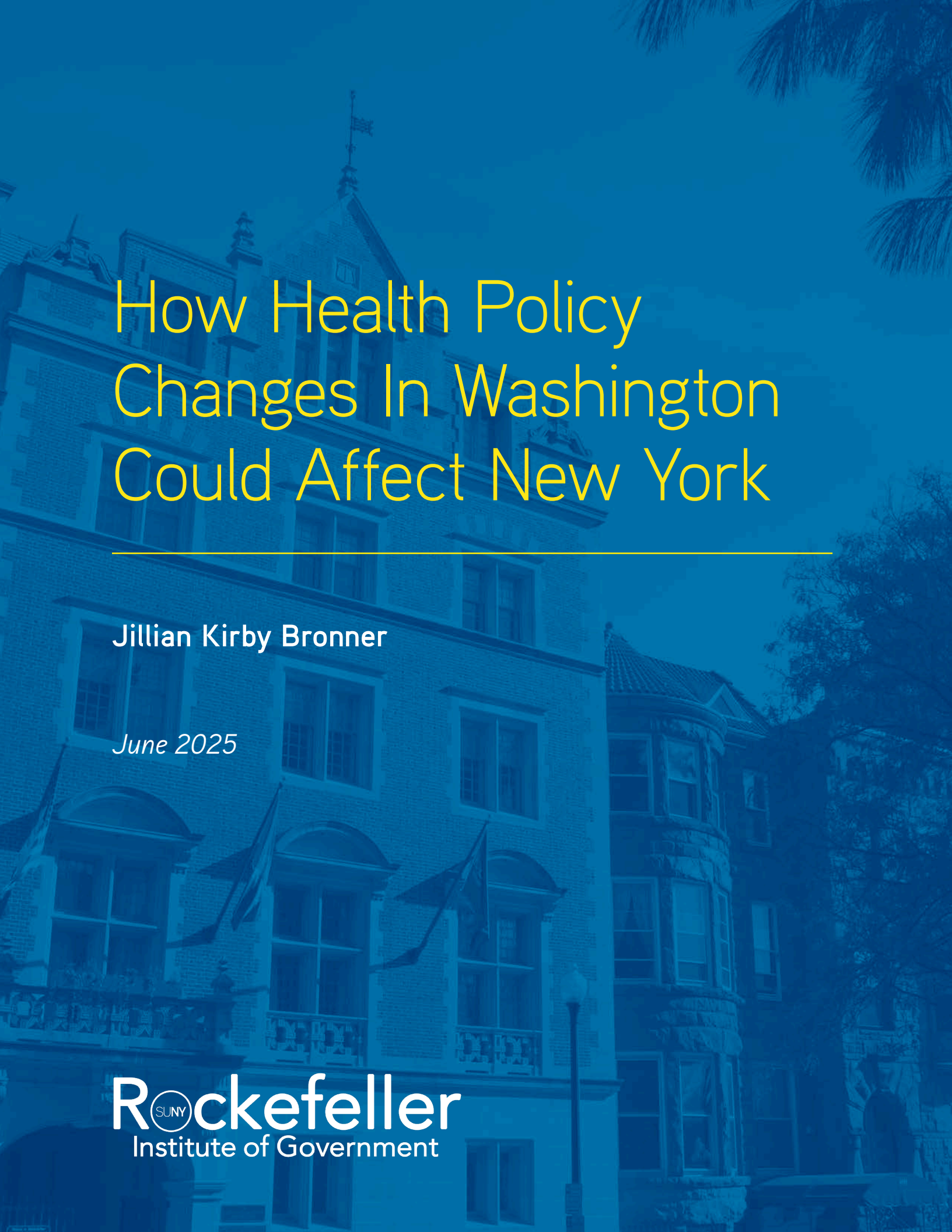

How Health Policy Changes In Washington Could Affect New York

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Executive Summary

Congress and the federal government are considering changes to healthcare policy and funding to address the national deficit and finance the federal budget. New Yorkers and New York's $300 billion healthcare industry stand to be significantly affected. The full direction of the Trump administration and Congress's healthcare agenda remains uncertain, but in addition to "make America Healthy again," the frame of *program integrity*—reducing fraud, waste, and abuse, as defined by the Trump administration and Congress in this context—has become a primary lens through which healthcare funding and policy decisions are being approached. This appears to include the framing of how current budget targets in Congress will be reached, even as such measures are not typically or technically considered in reaching those targets. Once more, many of the federal proposals outlined or policies referenced thus far have the potential to significantly impact New York's healthcare programs and budget and the coverage available to residents under existing federally funded programs. Given the evolving nature of these events, there will inevitably be new proposals and policies that unfold concurrently with and following this publication. This includes the recent portions of the House Reconciliation bill and the subsequent Senate proposal moving through Congress with initial approvals in the House. As the bill moves through Congress, additional changes are anticipated. Future work will look at that and other proposals that are moved forward in greater detail. The following provides a high-level summary and analysis, which examines key areas where federal policy shifts could materially impact New York's healthcare system and the New Yorkers for whom it cares.

Key Areas of Impact

This summary acts as a detailed table of contents of the issue areas covered in this report.

