FPI
Fiscal Policy Institute

540 Broadway
Albany, NY 12207

press@fiscalpolicy.org
fiscalpolicy.org

By Michael Kinnucan, *Director of Health Policy*
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What to Expect in the Budget Debate: Healthcare

Changes to Medicaid, Addressing Affordability, and the Problem of Trump

Healthcare didn't take center stage in Governor Hochul's State of the State address this week, but that doesn't mean it won't be central to New York politics this session. After all, rising healthcare costs are a key component of the affordability crisis squeezing New Yorkers, with premiums for individual and small-group health insurance set to increase by 12.7 percent this year.[1] Medicaid cost growth will be an issue too—particularly in long-term care, where the state's aging population continues to drive program growth. And mental health has become a hot-button issue in politics, with the governor and New York City Mayor Eric Adams calling for increased involuntary commitment to promote public safety, while advocates and providers demand more resources for New York's overburdened mental health system. Meanwhile, the state faces tremendous unknowns at the federal level, as the incoming Trump administration threatens dramatic cuts to Medicaid and other funding.

Here are the issues we're watching:

Healthcare Affordability for Everyone

As noted above, healthcare costs in New York State keep rising; the average premium for an employer-sponsored individual plan in New York was $9,173 in 2023, third-highest in the nation after New Jersey and Massachusetts, and that number has only gone up in recent years.[2] While policymakers in recent years have focused largely on protecting consumers from the *effects* of healthcare cost increases—by requiring insurers to cover basic services like insulin, for example, or making it harder for providers to collect medical debt—two promising initiatives suggest a growing interest in addressing the root causes of cost increases by directly regulating prices.

- **Price caps on outpatient procedures:** Hospitals across the country frequently charge exorbitant and irrational prices for services; indeed, studies show that commercial insurance companies pay between 2 and 2.5 times the Medicare rate for hospital care. One area of special concern to federal policymakers is procedures that can be performed either in a hospital outpatient department or in a doctor's office; studies have shown that hospitals charge far more than doctor's offices for the same service. A bill (S9952) recently introduced by Senator Liz Krueger and backed by the

[1] https://myportal.dfs.ny.gov/web/prior-approval/ind-and-sg-medical/summary-of-2025-requested-rate-actions
[2]https://www.kff.org/other/state-indicator/single-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Annual%20Premium%22,%22sort%22:%22desc%22%7D

powerful building services union SEIU 32BJ would end that practice by capping hospital prices at 150% of the Medicare price for a limited set of procedures that can also be performed in a doctor's office; this would reduce healthcare costs for individuals, employers, and public employee health plans statewide.[3]

- **Importing Canadian drugs.** Americans pay vastly more for prescription drugs than do residents of every other developed country, since virtually all countries besides the US regulate drug prices. In 2021, the Biden administration issued an executive order directing the FDA to work with US states to authorize importing drugs from Canada, which would allow Americans to take advantage of Canada's drug price regulation scheme.[4] Florida was the first state to get FDA approval for its program in early 2024. In her State of the State booklet, Governor Hochul proposed pursuing drug importation in New York. This policy is unlikely to work at scale—Canada, understandably, does not want Americans buying up its drugs—but the governor's proposal should spark much-needed conversation about whether New York should create its own drug price regulation scheme.

Unfinished Business in Medicaid

Regardless of what happens at the federal level, New York policymakers will face significant decisions about the State's Medicaid program this session—including on whether and how to implement decisions made during past budget cycles. Key issues include:

- **The MCO Tax: How much, and who gets it?** In last year's state budget, legislators authorized a "provider tax" on managed care organizations (MCOs), the insurance companies that operate New York's public and private healthcare system. This tax was recently approved by the Biden administration and will be revenue-neutral for the MCOs but draw down significant federal revenue for Medicaid. (See our explainer from last year on how it will work.) The State has not yet disclosed how much money it expects the tax to generate, but Bill Hammond of the Empire Center estimated[5] that the number could be as high as $1.8 billion. The question of how that money gets distributed is likely to be a major fight in this year's budget.
- **Cuts to long-term care eligibility: Will they be implemented? Should they be?** In early 2020, facing a Medicaid funding crisis of his own creation, then-Governor Andrew Cuomo advanced a number of cuts to Medicaid long-term care eligibility.[6] Among these cuts were a measure introducing an asset test "look-back" for older and disabled New Yorkers seeking Medicaid home care and a provision raising the bar for how disabled a person must be to qualify for home care.[7] However, the Covid-19 pandemic prevented the administration from actually implementing these cuts—and they still haven't been implemented. Many advocates have recommended repealing these cuts over the years, and that idea may come again in this budget.
- **CDPAP Fiscal Intermediary Consolidation: Will it go through?** Last year, Governor Hochul and state legislators agreed on a major change to how the state's Consumer Directed Personal

