TESTIMONY OF

THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS

("PHP COALITION")

ON THE EXECUTIVE PROPOSED FISCAL YEAR 2027 STATE BUDGET

SUBMITTED FOR THE

JOINT LEGISLATIVE BUDGET HEARING ON HEALTH

SENATE FINANCE COMMITTEE CHAIR LIZ KRUEGER AND

ASSEMBLY WAYS AND MEANS COMMITTEE CHAIR J. GARY PRETLOW PRESIDING

FEBRUARY 10, 2026

About the PHP Coalition

Members of the Joint Legislative Budget Committee: Thank you for the opportunity to submit testimony on behalf of the Coalition of New York State Public Health Plans ("PHP Coalition"). **The PHP Coalition represents eight health plans that collectively serve more than 5.5 million New Yorkers enrolled in the State's public healthcare coverage programs, including:**

- Medicaid Managed Care (MMC)
- HIV Special Needs Plans (HIV SNPs)
- Health and Recovery Plans (HARPs)
- Child Health Plus (CHP)
- Essential Plan (EP)
- Qualified Health Plan (QHP)

Most PHP Coalition plans also participate in the Managed Long Term Care (MLTC) and Medicaid Advantage Plus (MAP) programs and offer Medicare Dual Eligible Special Needs Plans (D-SNPs) that integrate Medicare and Medicaid coverage for New Yorkers who are dually eligible for both programs. *See the Appendix for more on Coalition plans and NY's healthcare coverage programs.*

PHP Coalition plans are committed State partners, focused on expanding access to coverage and care, while improving healthcare quality for the lowest-income and most vulnerable New Yorkers. Coalition plans specialize in serving populations that have traditionally faced barriers to care, with the goal of improving health and reducing health-related disparities.

The Pressing Need for *Smart* Public Healthcare Spending

New York's public healthcare coverage programs are the backbone of the State's safety net, supporting more than one-third of all residents. **Even with better-than-expected State revenues, our coverage programs face significant federal funding cuts and eligibility restrictions.** It is more important than ever to ensure our public healthcare dollars are being spent *effectively*, going toward activities that improve enrollee health and wellbeing.

To do this, several criteria must be met:

- Wasteful or exploitative practices that misuse taxpayer dollars must be curtailed;
- Coverage must be accessible and affordable;
- Managed care programs must be adequately funded; and
- Quality improvement initiatives must be sustainably funded.

Consistent with these criteria, PHP Coalition plans respectfully request that the Legislature take the following actions:

- **Codify and fund the Medicaid Managed Care Quality Incentive Program (QIP)** by including A.2044/S.6266 in the One House Bills.
- **Support State investment in making affordable coverage available to New Yorkers who will lose access to the Essential Plan because of federal law (H.R.1).**
- **Support the Executive's proposed reforms to the Independent Dispute Resolution (IDR) process (PPGG, Part T),** which will curb the diversion of public funds away from safety net providers toward high-end specialists and the private equity-backed companies they hire.

- **Reject the Executive's proposal to set a once-per-year cap on utilization review for treatment of *any* chronic health condition (TED, Part HH, Subpart D),** which it broadly defines as any condition expected to last for at least one year that requires ongoing treatment to manage—such a far-reaching restriction would open the floodgates to unnecessary care, abusive billing, potential fraud, and escalating costs.

Curb Inappropriate Spending and Practices that Misuse Public Healthcare Dollars

Reform Independent Dispute Resolution (IDR) in New York State

New York has been a leader in protecting patients from surprise medical bills,[1] preceding the federal *No Surprises Act*, which included many features of New York's program. One such feature is **Independent Dispute Resolution (IDR)**, an arbitration process to resolve payment disputes between plans and out-of-network providers.[2]

New York's IDR process is distinct, however, in how its arbiters decide the final payment amount: they use a higher and inflationary benchmark—80th percentile of billed charges. (Billed charges are list prices that providers can set unilaterally, not tied to market pricing and generally *many times higher* than negotiated rates or Medicare rates.) Other states rely on median in-network rates or a percentage of Medicare; in fact, citing the cost impact, CMS explicitly *prohibits* use of billed charges in its IDR.[3]

New York's own data show IDR is driving up the cost of coverage.[4] And because specialists can reap substantially more revenue through IDR than negotiating with a plan, a growing number of them are choosing to be out-of-network, impeding enrollee access to care. A signal of how lucrative IDR payments can be, a niche industry has formed, with private equity-backed companies promising to secure higher payments for providers billing out-of-network.

