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The One-House Healthcare Budgets: Generous to Providers, Stingy with Enrollees

Key Findings

- Neither the Assembly nor the Senate one-house budget address the coming Essential Plan cliff, which will cause 470,000 New Yorkers to lose health insurance this July.
- However, both one-house budgets significantly increase spending on Medicaid providers by reversing several reforms proposed in the Executive budget and providing approximately $260 million in additional funding. In addition, the Assembly proposes approximately $900 million (all-funds) in additional rate increases on top of the Executive's proposed $1.5 billion.
- The federal government's approval of the State's Essential Plan transition proposal will generate an additional $2.5 billion in available State revenue, offering lawmakers a final opportunity to address insurance coverage loss in the FY27 budget.

Executive Summary

This year's Executive and one-house budgets reflect a clear policy choice: Both the Governor and the legislature prioritize provider rate increases over protecting New Yorkers' health insurance coverage. It is a surprising choice given the scale of insurance losses the State is facing: the Fiscal Policy Institute has previously estimated that without State action, over one million New Yorkers will become uninsured in the next two years due to Essential Plan and Medicaid cuts.[1]

Governor Hochul's FY27 Executive budget proposal was notably generous to hospitals, nursing homes, and other providers. It fully backfilled federal cuts to provider rates and provided funding for significant additional rate increases—amounting to a total increase of $750 million state share / $1.5 billion all-funds in spending increases—all or most of which are likely to be permanent. However, the Executive

[1] Michael Kinnucan, "A Plan to Maintain Insurance Coverage After OBBBA," Fiscal Policy Institute, February 5, 2026, https://fiscalpolicy.org/wp-content/uploads/2026/02/2026.02.05-A-Plan-to-Keep-People-Covered.pdf

proposal included several cost-saving reforms opposed by providers, notably to the State's Independent Dispute Resolution (IDR) process and its subsidies for provider malpractice insurance. The Senate and Assembly one-house budget proposals largely reverse these moves, raising State spending by approximately $260 million relative to the Executive while maintaining Executive-proposed provider funding increases. The Assembly also adds an additional $450 million state share / $900 million all-funds for provider rate increases.

In striking contrast to this largesse for providers, neither the Executive nor the one-house proposals address the looming Essential Plan cliff, which will cause 470,000 New Yorkers to lose coverage beginning in July. Nor do the one-house budgets propose significant funding to address this looming crisis.

Recent federal actions provide a glimmer of hope for New Yorkers facing uninsurance, however. The federal government recently approved New York's Essential Plan transition proposal, making an additional $2.5 billion available in the State budget—more than enough to cover the entire population faced with loss of insurance, should policymakers choose to do so.

The Backdrop: Hospital Rate Increases in Recent Budgets

Medicaid hospital payment rates have been a bone of contention in the New York State budget for decades. Medicaid reimbursement rates to hospitals are far lower than commercial rates, making it virtually impossible for hospitals that treat a large share of Medicaid patients to stay solvent using reimbursement rates alone. The State supports these high-Medicaid hospitals through a complex system of supplemental non-rate payments. These supplemental payments have increased dramatically since the pandemic, as pressure on hospital budgets from a variety of sources has increased.

The hospital industry, which is among the most powerful forces in Albany, has long pushed for substantial rate increases, which would benefit both safety net and non-safety net providers. The Cuomo administration resisted these calls for years, holding hospital rates virtually flat between 2011 and 2021.

Hochul has taken a different approach, increasing hospital rates substantially in recent years. In FY24, the State raised hospital inpatient and outpatient rates by 7.5 percent and 6.5 percent, respectively, at an all-funds annual cost of around $800 million ($400 million state-share), although these increases were offset to some extent by changes in how the Medicaid program purchased pharmaceuticals, which reduced revenue for some providers.

The MCO Tax

In FY25, the State again increased outpatient rates, this time by 10 percent, and made other rate adjustments totaling $400 million in all-funds spending ($200 million state-share), offset this time by a much smaller cut to the capital component of hospital rates. The FY25 budget also authorized the State to pursue a managed care organization (MCO) tax to increase federal funding for New York's Medicaid program, and created a new financing vehicle, the Healthcare Stability Fund (HSF), to collect and spend MCO tax revenue outside the Medicaid Global Cap.