[3] https://www.timesunion.com/state/article/cap-outpatient-hospital-costs-proposed-n-y-curb-19769299.php
[4] https://www.kff.org/health-costs/issue-brief/faqs-on-prescription-drug-importation/
[5] https://www.empirecenter.org/publications/proposed-mco-tax-would-generate-a-fraction/
[6] https://www.cityandstateny.com/policy/2019/12/cuomos-multibillion-dollar-headache/176642/
[7] http://health.wnylc.com/health/news/85/

Assistance Program (CDPAP) is run, consolidating from over 600 fiscal intermediaries to a single statewide intermediary. Under current law, the transition must be completed by April 1, 2025, an extremely compressed timeline given the scale of the program, which employs hundreds of thousands of home care workers to provide care for 250,000 beneficiaries. The state claims that this change will save the state $500 million annually when fully implemented. However, the change is highly controversial; disability rights advocates worry that the new system will restrict access and that the rapid transition will cause vulnerable enrollees to lose access to care, while fiscal intermediaries—who will be put out of business by the shift—have run an extremely well-funded lobbying and litigation campaign to block the change. Governor Hochul has stood firm on the subject so far, and the powerful healthcare workers union 1199SEIU also backs it. Senate health chair Gustavo Rivera has introduced a bill proposing a compromise.[8] If the transition really does happen on the timeline currently proposed, it may be a *fait accompli* by the time the state budget is settled—but if, as seems quite possible, the transition is delayed, it may become a key issue in the state budget.

- **The fate of Managed Long-Term Care (MLTC):** The state's Medicaid home care system is overseen by private managed care organizations (MCOs) in a program that many advocates and even some of its architects regard as poorly designed and wasteful. Last budget, disability rights and elder advocates along with 1199 pushed to eliminate the program, arguing that the MLTC MCOs were little more than wasteful middlemen. In her State of the State booklet this year, Governor Hochul proposes a different path, arguing that the program should be reformed by merging MLTC with Medicare Advantage managed care plans. While the single FI will likely take center stage in this budget cycle, the long-term fate of New York's Medicaid long-term care program remains an open question.

Hospitals and Mental Health

- **Involuntary commitment and mental health infrastructure:** Governor Hochul and Mayor Adams have both pushed to make it easier for the state to involuntarily commit mentally ill people, arguing that this is a solution to New York's homelessness crisis. Yet police and mental health professionals already have substantial authority to force people to seek mental healthcare, with the NYPD reportedly removing over 100 people a week since Adams initiated a push for such removals in late 2022.[9] The state and city face a shortage of psychiatric hospital beds and supportive housing for the mentally ill, creating a "revolving door" dynamic in which homeless people suffering from mental illness often wind up back on the street or in jail. Hochul and Adams have both proposed initiatives to increase mental health system capacity, while many advocates have argued that these don't go far enough.
- **Hospital funding: Rate increases and safety-net support:** Nearly a third of New York State hospitals require ongoing state support to keep the doors open, with rural hospitals and those that serve Medicaid and uninsured populations particularly at risk. State policymakers will face questions about whether to renew ongoing programs that provide operating support to these hospitals, such as the Vital Access Provider Assistance Program (VAPAP), and whether to raise Medicaid payment rates to hospitals overall.