1. Insurance Coverage

Medicaid, Child Health Plus, and the Essential Plan

New York's Medicaid, Child Health Plus, and Essential Plan programs provide public health insurance benefits for nearly 9 million residents. The programs rely heavily on federal funding.[1] Federal spending reductions could come through rulemaking, waiver rescissions, or legislation that disproportionately impacts New York due to its broader eligibility criteria, extensive benefits, and use of a variety of Medicaid financing arrangements.[2]

Potential policy changes and their impacts include:

- **Medicaid Eligibility:** Federal proposals, such as those advanced through the House Energy and Commerce committee, are likely to require cost-sharing, additional eligibility checks, and/or work requirements, affecting Medicaid enrollees in New York. While most Medicaid recipients are employed, administrative hurdles could lead to temporary coverage losses. Presumably, as markups of these proposals continue, work requirements would be targeted towards nondisabled individuals and would not be extended to those meeting eligible disability standards.
- **Waiver Rollbacks or Nonrenewals:** New York recently secured over $6 billion in federal funding under its 1115 Health Equity Reform (NYHER) waiver. Under the current financing arrangement, the Trump administration has signaled that it will not extend this waiver beyond 2027 and may still choose to rescind it early, eliminating new benefits and expanded eligibility for children. New York may need to take precautions with respect to submitting new or requesting modifications to Medicaid waivers, including for noncontroversial actions, so as to protect sensitive programs and other key policy objectives that are currently approved from being subject to federal repeal or alteration.

  Additionally, the Essential Plan (1332) waiver includes coverage in New York for certain noncitizens, such as those covered under Deferred Action for Childhood Arrivals (DACA) and those on a path to citizenship, but who are not yet eligible for federal funding in Medicaid. The Trump administration's proposed rulemaking already modifies coverage for certain noncitizens, and the initial Reconciliation proposals would significantly reduce funding for the Essential Plan.
- **Reductions in Federal Contributions:** Limits on the use of mechanisms that increase federal funding, like healthcare-related taxes, directed payment templates, cuts to Medicaid matching funds, or caps on federal reimbursements, including block grants, could significantly reduce funding available to finance the current program. Depending on the mechanisms used to effectuate such

reduction, the loss of funding to New York and different Medicaid enrollment populations is impacted to varying degrees. For example, a reduction to enhanced federal financial participation with respect to expansion populations authorized under the Affordable Care Act, as proposed by the House and Senate, would disproportionally apply to the working, nondisabled membership, whereas a per capita limit or block grant program, neither of which were included in the initial Reconciliation proposals, may apply more broadly, including to more vulnerable populations.

Despite statements by President Trump and Congressional Republicans that they will not cut "traditional" Medicaid, Medicaid funding reductions are all but certain to be necessary if they are to meet the required federal spending targets established by Congress and supported by the Trump administration. The initial bills proposed by the House and Senate through the Reconciliation process include significant reductions to Medicaid funding for New York in the form of cost shifts and eligibility reductions with the initial Senate bill increasing the impact to New York over the House-passed proposal. The various types of proposals that could impact New York are described in greater detail throughout this paper.

Medicare

Despite assurances that Medicare, which covers over 3.9 million New York residents, would not be cut, structural changes remain possible, including how providers are reimbursed. Expansion of Medicare Advantage plans could shift enrollees from traditional fee-for-service models, affecting provider reimbursements, which differ between the two programs. And, potential reductions to graduate medical education (GME) funding through Medicare could also impact New York, which trains 12 percent of the nation's physicians.[3] While the initial House and Senate Reconciliation bills did not make dramatic changes to Medicare financing, eligibility changes included limiting eligibility for Medicare for certain citizens and delaying implementation of the Biden-era rule streamlining eligibility for the Medicare Savings Program. Additionally, it's still possible that proposals not in the House bill or the initial Senate bill could resurface or be implemented administratively.

Commercial Health Insurance Markets and New York State of Health (NYSOH)

Already, through finalized rulemaking, the Trump administration has advanced significant changes to the guidelines for purchasing coverage on a state insurance exchange (or marketplace).[4] The House and Senate Reconciliation bills largely codifies and expands such changes in its initial bill drafts, passed by the House. Additionally, the potential expiration of COVID-19-era enhanced subsidies, available to consumers to reduce the cost of purchasing coverage, could lead to steep premium increases. Notably, an extension was not included in the House or Senate Reconciliation bill. The Kaiser Foundation estimates that without legislative action, individual market insurance costs could rise by over 75 percent, with New York projecting a 58 percent premium increase based on 2022 estimates.[5] New York recently updated its estimate to a potential 38 percent increase, following the passage of the House Reconciliation bill. Premium increases could disproportionately affect the roughly 140,000 New

Yorkers who currently receive such subsidies, making coverage less affordable and potentially shrinking New York's individual and small group health insurance markets.

Further, the Trump administration and Congress could promote short-term and association health plans, which shift more costs to consumers. And, if federal support for state-mandated coverage expansions is reduced, New York would need to cover additional costs or reduce benefits.

2. Other Key Policy Areas

Program Integrity

Program integrity refers to the measures taken to reduce fraud, waste, and abuse in public programs. The Trump administration and Congressional Republicans are heavily focused on using this approach to achieve spending targets and reform existing programs. While some of these measures are not traditionally considered as metrics towards achieving budget targets, it's anticipated that proposals that can be framed through this lens or to close perceived loopholes will be prioritized, as was the case with the initial proposals approved by the House and included in the Senate Reconciliation draft.

