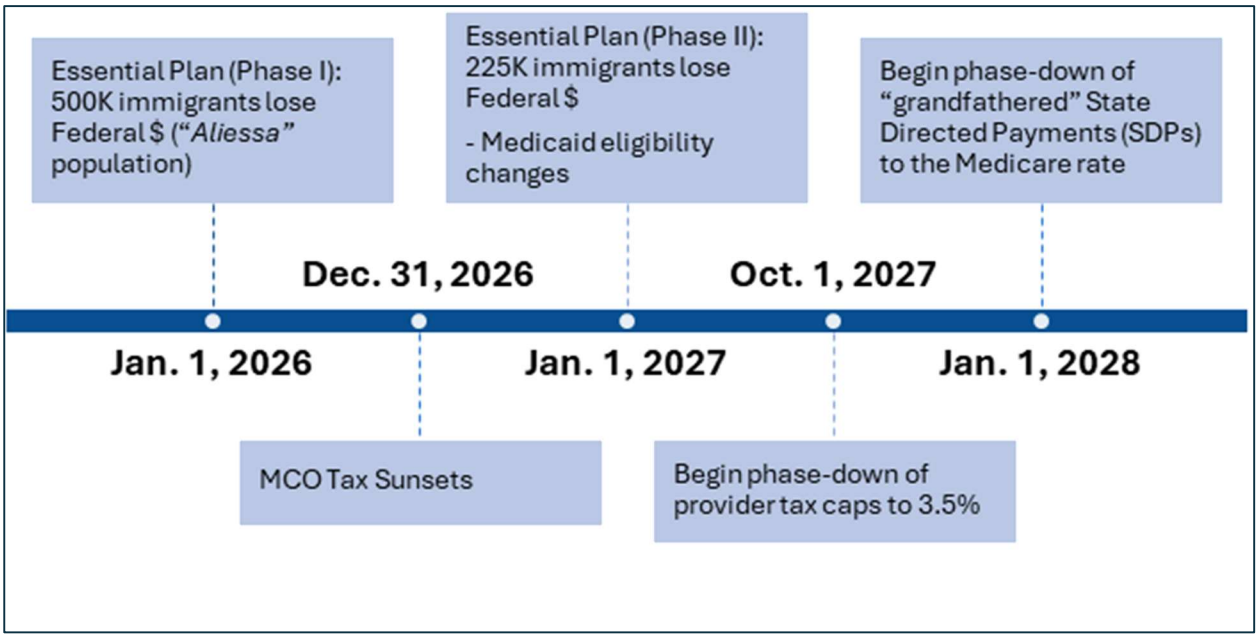
We also urge the Legislature to reject harmful policies that would shift the balance of power towards health insurance companies in provider rate negotiations, such as the proposed changes to the State's Independent Dispute Resolution (IDR) process (details in the section below), or impose additional cuts to hospitals through the "site-neutral" payment policies and payment rate caps (i.e., the so-called Fair Pricing Act).

A detailed table outlining the Executive budget's provisions of interest to hospitals and nursing homes, and GNYHA's positions on them, is attached. Thank you for the opportunity to deliver this testimony. I am happy to answer your questions.

HR 1's Impact on New York

As previously mentioned, HR 1 imposes the largest health care cuts in history. An estimated 1.5 million New Yorkers will lose health insurance coverage, driving up uncompensated care costs for hospitals and threatening their financial viability. A high-level timeline of HR 1's most damaging provisions is provided in Chart 1 below.

