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Medicaid spending is too high and rising too fast

For the fourth year in a row, the governor has used the word "unsustainable" to describe the growth rate of her own Medicaid budget.

It's hard to dispute that assessment.

Since 2022, the state share of Medicaid has soared by 60 percent, or roughly five times the inflation rate. That increase amounts to an additional $16 billion per year on top of what was already the highest per capita Medicaid spending in the U.S.

With federal aid included, total Medicaid spending is up by $28 billion annually.

The executive proposal would continue the unsustainable upward trend, increasing the state share by another $4.3 billion or 10 percent, almost four times the rate of inflation.

This raises the question of what those additional tens of billions are buying for the people of New York.

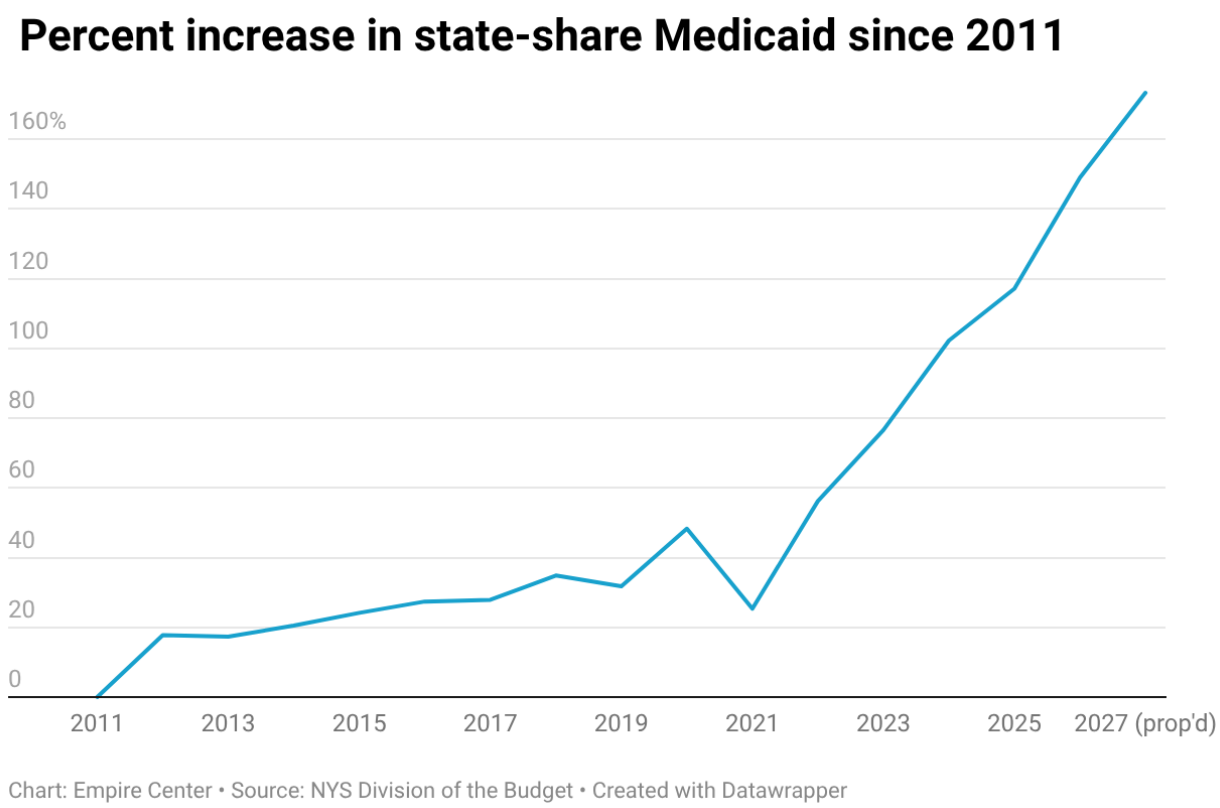
It's not more coverage or better quality. Enrollment is down compared to four years ago, and the average Medicaid rating for New York hospitals, at 2.5 of 5 stars, ranks 48th among the 50 states.

Instead of simply pouring more tax dollars into an already well-funded health care industry, the state's leaders should be looking for ways to constrain Medicaid costs and achieve better value for consumers.

Federal funding for Medicaid is going up, not down

Last summer's federal budget legislation has not yet resulted in the catastrophic loss of funding for New York's Medicaid program that was predicted by some. To the contrary, the federal share of Medicaid proper is projected to go up by $3 billion or 5 percent in fiscal 2027.

This is because Medicaid's open-ended matching system, in which the federal government pays 50 percent or more of New York's costs, remains largely unchanged.



In future years, the state is likely to lose federal funding due to Washington's newly enacted community engagement rule, which requires most non-disabled adults to do a minimum amount of paid work, education or community volunteering to stay on Medicaid. However, that funding loss would go along with a decline in enrollment that would result in savings for the state budget.

The state is also likely to see a rise in its uninsured population, which would create pressure to compensate hospitals and other providers for their added charity care expenses.

However, these parts of the federal legislation have not yet taken effect and their financial impact on the health-care system remains to be seen. State lawmakers should resist any proposal to offset federal cuts until they have a clearer idea what those cuts will be.