Beyond driving up the cost of coverage for New Yorkers, it is costing taxpayers in the form of increased Medicaid costs—to the tune of *hundreds of millions of dollars* annually. In 2024, Medicaid plans paid an estimated $116 million in IDR claims, a staggering amount that continues to rise. **These public dollars are being diverted from safety net providers to high-end specialists who refuse to participate in Medicaid and the for-profit "IDR expert" companies they hire.**

New York's IDR process:

- **Disincentivizes providers from participating Medicaid**, working against efforts to expand Medicaid managed care networks and improve access for Medicaid enrollees.
- **Drives up Medicaid costs** by requiring plans to pay out-of-network providers *many* multiples of typical in-network rates that participating providers receive.

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[1] Also known as "balance billing," when providers bill patients for any balance remaining after health plan payment.
See N.Y. Laws Ch. 60 (2014), Part H; N.Y. Fin. Serv. Law §§ 601–608; N.Y. Pub. Health Law § 2807-k.
[2] NYS DFS Insurance Circular Letter No. 2 (2023), Criteria to Determine a Reasonable Fee Under the IDR Process.
[3] 45 CFR 149.510(c)(4)(v).
[4] Adler, L. (2019, October 24). *Experience with New York's arbitration process for surprise out-of-network bills*. Brookings.

- **Is redundant given existing out-of-network cost protections in Medicaid**.[5] Medicaid enrollees are already held harmless for out-of-network costs, so exempting Medicaid from IDR requirements would not negatively impact them.

The Coalition urges the Legislature to fix New York's IDR program by exempting Medicaid and reforming how payment is determined—enact Executive PPGG Part T in the FY27 Budget.

Reject Excessively Broad Cap on Utilization Review

The FY27 Executive Budget (TED, Part HH, Subpart D) includes a new cap on utilization review for treatment of *any* chronic health condition, which it broadly defines as any condition expected to last for at least one year that requires ongoing treatment to manage. While Coalition plans support efforts to streamline and modernize utilization management processes—which play an important role in ensuring that care is safe and effective—imposing such a sweeping cap on utilization review risks opening the State's coverage programs to unnecessary care, abusive billing practices, potential fraud, and runaway spending.

Capping utilization review for treatment of any condition deemed "chronic" to once per year could lead to enrollees receiving unnecessary or duplicative services, including preventable hospitalizations, and experiencing delays in accessing needed care. It would also impede plans' ability to ensure the care being delivered is safe and consistent with evidence-based protocols, and it would severely hinder plan efforts to prevent fraudulent, wasteful, and abusive behavior in our public coverage programs. Such a cap is certain to increase costs—for enrollees and the State—at a time when we should be making coverage *more* affordable, not less.

The Coalition urges the Legislature to reject this proposal from the Executive (TED, Part HH, Subpart D) and instead work with plans to advance utilization management improvements that do not carry such wide-ranging risks to enrollees and the State.

Make Sustainable Investments in Medicaid Quality

Codify and Fund the Medicaid Managed Care Quality Incentive Program (QIP)

The State's Medicaid Managed Care Quality Incentive Program (QIP) plays two key roles: (1) it funds provider-facing initiatives to improve the quality of care delivered by safety net providers and community-based initiatives to improve Medicaid enrollee health outcomes, and (2) it drives plans to meet State-set quality metrics. Plans that meet these quality metrics earn QIP awards that enable them to reinvest in the delivery system (e.g., through enhanced or bonus payments to partner providers).

New York's Medicaid Managed Care QIP enables:

- **Increased payment to safety net providers**—primary care providers, behavioral health providers, others—who deliver high-quality care and adopt evidence-based practices that support enrollee care and outcomes (e.g., expanded practice hours, patient engagement activities to address gaps in care).
- **Development, testing and scaling of care models proven to improve outcomes**, such as specialized maternal care navigators for high-risk mothers, community health workers to

[5] See 42 CFR § 438.114 and MMC Model Contract Appendix G.2.

improve cardiovascular outcomes, and care transition supports for enrollees with schizophrenia.

- **Technical assistance and supports for providers of important in-demand services** like maternal and child health, pediatric care, substance use disorders, and geriatric care.

Despite the positive downstream impacts, State funding for the QIP has declined steadily over recent years: in FY20, State investment was $189 million; last year, it was down to $50 million.

Further, the fact that QIP funding allocation is administrative and subject to the uncertainties of the annual budget process has led to massive instability in the programs, impeding sustainable investment in quality for our safety net healthcare program. **Assemblymember Paulin and Senator Salazar have introduced legislation this session, Assembly Bill 2044 and Senate Bill 6266, that would codify the QIP in statute and provide it with sustained funding.**

The Coalition urges the Legislature to support New York's primary tool for driving quality in Medicaid managed care by including A.2044/S.6266 in the One House bills.