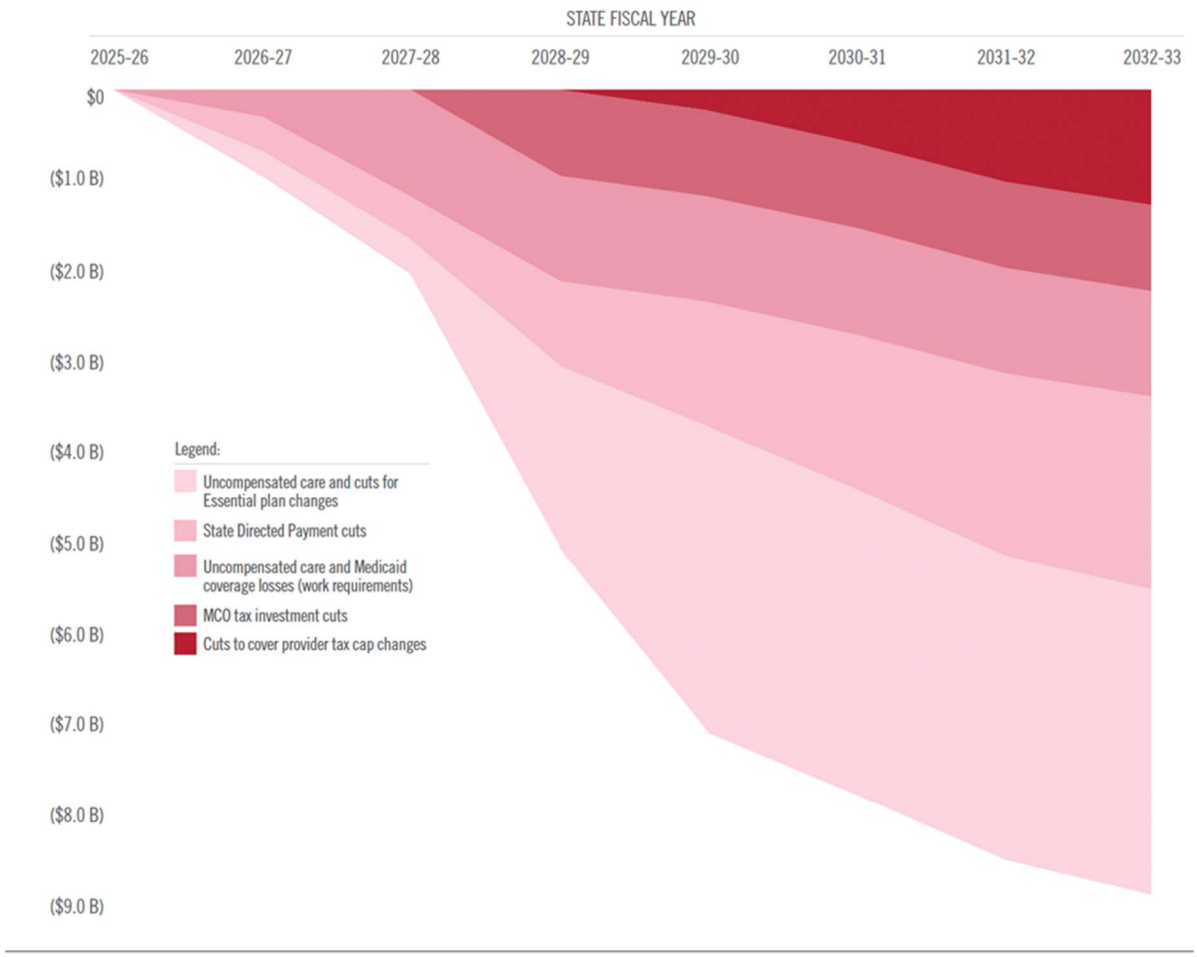
Chart 1. HR 1 Implementation Timeline



A GNYHA/HANYS analysis found that HR 1 will cut $8 billion from New York hospitals when fully implemented. That represents a stunning 7% of New York hospitals' *total* operating revenues (not just Medicaid). Unfortunately, the New York State Nurses Association's leadership has ignored this harsh fiscal reality facing hospitals throughout the ongoing, protracted nurses strike at three large health systems in New York City.

The chart below shows the estimated hospital impacts and implementation timeline of HR 1's various provisions.

Chart 2. Impact of HR 1 on New York Hospitals (SFY 2026-SFY 2033)



Access the data sources and methods HANYS and GNYHA used to develop this analysis: [link]. Graph above reflects low-end estimates.

Given hospitals' already thin operating margins, HR 1's cuts threaten 34,000 hospital jobs across New York, deepening a workforce crisis that already has critical shortages. HR 1's economic impact will ripple beyond the hospitals and result in 29,000 additional (non-hospital) job losses and a total of $14.4 billion in lost hospital-generated economic activity.

NYS Medicaid Funding Grows, But Not for Hospitals and Nursing Homes

There have been many discussions about the growth rate New York's Medicaid program (the Governor's proposed budget assumes an 11.4% Medicaid spending increase over the previous SFY). However, it is important to understand *where* Medicaid spending has increased and where it has not. Since 2011, when New York eliminated annual Medicaid inflationary trend factors, hospitals and nursing homes have not received regular Medicaid rate increases while their costs have soared. Over the last 15 years, hospitals have only received a 1% rate increase in SFY 2023 and partial implementation of a 10% outpatient rate increase that began in SFY 2025.

New York hospitals' Medicaid rates are therefore are only marginally higher than their rates from *15 years ago*. Put another way, New York's Medicaid program severely underpays hospitals, covering only about 70% of the cost of the care they provide to Medicaid patients. As for nursing homes, Medicaid payments cover roughly 75% of their costs.

In addition, recent Medicaid provider investments are primarily self-funded within the health care system by a dedicated tax mechanism (the MCO tax), rather than on reliance from greater contributions from State general funds.

Here are the primary cost drivers of New York's Medicaid program over the past decade:

- Enrollment growth —current enrollment includes 700,000 individuals more than pre-COVID-19 levels, and two million more than 2011
- Enrollment growth in long-term care programs, with a 20% increase in managed long-term care enrollment from 2022 to 2024 and more than a 300% increase in Consumer Directed Personal Assistance Program (CDPAP) enrollment from 2019 to 2024
- Reimbursement rate increases in managed long-term care (MLTC) and CDPAP programs, driven by minimum wage increases of 13% in the last two years and 55% in the last 10 years
- Increased pharmaceutical costs, with reports that net prices in the United States increased 11.4% in 2024

GNYHA strongly supports expanded coverage and paying health care workers adequate wages, to ensure adequate health care for all New Yorkers. However, it is important to recognize that while these factors are significant drivers of Medicaid spending growth in New York, they are not related to cost or spending in hospitals and nursing homes.

Investments in the Executive Budget

1. Healthcare Stability Fund: MCO Tax and New Investments

As stated above, the proposed SFY 2027 Executive budget dedicates the remaining MCO tax receipts to support the continuation of the hospital and nursing home rate investments adopted in the SFY 2026 budget (shown as State-share dollars):

- Hospitals ($196 million for SFY 2026 and $155 million for SFY 2027 for a 10% outpatient rate increase)
- Nursing Homes ($223 million for SFY 2026 and $193 million for SFY 2027 for a 4% per diem increase)

The proposed budget also dedicates MCO tax receipts to Medicaid global cap savings ($500 million annually in SFYs 2026 and 2027) and investments in the managed care quality pool, assisted living program, physician and clinic rate increases, value-based program incentive payments, and additional funding for the Safety Net Transformation Program (discussed below).

As we noted above, with the extension of the MCO tax until December 31, 2026, we expect an additional $1.25 billion in net revenues to be available for investments. We support dedicating these funds to continuing the provider rate investments outlined in the Executive budget through SFY 2028 and restoring

the hospital quality pool that was administratively swept ($165 million State share). Otherwise, providers will experience a significant funding cliff in SFY 2028, exacerbating the HR 1 impacts.

We also strongly support the Governor's proposed new investment of $750 million ($500 million of which is recurring) for new hospital and nursing home rate investments. These investments are critically needed to stem the financial challenges these sectors face and to help blunt HR 1's financial impacts. We seek traditional Medicaid rate increases and the restoration of the 20% Medicaid hospital capital rate cut and the capital reconciliation penalties ($78 million State share combined).

The proposed budget would repurpose the $20 million Nursing Home VAPAP pool to restore the 10% capital reimbursement cut enacted in the SFY 2026 budget. GNYHA strongly supports this proposal to address the financial challenges not-for-profit nursing homes have faced over the last several years.

2. Safety Net & Distressed Hospital Funding

The Governor's proposed budget provides a $2.6 billion "base" investment in financially distressed hospitals, critical access hospitals, and facilities receiving VAPAP funding. This crucial funding supports 75 hospitals in rural and underserved areas, ensuring that access to care is preserved in communities with scarce health care resources. In addition, the budget supports the 1115 Medicaid waiver's global budget demonstration program for downstate safety net hospitals that serve high volumes of Medicaid patients.

The State should invest more in financially distressed/safety net hospitals so they can address structural financial gaps to not only sustain services but also make critical transformational investments to better serve their communities. Alarmingly, the Governor's proposed SFY 2027 budget eliminates $500 million in supplemental VAPAP funding. VAPAP funds are critical to hospitals struggling to meet essential financial obligations. Without these funds, many hospitals will be forced into impossible decisions about which bills to pay, further hindering their ability to invest in expanded services, staff, or capital infrastructure improvements. We urge the Legislature to restore this funding to ensure that patient care is not impacted.