The State received federal authorization for the MCO tax and began collecting revenues in the final quarter of FY25, setting off a scramble to spend that money in the FY26 budget. Hospitals did notably well in this scramble: Of the roughly $2 billion state-share in projected receipts in FY26, hospitals received $646 million state-share (or $1.3 billion all-funds), supporting the Safety Net Transformation Program ($300 million), a 10 percent outpatient rate increase ($145 million), a hospital "quality pool" ($125 million), maternal health investments ($25 million), and investments in rural hospitals ($10 million). Other providers—notably nursing homes, physicians, and Federally Qualified Health Centers (FQHCs)—also received substantial rate increases.

All this funding, however, was contingent on the availability of MCO tax revenue, and in the summer of 2026 Congress threw a wrench in that plan by enacting the One Big Beautiful Bill Act (OBBBA), which banned the tax and similar mechanisms in other states. Analysts initially feared that the tax could sunset as early as December 2025, although it has now been extended to December 2026. As a result, a major question as the State entered the FY27 budget season was to what extent MCO-tax-funded rate increases would be preserved. Would the state "backfill" these federal cuts, or would the rate increases be allowed to lapse?

Provider Rate Politics in the FY27 Budget

Governor Hochul's executive budget proposal, released in January, made clear that when it came to provider rate increases at least, the State was committed to backfilling federal cuts (see table 1). The Governor preserved rate increases for most providers and created room for further increases by investing $750 million state-share ($1.5 billion all-funds) in so-called "targeted healthcare investments" to replace lost MCO tax revenues in the Healthcare Stability Fund, making good all losses in projected revenues.

Table 1 compares provider funding in FY27 that is anticipated in the FY26 enacted budget to provider spending that is in the initial FY27 executive budget proposal. Despite a projected massive loss of MCO tax revenue, which was anticipated to fund provider rate increases, the Executive actually *increases* total provider spending by over $600 million (state-share) / $1.2 billion all-funds. The Executive preserves rate increases to hospitals, nursing homes, and assisted living providers; and those to physicians, clinics, and MCOs, though in some cases implementation of those increases has been delayed from last year to this year. The executive budget drops some hospital investments (including the hospital quality pool and maternal health investments, totaling $150 million), but it also creates a new pot of money, labeled "targeted healthcare investments," which could be used to fund these initiatives as well as additional rate increases. In budget hearings, State officials made clear that the Governor intends to negotiate with legislators over how to apportion this funding.

How can the State afford such investments given federal cuts? In part, the answer lies in changes elsewhere in the Medicaid program: As FPI described in its the State saved billions of dollars a year in projected spending through changes to the Consumer Directed Personal Assistance Program (CDPAP), which dramatically lowered enrollment in the program, creating fiscal headroom for provider rate increases.[2]

[2] See "Chapter IV: Healthcare," in *Annual Budget Briefing Fiscal Year 2027*, Fiscal Policy Institute, February 24, 2026, https://fiscalpolicy.org/annual-briefing-on-the-executive-budget-2026. Specifically, the State restructured the program by transitioning its administration from multiple fiscal intermediaries to a single fiscal intermediary and raised eligibility

Table 1. Comparing FY27 Provider Spending in the FY26 Enacted Budget and the FY27 Executive Budget, millions of state-share dollars

	FY27 Spending in FY26 Enacted	FY27 Spending in FY27 Executive	Notes
"Targeted Healthcare Investments"	N/A	$750	New in the FY27 Exec, this pool of money is reserved for unspecified provider payments; the Executive has said it intends to negotiate with the legislature over specific spending.
Hospitals	$305	$155	Rate increase preserved; quality pool and other funding moved to "targeted healthcare investments."
Nursing Homes	$193	$193	Rate increase preserved.
Safety Net Transformation	$300	$330	Spending apparently deferred from FY26 to FY27
Managed Care Quality Pools	$50	$50	Preserved
Physician Fee Schedule	$50	$50	Delayed to FY27 and preserved.
Clinics	$10	$30	Delayed to FY27 and preserved.
Value-Based Payments	$0	$15	Delayed to FY27 and preserved.
Assisted Living	$8	$8	Preserved.
Providers, Total	**$916**	**$1,581**	

Sources: FY26 Enacted, FY27 Executive

The initial Executive proposal anticipated the MCO tax to sunset in December 2025. Subsequently, the federal government announced that the tax would be allowed to remain through December 2026, generating an additional $1 billion in net revenue for the State. In her thirty-day amendments to the Executive proposal, the Governor chooses to reserve this new funding to continue rate increases in the out-years rather than allocating it to further rate increases or protecting insurance coverage.

