African Services Committee • Center for Independence of the Disabled NY • Children's Defense Fund-New York
Coalition for Asian American Children and Families • Community Service Society of New York
Consumers Union • Empire Justice Center • Entertainment Community Fund • Hispanic Federation
Hospital Equity and Accountability Project • The Legal Aid Society • Make the Road New York
Medicare Rights Center • Metro New York Health Care for All Campaign • New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York • Raising Women's Voices-New York
Schuyler Center for Analysis and Advocacy • South Asian Council for Social Services • Young Invincibles

February 6, 2026

Testimony of the Health Care for All New York Campaign
on the
Proposed Executive FY27 Health and Mental Hygiene Budget

Health Care for All New York (HCFANY) would like to thank the Chairs and Members of the Senate Finance and the Assembly Ways and Means Committees for providing an opportunity to provide public comment on the State Budget proposal. HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers.

The enactment of H.R. 1 will result in draconian changes to eligibility and funding for health insurance, causing an estimated 1.7 million New Yorkers to lose their coverage. HCFANY urges the State to use the FY27 budget to mitigate the harm of H.R. 1 and keep as many New Yorkers enrolled in health coverage as possible.

Fortunately, New York State has several revenue sources that can help mitigate the worst-case scenarios triggered by H.R. 1. These sources should be committed to a "coverage lock box" to protect New Yorkers losing coverage.

First, the Executive Budget has conservatively assumed that the State will need to provide State-only funded Medicaid to the Aliessa population, or to State residents with lawfully present immigration status. Assuming the State successfully returns to operating its Essential Plan (EP) program under the federal Basic Health Program (BHP) authority, this would free up approximately $3.9 billion. Second, the State has recently been awarded a delay in the Managed Care Organization (MCO) tax, which will generate another $1 billion in revenue. Together, this $4.9 billion in found resources should be set aside in New York's "coverage lock box" to fund quality, affordable health coverage for those targeted to lose it.

To this end, HCFANY has the following three categories of recommendations to offer to the State Legislature: (I) protect and improve health coverage; (II) regulate prices to create a more affordable health care system for New Yorkers; and (III) robustly fund consumer assistance and enrollment programs and increase Article 6 funding to help New Yorkers navigate new complex hurdles.

Our detailed comments are offered below.

I. Protect and improve health insurance coverage.

HCFANY urges the Legislature to ensure the final budget protects and improves New Yorkers' access to health insurance coverage. The Executive Budget could be improved to mitigate coverage losses resulting from H.R. 1. It also includes several components to improve health insurance coverage, as described below.

HCFANY has recommendations in the following areas: (1) stemming insurance coverage losses for citizens and lawful immigrants; (2) proposals related to Managed Care; (3) amendments to the emergency medical services and Surprise Bills law; (4) reforms to Prior Authorization; and (5) enacting the New York Health Act.

Specifically, among reforms to Prior Authorization (4), the Executive Budget proposes to expand the Consumer Guide, which is issued annually. HCFANY noted in its 2025-26 rate review comments that **this "Consumer Guide" excludes 80 percent of the individual market**. The legislature should ensure that all plans are included in the Guide along with the proposed further expansions.

1. Stem insurance coverage losses for citizens and lawful immigrants as a result of H.R. 1 (not included in FY27 Executive Budget).

The enactment of H.R. 1 will cause significant disruptions to federal funding for lawful immigrant enrollment, including substantial eligibility cuts, prompting New York to phase out its 1332 Waiver program and revert to operating a 1331 BHP.[1]

The FY27 Executive Budget was developed under the prudent assumption that the State's request to roll back the 1332 waiver and return to the Section 1331 BHP will be denied by the Center for Medicare and Medicaid Services (CMS). As a result, the FY27 Executive Budget allocates $3.89 million in new Medicaid spending to cover lawful immigrants currently enrolled in the EP who are newly ineligible for federal financial participation.[2] In 2001, in *Aliessa v. Novello*, the New York State Court of Appeals ruled that the State must provide coverage, as part of its duty to care for the needy, to low-income immigrants who are otherwise Permanently Residing Under Color of Law (PRUCOL). As a result of the *Aliessa* case, the State must make up cuts to federal funding for lawful immigrants who are newly ineligible, hence the FY27 budget allocation.