3. Safety Net Transformation Program

The Safety Net Transformation Program seeks to improve safety net hospitals' financial sustainability by supporting collaborations between safety net hospitals and a partner (either a health system or other provider partner). The State proposes increasing its investment in the Safety Net Transformation Program by providing $1 billion in new capital support. The $1 billion is allocated as $500 million in "soft" capital for health information technology and debt restructuring and $500 million in "hard" capital for construction projects. The budget also provides a minimum of $330 million in operating funding from MCO tax revenues that would be available to support new and existing partnerships. These investments are on top of the $1 billion base in dedicated capital funding the Governor has provided in previous years. *GNYHA strongly supports these investments and believes the program can improve the financial sustainability of safety net hospitals while also improving health care quality and access for New Yorkers.*

4. Rural Health Transformation Fund

The proposed budget includes the anticipated $212 million Federal award under HR 1 to improve health care access for rural patients and communities. New York State's approved application will implement a Rural Health Integration Initiative to create formal partnership networks to improve rural health care coordination among hospitals, Federally Qualified Health Centers, primary care providers, and community

organizations. New York also plans to increase the number of primary care medical homes in the State and implement an eConsult platform to improve access to rural providers.

The State also plans to address maternal care workforce gaps by providing advanced training in rural communities, including lactation counseling, EMT obstetrics, and maternal care training for nurses and medical students. In addition, the State will invest in programs to reduce preventable hospital visits, improve maternal health outcomes, decrease rural health workforce gaps, and increase access to primary and specialty care in rural areas. GNYHA supports these investments and will work with the State to implement the plan and support rural health providers and communities.

5. Changes to the Essential Plan

HR 1's worst impact on New York is the drastic reduction of Federal funding for immigrant coverage under the State's Essential Plan. This program, funded primarily by Affordable Care Act (ACA) tax credits, effectively lowered the uninsured rate in New York to below 5% (among the lowest in the nation) and reduced hospital uncompensated care costs.

On January 1, 2026, approximately 500,000 lawfully present immigrants lost their ACA premium tax credits, leading to an estimated $2.7 billion annual cost for New York to provide State-funded Medicaid without Federal assistance as required under New York's Constitution. Another 225,000 will lose their tax credits in January 2027.

To mitigate these impacts, Governor Hochul submitted an application to CMS to sunset New York's Section 1332 Innovation Waiver and return to the Basic Health Plan. If approved, this would provide access to nearly $10 billion in Federal Basic Health Plan Trust Fund dollars, protecting coverage for 1.3 million individuals at 0-200% of the Federal Poverty Level (FPL), including those losing ACA tax credits. Unfortunately, because the ACA caps eligibility for the Basic Health Plan at 200% of FPL, 460,000 individuals between 200-250% of FPL would lose their Essential Plan coverage and may become uninsured.

The State's Financial Plan currently assumes that the transition won't be approved and dedicates over $2 billion in SFY 2027 and $3 billion in SFY 2028. The Financial Plan will be updated if/when the Federal government approves the 1332 waiver recission. GNYHA is advocating in Washington, DC, for delaying Essential Plan cuts and supports the Executive proposal setting aside resources to provide coverage for the *Aliessa* population (lawfully present immigrants with incomes between 0-138% the FPL who are not eligible for Federal Medicaid coverage) if the transition does not occur. If the transition back to the 1332 waiver is approved, GNYHA also supports dedicating a pool of funding to address health insurance affordability for the 460,000 individuals between 200-250% of the FPL who would lose Essential Plan coverage and likely would not be able to afford ACA Exchange coverage without a subsidy (only 80,000 individuals in this income band were enrolled in ACA Exchange coverage prior to the 1332 Waiver).

Other Issues of Importance in the Executive Budget

Medical Liability and the Medical Indemnity Fund (MIF)

A fundamental principle of the MIF is that not all birth-related injuries result from negligence. Prior to the MIF's creation in 2011, hospitals providing obstetrical services faced full lifetime care costs for

individuals with birth-related neurological injuries, despite the complex causes of these injuries. This created severe and unpredictable financial exposure, particularly for safety net hospitals serving low-income communities

The MIF was established to cover future medical costs for affected individuals while reducing malpractice premiums for providers. Continued State investment in this program is essential to ensure its long-term sustainability and to protect both affected families and the providers that care for them. The Executive Budget includes $75 million in additional funding beyond the MIF's annual $52 million appropriation, allowing it to remain open to new enrollees through the fiscal year. We commend the Governor for this investment.

To improve long-term viability, the budget reduces provider reimbursement rates paid by the MIF from 80% of "usual and customary charges" to Medicare rates, or Medicaid rates where Medicare does not apply. Rates based on 80% of "usual and customary charges" are substantially above negotiated rates paid by commercial health insurance. These high payment rates, which were implemented through a 2017 statutory change, have been a major driver of MIF expenditures. GNYHA supports aligning provider reimbursement with established public payer rates as a necessary step toward ensuring the MIF's long-term financial sustainability.

Independent Dispute Resolution/Cooling Off Periods

The Executive budget also proposes a very significant change in the Independent Dispute Resolution (IDR) process for all payers and providers covered by the State's IDR law. Current law requires the Independent Dispute Resolution Entity (IDRE) to equally weigh a variety of factors in determining the final payment amount (with no one factor being determinative), and with a cap on final payment amount based on out of network charges. This proposal would almost always require the IDRE to default to a payment equivalent to the 50th percentile in-network amount paid by participating providers in that region. GNYHA strongly opposes this "allowed benchmark" proposal because it would significantly shift the IDR review in favor of payers.

Plans would almost always be closer to the "allowed benchmark," and the final payments would always end up at median of in-network rates. This would broadly disrupt the balance in network contract negotiations in favor of plans. Payers would know they can simply pay out-of-network providers an in-network rate, which will remove incentives for payers to include hospitals in their networks. GNYHA is also reviewing whether these proposed changes align with the Federal No Surprises Act, particularly in context of litigation in Federal courts regarding the weight given to different elements when reaching a determination of the final payment amount.

The budget also proposes changing the State law provisions related to statutorily mandated "cooling off" periods at the termination of contracts between insurers and hospitals by increasing the cooling off period from 60 days to 120 days and covering hospital-owned provider practices under these provisions. We understand that these provisions are believed to help protect consumers and patients from being affected by contract terminations. However, GNYHA believes that these changes will inadvertently cause more patients to be affected by contract negotiations and terminations between health plans and hospitals. These two proposals—reducing rates of payments to out-of-network providers and extending the cooling off periods—are likely to embolden health plans to become more aggressive about terminating contracts with hospitals,

knowing that they can safely maintain their networks at existing or lower rates for a longer time period after termination.

