Testimony of the New York Health Plan Association

to the

Senate Finance Committee
and the Assembly Ways & Means Committee

on the subject of

2026-27 Executive Budget Proposals on Health Care

February 10, 2026

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 20 health plans that provide comprehensive health care services to more than eight million fully-insured New Yorkers, appreciates the opportunity to present its members' views on the Governor's budget proposals.

HPA members include plans that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), public health plans (PHPs) and managed long-term care (MLTC) plans. The New Yorkers who rely on these plans are enrolled through employers, as individuals, or through government sponsored programs — Medicaid managed care, Child Health Plus — and through New York's exchange, the NY State of Health (NYSOH).

Our member health plans have been consistent and reliable partners with the state in achieving its health care goals. These partnerships include collaborating on efforts to develop affordable coverage options for individuals, families and small businesses, providing access to care that exceeds national quality benchmarks for both commercial and government program enrollees, and improving access to quality care in its government programs. Plans have also supported and participated in New York's ongoing efforts to address and eliminate long-standing racial and ethnic disparities, working on multi-faceted strategies to build an equitable health care system. Plans have strongly supported the state's Medicaid 1115 Health Equity Reform waiver, which invests significant resources into efforts to eliminate disparities, and in which plans have a major role, working closely with social care networks. This waiver is set to end in March of 2027, however, HPA's members remain committed to continuing to work with policy makers and lawmakers to further the efforts to promote health care equity and ensure the availability of high quality, affordable health care for all New York consumers and employers.

For the past three decades, New York's managed care plans have been partners with the State, establishing and growing the extremely successful Medicaid managed care program, working together to expand coverage, increase access and improve quality of care. With plans' leadership, New York's Medicaid managed care program routinely meets or exceeds the

national average on quality measures and improving patient satisfaction. Today, nearly five million of New York's Medicaid beneficiaries — approximately 73% — receive their care through a Medicaid managed care plan.

We recognize the damaging impact that deep cuts in federal funding will have on New York's Medicaid program and the state budget as a result of H.R. 1. In addition to tackling the fiscal impact of the cuts, there is the task of operationalizing the changes that will result from H.R.1 to ensure people remain covered. HPA and our members remain committed to working with the state along with consumers, our partners in the delivery system, the business community, and local government on these implementation challenges to protect, preserve, and strengthen New York's Medicaid program.

New York's health care costs are among the nation's highest and affordability is the most pressing health care issue for individuals, families and employers. We appreciate Governor Hochul's focus on protecting and expanding access to quality, affordable health coverage and the Executive Budget takes a measured approach to maintaining stability for the health care system. Our specific comments on these and other Executive Budget proposals, and HPA's requests related to them, are as follows:

Support: Maintaining Coverage Through Investment in the Essential Plan (EP)

As a result of the loss of a portion of the premium tax credit funding due to H.R.1, the state applied to the Centers for Medicare and Medicaid Services (CMS) to end its 1332 waiver and revert to funding the EP pursuant to the Affordable Care Act (ACA) section 1331. This was intended to preserve the funding needed to cover individuals up to 200% of the federal poverty level (FPL). If CMS rejects the state's application, 780,000 individuals will lose EP coverage. Since the FY27 Executive Budget was released, CMS issued a Final Rule related to the MCO tax, allowing the state to continue the tax through calendar year 2026, nine months longer than expected generating additional revenue of approximately $1 billion for the upcoming year. **We urge the Legislature to allocate a portion of this funding to keep as many EP-eligible individuals covered as possible. Maintaining insurance coverage for**

these individuals will also provide more revenue to the providers who serve them because it will reduce uncompensated care.

Support: Funding for the Medicaid Quality Incentive (QI) Program

We were pleased to see that Governor Hochul's Executive Budget included funding for New York's Quality Incentive (QI) Program. This program has been vital in enhancing the quality of care for individuals in Medicaid, supporting a broad range of initiatives between health plans and their provider partners to address racial and ethnic disparities in care and improve health outcomes for underserved populations across the state. Sustainable funding is critical to building on these efforts — especially given the federal cuts and measures aimed at eliminating health-related social needs programs. We urge your continued support and further investment in the FY27 budget to fully fund the program.