While a return to BHP will allow 609,000 lawfully present immigrants to retain EP coverage, H.R. 1 will still eliminate coverage for approximately 480,000 New Yorkers,

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[1] Draft Submission to the Centers for Medicare and Medicaid Services (CMS): New York State's Request to Terminate the Section 1332 State Innovation Waiver and Return to the Basic Health Program. 2025. https://info.nystateofhealth.ny.gov/sites/default/files/Draft%20Notice%20to%20CMS_Request%20to%20Terminate%201332%20and%20Transition%20to%201331.pdf

[2] Financial Plan, NYS FY27 Executive Budget. Page 17. https://www.budget.ny.gov/pubs/archive/fy27/ex/fp/fy27fp-ex.pdf.

including: (1) 444,000 EP enrollees (citizens and immigrants) with incomes between 200-250 percent of the Federal Poverty Level (FPL); (2) 6,000 individuals with Deferred Action for Childhood Arrival (DACA) immigration status or residual PRUCOLs; and 30,000 lawfully present immigrants with incomes over 200 percent of the FPL.

Assuming New York's return to a BHP is approved, there are three options that the State can take to provide coverage for these three groups:

- Offer State-only funded EP coverage to the 444,000 New Yorkers expected to lose EP eligibility in July 2026. Six-month coverage with no premium would cost between $960 million and $1.7 billion, depending on the premium rate level set. If a modest $50 premium is levied, this option would cost between $710 and $943 million per year, depending on the premium rate level set.

- Offer State-only funded EP to the 6,000 DACA and other residual PRUCOL immigrants with incomes between 138-200 percent of the FPL. This would cost the State between $29 and $50 million per year, depending on the level of the EP premium rates.

- Create a State-only funded premium assistance program to make Qualified Health Plans (QHPs) equally affordable for 30,000 lawfully present immigrants, like the State does for their citizen counterparts. This would cost $244 million per year, beginning in 2027.

A full description of these options can be found in the Community Service Society's February 2026 report: *Mitigating the Impact of HR 1 on New York's Health Insurance Landscape: Four Policy Proposals to Preserve Coverage.*

2. Proposals related to Managed Care (HMH Article VII, Part M).

The FY27 Executive Budget includes several changes related to managed care, including: the repeal of continuous coverage for children, amendments to the EP benefit package, and termination of presumptive eligibility for immigrants and children. HCFANY makes the following recommendations regarding these provisions:

Delay the repeal of continuous coverage for children up to age six. The FY27 Executive Budget repeals the State's continuous coverage program for children up to age six, effective July 1, 2026.[3] Currently, continuous coverage for children is authorized under the State's Medicaid 1115 Waiver, which expires on March 31, 2027.[4] New federal rules indicate that the federal government will not reauthorize children's continuous coverage – used by a dozen states – as their Waivers expire. The Legislature should delay the repeal to the last possible

[3] FY27 Executive Budget, HMH Article VII, Part M, Sections 13, 14, and 15.
[4] 1115 Waiver, New York Medicaid Redesign Team. https://www.health.ny.gov/health_care/medicaid/redesign/1115_waiver/.

moment, or at the very least until January 1, 2027, to ensure a smooth transition for these children.

Amend the Essential Plan benefit package. The FY27 Executive Budget amends the definition of health care services to be provided by a BHP in Section 369-gg(c) of the Social Services Law.[5] Specifically, it requires the Commissioner of Health to set the benefits to include Essential Health Benefits, effectively adding vision, dental, and access to all cancer care centers in the area. This section of the HMH Article VII bill removes long-term services and supports from the definition of health care services to be provided by a BHP, thereby extending the period during which the BHP trust fund can be used to provide coverage and offset federal cuts. HCFANY supports all these changes to the Essential Plan benefit package.

Terminate presumptive eligibility for immigrants and children. The FY27 Executive Budget eliminates presumptive eligibility for pregnant women and children.[6] Since the New York State of Health Marketplace was launched, this process is no longer used by consumers. Accordingly, HCFANY does not oppose its repeal.

3. Amendments to the Emergency Medical Services and Surprise Bills law (PPGG Article VII, Part T).

The Executive Budget seeks to strip consumer protection for Medicaid beneficiaries under New York's landmark surprise billing legislation. HCFANY urges the Legislature to reject any effort to treat Medicaid beneficiaries less advantageously than other New Yorkers.