Workforce

The Governor proposes several health care worker flexibilities, including allowing supervised medical assistants to administer immunizations in an outpatient setting, permitting experienced physician assistants to practice in certain settings without supervision, and creating the title of certified medication aide and allowing them to administer routine and prefilled medications in nursing homes.

GNYHA strongly supports these measures, which will help hospitals hire and retain qualified health care workers as they confront historic workforce shortages and prioritize patient care without compromising patient safety.

Other Significant Policy Issues

340B Program Protections

Congress created the 340B program in 1992 to support providers that serve the most vulnerable by allowing them to purchase prescription drugs at significant discounts. 340B helps distressed, rural, and urban safety net providers around the country stretch scarce resources and increase access to prescription drugs—including not-for-profit and public safety net hospitals and federally qualified health centers in New York State.

Unfortunately, the trillion-dollar pharmaceutical and pharmacy benefit manager industries have been taking creative steps to undermine this critical program. These companies are implementing policies to limit patient access to 340B drugs by limiting the sites that are covered, imposing onerous administrative and logistical requirements to establish procedural barriers for providers, and imposing "back-end" rebates to delay and challenge claims. *Implementation of these policies could cost New York's hospitals and other safety net providers hundreds of millions of dollars in savings, just as HR 1's massive health care cuts are taking effect. Hundreds of millions of dollars in revenue will effectively be transferred from financially struggling health care providers in New York to the shareholders of giant, massively profitable pharmaceutical companies. Such a transfer would severely harm safety net providers and threaten access to care for the vulnerable populations they serve.*

GNYHA strongly supports legislation (A.6222/S.1913) that would protect safety net providers and patients by banning these discriminatory practices. This bill would allow New York to join a growing group of states that have enacted laws to protect their safety net providers and those they serve by banning these harmful pharmaceutical industry practices. For example, Eli Lilly recently implemented a policy to enormously expand their data and information requirements from 340B providers before they will honor the mandated 340B pricing. However, they acknowledged that this onerous new requirement would not apply in states with laws providing protections similar to those proposed in A.6222/S.1913. If New York enacts this bill, our safety net providers will immediately benefit.

GNYHA believes this legislation will help safety net providers maintain their financial stability. GNYHA therefore strongly urges the Legislature to include A.6222/S.1913's provisions in the final budget agreement with the Governor.

(Note: In 2023, New York State carved the Medicaid pharmacy benefit out of managed care, which resulted in lost savings amounting to hundreds of millions of dollars for safety net hospitals and community providers. A.6222/S.1913 does not reverse that policy change but protects these essential providers from further harm by limiting unilateral actions that manufacturers and others are taking to undercut the 340B program. This bill would also cost the State nothing.)

The Failure of "Fair Pricing"

The so-called "Fair Pricing Act" is an Albany bill that mandates that commercial health insurers cap reimbursement to hospitals, physicians, and other providers at no more than 150% of the amount paid by Medicare for certain specified services. The bill's supporters argue that many health care services can and should be provided in a physician's office rather than hospital outpatient departments, and the bill would virtually eliminate reimbursement for those services if provided by a hospital. While the bill's goal is to reduce the cost of health insurance, it is flawed in many ways:

- It does not address the main driver of increased hospital prices for commercial health insurers, which is the failure of Medicaid and Medicare to pay their fair share of increased costs.
- The bill would cut hospital revenue by more than $1.5 billion, *which the bill's supporters acknowledge*. Combined with HR 1's $8 billion cut to New York hospitals, this bill would reduce health care access for vulnerable populations and force hospital layoffs.
- Implementation of this legislation would impede care for vulnerable populations (such as Medicaid, uninsured, non-English language speakers, individuals with complex medical needs) who rely on hospitals for their care and are unlikely to be able to access appropriate care in a private physician's office.
- The bill's savings would accrue primarily to large, national for-profit health insurance companies that have transferred approximately $6 billion in windfall profits to their out-of-state corporate parents and shareholders over the last eight years. In an acknowledgement of this fact, the bill was recently amended to require the Department of Financial Services (DFS) take into consideration savings from this legislation when approving new health plan premiums. However, the health insurance for most individuals is not covered by DFS review.

Where Profit Making Exists in Health Care

The operating margins of New York's hospitals are among the lowest in the country, with an estimated median operating margin in 2025 of 0%. By contrast, large national for-profit insurance companies and pharmaceutical companies continue to record massive profits. There is extensive research by government oversight agencies showing that pharmaceutical companies' operating profits regularly fall between 15%-25%, generating hundreds of billions of dollars in profit for executives and shareholders. The four largest for-profit health insurance companies in New York, weighted for approximate market share, averaged an approximately 7% operating margin over the last five years of available data. With these massive margins, these companies transferred approximately $6 billion in profits out of New York and into their shareholders' bank accounts over the last nine years.

Health Plan Dividends
NAIC Health Plan Financial Statements, Statement of Revenue and Expenses, Line 46

Standard Plan Name (Most Recent)	2023	2024	9-Year Total 2016-2024
Aetna Health (New York)	-	-	125,000,000
Empire Healthchoice Assurance	97,200,000	146,600,000	897,100,000
Healthplex Insurance Company	-	-	2,500,000
Oxford Health Insurance	847,000,000	850,000,000	3,657,000,000
Oxford Health Plans	110,000,000	-	425,000,000
UnitedHealthcare	235,000,000	-	330,000,000
UnitedHealthcare	280,000,000	75,000,000	585,000,000
Total	**$1,569,200,000**	**$1,071,600,000**	**$6,021,600,000**

At the same time, these large for-profit insurers remain extremely profitable.

Company	Avg. Operating Margin (2020-2024)
UnitedHealth Group	8.52%
Elevance Health	4.94%
Cigna	4.06%
CVS/Aetna	3.81%

If New York's hospitals experienced that same 7% average margin, it would result in more than $8 billion in additional funding for those facilities every year, putting them in a very different financial position.

Bill such as the Fair Pricing Act and efforts to undermine 340B pharmacy savings simply shift desperately needed funding from community-based health care providers, health care workers, and the communities they serve to national for-profit insurance companies that prioritize their shareholders.

Health Insurance Company Abuses

In addition to the budgetary issues, we urge the Legislature to expeditiously adopt comprehensive reforms to curb health insurance company abuses that harm both patients and providers (see Attachment C). Too often, insurance companies have the final say on whether a patient can receive medically necessary care, even when that care has been ordered by a trusted clinician. According to the Kaiser Family Foundation, 16% of insured adults reported delays due to prior authorization. In addition, New York State Department of Financial Services data show that New York's commercial health insurance plans denied approximately 25% of all inpatient hospital claims in 2024 and 2025.