Coverage of Care for Noncitizens

The Trump administration has already taken actions to limit the ability of states to cover noncitizens, and the House proposals would further restrict states' option to cover noncitizens. New York, along with other states, provides health insurance to noncitizens in certain circumstances, a portion of whom the state was required to cover, per litigation. Proposed changes in the House and Senate bills, which penalize the state for using state-only dollars and restrict the availability of federal funds, could necessitate further discussion between the governor, the legislature, and stakeholders on future coverage.

Hospital Consolidation

One-third of New York's hospitals are financially distressed. The availability of federal funding to support distressed hospitals at current levels is at risk. Further, recent federal proposals include a reference to limiting hospital consolidations in the name of avoiding unnecessary price growth[6] and maximizing competition.[7] New York hospital systems are smaller than those nationally, and Congressional or Trump administration proposals could impact consolidation in New York that New York State officials see as necessary to address financial sustainability and preserve access to care.[8] Recent data suggests uncertainty related to pending reductions has already had a cooling effect on hospital consolidation nationally. The state's safety net transformation program could be leveraged as a tool to mitigate the potential impacts of federal reductions. The Reconciliation bills moving through Congress limits the availability of additional federal financial participation to support distressed hospitals through the directed template program by capping future payments or payment changes to the Medicare rate, and expands access to enhanced payments for certain rural hospitals.

Coverage of Gender-Affirming Care

Already, the Trump administration has made clear in executive orders[9] and guidance that they intend to challenge states and providers that use federal funds in conflict with the administration's policies regarding gender. Initial Congressional proposals also included limits on such care for minors; the version of the bill ultimately approved by the House and introduced in the Senate extended such restrictions to adults.

Abortion Access

The Trump administration has already sought to limit access to medication-induced abortions, defund Planned Parenthood, and reinstate restrictions on Title X funding.[10] While New York has enacted strong related protections, federal defunding could require the state to make a decision on whether to backfill lost resources.[11] Restrictions on payments to abortion providers were a component of the initial House and Senate Reconciliation bills moving through Congress.

Prescription Drug Pricing

Federal efforts to lower drug prices include greater regulation of pharmacy benefit managers (PBMs) and renewed scrutiny of pharmaceutical practices and pricing.[12] Statutory changes to effectuate these proposals are included in the Congressional Reconciliation bills, and additional actions may be proposed.

Key Takeaways

New York's healthcare system, which is deeply intertwined with federal funding and policies, faces significant uncertainty under proposed and potential Trump administration and Congressional policy proposals. While not all proposed policies will advance, shifts in Medicaid funding, insurance subsidies, and regulatory oversight could create financial and operational challenges for the state, entities operating within it, and residents trying to access care.

Already, the proposals advancing through the Congressional Reconciliation process would have significant impacts to New York in current and future fiscal years. Such proposals both reduce funding for public insurance programs and modify eligibility for such programs.

The magnitude of proposals advanced in the Reconciliation bills, in combination with potential actions and/or actions already taken administratively by the Trump administration, is significant. The level of funding and eligibility reductions proposed in the Reconciliation bills moving through Congress, which reduces funding to New York even further in the Senate proposal, will necessitate conversations between the governor, the legislature, and stakeholders on healthcare funding and program design. The Rockefeller Institute of Government will continue to closely monitor federal actions in order to allow state policymakers to better anticipate and mitigate any potential impacts on New Yorkers and New York's healthcare sector.

Introduction

As the federal government contemplates significant changes to healthcare funding as part of overall efforts to reduce the federal deficit and extend tax cuts, it's certain that New Yorkers and New York's $300 billion healthcare industry will be impacted. The extent and scope of potential changes, however, remain a moving target as discussions continue between the Trump administration and Congress on a potential plan. This report provides a detailed summary of various health policy proposals under consideration in Congress and by the Trump administration.

After an early April meeting with Congressional Republicans, President Trump stated, "I am for major spending cuts… all of which will go into 'The One, Big, Beautiful Bill.'"[13] The Trump administration's proposed budget, released on May 2nd, would reduce spending for Health and Human Services by 26 percent compared to 2025 levels.[14] We do not know the details of how the final bill would achieve that at present, but some details are emerging through the reconciliation process. The Trump administration continues to indicate that it believes significant reductions can be achieved through eliminating fraud, waste, and abuse, and both the House and Senate proposals use this framing to advance their agenda.

In February, after the Senate passed its initial budget, the House of Representatives passed its budget resolution, paving the way for a reconciliation process, which expedites the legislative timeline between the House and the Senate, avoids a filibuster, and allows for the passage of legislation with a simple majority. The House resolution established an $880 billion spending reduction target for programs overseen by the Energy and Commerce Committee, which according to the Committee website, "has responsibility for matters including telecommunications, consumer protection, food

and drug safety, public health and research, environmental quality, energy policy, and interstate and foreign commerce among others."[15] Importantly, the Committee oversees the Medicaid, Medicare, and Children's Health Insurance Programs, the former of which is expected to bear the brunt of reductions. The Ways and Means Committee also oversees certain health-related items, such as tax credits for purchasing health insurance.