HCFANY has no objection to extending the Surprise Bills law to Empire Plan enrollees or to cap the amount of fees awarded under the Independent Dispute Resolution process.

4. Reforms to Prior Authorization (TED Article VII, Part HH).

The FY27 Executive Budget includes a series of reforms to prior authorization, continuity of care, formulary disclosures, and the annually issued consumer guide. Recent national polling found that people with insurance ranked prior authorization requirements as their largest health care burden, aside from cost.[7]

Consumer Guide. The FY27 Executive Budget requires that the Department of Financial Services (DFS) include several additional data points on grievances, approvals, appeals, and adverse determinations.[8] HCFANY supports expanding the Consumer Guide.

Unfortunately, these laudable improvements to the Consumer Guide are a meaningless expenditure of State funds unless the Legislature requires the Guide to include all products. As of

[5] FY27 Executive Budget, HMH Article VII, Part M, Section 3.
[6] FY27 Executive Budget, HMH Article VII, Part M, Section 13.
[7] Kirzinger, Ashley et al. "KFF Health Tracking Poll: Prior Authorizations Rank as Public's Biggest Burden When Getting Health Care." KFF, February 2026. https://www.kff.org/public-opinion/kff-health-tracking-poll-prior-authorizations-rank-as-publics-biggest-burden-when-getting-health-care/.
[8] FY27 Executive Budget, TED Article VII, Part HH, Subpart A.

2025, 80 percent of New Yorkers enrolled in the individual market are enrolled in plans that are omitted. The Consumer Guide should report on the plans to which its purported consumer audience is enrolled. The Legislature should expand on the FY27 Executive Budget additions to the Consumer Guide and require DFS to partner with the Department of Health (DOH) to ensure that the Consumer Guide serves all consumers. *See* Figure 1.

Figure 1. DFS Consumer Guide by Plan and Market Share

Plan	*2025 Market Share (Members)*	*"Quality of Care and Service for Health Insurance Companies"*
Fidelis	39.8% (95,600)	**Excluded**
Healthfirst	17.9% (43,000)	**Excluded**
Anthem	10.3% (24,700)	**Excluded**
Excellus	8.8% (21,000)	Included
MVP	8.0% (19,100)	Included
Oscar	3.7% (8,900)	**Excluded**
IHBC	3.1% (7,300)	**Excluded**
United	2.5% (6,000)	**Excluded**
MetroPlus	2.4% (5,700)	**Excluded**
Highmark	1.3% (3,200)	Included
CDPHP	1.3% (3,100)	Included
Emblem	1.0% (2,400)	Included
Market share excluded	**---**	**79.7%**

Continuity of care. The FY27 Executive Budget expands the period insurers must cover out-of-network treatment for new enrollees ("continuity of care") to 90 days for all health conditions. For pregnant enrollees, this includes care throughout pregnancy and postpartum.[9] HCFANY supports this proposal to expand continuity of care.

Preauthorization. The FY27 Executive Budget requires that prior authorizations for designated chronic conditions remain valid for at least 1 year. However, HCFANY recommends the Legislature go further and requires carriers to accept simple provider attestations for enrollees who have permanent chronic conditions that do not change over time, instead of a full annual utilization review.

Formulary disclosure. The FY27 Executive Budget requires formularies to be posted publicly in a standard, accessible format. Specifically, a formulary drug list is considered accessible if it can be viewed on an insurer's public website without creating an account and if a patient can easily determine which formulary applies to each plan. HCFANY supports this proposal to expand access to information on health plans' formulary drug lists.[10]

5. **Enact the New York Health Act (not included in FY27 Executive Budget).**

[9] FY27 Executive Budget, TED Article VII, Part HH, Subpart B.
[10] FY27 Executive Budget, TED Article VII, Part HH, Subpart C.

Of course, many of the changes above would be unnecessary if the State enacted the New York Health Act, which would provide affordable, comprehensive coverage for all New Yorkers, regardless of income or immigration status. HCFANY recommends that the Legislature enact the New York Health Act to address the long-term health care needs of New Yorkers.