The Executive Budget provides $50 million state share funding for the Mainstream Medicaid Quality Incentive Program. Given the federal government's approval of the MCO tax through the end of 2026, providing approximately $1 billion in extra revenue to New York —revenues that were paid by MCOs and their customers —we ask the Legislature to provide $300 million state share in the final FY27 budget for the QI Program.

This program, which has been in place for more than two decades, has a proven track record of improving the quality of care for the Medicaid population and helping to address the social factors that create barriers to equitable care for residents.

Initiatives supported by the QI Program include:

- Screening for post-natal depression and connecting these mothers with therapy as well as other health services and social supports in New York City;
- Providing diabetes management tools and education to help high risk, non-compliant patients lower their A1C levels and improve medication adherence;
- Assisting homeless members with a history of long-term substance abuse to successfully maintain sobriety, manage their medical care, avoid inpatient treatment, and help them secure housing in the Bronx; and

- Providing a pediatric practice on Long Island with resources that allowed them to extend office hours to make care available in evenings and on weekends for working families, and to be open extra days for immunizing patients who fall behind on their schedules, as well as investing in reminder systems to improve compliance with well care visits and disease screenings, education for medication compliance and hospitalization prevention.

Quality funding is directly invested back into the community, with plans using QI Program dollars to partner with providers and community organizations on programs that benefit low-income New Yorkers. The success of the programs that receive funding is closely monitored and health plans are measured on performance metrics that the State sets. Plans only receive incentive funding for achieving results that meet or exceed these metrics.

We appreciate that the Legislature has consistently supported this program by including funding in the final budget to sustain the vital services of the QI Program. **Increasing the proposed funding in the FY27 budget to $300 million will help preserve and enhance these critical programs and maintain the ongoing efforts to eliminate disparities and deliver high-quality, equitable care to the state's most vulnerable residents.**

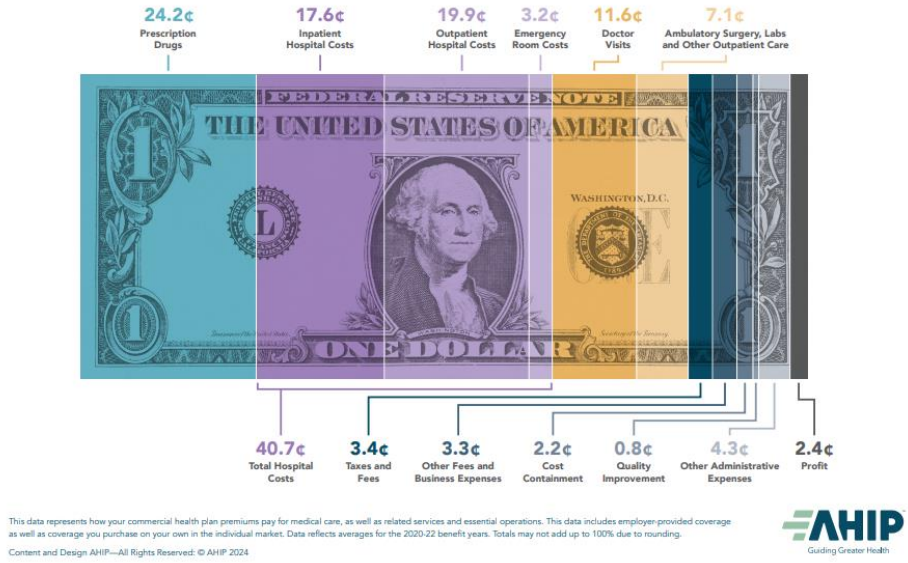
Additionally, to ensure continued progress on improving equity, eliminating disparities and incentivize ongoing health care reforms, it is imperative that the QI Program be adequately and consistently funded. Codifying this program in statute would be an important step to protect the QI Program and initiatives it supports. **HPA strongly encourages the inclusion of legislation (S.6266/A.2044) in each house's one-house budget proposals to establish the Medicaid QI Program in statute.**

ADDRESSING RUNAWAY PROVIDER PRICES

U.S. health care spending grew by 7.2% in 2024, hitting $5.3 trillion, according to the January 2026 National Health Expenditure annual report from the Centers on Medicare and Medicaid Services. This marked the second straight year in which health spending increased

more than 7%. Per capita spending in New York remains among the highest in the country and 37% higher than the national average.