In early April, the Senate, during a marathon budget resolution session, narrowly passed (51–48) its response to the House budget. During the debate, three Senate Republicans (Sens. Susan Collins, R-ME; Josh Hawley, R-MO; and Lisa Murkowski, R-AK) voted against party lines for a failed amendment (49–50) to strike the $880 billion reduction target, suggesting that it will be difficult to get enough votes to legislatively reduce spending at that level; however, at present, the $880 billion reduction target remains.[16]

As expected, in early May, the House Energy and Commerce and Ways and Means Committees met to review proposals.[17] On the Democratic side of the aisle, lawmakers expressed that they expect the proposals to result in drastic cuts decimating the healthcare safety net and triggering a crisis.[18] Republicans have, in contrast, framed the reductions as simply shaving growth from an unsustainable program that, even after the proposed reductions, will grow by 25 percent over five years.[19]

Despite the rather swift committee approvals in the House, as reported in the media,[20] agreement between the House and Senate on how to restrict spending will be complicated to achieve. In April, a group of 12 Republican members of Congress sent a letter to House leadership opposing reductions in Medicaid coverage for vulnerable populations, while at the same time expressing support for "targeted reforms to improve program integrity, reduce improper payments, and modernize delivery systems to fix flaws in the program that divert resources away from children, seniors, individuals with disabilities, and pregnant women—those who the program was intended to help." Meanwhile, in May, a group of 20 conservative house members, led by Texas Congressman Chip Roy, issued a letter to House colleagues urging them to "pursue meaningful [Medicaid] reforms"[21] by reducing the federal contribution for certain childless adults (the expansion population), limiting mechanisms to leverage federal funds (such as provider taxes), and placing a greater emphasis on eligibility verification and program integrity. Several key votes in the House were linked to the restoration of state and local tax (SALT) deductions, which have little to do with healthcare policy in New York.

Despite these differing views and external forces, it's been widely documented that reductions to healthcare funding will be necessary to achieve the targeted savings. However, based on the above and other recent statements by Congressional leaders, it remains unclear how much of the targeted savings are expected to be achieved through legislative budget processes, as opposed to administrative actions that, as was noted above, do not count towards reconciliation targets.[22] Additional savings, outside of the reconciliation process, are likely to come from rescission packages, which would prevent appropriated funds from being spent and obtain Congressional approval for administrative actions taken by the Trump administration. Nonetheless,

Senate Majority Leader John Thune has said administrative actions will be used to detail the overall strategy for spending reductions. Additionally, the chair of the Ways and Means Health Subcommittee has emphasized a need to identify "inefficiencies" in Medicaid and Medicare, and the chair of the House Energy and Commerce Committee said the savings target could be achieved "without cutting Medicaid benefits."

While Congress takes steps to implement legislative actions, the Trump administration wields considerable power over healthcare spending through the Health and Human Services (HHS) agencies. Actions taken by the Trump administration may help operationalize Congressional reductions or add on to their actions, especially if such actions fit within the pretext of eliminating fraud, waste, or abuse. For example, the House and Senate Reconciliation bills codified rulemaking already proposed by the Trump administration.

In February 2025, Robert F. Kennedy, Jr., was confirmed by the Senate as secretary of health and human services. In addition, Dr. Jay Bhattacharya was confirmed as the director of the National Institute of Health (NIH), Marty Makary was confirmed as the director of the Food and Drug Administration (FDA) late in March 2025, and Dr. Mehmet Oz was confirmed to lead the Centers for Medicaid and Medicare Services (CMS) in early April. Despite the announcement of a major reorganizational plan for HHS, it's unlikely that the Trump Administration will outline in significant detail any administrative health insurance policies until after the reconciliation process has been completed. However, Dr. Oz provided four pillars as the primary vision for CMS following his confirmation:

- "Empowering the American People with personalized solutions they can better manage their health and navigate the complex health care system. As a first step, CMS will implement the President's Executive Order on Transparency to give Americans the information they need about costs.
- Equipping health care providers with better information about the patients they serve and holding them accountable for health outcomes, rather than unnecessary paperwork that distracts them from their mission. For example, CMS will work to streamline access to life saving treatments.
- Identifying and eliminating fraud, waste, and abuse to stop unscrupulous people who are stealing from vulnerable patients and taxpayers.
- Shifting the paradigm for health care from a system that focuses on sick care to one that fosters prevention, wellness, and chronic disease management. For example, CMS operates many programs that can be used to focus on improving holistic health outcomes."

Given the above proposals and lenses guiding policy and funding decisions, it's clear the Trump administration's vision and congressional reforms will impact national healthcare policy, thereby affecting New Yorkers and the state's healthcare delivery system. New York's healthcare system is not only crucial to the everyday well-being of New Yorkers, but a significant component of New York's economy. Therefore, large changes to Medicaid could have significant impacts on the future health of New Yorkers and the broader performance of the state's economy.

This summary and analysis, in particular, synthesizes the major ways in which funding for healthcare may be impacted in the state as a consequence of these changes. These changes may not only materially impact New York's healthcare system, but they will almost certainly affect the terms under which health insurance in the state is financed and the coverage that is accessible to the nearly 20 million people in the state of New York. Given our analysis here and in the context of the significant savings targets being discussed, these impacts could be significant, and some of the proposals being considered by Congress, such as several of the proposals included in the initial House and Senate Reconciliation bills, would disproportionately impact New York.