These denials and delays are not harmless administrative decisions. They can interrupt treatment, worsen health outcomes, and force patients to postpone or forgo care. They also destabilize providers and hospitals by shifting financial risk onto the health care system after care has already been delivered. In effect, insurers increase their profits by delaying, denying, or limiting coverage, leaving patients with higher out-of-pocket costs and hospitals with higher uncompensated care costs.

The proposed budget includes reforms to prior authorization and utilization review, including enhanced reporting and public disclosure of prior authorization data, expanded transition-of-care protections for

enrollees who change managed care plans, improved public access to formulary drug lists, and limits on repeated utilization review for ongoing treatment of chronic conditions. While GNYHA supports these proposals as part of broader efforts to ensure timely access to care and prevent inappropriate disruptions in coverage, Albany can and must do more.

New York needs common-sense insurance reforms that protect patients' access to timely care, strengthen accountability, and increase transparency into how insurers influence health care pricing, coverage decisions, and claim denials. To achieve this, GNYHA has also developed legislative recommendations to strengthen these provisions and address additional managed care plan practices, including improving data collection and analysis, broadening transition-of-care protections across insurance products, preventing disruption of ongoing treatment, establishing clear, enforceable standards for utilization review decision-making (including guardrails on the use of artificial intelligence and firm review timeframes), and prohibiting unilateral insurer policy changes that undermine access to care.

STATE FISCAL YEAR (SFY) 2026–27 NEW YORK STATE EXECUTIVE BUDGET HEALTH CARE PROPOSALS, GNYHA POSITIONS

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Below is a detailed summary of important health care-related provisions in the proposed Executive budget and GNYHA's position on them.

ISSUE	EXECUTIVE PROPOSAL SFY 2026–27	GNYHA POSITION
MEDICAID: ALL PROVIDERS		
Healthcare Stability Fund: MCO Tax Receipts and New Investments	The proposed budget includes $750 million (State share) in new Medicaid investments in SFY 2027 ($500 million recurring in future SFYs) for hospitals and nursing homes. The proposed budget also anticipates the expiration of the managed care organization (MCO) tax on March 31, 2026, under preliminary Trump Administration guidance implementing HR 1. The proposed budget dedicates the remaining MCO tax receipts to supporting the continuation of the hospital and nursing home rate investments adopted in the SFY 2026 budget (shown as State-share dollars): • Hospitals ($196 million for SFY 2026 and $155 million for SFY 2027 for a 10% outpatient rate increase) • Safety Net Transformation ($330 million for SFY 2027) • Nursing Homes ($223 million for SFY 2026 and $193 million for SFY 2027 for a 4% increase) The proposed budget also dedicates MCO tax receipts to Medicaid global cap savings ($500 million annually in SFYs 2026 and 2027) and investments in the managed care quality pool, assisted living program, physician and	GNYHA **supports** the Executive's investments, which establish a foundation of stability for hospitals. This stability is desperately needed because HR 1, when fully implemented, will cut $8 billion from New York hospitals. However, because of the anticipated Federal changes to the MCO tax, under the Governor's proposed budget hospitals are set to receive over $1 billion (gross) less in investments from MCO tax receipts enacted in last year's budget. In addition, hospitals will lose more than $1.8 billion in revenue this year because of the implementation of HR 1. Among all providers, hospitals almost uniquely suffer from HR 1 cuts. GNYHA therefore believes a significant portion of the $750 million in new investments for SFY 2027 must be used to backfill these losses and stabilize hospitals. We are also concerned about the financial sustainability of not-for-profit nursing homes. GNYHA will advocate for additional Medicaid funds for hospitals and nursing homes throughout the State budget process, including via the GNYHA/1199SEIU Healthcare Education Project (HEP) "Code Red! Protect Our Healthcare!" campaign. GNYHA's intense engagement with the Trump Administration was a pivotal factor in this

ISSUE	EXECUTIVE PROPOSAL SFY 2026–27	GNYHA POSITION
Healthcare Stability Fund (continued)	clinic rate increases, and value-based program incentive payments. The Centers for Medicare & Medicaid Services (CMS) final regulations released on January 29 will allow New York's MCO tax to be extended until December 31, 2026. Based on the preliminary guidance released in 2025, the Governor's proposed budget assumed the MCO tax would sunset on March 31, 2026. This extension of the MCO tax could generate as much as an additional $1 billion in the Health Stability Fund for investment in hospitals and nursing homes.	extension of the MCO tax. New York's hospitals face deeper and sooner cuts from HR 1 than other states. Extending the MCO tax will help mitigate the impact of HR 1 cuts in New York and provide resources to ensure a more gradual implementation of the cuts on providers. GNYHA therefore believes it is imperative that any new revenue created by the extension of the MCO tax be used exclusively to support hospitals and nursing homes and should supplement the funding levels in the Governor's proposed budget.
FINANCIALLY DISTRESSED/SAFETY NET HOSPITALS		
Financially Distressed Hospitals	The proposed budget continues support for: • Directed Payment Template programs for financially distressed critical access hospitals, sole community hospitals, and the maternal quality program • The Vital Access Provider Program • The Safety Net Hospital Global Budget initiative in the State's Medicaid waiver ($550 million) The budget also includes new investments in the Safety Net Transformation Program (see below).	The State should invest more in financially distressed/safety net hospitals so they can address structural financial gaps to not only sustain services, but also make critical transformational investments to better serve their communities. The proposed budget once again reduces State funding for the Vital Access Provider Assurance Program (VAPAP) by $500 million compared to SFY 2026 levels. GNYHA will work with the Executive and the Legislature to ensure that the final budget appropriately addresses safety net hospital funding needs.
Safety Net Transformation Program	The proposed budget also includes new investments in the Safety Net Transformation Program, including $1 billion in new capital support: • $500 million is "soft" capital for health information technology and debt restructuring • $500 million is "hard" capital for construction projects A minimum of $330 million in operating funding (from MCO tax revenues) would also be available to support new and existing partnerships.	GNYHA **supports** this proposal.