II. Regulate prices to create a more affordable health care system for New Yorkers.

HCFANY commends the Legislature and the Governor for taking action to lessen the impact of medical debt on New Yorkers over the past few years. Unfortunately, health care costs remain unaffordable for many New Yorkers, a problem that will worsen significantly under H.R. 1. Given that 75 percent of people with medical debt owe at least some of it to hospitals, HCFANY urges the Legislature to consider the following consumer protections.[6]

Health care spending has increased rapidly over the past several decades in New York and nationwide. Between 2000 and 2020, health care costs rose approximately twice as fast as inflation.

It is well established that prices, rather than patient care utilization or the complexity of services used, drive rising health care spending.[11] Specifically, rising hospital prices have had the greatest impact, with hospital spending accounting for more than one-third of New York's health care expenditures.[12] Importantly, higher hospital prices are not necessarily associated with higher-quality care and may even be linked to *lower* hospital performance and patient experience scores.[13]

It is critical that the Legislature take action to control prices in the long-term in conjunction with short-term solutions to mitigate the harm of H.R. 1. HCFANY recommends that the State take several modest options, including adopting site-neutral payment policies for low-complexity services, requiring increased investment in primary care, and creating an Office of Health Care Affordability.

1. Adopt the Fair Pricing Act (site-neutral payment policies) for certain low-complexity services (not included in FY27 Executive Budget).

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[11] Sisko, A. et al. (2019), *National Health Expenditure Projections, 2018–27: Economic And Demographic Trends Drive Spending And Enrollment Growth,* Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05499.

[12] Centers for Medicare & Medicaid Services. (n.d.). *Health Expenditures by State of Residence: Summary Tables*. (*supra*, n.1.).

[13] Jamalabadi, S., Winter, V., & Schreyögg, J. (2020). A Systematic Review of the Association Between Hospital Cost/Price and the Quality of Care. *Applied Health Economics and Health Policy*, *18*(5), 625–639. https://doi.org/10.1007/s40258-020-00577-6.; Beauvais, B., Gilson, G., Schwab, S., Jaccaud, B., Pearce, T., & Holmes, T. (2020). Overpriced? Are Hospital Prices Associated with the Quality of Care? *Healthcare (Basel)*, *8*(2). https://doi.org/10.3390/healthcare8020135.

The Legislature should require plans to reimburse no more than 150 percent of the Medicare rate for a list of low-complexity procedures recommended by MedPAC. Adopting this price cap, along the lines of what is suggested in the Fair Pricing Act (S705A|A2140), would reduce cost disparities between hospitals and non-hospital providers.

Brown University researchers estimate that if the Fair Pricing Act were adopted statewide, it could save the State $1.14 billion annually, including $213 million in reduced out-of-pocket costs for consumers with commercial insurance.[14]

2. **Invest in primary care to improve outcomes and promote health equity (not included in FY27 Executive Budget).**

HCFANY urges the Legislature to include the provisions of the Primary Care Investment Act (S1634|A1915A) which would require: (1) the State to measure and publicize the current level of primary care spending and (2) require insurers that report spending less than 12.5 percent of their overall health spending on primary care to increase that investment by one percent each year until they reach at least 12.5 percent.

Nationally, only an estimated 4.6 percent of health care spending is on primary care. New York spends less than the national average: 4.2 percent of health care spending is on primary care for Employer Sponsored Insurance and 2.7 percent for Medicare FFS plans.[15] However, primary care accounts for approximately 48 percent of office visits each year.[16] At least 17 other states have enacted laws or promulgated regulations to remedy this underinvestment in primary care.[17]

The New York State of Health's (NYSOH) Provider Access and Availability Survey Results, published in May 2025, found significant problems with patient access to primary care. For example, the primary care provider directory access rate was 26 percent for QHPs and 28 percent for EP networks. In addition, the timely appointment rates for sick visits were only 32 percent and 17 percent for QHP and EP networks, respectively.[18]

HCFANY urges the Legislature to include the provisions in the Primary Care Investment Act (S1634|A1915A) in the final budget to reduce health care costs, improve patient outcomes, and promote health equity.

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[14] Murray, Roslyn et al. "Estimating Savings from the Fair Pricing Act and Commercial Site-Neutral Payments in New York State." Center for Advancing Health Policy Through Research, Brown University School of Public Health. February 2025. https://www.ajmc.com/view/how-price-caps-on-hospital-services-could-have-saved-new-yorkers-over-1-billion.