Many of the proposals described below are included in the bills moving through Congress, while others may not be entirely off the table as the first bill is not likely to be the final, and many not in the bills could be effectuated by the Trump administration without legislation.

The proposals in the bills moving through Congress, and which have been floated as potential actions, generally fall in two categories: 1) financing—proposals that reduce funding to the state (or providers or consumers in the case of Medicare or the commercial market) without a commensurate policy change; and 2) eligibility or benefits—proposals that mandate policy changes to the current program design with commensurate funding increases or decreases. The majority of the proposals in the House and Senate bills, and certainly the most impactful from a funding standpoint to New York and New York's healthcare economy, largely affect the state's public insurance programs, particularly Medicaid and the Essential Plan.

In category one (financing), several proposals in the bills impact New York and a handful of other states, shifting costs from the federal government back to the state. Such actions create gaps between current state policies and available funding in the New York State budget and are likely to necessitate conversations between the governor, the legislature, and stakeholders.

In category two (eligibility), the remainder of the proposals will prohibit payment for certain services or restrict enrollment in the program due to additional administrative hurdles. While such proposals may result in a net savings to the state, after administrative implementation costs, there is a potential that eligible New Yorkers could become uninsured.

The Senate bill builds off of the House proposal with a majority of the proposals repeated. The following is a summary of the major impacts to New York proposed in the Reconciliation bills now moving through Congress grouped by financing and eligibility/benefits. Significant variations between the House and Senate bills are noted.

Category One—Funding Reduction Proposals:

- Eliminating advance premium tax credits (APTC) and subsidies for certain legally residing noncitizens, most of whom are known as the Aliessa population. There are currently approximately 500,000 noncitizens enrolled in the Essential Plan that would no longer qualify for federal subsidies.[23] While

estimates on the lost revenue have varied and are higher than the cost due to the funding structure, eliminating these subsidies could cost the state $3 billion in state funds to provide equivalent healthcare, effective January 2026, if passed.

- Excluding a proposal to extend enhanced APTCs subsidies set to expire at the end of 2025, which generate $1 billion to $1.2 billion in additional Essential Plan funding.[24] When combined, as if separate actions, with the loss of eligibility for certain legally residing noncitizens, the state estimates the lost revenue impact could be as high as $7.5 billion raising questions about whether the $10 billion in suspended Essential Plan trust funds could be used to smooth the impacts to consumers and the state should the state revert back to a basic health program.
- Subjecting New York to a federal matching rate penalty for being one of 14 states that cover nonqualified alien children and one of seven states that cover 16,000 nonqualified alien adults using state-only dollars.[25] This penalty, if enacted, could range from $300 million to $1.6 billion, depending on application, effective January 2027.[26] The penalty also applies to certain aliens residing under the color of law.
- Restricting the use of managed care taxes and other taxes that require a broad-based and uniform waiver. States, like New York, with approval for such a tax within the past two years, would not be subject to a transition period under the proposal. New York's managed care tax was estimated at $3.7 billion over two years.[27] At least one year of the tax revenue could be at risk, depending on implementation. All new provider taxes would be prohibited under the proposal. The Senate bill further restricts the use of existing provider taxes by reducing the allowable threshold from 6 percent currently by 0.5 percentage points annually until reaching 3.5 percent in 2031.
- Limiting the maximum reimbursement to financially distressed hospitals through directed payment templates (DPT) to the Medicare rate rather than the average commercial rate, which for inpatient services can be more than 200 percent greater. New York uses the average commercial rate for roughly $2 billion in DPT payments to distressed hospitals and other providers. Approved DPTs would not be impacted, but the bulk of New York's DPT programs, and in particular the financially distressed hospital DPT, expired in March 2025 and could, therefore, be subject to the new requirements or frozen at current levels for fiscal year 2026 payments. Additionally, the $15.75 million prenatal services DPT was formerly approved at 156 percent of Medicare, and presumably could also be impacted by the House's proposal. Presuming a similar relationship with the proposed Medicare payment limit, at least one-third of federal DPT funding ($500–$600 million) could be at risk; however, a grandfathering clause included in the bill passed by the House could freeze payments at current levels without the ability to make changes based on facility and community need. The Senate bill modifies the House's grandfathering of existing DPT payments by requiring a reduction to such payments by 10 percent annually until such time as the payments do not exceed Medicare reimbursement.

- Directing HHS to restrict the availability of federal funds available to support Medicaid waiver initiatives is proposed on top of recent CMS guidance limiting availability of designated state health programs (DSHPs) and HHS rescinding CMS prior guidance on health-related social needs (HRSNs). The budget neutrality test for New York's Health Equity Reform (NYHER) 1115 waiver, which adds approximately $6 billion in federal funding,[28] was met by CMS treating certain HRSN expenditures as "hypothetical" rather than applying CMS's 2018 budget neutrality policies. Additionally, other statutory eligibility changes proposed in the bill modify eligibility standards, including continuous coverage for childless adults, for example, that are requirements in New York's waiver, raising questions about whether the terms of the waiver or any other amendments New York would like to pursue for the foreseeable future would need to be amended or renegotiated with the Trump administration. The waiver also includes maintenance of effort provisions restricting New York's ability to modify funding for certain programs in the face of federal reductions.