[8] https://www.nysenate.gov/newsroom/press-releases/2024/gustavo-rivera/senator-gustavo-rivera-introduces-bill-establish
[9] https://www.cityandstateny.com/policy/2024/09/involuntary-removals-steady-over-last-year-under-adams-policy/399261/

Trump and Healthcare Funding: The Big Unknown

New York State's Medicaid program, which provides healthcare or long-term care to nearly 7 million state residents, is the state's largest program—and its largest source of federal funding, at over $80 billion annually. That funding could be under threat from the incoming Trump administration. Project 2025 proposes extensive cuts to Medicaid, and Politico recently reported that House Republicans are considering cutting the program by over one-third, largely to fund tax cuts for the wealthy. Cuts this large will be difficult to get through Congress, but any move in this direction will create significant fiscal uncertainty for New York.[10] The specific cuts being proposed would hit New York especially hard. Most concerning are proposals to cap federal contributions and change the way these are calculated.

- **Per-capita caps on Medicaid spending:** Under current law, the federal government matches state spending for Medicaid. That's good for states like New York that run relatively generous Medicaid programs: As state spending increases, federal funding does too. Under this proposal, the federal government would only match funding up to a set level per enrollee. This is a form of "block grant" that would dramatically reduce federal funding for Medicaid over time.[11]
- **Changes to FMAP:** The federal share of funding to Medicaid, set through the Federal Medical Assistance Percentage (FMAP), varies by state and beneficiary category. The FMAP for most categories of spending varies between 75 percent in low-income states like Louisiana and 50 percent in high-income states like New York. In addition, states receive a higher FMAP—currently 90 percent—on the "ACA expansion population" of adults making between 100 percent and 138 percent of the federal poverty line. Republicans have proposed lowering the FMAP for wealthy states like New York and eliminating the higher FMAP for the expansion population. One proposal by The Paragon Institute, an influential right-wing think tank, suggests phasing in the cuts over time; such cuts would hit New York hard, rising to $710 million in 2027, $1.4 billion in 2028 and $3.8 billion by 2031.[12]
- **Expiration of Enhanced Premium Tax Credits:** The Biden administration significantly expanded premium tax credits to help people who buy healthcare on the exchange. Republicans will likely let these tax credits expire next year, which will not only harm New York's exchange population but also reduce funding for New York's Essential Plan, which covers 1.6 million New Yorkers with incomes below 250% of the poverty line who do not qualify for Medicaid.
- **Other changes:** An incoming Trump administration might also seek to revisit recently approved New York Medicaid waivers that have allowed the State to cover more people in Medicaid, use federal funds to cover immigrants with legal status through the Essential Plan, increase funding through an MCO tax, and make other program improvements. Attempts to revoke already-approved waivers would face litigation, but New York will likely have a hard time getting existing waivers renewed or seeking new waivers, which will significantly limit program flexibility.[13]

It is not yet clear what cuts the Trump administration will back, and achieving the truly massive cuts being floated by House Republicans will be difficult. But the possibility or reality of cuts creates

[10] https://www.politico.com/news/2025/01/10/spending-cuts-house-gop-reconciliation-medicaid-00197541
[11] https://www.cbpp.org/research/health/medicaid-per-capita-cap-would-harm-millions-of-people-by-forcing-deep-cuts-and
[12] https://paragoninstitute.org/wp-content/uploads/2024/07/Medicaid-Financing-Reform_FOR-RELEASE_V1.pdf Table 6 Page 29
[13] https://fiscalpolicy.org/the-medicaid-mco-tax-strategy

significant fiscal uncertainty for New York and may require further investment of state dollars to protect our healthcare system.

Trump, Waivers and the Progressive Healthcare Agenda

Because the federal government funds Medicaid, many key program decisions require federal approval. The Biden administration approved a broad range of initiatives to expand New York's Medicaid program. Some progressive agenda items didn't make it through, though. Efforts to expand Medicaid continuous eligibility, the "Coverage for All" campaign to cover undocumented immigrants under the Essential Plan, proposed expansions in long-term care eligibility, and most ambitiously the New York Health Act to achieve state-level single-payer healthcare, would all require federal approval—and that approval is unlikely to be forthcoming under Trump. Furthermore, the state may hesitate even to *ask for* approval given the incoming administration's hostility to Medicaid; giving the federal government as few opportunities as possible to intervene in New York's program may seem like the wisest course.

Given this situation, advocates for expansion will need to reconsider their strategy: Should they pause these initiatives and hope for a more friendly administration in 2028? Keep pushing at the state level and let the federal government do its worst? Or develop alternative strategies to achieve the same goals using state-only funds, avoiding the need for federal approval?