Health insurance premiums are a direct reflection of the cost of care. Nationally, hospital costs account for over 40 cents of the dollar and nearly 19 cents is spent on doctor visits, lab work and other outpatient care. Hospitals and other providers continue to demand significant price increases at a time when New York's inpatient hospital prices are the third highest in the country. Policy measures to address these factors is critical to make health care more affordable for New Yorkers.



The Executive Budget includes several sensible solutions – including changes to the state's No Surprises Act and Independent Dispute Resolution (IDR) process – to address excessive provider pricing practices and contain the cost of care for consumers and families, employers, and taxpayers.

Support: Excluding Medicaid from the IDR Process

Part T of the Public Protection and General Government Article VII bill would exempt Medicaid from the IDR process. The process is intended to protect patients when there is an out-of-network emergency service or a surprise bill from a nonparticipating provider and resolve disputes between a provider and health plan over whether the provider's fee or the health plan's payment is more reasonable.

Exempting Medicaid from the IDR process is appropriate for two reasons. First, members are already protected from balance bills when out-of-network reimbursement disputes arise. Second, when a nonparticipating provider uses the IDR process for a Medicaid member, it can result in significantly higher costs than what Medicaid pays for services, enabling providers to increase their reimbursement at the expense of taxpayers. This is because in determining whether the provider's billed charges or the plan's Medicaid rate is more reasonable, the entity reviewing the dispute compares the two rates to the 80th percentile of the rate paid for the service according to FAIR Health. When the provider's billed charges are closer to the FAIR Health rate than the Medicaid rates, the existing statutory setup has the result of driving the decision to choose the provider's billed charges as more reasonable, as the current process does not take into account differences in payments between commercial and Medicaid payors.

Providers utilizing the IDR process often are not primary care physicians but rather those in high cost specialties such as neurology/neurosurgery, orthopedics/ortho surgery, anesthesiology, cardiology, and thoracic surgery. The current structure has created a loophole that these providers are using to exploit the Medicaid system, incentivizing high priced providers to remain out-of-network to charge exorbitantly higher rates, while providing no benefit to patients and increasing costs for taxpayers. New York should not allow providers to intentionally stay out-of-network and then refuse the Medicaid rate. If these providers have issues with the rates Medicaid reimburses, they should seek other solutions and not misuse state law to get paid more.

CASE STUDY

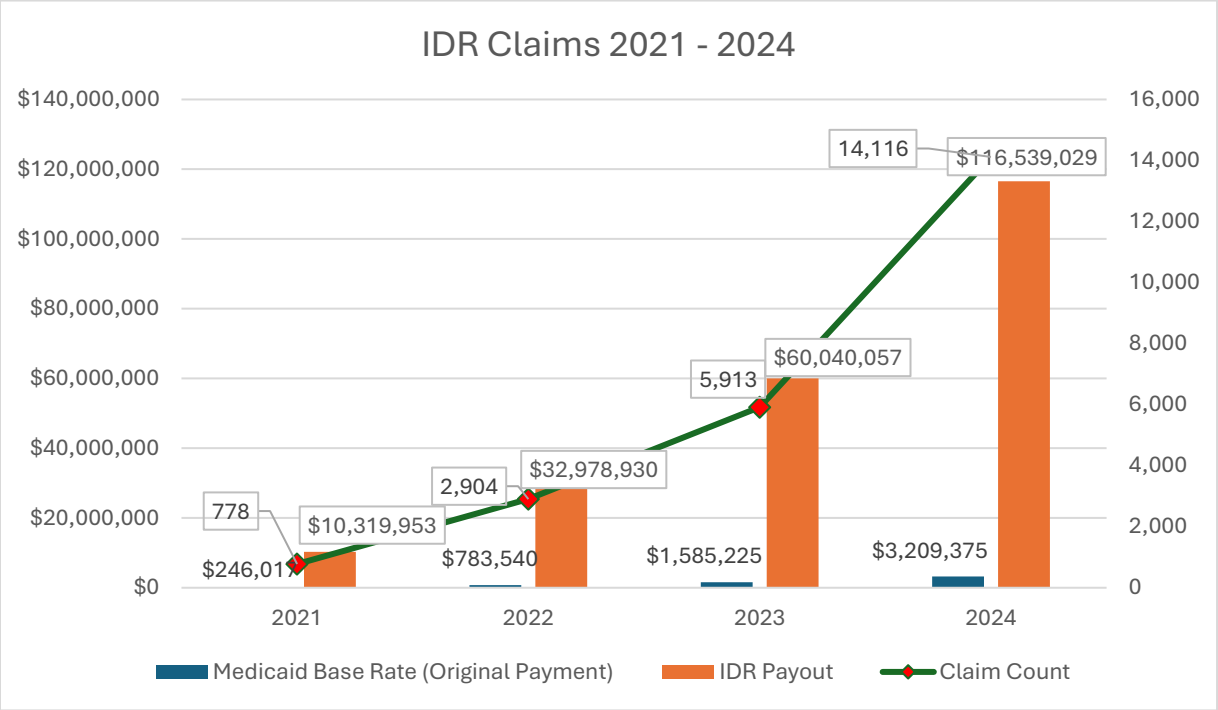
Medicaid member was admitted to a downstate, nonparticipating facility for emergency back surgery. Surgery was performed by an out-of-network provider. Because of the nonparticipating status of both the facility and the provider, the plan paid the provider's claim at 100% of the Medicaid fee schedule, but the provider disputed the reimbursement rate, submitting a bill more than 200 times higher than the Medicaid rate.