Category Two—Proposed Eligibility and Benefit Changes:

- Imposing administrative hurdles to maintain eligibility, including mandating an average of 20 hours per week of work or school for able-bodied childless adults (19–64), effective July 2027, requiring biannual eligibility verification for expansion population (100–138 percent of the federal poverty level [FPL]) adults, limiting reasonable opportunity periods, and requiring cost sharing up to 5 percent of income, for example, are proposed in the Reconciliation bills progressing through Congress. The Senate accelerates implementation to no later than January 1, 2027, and eliminates the exemption from work requirements for parents with children over 14.
- Limiting retroactive enrollment to one month (from three) and capping the home equity exemption for seniors requiring long-term care at $1 million are also proposed. New York's home equity exemption is currently $1,097,000 and indexed to inflation.
- Delaying until January 2035 the implementation of the Biden administration rules related to: 1) enrolling in the Medicare savings program, 2) streamlining Medicaid eligibility determinations, and 3) imposing minimum staffing requirements for nursing homes is also proposed.
- Prohibiting the availability of federal financial participation for any abortion or gender transition procedures for minors, effective immediately.

It's expected that the specifics regarding some or all of these proposals may change as the House and Senate work to reach a final agreement. The Rockefeller Institute will continue to monitor these developments closely as they unfold and to provide relevant and timely analysis.

Section One—State-Run Public Insurance Programs

Medicaid, Medicaid Waiver (1115 Waiver), Child Health Plus, and the Essential Plan (1332 Waiver)

The Medical Assistance Program, known as Medicaid, provides comprehensive health insurance to low-income children, adults, and seniors. The federal government, along with states, jointly finances the Medicaid program. According to the Kaiser Family Foundation, Medicaid spending nationally was $880 billion in federal fiscal year 2023, of which $606 billion (69 percent) was funded by the federal government and $273 billion (31 percent) was funded by states and localities.[29] As discussed further below, in New York, local governments have an important role in financing the program.

New York's Medicaid program, which covers nearly seven million of the state's nearly 20 million residents, has long been known for having more expansive benefits and broader eligibility standards compared to other states.[30]

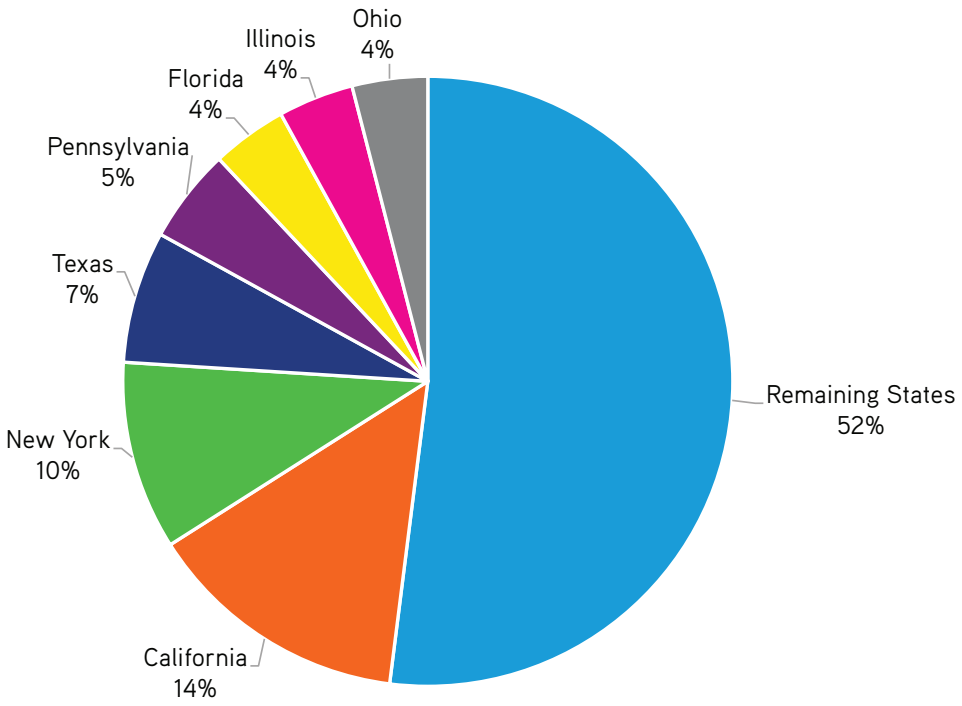
FACT SHEET

- New York receives approximately 10 percent of total federal spending for Medicaid.[31] According to Kaiser, of the $97.9 billion spent in New York on Medicaid, $62.4 billion (64 percent) was funded by the federal government and $35.5 billion (36 percent) was financed by the state and local governments.[32] The local share has been frozen at $7.6 billion since the state fiscal year 2015, following a series of reforms to address Medicaid local cost growth and administration.
- Almost 30 percent of the state's population is on Medicaid, including 25 percent of adults ages 19 to 64, nearly 45 percent of children, more than 60 percent of nursing home residents, and nearly 30 percent of Medicare beneficiaries. Almost 50 percent of all births are paid for by Medicaid.[33]
- A 2020 Health Affairs study, "Trends in State Medicaid Eligibility, Enrollment Rules, and Benefits," found that between 2000 and 2016, New York' eligibility rules and benefits were the most generous of nearly any state, while at the same time requiring smaller copays and fewer administrative hurdles to remain on the program.
- New York's spending per enrollee of $9,872 exceeds the national average of $7,593 by 30 percent.[34]

The National Association of Medicaid Directors often uses the phrase "if you've seen one Medicaid program, you've seen one Medicaid program."[35] The federal government does not operate the Medicaid program like it does the Medicare program; there is wide variation in how each state designs and implements its Medicaid program. States enter into contracts through a state plan or through waiver agreements with

the federal government to set out the terms and conditions of the state's program. This allows states the flexibility to tailor their programs according to their policy preferences and needs of their residents. New York has historically built its program to maximize federal funding to support expansive coverage through waivers, directed payment templates,[36] and other financing strategies.