ISSUE	EXECUTIVE PROPOSAL SFY 2026–27	GNYHA POSITION
OTHER		
Rural Health Transformation Fund	The proposed budget includes the anticipated $212 million Federal award under HR 1 to improve health care access for rural patients and communities. New York State's approved application dedicates funding to integrating providers, strengthening telehealth and primary care, enhancing the workforce, and improving technology and cybersecurity in rural areas. New York used the Health Resources and Services Administration's rural definition in its application and has identified 47 of the State's 62 counties as eligible for funding. New York's full application to CMS is available here.	GNYHA will work with the State to implement its plan and support our rural health providers and communities.
Nursing Home VAPAP	The proposed budget redirects the $20 million Nursing Home VAPAP pool to restore the 10% capital reimbursement cut implemented in the SFY 2025 budget.	GNYHA **strongly supports** this proposal.
School-Based Health Centers (SBHCs)	The proposed budget continues the additional $3 million for SBHCs included in the SFY 2024-25 budget, but does not add any new funding.	GNYHA **supports** this continued investment. We urge Albany to also include an additional $3.8 million to address a SFY 2017-18 budget cut and a subsequent New York State Department of Health (DOH) administrative redistribution that disproportionately harmed many urban hospital-sponsored SBHCs. (For the past eight years, the Legislature has provided these funds in the final budget.) SBHCs provide critical primary care services to underserved public school children across the State.
WORKFORCE		
Temporary Staff	The proposed budget would authorize the DOH Commissioner to limit the amount of money temporary staffing agencies could retain as profit. The proposed budget would also provide DOH with $4.2 million to develop guidance and share best practices for health care organizations securing temporary staff.	We are discussing this proposal with our members. While GNYHA appreciates the Executive's goal to ensure that health care workforce funding is used in the most effective way, temporary staffing is a national market. We believe the proposal could hamper New York hospitals and other health care facilities from accessing needed clinical staff.

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Health Care Worker Flexibilities	The proposed budget has several health care worker flexibilities, including: • Allowing supervised medical assistants (MAs) to administer immunizations in an outpatient setting • Permitting experienced physician assistants (PAs) to practice in certain settings without supervision • Creating the title of certified medication aide and allowing them to administer routine and prefilled medications in nursing homes	GNYHA **supports** these proposals. Permitting supervised MAs to administer immunizations in outpatient settings under the supervision of a physician, nurse practitioner (NP), or PA would allow physicians, NPs, and PAs to prioritize patient care services specific to their professions and work at the top of their licenses without compromising patient safety. Allowing experienced PAs to independently practice primary care in general hospitals, rural emergency hospitals, diagnostic and treatment centers, and certain primary care practices would allow PAs to practice at the top of their license without compromising patient safety. Creating the title of certified medication aide and allowing them to administer routine and prefilled medications in nursing homes under supervision would improve timely medication delivery and allow licensed practical nurses and registered nurses to focus on higher-acuity nursing care.
Licensure Oversight	The proposed budget transfers from the State Education Department to DOH the authority to define, license, and oversee physicians, PAs, and specialist assistants.	GNYHA believes it is imperative for New York State to 1) ensure expedited licensure processing and 2) consistently review and update medical license policies to ensure an adequate physician, PA, and specialist assistant workforce. GNYHA believes New York policymakers should determine the administrative structure that can accomplish that goal.
Nurses Across New York (NANY)	The proposed budget includes $3 million in continued support for the NANY loan repayment program, which provides educational loan repayment in exchange for a three-year service commitment in an underserved area of the State.	GNYHA **supports** this proposal. NANY encourages nurses to practice in underserved areas of the State and prioritizes those who provide care to high-need patient populations, including children and those with behavioral health care needs.

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Doctors Across New York (DANY)	The proposed budget includes $15.9 million in continued support for the DANY loan repayment program, which provides educational loan repayment in exchange for a three-year service commitment.	GNYHA **supports** this proposal. DANY encourages physicians to practice in underserved areas of the State.
Mental Health Workforce	The proposed budget continues $18 million in support for the Office of Mental Health (OMH) Community Mental Health loan repayment program, which provides funding to organizations with certain OMH-licensed mental health programs to develop their own loan repayment programs to recruit and retain psychiatrists, psychiatric NPs, and other mental health clinicians.	GNYHA **supports** this proposal. OMH's Community Mental Health loan repayment program bolsters the State's mental health workforce and prioritizes mental health professionals who provide care to high-need patient populations, including children and those with substance use disorder.
Hospital at Home	The proposed budget allows general hospitals to provide care in patient homes without obtaining a license as a home care agency. This proposal would codify the Federal Acute Hospital Care at Home program in State law. Participating hospitals would be required to submit annual operating cost data to DOH.	GNYHA **supports** this proposal. Many GNYHA members either have or are exploring hospital-at-home programs.
Health Care Worker Financial Burden Relief	The proposed budget includes $47 million to continue supporting this program, which funds grants to health care facilities or institutions of higher learning to defer the costs of tuition, instructional fees, stipends, and wrap-around services.	GNYHA **supports** this proposal.
Training Capacity Expansion	The proposed budget includes $22.5 million to continue supporting this program, which funds grants to Article 28 health care facilities to cover the costs of new programs, compensation for workers to train full-time support staff, and to develop new techniques to increase the training capacity of medical institutions.	GNYHA **supports** this proposal.
Workforce Innovation Center	The proposed budget includes $20.2 million to continue supporting this office's activities and programs.	GNYHA **supports** this proposal.
Scholars in Medicine and Science	The proposed budget includes $3.6 million for this program (formerly the Diversity in Medicine program), which supports minority and economically disadvantaged students in medical school.	GNYHA **supports** this proposal.

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Empire Clinical Research Investigator Program (ECRIP)	The proposed budget discontinues ECRIP.	GNYHA **opposes** this proposal. ECRIP plays a critical role in helping GNYHA members recruit early career researchers who strengthen the State's global biomedical footprint.
Community Promise Scholarship	The proposed budget includes $60 million to cover the cost of tuition for New Yorkers ages 25-55 pursuing associate degrees at CUNY and SUNY schools in "high demand" fields, including nursing and allied health.	GNYHA **supports** this proposal. Tuition aid for New Yorkers pursuing associate-level degrees in high-demand fields, including nursing, will strengthen and diversify New York State's health workforce.
Workers' Compensation	The proposed budget includes provisions related to Workers' Compensation, including replacing repeated references to "physicians" with the broader term "authorized providers," thereby clarifying that injured workers may select and receive care from any provider authorized by the Workers' Compensation Board consistent with scope of practice rules.	GNYHA **supports** this proposal.
INSURANCE/ MANAGED CARE		
Essential Plan	The proposed budget assumes implementation of HR 1's funding changes to the Essential Plan beginning January 1, 2026. The State applied to the Federal government to sunset its 1332 Essential Plan waiver and revert to the Basic Health Plan (BHP) beginning July 1, 2026, mitigating an estimated $3 billion annual State Medicaid cost (temporarily). The State expects 460,000 individuals above BHP eligibility levels (200-250% of the Federal Poverty Level [FPL]) to lose Essential Plan coverage, with some portion moving to other coverage options. Since reverting to the BHP is contingent on Federal approval, the State's Financial Plan currently assumes that the transition won't occur and dedicates over $2 billion in SFY 2027 and $3 billion in SFY 2028. The Financial Plan will be updated if/when the Federal government approves the 1332 waiver recission.	GNYHA continues to advocate in Washington, DC, for delaying the cuts to the Essential Plan. However, reverting to the BHP would allow the State to access about $10 billion in Federal BHP Trust Fund dollars to temporarily stem HR 1's financial hit to New York State and its health care system. It would also preserve coverage for 1.3 million New Yorkers earning 0-200% of the FPL. If the Federal government rejects the 1332 waiver recission, GNYHA supports the Executive setting aside resources to provide State-only Medicaid coverage for the Aliessa population as required by the State Constitution. GNYHA has long championed universal health insurance coverage and will work with the State and other stakeholders to advocate for affordable health insurance solutions for individuals losing health coverage because of the HR 1 changes.