- **Provider's Billed Charges:** $566,319
- **Medicaid Paid Amount:** $2,807
- **80th Percentile Fair Health:** $357,489

The IDR rendered a decision that the provider was owed an additional payment of $511,396.

- **Final Judgment Award Amount:** $514,169, with the plan required to pay this amount despite the charges being well in excess of the amount Medicaid reimburses for this procedure.

According to data collected from health plans covering more than 91% of the Mainstream Medicaid program, in 2024 IDR payouts to providers totaled $116.5 million, compared to $3.2 million that Medicaid would have reimbursed for the same services without the IDR process. Exempting Medicaid from the process would have saved the state more than $100 million. Additionally, the number of Medicaid claims providers submitted to the IDR process has grown from 778 in 2021 to more than 14,000 in 2024 – an increase of more than 1,700%.



Part T would be an important step to rein in Medicaid spending, providing savings for the state and taxpayers, while ensuring vulnerable New Yorkers have access to critical services, and we urge its inclusion in the final enacted budget.

Support: Updating the State's No Surprises Act

Part T of the Public Protection and General Government Article VII bill also proposes changes to the state's No Surprises Act. Proposed reforms to the law include redefining the benchmark for payment disputes and establishing a cap on payments. The Executive's support memo notes, "Current law requires arbitrators to consider usual and customary charges, defined as the 80th percentile of charges for health care services…" which results in "significant and consistent upward cost pressures, as providers are free to set initial charges at

whatever level they wish." The provision will help to protect consumers and employers from out-of-network providers charging excessive prices and is an important step to make health care more affordable for New Yorkers. **We urge the Legislature to adopt this proposal in the final enacted budget.**

OPPOSE: NEW REPORTING REQUIREMENTS AND RESTRICTIONS ON UTILIZATION REVIEW (UR)

Part HH, of the Transportation, Economic Development and Environmental Conservation bill would impose new reporting requirements for adverse determinations (Subpart A), extend current statutory continuity of care provisions for ongoing treatment and pregnancy (Subpart B), mandate publication of plans' drug formularies (Subpart C), and prohibit utilization review (UR) for chronic conditions to no more than once per year (Subpart D).

Medical management tools, such as utilization review (UR), prior authorization (PA) and other reporting requirements, provide a vital check to ensure patients receive safe, evidence-based care and to reduce low-value and inappropriate services so that coverage is as affordable as possible. Low-value care significantly impacts the U.S. healthcare system, and more importantly, low-value care impacts patients by exposing them to harm and additional out-of-pocket healthcare costs, and many experts agree that up to 25% of care is wasteful at best and harmful at worst.

When developing prior authorization policies, health plans review information on the use of inappropriate treatments, practice variation for specific services, the extent to which providers deliver care consistent with evidence, safety concerns, and other relevant factors to determine what services or drugs should be subject to prior authorization. Health plans regularly review the medical services and prescription drugs that are subject to prior authorization and make changes based on new evidence, adherence to recognized standards of care, or, in the case of new and emerging therapies, limited available evidence or safety concerns. These reviews are conducted by Pharmacy and Therapeutics committees that include independent community physicians and pharmacists with relevant clinical expertise.