FIGURE 1 | States' Share of Total (State and Federal) Medicaid Expenditures



NOTE: The expenditures in this figure include all Medicaid expenditures, which include both administrative and benefit spending. These expenditures exclude state Medicaid Fraud Control Units, Medicaid survey and certification of nursing and intermediate care facilities, and the Vaccines for Children program.

SOURCE: Medicaid Financing and Expenditures (Washington, DC: Congressional Research Service, updated May 5, 2025), https://www.congress.gov/crs_external_products/R/PDF/R42640/R42640.13.pdf.

Given that the federal government funds nearly 70 percent of the national Medicaid program, it is expected that states will be deeply impacted by any significant federal spending reductions. There are a series of ways in which federal Medicaid funding to New York can be modified, including through rulemaking, waiver recissions, and/or legislation.

In Medicaid, because of the joint funding structure with the federal government, proposals and actions from the Trump administration or Congress will fall into one of two categories: funding or eligibility and benefits. Funding modifications would change how much the federal government is providing to operate the program, without dictating a commensurate policy change at the state level. Federal funding increases reduce the required state spending, while federal funding decreases increase how much the state would need to spend, absent policy changes. In the case of significant

reductions to federal funding, conversations between the governor, the legislature, and stakeholders could be necessitated to bring the program design and funding in line. On the other hand, eligibility or benefit changes modify who is eligible for the program or which services are covered and thus such changes either reduce or increase federal and state spending commensurately. While such changes would be dictated by the Trump administration or Congress, there is a potential that state laws would need to be adjusted to accommodate shifts at the federal level.

There is considerably more immediate risk to the state's healthcare financing associated with federal financing changes, which are presumably the target of reductions. A March 2025 report by the Paragon Health Institute—a health policy organization founded by Brian Blase, who was an advisor to President Trump in his first administration—examined "how states use Medicaid financing…to shift costs from state budgets to federal taxpayers." The report detailed numerous proposals to reduce the availability of such arrangements, which include supplemental payments, directed payment templates, provider taxes, intergovernmental transfers, and enhanced federal funding. The proposals identified in the report, along with Medicaid waivers, are therefore areas where funding to New York could be reduced through Congressional or administrative action. Eligibility changes, which as proposed take effect later, may also be impactful, such as those proposed by the House, and could reduce coverage. However, it is likely that Congressional and administrative actions would be subject to litigation from impacted states. While the administration has been in office for only a handful of months, over 200 lawsuits have been filed to challenge the Trump administration's actions.[37]

In addition to the Medicaid program, New York State operates two additional public health insurance benefit programs as follows:

Child Health Plus (CHP), which offers health insurance to over 580,000 children with incomes above the Medicaid program limits, has similar program features as the Medicaid program for children, but is almost exclusively run through managed care plans, a type of health insurance structured to manage the costs and quality of service through contracting with particular providers or facilities.[38] The federal match rate for CHP is 15 percentage points higher than in Medicaid, or 65 percent in the case of New York. According to the Enacted Budget Financial Plan, "the State is covering over 140,000 undocumented children, an increase of roughly 75,000 enrollees from January 2020" with 100 percent state funding. Like Medicaid, federal financing changes create budgetary relief or pressures, while eligibility or benefit changes modify both the funding and policy concurrently.

The Essential Plan (EP) is a state option authorized under the Affordable Care Act (ACA) for persons above Medicaid eligibility, up to 200 percent of the federal poverty limit (FPL). This allows states to receive 95 percent of the advance premium tax credit and cost-sharing reduction payments that would have been provided to an individual purchasing insurance on the individual market in exchange for state-administered health insurance. New York converted its Essential Plan to a 1332 waiver, starting in April 2024, to expand eligibility to up to 250 percent of the federal poverty limit. Total enrollment for this program exceeds 1.6 million, including roughly 500,000 legally

residing noncitizens and over 400,000 individuals in the 200 to 250 percent of poverty expansion group. Due to the federal financing structure, the Essential Plan program is entirely federally funded.[39] Like Medicaid and CHP, changes to federal funding for the EP increase or decrease available funding for the program, while eligibility or benefit changes modify funding and program design concurrently. However, unlike Medicaid and CHP, the Essential Plan is discreetly financed, and federal funding cannot be used for other purposes, unless approved by CMS. New York uses excess EP resources to reduce out-of-pocket and premium expenses for the 400,000 adults who fall between 200 percent to 250 percent of the federal poverty limit through a 1332 waiver. Accordingly, while the loss of EP funding does not necessarily result in an impact on state funding, federal funding changes would raise questions about whether the $10 billion in Essential Plan trust funds could be used to smooth the impacts should the state revert to a basic health plan.