ISSUE	EXECUTIVE PROPOSAL SFY 2026–27	GNYHA POSITION
NY State of Health	The proposed budget includes $722 million to operate the NY State of Health. This funding includes support for the implementation of Medicaid Community Engagement needs and eligibility changes related to HR 1.	GNYHA **supports** this proposal.
Prior Authorization and Utilization Review	The proposed budget includes reforms to prior authorization and utilization review processes, such as: • Requiring plans to report, and the Department of Financial Services to annually publish, detailed prior authorization request and outcome data. (Medicare Advantage plans are required to publicly report this information starting in 2026.) • Extending transition of care requirements for patients who enroll in a new managed care plan for which their provider is out of network. Enrollees in an ongoing course of treatment could continue with their existing provider for 90 days regardless of whether they have a life-threatening, degenerative, or disabling disease. Pregnant individuals in any trimester would be entitled to transitional care through post-partum. • Mandating that formulary drug lists be easily accessible to the public • Prohibiting utilization review more than once a year for a course of treatment for a chronic health condition (defined as a condition expected to last at least a year and requiring ongoing treatment to effectively manage or prevent an adverse health event)	GNYHA directionally supports these proposals as part of broader reforms to health plan utilization review processes that are needed to protect patient access to care and coverage. GNYHA has developed a package of proposed legislative changes to the State's utilization review laws that would improve the proposed budget provisions and address additional critical issues related to inappropriate behavior by managed care plans. These include: • Suggestions to expand and improve data collection and analysis related to the proposed budget's plan reporting provisions • Ensuring that transition of care provisions apply broadly to all appropriate insurance products • A broader set of proposals to ensure that utilization review does not interfere with ongoing courses of treatment • Ensuring that the decision-making process for a plan's utilization review meets appropriate standards, including limits on AI and time of review • Prohibiting unilateral policy changes by insurers GNYHA will provide these detailed statutory proposals separately.

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"Cooling Off" Period	The proposed budget changes the State law provisions related to statutorily mandated "cooling off" periods at the termination of contracts between insurers and hospitals by: • Increasing the cooling off period from 60 days to 120 days • Adding language to include hospital-owned provider practices • Removing the distinction between mutual and non-mutual contract terminations (or non-renewals) • Clarifying that the DOH Commissioner can waive this cooling off period for any contract termination if they choose (not just one-sided terminations)	GNYHA **opposes** this proposal. We believe the revisions will shift the balance of network negotiations in favor of plans. We will further study the impacts of this proposal on payer negotiations.
Independent Dispute Resolution (IDR)	The proposed budget removes Medicaid managed care plans from the IDR process and includes the State's employee health benefit plan as an eligible entity. The proposed budget also makes a significant change to the IDR process for all payers and providers covered by the State's IDR law. Current law requires the IDR entity (IDRE) to equally weigh various factors in determining the final payment amount, with no cap on it. This proposal would almost always require the IDRE to default to a payment equivalent to the 50th percentile in-network amount paid by participating providers in that region. The proposed budget makes numerous other process changes to the IDR law, such as to lengthen the timeframe for limiting co-mingling of funds and streamline the payment of awards.	GNYHA is studying the proposal to remove Medicaid plans from the IDR process. We are concerned it could make it harder for hospitals to contract with physician groups to work in emergency rooms, exacerbating severe workforce issues and harming New Yorkers' access to care. GNYHA **strongly opposes** the "allowed benchmark" proposal because it would significantly shift the IDR review in favor of payers. Today, IDREs must consider multiple factors of equal weight. No one factor is determinant. The proposal gives disproportionate weight to the new "allowed benchmark." The proposed plan payment would almost always be closer to the "allowed benchmark," as it is based on plan payments to participating providers. IDREs would not be required to consider additional factors when determining appropriate payment for out-of-network care. Beyond the discrete payments at stake in individual IDR cases, the proposed changes would more broadly disrupt the balance in network contract negotiations in favor of plans. Payers would know they can simply pay

ISSUE	EXECUTIVE PROPOSAL SFY 2026–27	GNYHA POSITION
IDR (continued)		out-of-network providers an in-network rate, which would remove incentives for payers to include hospitals in their networks. GNYHA is also reviewing whether these proposed changes align with the Federal No Surprises Act, particularly in the context of Federal court litigation on the weight given to different elements when determining the final payment amount.
SBHC Carve-Out	Last year's budget carved SBHCs out of Medicaid managed care until April 1, 2026. The proposed budget does not include an extension of this carve-out, nor does it make it permanent. The Governor also recently vetoed a bill that would have made the carve-out permanent.	GNYHA **supports** a permanent SBHC carve-out. Mandatory SBHC participation would impose a costly administrative burden on critical safety net clinics, with little benefit for the children they serve.
MEDICAL LIABILITY		
Excess Insurance	The proposed budget alters the "Section 18" Excess Medical Malpractice Program by requiring physicians and dentists eligible for excess coverage to pay half the cost of premiums.	GNYHA **opposes** this proposal. Many hospitals rely on the Excess Medical Malpractice Program to augment coverage for their physicians. Safety net hospitals, in particular, benefit from this additional layer of protection. GNYHA believes that many physicians would choose not to obtain excess coverage rather than pay half the premium. This would shift liability exposure to hospitals in cases involving hospitals.
Rate of Interest on Judgments	The proposed budget ties the annual rate of interest on certain judgments and accrued claims to the one-year US treasury bill rate rather than the current statutory provision of 9%.	GNYHA **supports** this proposal. It would rationalize awards in lawsuits and mitigate the windfall that plaintiffs currently receive by virtue of the flat 9% statutory interest rate in current law.
Medical Indemnity Fund (MIF)	The proposed budget provides $127 million to keep the MIF open to new enrollments for SFY 2027. To address longer-term financial viability, the proposed budget reforms the provider reimbursement rates from 80% of "usual and customary charges" to the Medicare rate (or if no Medicare rate exists, the Medicaid rate).	GNYHA **supports** both adequate funding for the MIF and reforming reimbursement rates for all providers to ensure the MIF's financial sustainability. Currently, provider rates are significantly more generous than any other rates paid, including commercial rates. These high reimbursement rates, implemented through a 2017 statutory change, have been a significant driver of MIF expenses and the need for additional State financing of the MIF.