Our industry has taken steps to streamline and simplify the prior authorization (PA) process for patients and providers, which is utilized very selectively. Most claims do not require a review and, for those that do, the vast majority of prior authorization requests are approved. Data from 2024 found 96% of claims for prescription medications and 93% of claims for medical services do not require prior authorization, and of those subject to review, the average final approval rates for commercial health plans are 90% for prescription medications and 97% for medical services.

Subpart D would prohibit UR for chronic conditions to no more than once per year. Utilization review is a critical safeguard to ensure patients receive care that is backed by sound clinical evidence and best practices, and helps to ensure that providers follow nationally recognized care guidelines.

Limiting UR to an annual authorization would fail to capture shifts in treatment plans or changes in an individual's condition and delay interventions when services no longer provide clinical value. Further, it would limit the ability to detect aberrant billing patterns or inappropriate utilization, increasing the potential for fraud and requiring coverage of services that may no longer be effective or clinically appropriate.

We are committed to continuing to work collaboratively on efforts that seek to ensure patients can more quickly access the care they need while also minimizing administrative requirements on providers. However, it is vital that any changes result in reducing low-value and inappropriate services and don't increase costs for employers and consumers.

Rather than imposing timeframe restrictions on UR that will undermine quality and care coordination and lead to higher costs, the Legislature should adopt A.2348/S.5456, which would require providers to share health information with health plans via electronic medical records (EMRs). This is a simple, common-sense solution that would facilitate the exchange of information between health plans and providers. While providers frequently cite prior authorization as an administrative "burden," many continue to submit PA requests manually despite the growing availability of electronic tools. Requiring EMR access would reduce

administrative complexity, cost and waiting time for patients. **The Legislature should reject Part HH, Subpart D and adopt A.2348/S.5456**.

Subpart A would require additional reporting of adverse determinations. Plans currently collect and submit extensive data to DFS quarterly and annually, with information on claims received, claims paid, and claims denied and the reasons for denials, which is available to the public on the DFS website. According to the data, the majority of denials are due to provider mistakes such as coding errors, duplicate submission and untimely filing. Less than one percent of claims are rejected on medical necessity criteria. **Given the amount of information currently reported, the provision is unnecessary.**

Subpart C would mandate publication of health plans' drug formularies to their websites. **Health plans already make this information available as required under both state and federal law, making this provision unnecessary**.

Subpart B would extend continuity of care for ongoing treatment and pregnancy. This proposal in the Governor's budget extends a transitional period of coverage between health plans to allow patients to pursue an ongoing treatment with the insured's current healthcare provider from 60 to 90 days and extends this transitional period to the duration of the pregnancy and postpartum care for pregnant patients. **We believe this provision is unnecessary**.

Changes Suggested: Health Plan/Hospital "Cooling Off" Provisions

Part M of the Public Protection and General Government Article VII bill would extend the current "cooling off period" of two months to 120 days. It would also eliminate the ability to waive the cooling off period if both parties mutually agree and give the Commissioner (or Superintendent) the ability to review and approve any correspondence, publication or communication from the hospital or health plan to its members. While plans do not oppose

extending continuity of care to 120 days, the ability of a health plan and hospital to agree to forego the "cooling off" period should be maintained. There could be various reasons hospitals and health plans may choose to waive this period, such as aligning with Medicare requirements. Such alignment can minimize confusion for consumers. Additionally, member communications may also be tailored to specific member populations. Given the dynamic nature of contracting negotiations, health plans need to remain agile in the ability to modify and adjust communications to members. Adding a level of bureaucratic review and oversight for all such communications could impede resolution of negotiations **We urge the Legislature to reject these two changes**.

Unnecessary: Mandated Coverage for Gambling Addiction Services

Part R of the Health and Mental Hygiene bill would require commercial insurance policies to include coverage for the diagnosis and treatment of substance-related and addictive disorders, including detoxification and rehabilitation services. As the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) recognizes gambling addiction, health plans are already covering these services as part of the state's Mental Health Parity Law, **Part R is unnecessary**.

CONCLUSION

We thank you for the opportunity to share our views today and look forward to continued discussions with you and your colleagues on these and other health care related provisions in the FY27 state budget.