Ensure Continued Access to Coverage in Response to Federal Changes

Support State Investment to Maintain Affordable Coverage for Enrollees Affected by H.R.1

Congress enacted the "One Big Beautiful Bill Act," or H.R.1, last July, making sweeping changes to Medicaid and other public healthcare programs that are expected to result in significant coverage losses for New Yorkers in the coming years. H.R.1 has particularly significant implications for New York's **Essential Plan (EP)**, a highly successful program that provides low- or no-cost coverage to 1.7 million New Yorkers whose income is just above Medicaid eligibility (i.e., 138%-250% of the federal poverty level or "FPL") or who are lawfully present in the U.S. but do not quality for federally funded Medicaid due solely to immigration status.

Among other changes, H.R.1 eliminates certain immigrant populations' eligibility for federal premium tax credits (which finance the EP program), putting the EP's financial stability at risk. New York is currently awaiting federal approval of a request to change EP program authority, which would allow it to maintain the EP to cover individuals with income up to 200% FPL, including immigrant populations.[6] If the federal government approves the State's request, however, **nearly 500,000 enrollees whose incomes are 200-250% FPL will lose access to EP.** For many of these individuals, Marketplace coverage or employer-sponsored insurance is not a viable option. By the State's own estimate, **nearly half of this population is likely to become uninsured.**

The Coalition reviewed potential strategies for New York to continue making affordable coverage available for impacted individuals and determined the most effective approach to minimizing uninsurance is to implement a **State-funded premium subsidy** that reduces the cost of purchasing Silver-level Qualified Health Plan (QHP) coverage on the Marketplace to no more than

[6] The EP was originally authorized through Section 1331 ("Basic Health Program" or "BHP") of the Affordable Care Act; consistent with Section 1331, New York established a BHP Trust Fund to hold federal funding for the program. In 2024, when New York transitioned the EP to Section 1332 ("State Innovation Waiver") authority so that it could cover individuals with incomes 200-250% FPL, its access to the BHP Trust Fund was frozen. Now, with H.R.1 enacted, New York has opted to terminate its 1332 waiver and revert to 1331 authority, so it can access the BHP Trust Fund to cover EP program costs for individuals with incomes up to 200% FPL.

4-7% of each consumer's income. Such a premium subsidy could be paired with regulatory changes that address cost drivers in the QHP and commercial markets to reduce costs further.

Absent State action to offset the higher cost of coverage for this affected population, many New Yorkers are likely to become uninsured, hindering their ability to access to care and increasing uncompensated care and related costs for the State.

The Coalition urges the Legislature to support efforts to maintain affordable coverage for the hundreds of thousands of New Yorkers currently enrolled in the EP who are affected by H.R.1.

Beyond the changes to New York's EP program, H.R.1 will also impact the State's Medicaid eligibility and enrollment policies starting January 2027, by requiring more than 2 million enrollees to comply with work requirements and go through more frequent eligibility checks (every six months). The Department of Health has estimated that nearly 1.5 million enrollees will lose healthcare coverage as a result of these changes, even if they remain otherwise eligible for Medicaid. Coalition plans stand ready to partner with the Department of Health and other stakeholders on activities to keep New Yorkers covered.

Adequately Fund Medicaid Managed Care

New York relies on plans, including members of the PHP Coalition, to administer its Medicaid program and implement State policy initiatives, large and small. Medicaid plans assume full financial risk for each enrollee they serve; they must ensure enrollees have access to safe and effective healthcare, consistent with State and federal requirements, and provide around-the-clock support to enrollees in service of that charge. They must also execute a never-ending flow of State directives and program changes. (Some recent examples include: the hurried transition to a single, Statewide Fiscal Intermediary (FI); implementation of the New York Health Equity Reform 1115 waiver; retrospective updates to mandated rates for mental health providers; and State-directed payment programs for safety net hospitals.)

Plans have been doing all this amid an increasingly challenging rate environment, made more challenging by a cloistered rate development process that lacks transparency found in most other states.[7] The State has relied on plans to absorb significant cuts to achieve "savings," such as the recent Statewide FI transition and the change to FI administrative pay that preceded it.

Coalition plans are committed to serving New York's Medicaid program in delivering high-quality, high-value care to the State's lowest-income and most vulnerable residents, but when managed care rates fail to incorporate program changes or cover the actual cost of care, delivering on this commitment becomes difficult. This is especially true amid all the recent *and forthcoming* program changes.

The Coalition urges New York State to take steps to ensure our Medicaid managed care program is adequately funded—a good first step is to release its rate certifications to plans and the public.

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Please contact the PHP Coalition's representatives, Tony Fiori (AFiori@manatt.com), Hailey Davis (HDavis@manatt.com) and Greg Pratt (GPratt@manatt.com), with any questions.

[7] While other states release the Medicaid managed care rate certification they submit to the federal government each year, New York has repeatedly refused to do so.