The Executive proposal, then, is a striking declaration of priorities: While Governor Hochul has frequently argued that the State cannot afford to "backfill" federal Medicaid cuts, her application of this principle is highly selective. The Executive can and will backfill cuts to *providers*—and indeed further

thresholds by requiring that applicants demonstrate need for assistance with at least three activities of daily living rather than only two, as was formerly the case.

increase their funding despite federal cuts. It is only with respect to *coverage for Medicaid and Essential Plan enrollees* that the State must accept federal cuts.

Provider Rates in the One-House Proposals

In this respect, the Senate and Assembly follow the Executive's lead – but go even farther (see Table 2).

The Senate tracks the Executive on overall spending levels by allocating Healthcare Stability Fund (HSF) spending, but goes further by proposing to allocate most of the Executive's $750 million in "targeted healthcare investments" to hospitals ($405 million) and nursing homes ($269 million). This level of funding could likely support both the hospital quality pool contemplated in the FY26 enacted budget and also substantial additional rate increases for hospitals and nursing homes. The Senate also makes substantial additional allocations to home healthcare providers ($25 million) and FQHCs ($50 million).

The Assembly takes a vaguer and more munificent route, substantially increasing overall spending while not specifying an allocation among hospitals, nursing homes, and other providers. In the Assembly proposal, an additional $450 million state share ($900 million all-funds) is allocated to targeted healthcare investments; this spending creates room for hospital and nursing home rate increases even larger than those contemplated by the Senate and Executive. The Assembly also, strangely, reverses the Executive's proposed $50 million increase to the State's notoriously inadequate physician fee schedule, apparently in order to allocate more funding to MCOs.

How does the Assembly find an extra $450 million for provider rate increases? It is not clear from the Assembly's budget documents, but reporting indicates that legislators intend to spend much of the $1 billion in extra revenue from the unanticipated MCO tax extension described above, which the Executive proposes to save for future years.[3] This is a fiscally questionable move; the MCO tax certainly will not be extended further, so the Assembly is in effect proposing to spend one-time money on permanent rate increases.

The one-houses' generosity to providers is not limited to Healthcare Stability Fund spending. The Senate and Assembly both propose to raise the capital component of nursing home rates, spending an additional $14 million. The Assembly also increases the capital component of *hospital* rates, spending an annualized $85 million.

The one-houses also allocate more money to providers by rejecting several Executive proposals intended to rein in spending. For example, the Executive proposes much-needed reforms to the State's Independent Dispute Resolution (IDR) process, which would reduce Medicaid and state employee health insurance program spending on providers by nearly $60 million; the one-houses reject these proposals. Likewise, the Executive proposes reductions to state spending that subsidizes malpractice insurance for doctors and hospitals through the Excess Medical Malpractice and Medical Indemnity Fund programs; the one-houses reject both proposals, raising spending by $120 million. The legislature also rejects changes to the way the state Medicaid program reimburses for biomarker testing and Applied Behavioral Analysis (ABA) therapy; these proposals, too, are rejected, adding a further $80 million in spending. All told, rejecting these proposals adds nearly $260 million in all-funds spending. While the merits of each

[3] Ethan Geringer-Sameth, "Hospital industry leaders lay out roadmap for final stage of state budget negotiations," *Crain's New York Business*, March 13, 2026, https://www.crainsnewyork.com/health-care/cny-gnyha-hanys-one-house-budget-20260312/

of these reforms could be debated, taken together they are striking evidence of the legislature's willingness to spend more on providers.

Table 2: Healthcare Stability Fund Spending in the Executive and One-House Budgets, millions of state-share dollars

	FY27 Exec 30-Day	Senate	Assembly
Targeted Healthcare Investments	$750	$0	$1,200
Hospitals	$155	$560	$155
Nursing Homes and Assisted Living	$201	$470	$205
Safety Net Transformation Program	$330	$330	$330
MCO Quality Pools	$50	$50	$100
Physician Fee Schedule	$50	$50	$0
FQHCs	$30	$80	$40
Value-Based Payment Initiatives	$15	$15	$15
Home Health	$0	$25	$15
Providers, Total	**$1,581**	**$1,580**	**$2,060**

Safety Net Hospital Funding

While both the Executive and the one-house proposals make significant investments in overall provider rates, none of them does much for safety-net hospitals; aid to safety nets is cut in the Executive and mostly flat-funded in the one-houses.

This is somewhat remarkable, given the threat posed by OBBBA to safety nets. The massive loss of insurance coverage threatened by OBBBA, and left unaddressed in these budget proposals, will likely dramatically increase the charity care burden on hospitals that serve low-income populations. Meanwhile, looming federal cuts to funding streams the State uses to finance these hospitals (notably the Directed Payment Template program, the State's most significant safety net funding mechanism) may reduce the State's ability to direct supplemental payments to these facilities.