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BEHAVIORAL HEALTH		
Targeted Inflationary Increase	The proposed budget provides a one-time 1.7% targeted inflationary increase for eligible mental hygiene and human services programs for SFY 2027.	GNYHA **supports** increased funding for behavioral health and social service providers working with this vulnerable population.
Supportive Housing Investment	The proposed budget invests $71 million in scattered-site and single-room occupancy-supportive housing units for OMH and Office Addiction Services and Supports (OASAS) clients.	GNYHA **supports** this proposal.
Co-Occurring Capable Designation	The proposed budget allows clinics to provide mental health and substance use services under a single jointly issued license. It also proposes the creation of a new Co-Occurring Capable designation for OASAS to help individuals find a provider.	GNYHA **is reviewing the need for this proposal** since OMH, OASAS, and DOH already have an integrated outpatient services (IOS) licensing structure that appropriately addresses the provision of mental health, substance use, and physical health services. A new Co-occurring Capable designation is redundant to the existing IOS and does not include medical services provided under DOH oversight. The proposal could perpetuate fragmented care and create additional and unnecessary licensing and regulatory requirements for providers seeking to provide integrated care.
Pain Management and Drug Control Strategy	The proposed budget directs DOH to develop a comprehensive Pain Management and Drug Control Strategy to prevent opioid misuse and treatment, strengthen prescription oversight, and promote best practices in pain management.	GNYHA **is reviewing the need for this proposal.** Existing requirements include mandatory continuing medical education and Internet System for Tracking Over-Prescribing (I-STOP) statutory requirements for prescribers to access the State's prescription monitoring program before prescribing controlled substances.
REGULATORY		
Certificate of Need (CON)	The proposed budget transforms the CON process via an $11 million multi-year investment to establish a new "NYSE-CON" online system. The State recognizes that the current CON process has become burdensome and inefficient over time. The reforms would add new performance metrics, streamline the review process for efficiencies, and transform the regulatory process. This is an administrative proposal.	GNYHA **supports** this proposal and long advocated for streamlining the CON and related health planning and oversight processes.

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Protection of Sensitive Locations from Civil Immigration Enforcement	The proposed budget includes legislation to prohibit sensitive locations that are owned or operated by a State or local governmental entity or public authority (including public hospitals) from allowing civil immigration enforcement authorities access to non-public areas of their facilities without a judicial warrant. Sensitive locations that are privately owned (including private hospitals) would be empowered to adopt the same position if they choose without liability under State law.	GNYHA is **studying** this proposal.
Health Care Reform Act (HCRA)	The proposed budget extends for three years (through March 31, 2029) the provisions of HCRA that expire this year.	GNYHA **supports** this proposal.
Pharmaceuticals	The proposed budget directs DOH to negotiate with manufacturers the prices on certain high-cost drugs to produce savings for the Medicaid program. This is an administrative proposal.	GNYHA **supports** this proposal.
Oversight of Health Care Transactions	The proposed budget requires parties to certain transactions to disclose information about other health care ownership and operations interests and whether the transaction includes sale-leaseback or real estate–related components. The proposed budget also requires annual reporting to DOH—for five years after closing—on the transition's impacts on cost, quality, access, health equity, and competition and allow DOH to conduct a preliminary review of all proposed transactions, with discretion to conduct a full-cost and market impact review under certain circumstances. In addition, it gives DOH the power to delay closing up to 180 days from the date DOH completes its preliminary review. While the proposal includes certain confidentiality provisions, it would allow DOH and the Attorney General's office to use information	GNYHA is **studying** this proposal.

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Oversight of Health Care Transactions (continued)	and findings from the preliminary review as evidence in other reviews and actions, including CON applications by the same parties.	
Artificial Intelligence (AI)	The proposed budget includes initiatives to support the adoption of ethical and emerging AI technology within DOH and across health care. The proposed budget also directs DOH to convene a new consortium of health care and AI experts to share data and best practices and strengthen the use of AI in health care delivery. In addition, it incentivizes partnerships between safety net hospitals and other health care institutions to ensure equitable access to AI solutions.	Careful consideration must be given prior to creating new policies and regulatory standards that could either accelerate or hamper adoption of important new tools, particularly in health care settings. GNYHA will evaluate these initiatives and engage with this consortium to ensure that hospitals are appropriately represented in crafting new AI initiatives and policies.
End-of-Life Care	The proposed budget directs DOH to launch an awareness initiative to inform providers and staff about options for community-based palliative and hospice care to encourage their appropriate use. This is an administrative proposal.	GNYHA **supports** this proposal.
MATERNAL AND REPRODUCTIVE HEALTH		
Abortion-Related Services	The proposed budget gives providers $20 million for enhanced reimbursement of abortion-related services. It also continues the $25 million from last year to support reproductive health providers and critical support programs to ensure equitable access.	GNYHA **supports** this proposal.
Reproductive Freedom and Equity Grant Fund	The proposed budget includes $25 million to continue supporting reproductive health providers and critical support programs to ensure equitable access to abortion care across the State.	GNYHA **supports** this proposal.

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Sexual Offense Evidence Collection	The proposed budget amends the retention period for sexual offense evidence, extending it from 20 years after collection to 20 years after collection or the survivor's 40th birthday, whichever is later. The proposed budget also strengthens survivor notification and consent rights, expands autonomy for certain minors, and clarifies the definition of reported kits.	GNYHA is **studying** the operational impacts of these proposals.
EMERGENCY MEDICAL SERVICES		
Emergency Medical Services (EMS)	The proposed budget extends mobile-integrated and community paramedicine programs for existing EMS providers to include new EMS agencies. It also authorizes EMS to administer vaccines ordered by a physician or NP.	GNYHA **supports** these proposals.