[15] Health Care Cost Institute. September 2025. https://healthcostinstitute.org/all-hcci-reports/4-of-health-spending-goes-to-primary-care/.

[16] "Investing in Primary Care: A State-Level Analysis," *Patient-Centered Primary Care Collaborative,* July 2019, 8, https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf.

[17] "Primary Care Legislative Trends 2023," *Primary Care Development Corporation,* January 2024, https://www.pcdc.org/wpcontent/uplo ads/2023-State-Primary-Care-Legislation-Trends-FINAL_010423.pdf.

[18] Provider Access and Availability Survey Results, New York State of Health. May 2025. https://info.nystateofhealth.ny.gov/provider-access-and-availability-survey-results.

3. **Establish an independent New York Office of Health Care Affordability to slow health care spending growth, promote high-value care, and assess market consolidation (not included in FY27 Executive Budget).**

New York has demonstrated a need for increased regulation of its health care spending growth, quality, and market consolidation. Fortunately, other states offer models for structural solutions to address these issues, such as California's Office of Health Care Affordability (OHCA). Following California's lead, New York should require its members not to receive compensation from health care entities. New York's Public Health and Health Planning Council (PHHPC) is comprised of political appointees who are mostly affiliated with hospitals and other health care industry representatives. [9] Other states, including Vermont, Indiana, and Maryland, have similar affordability boards that are increasing oversight of health care costs through price caps, transparency rules, and budget reviews.[19]

The Legislature should consider creating an independent New York Office of Health Care Affordability to address long-term structural issues to improve health care delivery in New York.

4. **Strengthen oversight of health care transactions (HMH Article VII, Part H).**

HCFANY supports the series of proposals in the FY 27 Executive Budget to expand oversight of health care transactions, with minor amendments to improve transparency and further strengthen oversight.[20]

Tracking the impact of material transactions on costs, quality, access, health equity, and competition. The FY27 Executive Budget requires annual reporting to the DOH for the five years following a material transaction. These reports must include metrics that allow the DOH to assess the transaction's impact on costs, quality, access, health equity, and competition.[21] Research supports that consolidation leads to higher prices, worsening the health care affordability crisis.[22] HCFANY strongly supports the initiative to track the impact of material transactions on the broader health care system, as is outlined in the FY27 Executive Budget. However, the Legislature should consider requiring the DOH to publicly post an annual summary of its findings, allowing consumers and advocates to understand the impact of health care transactions on costs, quality, access, health equity, and competition. In addition to lacking a public summary, this annual reporting does not include a penalty for material transactions that

[19] Healthcare Affordability Snapshot, Healthcare Value Hub. https://healthcarevaluehub.org/healthcare-affordability-snapshot/.
[20] Empowering New York Consumers in an Era of Hospital Consolidation. May 2018. https://nyhealthfoundation.org/wp-content/uploads/2018/05/empowering-new-york-consumers-era-of-hospital-consolidaiton-full-report.pdf.
[21] FY27 Executive Budget, Part H, Section 3 (b).
[22] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00727. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.0472?casa_token=utWEj0r9-T0AAAAA:lCWpgH9CJQ0TQfFFxm1ON6M3Cuu6nUzV5AHUKQxAfQdF8b1xz3W_e5iEdn6YWsdQX2HxuJ1FqnP-iQ. https://www.rand.org/pubs/working_papers/WRA621-1.htmhttps://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1279l.

are detrimental to cost, quality, access, health equity, and/or competition. To address this, the Legislature may consider granting conditional approval to transactions during this tracking period, which only becomes finalized after being monitored for five years without incident.

Expanding the statements required for written notices of health care transactions. The FY27 Executive Budget requires two new statements to be included in the written notice that health care entities must submit to the DOH. These statements require disclosure of whether any party to the transaction has closed operations, is in the process of closing operations, or has substantially reduced services in the past three years.[23] Another statement requires disclosure of whether real estate-related payments, including sale-leaseback agreements, are part of the proposed transaction.[24] HCFANY supports both of these additions.