The State directs funding to New York's safety nets through a complex group of programs (see table 3) which may account for as much as a third of total Medicaid hospital funding, with the other two-thirds channeled through Medicaid rates. The Executive proposes cutting one of these programs, Vital Access Provider Assurance Program (VAPAP), by $500 million, to $300 million; this move, which has featured in several past Executive proposals, is reversed in both one-houses, and it is unlikely that it will occur. The Executive also proposes increasing Safety Net Transformation Program (SNTP) operating support by $30 million, to $330 million, a move endorsed by both legislative proposals. For the most part, however, safety net funding is left at current levels.

Table 3. Safety net funding sources in New York, millions of all-funds dollars

Program	Funding Level (FY 26 All-Funds)	Description
Directed Payment Template (DPT)	$4,500	Increased rates for safety net hospitals.
Vital Access Provider Assistance Program (VAPAP)	$800	Discretionary funding for severely distressed providers.
Safety Net Transformation Program (SNTP)	$300	Operating support for providers engaged in "transformation." (Associated with capital funding.)
1115 Global Budget Initiative	$500	Funding for downstate private safety net hospitals.
Vital Access Provider (VAP)	$300	Discretionary funding for severely distressed providers.
Total	**$6,400**	

Of course, provider rate increases will benefit safety net providers as well. It is unlikely, however, that rate increases alone will allow struggling hospitals to weather the storm generated by massive coverage loss and other OBBBA-related cuts. More targeted funding is needed—but in this budget, it appears to be absent.

Coverage in the One-Houses

As FPI has previously written, the executive budget proposal would result in approximately one million New Yorkers becoming uninsured over the next two years, approximately doubling the State's uninsurance rate. Specifically, under the executive proposal:

- 470,000 New Yorkers would lose Essential Plan coverage beginning July 1, 2026, with roughly half of this population becoming uninsured.
- A further 800,000 New Yorkers would become uninsured over time due to Medicaid work requirements, due to be implemented on January 1, 2027.

Remarkably, neither one-house invests money in protecting insurance coverage for these populations. The Senate one-house would instruct the State Department of Health to devise a plan to maintain coverage—but, absent a financial commitment, such a plan could do little. The Senate also proposes $80 million for legal and enrollment assistance for populations faced with loss of coverage—a helpful

investment, but one that will scarcely make a dent in coverage losses. The Assembly one-house is entirely silent on the issue of coverage.[4]

Essential Plan Approval Could Change the Conversation

Is there any hope that policymakers will address coverage this year? A glimmer has emerged from a surprising source: the federal government.

The Trump administration provided partial approval of the State's Essential Plan transition plan on February 27, but the approval was not made public until immediately after the one-houses were published last week.[5] The State announced that it had received final approval on March 20. While the transition plan does not provide coverage for the 470,000 EP enrollees between 200% and 250% of the federal poverty line (the EP 200–250 Population), it does offer the State fiscal space to do so.

That is because, if the federal government had *not* approved the State's plan, the State would have been obligated to provide state-funded Medicaid coverage for approximately 500,000 low-income immigrants at a state-share cost of $2.5 billion. Federal approval of the Essential Plan transition means that the State can keep this population in the federally-funded Essential Plan, freeing up $2.5 billion in state funds for alternative uses. One such use would be to provide permanent state-funded coverage for the EP 200–250 population and temporary gap coverage to those disenrolled due to Medicaid work requirements; both could be done for $2 billion annually, and less than that in FY27.

Conclusion

Whether budget negotiations will in fact prioritize coverage is an open question. The funding to do so is certainly available—but so far in this budget process, policymakers in the Executive and both houses of the legislature have systematically chosen to direct all available funding to providers. This choice no doubt reflects the tremendous power of provider lobbies in Albany—but it makes little sense from a healthcare perspective. Allowing one million New Yorkers to lose insurance will have disastrous ramifications for public health, extending well beyond the population affected and impacting every community in New York. With new funding available due to federal approval for the Essential Plan transition, New York lawmakers have no excuse for allowing catastrophic insurance loss to happen.

[4] Unlike the Executive and Senate proposals, the Assembly proposal assumes that New York's Essential Plan transition will be approved—but even under this assumption, one million New Yorkers will lose coverage in the next two years.
[5] New York Department of Health, "Basic Health Program Blueprint Revision NY-25-0001-BHP," approved by the Centers for Medicare & Medicaid Services, February 27, 2026, https://www.medicaid.gov/basic-health-program/downloads/ny-bhp-blueprint-revision-feb2026.pdf.