APPENDIX

About the Coalition of NYS Public Health Plans ("PHP Coalition")

The PHP Coalition represents eight plans that collectively serve more than 5.5 million New Yorkers enrolled in Medicaid and other public health coverage programs.[8] Coalition members are longstanding State partners committed to expanding access to care and improving healthcare quality for low-income and vulnerable populations.

New York's public health coverage programs are the backbone of the State's safety net, supporting more than one-third of all residents. In the face of federal funding reductions and changes to Medicaid and Essential Plan eligibility, it is more important than ever that public healthcare dollars are used effectively to improve enrollees' health and wellbeing. ***PHP Coalition plans stand ready to work with the State to protect coverage and strengthen the value of New York's public programs.***

PHP Coalition Members

PHP Coalition Plans	Enrollment by Coverage Program*							Region(s) Served
	Medicaid Managed Care (MMC)*	Health & Recovery Plan (HARP)	Partially Capitated Managed Long Term Care (MLTC)	Medicaid Advantage Plus (MAP)	Child Health Plus (CHP)	Essential Plan (EP)	Qualified Health Plan (QHP)	
Amida Care	9,453	-	-	-	-	-	-	NYC
EmblemHealth	130,931	4,581	-	-	15,983	116,342	1,192	NYC, Long Island, Hudson Valley
Fidelis Care	1,461,087	49,883	17,982	4,452	188,771	437,756	103,906	Statewide
Healthfirst	1,123,292	31,681	11,656	41,696	121,462	450,610	43,469	NYC, Long Island, Hudson Valley
MetroPlus	405,621	11,417	2,722	386	45,092	167,863	5,114	NYC
Molina	212,129	7,847	22,720	235	20,610	72,455	-	NYC, Long Island, Hudson Valley, Central NY, Western NY
MVP Health Care	164,506	6,270	-	-	29,786	57,281	11,405	Hudson Valley, Central NY, Northeast NY, Western NY
VNS Health	3,990	-	25,826	7,683	-	-	-	NYC, Long Island, Hudson Valley, Central, Northeast, Western
Coalition Total	**3,511,009**	**111,679**	**80,906**	**54,452**	**421,704**	**1,302,307**	**165,086**	
NYS Total	4,459,238	149,748	295,287	72,123	562,533	1,708,583	221,508	
Coalition Share	79%	75%	27%	75%	75%	76%	75%	

**Enrollment data from NYS Department of Health and NY State of Health as of October 2025.*
***MMC includes HIV Special Needs Plan (SNP) enrollment.*

[8] These programs include New York's Medicaid Managed Care (MMC), HIV Special Needs Plan (HIV SNP), Health and Recovery Plan (HARP), Child Health Plus (CHP), Essential Plan (EP) and Qualified Health Plan (QHP) programs. Most of the PHP Coalition plans also participate in the Managed Long Term Care (MLTC) and Medicaid Advantage Plus (MAP) programs and offer Dual Eligible Special Needs Plans (D-SNPs) that integrate Medicaid and Medicare coverage for "dually eligible" New Yorkers. *See next page for more on NYS' coverage programs*.

APPENDIX

For Reference: Overview of New York State's Public Healthcare Coverage Programs

	NYS Coverage Program	Description
Mainstream Medicaid	**Mainstream Medicaid Managed Care (MMC)**	Provides comprehensive Medicaid benefits to traditional Medicaid population through full-risk plans
	HIV Special Needs Plan (HIV SNP)	Provides comprehensive and tailored Medicaid benefits to individuals living with HIV/AIDS, their families, people living with homelessness, and transgender people
	Health and Recovery Plan (HARP)	Provides enhanced and tailored benefits (on top of what is provided in MMC) for adults with serious mental illness and/or substance use disorder
CHP	**Child Health Plus (CHP)**	Provides comprehensive coverage to children who are ineligible for Medicaid, with family incomes up to 400% FPL
Marketplace	**Essential Plan (EP)**	Provides essential health benefits to individuals with incomes 138%-250% FPL (just above Medicaid for most people) and individuals with lower incomes who are lawfully present in the U.S. but do not qualify for federally-funded Medicaid due to immigration status
	Qualified Health Plan (QHP)	Commercial coverage providing essential health benefits to the individual and small group markets on the State's health insurance Marketplace (New York State of Health)
Long Term Care	**Partially Capitated Managed Long Term Care (MLTC)**	Provides long term care (LTC) benefits for Medicaid enrollees who are chronically ill or disabled, need >120 days of community-based LTC, and need assistance with activities of daily living (ADL)
	Medicaid Advantage Plus (MAP)	Provides comprehensive, *integrated* Medicaid and Medicare coverage for individuals eligible for both program ("dual eligibles") who have long term care needs
	Program of All-Inclusive Care for the Elderly (PACE)	Provides comprehensive, *integrated* Medicaid and Medicare coverage to dual-eligibles age 55+ who are medically eligible for nursing home care; enrollees must receive care from PACE providers