Utilizing a Cost and Market Impact Review (CMIR) to assess transactions. The FY27 Executive Budget includes language allowing the DOH, at its discretion, to review proposed material transactions with a CMIR.[25] HCFANY supports the utilization of CMIR; however, the Legislature should consider expanding this language to require public posting of related documents, such as notices and preliminary and final reports. This change mirrors transparency requirements in other states: Connecticut's Office of Health Strategy publicly posts documentation of material change notices (MCN) requiring CMIR and OCHA posts a complete list of MCNs on its website[26]. Relatedly, the FY27 Executive Budget authorizes the DOH to postpone a transaction closing by up to 180 days after its preliminary review to conduct a CMIR.[27] HCFANY supports this provision.

Currently, transactions that undergo the DOH's Certificate of Need (CON) process do not count as "material" and would not be subject to the changes outlined in Part H[28]. HCFANY urges the Legislature to change this precedent so that transactions related to sites such as hospitals and nursing homes are also reviewed and, if appropriate, subject to CMIR. For example, in Connecticut, review for CMIR is woven into the CON application process[29]. In California, OCHA's first transaction review requiring CMIR involved a skilled nursing facility[30].

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[23] FY27 Executive Budget, HMH Article VII, Part H, Section 1 (g).
[24] FY27 Executive Budget, HMH Article VII, Part H, Section 1 (h).
[25] FY27 Executive Budget, HMH Article VII, Part H, Section 4 (a).
[26] California Department of Healthcare Access and Information, "OHCA Background & Resources" https://hcai.ca.gov/affordability/ohca/ohca-background-resources/. California Department of Healthcare Access and Information "Material Change Transaction Notices (MCN) and Cost and Market Impact Review (CMIR)" https://hcai.ca.gov/affordability/ohca/assess-market-consolidation/material-change-transaction-notices-mcn-and-cost-and-market-impact-review-cmir/. CT Office of Health Strategy, "Cost and Market Impact Review" https://portal.ct.gov/ohs/health-systems-planning/cost-and-market-impact-review/cost-and-market-impact-review?language=en_US.
[27] FY27 Executive Budget, HMH Article VII, Part H, Section 4 (b).
[28] New York State DOH, "Public Health Law Article 45-A, Material Transactions Frequently Asked Questions" https://www.health.ny.gov/facilities/material_transactions/faq.htm.
[29] CT Office of Health Strategy, "General Process for Cost and Market Impact Review" generalprocessforcostandmarketimpactreviewpdf.pdf.
[30] California Department of Healthcare Access and Information, "Covenant Care California, Inc. Cost and Market Impact Review" https://hcai.ca.gov/affordability/ohca/assess-market-consolidation/material-change-transaction-

The Legislature should expand the language in the FY27 Executive Budget to ensure that the same affordability criteria outlined in Part H also apply to transactions requiring CON applications.

III. Funding Navigators, Consumer Assistance Programs, and Increasing Article 6 Funding.

HCFANY urges the Legislature to support consumer assistance programs by increasing funding for Navigators and Community Health Advocates. The devastating cuts to federal health programs make investing in Navigators and Consumer Assistance Programs more important than ever.

- **Increasing Funding for Health Insurance Enrollment Navigators.**

The Navigator program has been instrumental in ensuring New Yorkers enroll, keep, and use their health insurance. Navigators provide unbiased, personalized assistance year-round in more than 40 languages.[31] The Navigator program is predominantly run through trusted local community-based organizations (CBOs) that provide culturally and linguistically competent services.[32] Roughly 70 percent of Marketplace enrollees utilize in-person assistance, and over 400,000 people currently enrolled in coverage use NYSOH Navigators.

HCFANY is grateful that the Governor's budget includes $28.3 million for Navigators in FY27. Given the uncertainty surrounding the future of federal health care programs, HCFANY urges the Legislature to increase funding for the Navigator program. The 2023-24 budget included a $300,000 one-year cost-of-living increase. But the Navigator program has received only a single-year cost-of-living adjustment since 2013. Under this essentially flat funding scenario, the Navigator programs have had to lose staff to keep up with inflation. It is more important than ever to build infrastructure in the Navigator program. The Legislature should increase Navigator funding to $38 million to reflect over ten years without appropriate cost-of-living increases.