The executive makes questionable assumptions about the Essential Plan

One health program that does stand to lose substantial federal funding is the Essential Plan, because its enrollment includes hundreds of thousands of legally present immigrants who are no longer eligible for federal subsidies.

In response, the Hochul administration has requested federal permission to cancel the waiver under which the Essential Plan now operates and return it to its original status as a "basic health program" under the Affordable Care Act. Officials hope this maneuver would allow the state to use an accumulated surplus of some $9 billion to continue coverage for some 500,000 immigrants it is obliged to cover under a 2001 court ruling.

At the same time, the maneuver would entail lowering the plan's eligibility ceiling from 250 percent to 200 percent of the poverty level, leaving some 400,000 enrollees to find other coverage through an employer or the state's insurance exchange.

Although this application is pending in Washington, the executive budget does not explain how the revised program would fit into the state's financial plan. Nor does it explore the costs and benefits of continuing the Essential Plan under the existing waiver, albeit without its immigrant enrollees and the revenue they have drawn.

Instead, puzzlingly, the executive budget assumes CMS will reject the state's application and that the Essential Plan will shut down altogether as of July 1.

This would mean abruptly ending coverage for more than 1 million enrollees and turning down the federal aid that would still be available, which would amount to several billion dollars.

While there's a case to be made that the Essential Plan has distorted New York's commercial insurance market and should be scaled back, its enrollees deserve fair warning that their coverage will disappear in a matter of months. Also, the executive should be giving the Legislature and the public a full accounting of the costs and benefits of continuing the plan, with or without the redesign officials have requested.

More transparency is needed on home care

The Hochul administration has declared that its disruptive overhaul of the Consumer Directed Personal Assistance Program has saved the state $1.2 billion, or more than double its original estimate.

However, that number has little meaning without further context.

Does it mean that total spending on CDPAP, which was said to be $11 billion in 2024, has gone down? Does it factor in the tens of thousands of enrollees who shifted from CDPAP to agency-based home care, which tends to be more expensive? Does it focus only on administrative fees the Health Department pays directly to the statewide contractor, Public Partnerships Limited, or does it also account for the higher reimbursements PPL has demanded from Medicaid managed long-term care plans?

Given the disruption caused by this overhaul, a fuller accounting of its fiscal impact is warranted.

One encouraging sign is that overall enrollment in Medicaid managed long-term care – which had been rising at double-digit percentages for most of the past decade – appears to have begun declining shortly after the statewide contract took effect.

The Health Department should provide its best assessment of which recipients left and why. Is this a case of new management squeezing out waste, fraud and abuse, or have truly needy people – whom the program is meant to serve – fallen through the cracks?

The state should wean itself off the HCRA taxes on insurance

The executive budget includes a three-year extension of health insurance taxes levied under the Health Care Reform Act, which were first imposed 30 years ago and would otherwise expire in March.

These two taxes – the payor surcharge and the covered lives assessment – are expected to cost consumers and businesses $6.6 billion in fiscal 2027. They add hundreds of dollars a year to the typical family premium, which is part of the reason New York's premiums are among the highest in the U.S.

The revenue raised – originally earmarked to finance so-called public goods such as charity care and physician training – now flows mostly into the Medicaid budget.

Making health insurance less affordable has never been a good way to move the state toward universal coverage. The HCRA surcharges are also, in part, a "provider tax," a scheme for maximizing Medicaid funding that faces a crackdown in Washington.

Rather than simply extending the status quo, lawmakers should take this opportunity to begin phasing them out – and make insurance more affordable in the bargain.

Handle the MCO tax responsibly

Another provider tax issue in this year's budget is the recently enacted surcharge on managed care organizations, or MCOs. This tax applies far more heavily to Medicaid MCOs than to commercial MCOs as part of a strategy to extract billions in extra funding from Washington.

State officials have known from the beginning that this tactic, which exploits a loophole in federal regulations, would be shut down by federal regulators in a matter of a year or two. The executive budget assumes that the revenue will stop after March 2026, but it was recently reported that federal officials would allow it to continue through the end of the calendar year – which is worth an extra $1 billion.

Regardless of the precise amount, none of this temporary cash flow should be used to pay for continuing expenses – which would create a budget hole to be filled when the money runs out.

The executive budget allocates a portion of the MCO tax proceeds to increase Medicaid fees to hospitals, nursing homes, physicians and clinics. That is the wrong way to go. Although these increases would be theoretically temporary, lawmakers would inevitably come under pressure to continue them in future years.

Instead, these one-time revenues should be allocated to one-time expenses such as capital investments – ideally investments that make the health-care system more efficient in the long term.

The state should reform its "scope of practice" regulations

The executive budget includes constructive proposals to loosen the "scope of practice" restrictions on physician assistants, nurse practitioners and other provider types, allowing these professionals to handle more of the tasks they were trained to do and to work with more independence.

By shifting more care delivery to lower-paid providers, these overdue reforms would both save money and improve access to care.

In general, the more flexibility the state allows on scope of practice, the better things will be for consumers.