In addition, the Legislature should consider adopting a proven strategy of funding CBOs to conduct outreach in difficult-to-reach communities to maintain insurance enrollment in the face of federal policy changes. In 2023-2024, a group of philanthropies joined together to fund The Keep New York Covered program, which provided dedicated outreach funding to State-certified enrollment groups to get the word out about new federal policies requiring consumers to recertify their coverage. At a cost of just $30 per enrollment, 36 community-based assisters were able to generate a 3,850 percent return on investment, enrolling 85,132 New Yorkers into

notices-mcn-and-cost-and-market-impact-review-cmir/covenant-care-california-inc-cost-and-market-impact-review/.

[31] New York State of Health Marketplace, "Assistors Page" https://nystateofhealth.ny.gov/agent/assistors.

[3232] K. Pollitz, et. al, "Consumer Assistance in health Insurance: Evidence of Impact and Unmet Need," KFF. August 2020. https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidenceof-impact-and-unmet-need-issue-brief/.

coverage by conducting 63 million outreach engagements through social media, in-person presentations, mailings, and the like.[33]

HCFANY urges the Legislature to fund the Navigator program at $38 million to guarantee continued high-quality enrollment services. New York should also allocate $5 million in grants to CBOs to conduct outreach in underserved communities.

- **Maintain funding for Community Health Advocates (CHA).**

The CHA program helps people with health insurance access in-network care, resolve billing issues, avoid medical debt, appeal coverage denials, and address other barriers to obtaining affordable medical care. Since 2010, CHA has assisted more than 564,000 New York clients through a diverse network of CBOs serving each of the 62 counties in New York State. Altogether, the CHA network has helped consumers save nearly $252 million in health care costs. In FY24-25, CHA saved consumers $25 million, yielding a 407% return on investment.

CHA assists consumers through a toll-free helpline and a network of 24 CBOs and small business serving groups, operating in all New York counties. CHA's helpline number is listed on commercial health insurance "Explanations of Benefits" and claim denial notices; Medicaid Managed Care denial notices (as of 2022); and the NYS Hospital Financial Assistance uniform application (as of 2024). As a result, call volume has surged by 172 percent.

Last year, the Governor and Legislature made a critical investment in CHA by increasing funding from $5 million to $7.2 million. This investment strengthened CHA's capacity at a pivotal moment, as New York struggles to mitigate the damage caused by federal cuts under H.R. 1, which will cause an estimated 1.7 million New Yorkers to lose their health coverage. H.R. 1 eliminates federal funding and eligibility for coverage for hundreds of thousands of lawfully present immigrant New Yorkers, as well as imposes new administrative burdens for millions of others to retain their coverage. In addition, many more will no longer be able to afford coverage through the NYSOH Marketplace.

HCFANY is grateful that the Governor's budget includes $5.5 million for CHA in FY26-27 and urges the Legislature to allocate an additional $1.7 million to maintain CHA's funding at $7.2 million.

- **Funding Community Health Access to Addiction and Mental Healthcare Project (CHAMP).**

[33] M. Wagner, M. Flynn, E. Benjamin, S. Kunkel, "We'll Keep You Covered: How Funding Community-Based Outreach Reduces Coverage Losses in the Face of Federal Policy Changes," August 2025, https://www.cssny.org/publications/entry/how-funding-community-based-outreach-reduces-coverage-losses-in-the-face-of-federal-changes.

CHAMP provides specialized post-enrollment services for people seeking substance use disorder or mental health treatment. Its funding should be maintained at $3 million, as it is in the Executive Budget.

- **Increase Article 6 Funding in New York City.**

HCFANY strongly supports increasing Article 6 funding for New York City and restoring parity in reimbursement rates and urges the Legislature to include this increase in their one-house budget proposals.

New York City is the only locality in the state that is reimbursed at a lower rate for core public health services under Article 6, receiving just 20 percent for spending above its base grant compared to 36 percent for all other local health departments.

This inequitable policy has cost the City up to $90 million each year and unfairly shifts the burden of funding essential public health programs onto local taxpayers. Article 6 supports critical services such as maternal and child health, communicable disease prevention, and chronic disease management — programs that are especially vital in a large, diverse city with significant health needs. At a time of growing public health challenges and federal funding cuts, the state should correct this inequity by increasing Article 6 funding for New York City.

Thank you again for providing this opportunity to submit testimony and for your consideration of our comments. We stand ready to work with the Legislature to advance our recommendations**.** Please contact Mia Wagner (mwagner@cssny.org) with any questions.