Medicaid Waivers

In 2024, New York received approval for its New York Health Equity Reform (NYHER) 1115 waiver, authorizing over $6 billion in new federal funding. This waiver expands Medicaid benefits by covering what are referred to as health-related social needs (HRSNs).[40] A subsequent amendment expanded coverage by prohibiting eligibility checks through the provision of automatic continuous eligibility until the 6th birthday of a child born on Medicaid or Child Health Plus, impacting an estimated 800,000 children in that age group.[41, 42]

New York was one of five states approved by the Biden administration for a six-year continuous coverage expansion in November of 2024.[43] As of January 2024, all states are required to provide continuous coverage to children up to age 19 in Medicaid and Child Health Plus for a period of one year. This means that eligibility for children up to age 19 is renewed on an annual basis, rather than any other shorter duration, which was previously an option available to states. The one-year requirement was authorized in the 2023 Consolidated Appropriations Act and was estimated by the Assistant Secretary for Planning and Evaluation's Office of Health Policy in a 2024 issue brief to increase coverage for impacted states. As noted in the issue brief, New York was not affected by the 2024 change, as 12 months of continuous coverage annually for children up to 19 in Medicaid and Child Health Plus was already the standard for the state. However, eligibility changes proposed in the House and Senate Reconciliation bills would impact 12-month continuous coverage for certain childless adults, which is authorized through New York State's 1115 waiver.

In addition to the new provisions authorized through these waivers, all previously existing terms of the various Medicaid managed care programs operated in New York were reauthorized through March 31, 2027. New York's Care Management for All policy requires that nearly all Medicaid recipients (74 percent in New York[44]) be covered through managed care or insurance companies.[45] As a result of this waiver process, the Trump administration has a higher level of administrative discretion over the way in which New York's Medicaid program is designed and operated because the program features must be approved through the Medicaid waiver process.

At a minimum, it is likely that the terms of the waiver, including the new services and eligibility standards, are at risk of not being renewed and therefore expiring in 2027. This could result in the elimination of the newly added health-related social needs (HRSN) services provided for up to two years. Already, on March 4, 2025, the Centers for Medicare and Medicaid Services rescinded two Biden administration issued Center Informational Bulletins (CIBs), both of which detailed opportunities for covering HRSNs in Medicaid and Child Health Plus and a framework for coverage of HRSN services in Medicaid and Child Health Plus. Additionally, the March 4th letter details that CMS will now review requests to "cover these services on a case-by-case basis to determine whether they satisfy federal requirements for approval under the applicable provisions of the Social Security Act and implementing federal regulations, without reference to the November 2023 and December 2024 CIBs or the HRSN Framework." While this does not automatically invalidate New York's approval to offer HRSN services through the waiver, it does indicate CMS is no longer promoting such services and will be examining any such proposals through a different lens going forward.

In addition, in an April 10th press release to the states, CMS announced that it will no longer approve new or extend existing requests for federal matching funds on two types of programs, arguing that:

> designated state health programs (DSHP) and designated state investment programs (DSIP). DSHPs and DSIPs are state-funded health programs that, without "creative interpretations" of Section 1115 demonstration authority, would not have qualified for federal Medicaid funding.[46]

The NYHER waiver included $4.3 billion in allowable DSHP expenditures with a total cap of $3.9 billion.[47] At a minimum, CMS has made it clear this funding will not continue after March 2027. Further, while New York State's DSHP claiming protocol was approved by the Biden administration, it is conditional on the state meeting various milestones outlined in the standards, terms, and conditions document, and on the state "conducting monitoring and evaluation of all DSHP-funded activities." It's unclear whether the $3.9 billion in approved DSHP funds, which support HRSN and workforce programs in the waiver, will be fully claimable prior to 2027. It is clear, however, that going forward, DSHPs will not be available to support a future waiver under the current administration. As former New York Medicaid Director Jason Helgerson noted in a recent blog post on the DSHP letter, "New York and other states will now need to decide what to do—put up tax dollars to fund these services or wait until the next election, hoping for a different result."[48]

It is also possible that the Trump administration will seek to modify or rescind the waiver approvals prior to the March 2027 expiration, potentially opening the terms and conditions regarding services provided and eligibility criteria for all the Medicaid managed care programs operated through New York's 1115 waiver.

The Trump administration may follow a similar pattern (if in an opposing direction) to the Biden administration, which, in most cases, reversed Trump-era waivers, such as those implementing work requirements as part of eligibility criteria (which will

be discussed further below).[49] To do this, the Trump administration could direct the Health and Human Services (HHS) Secretary, Robert F. Kennedy, Jr., to review all Medicaid policies, rules, regulations, and administrative approvals, including waivers that conflict with the Trump administration's stated policy objectives. For example, the president issued a memorandum to the Health and Human Services Secretary directing HHS to "take appropriate action to eliminate waste, fraud, and abuse in Medicaid, including by ensuring Medicaid payments rates are not higher than Medicare, to the extent permitted by applicable law."

One objective seems clear: the new administration will likely seek to expand the general definition of fraud, waste, and abuse across all programs.[50] As a result, with written notice, the secretary has the authority to take administrative action to reverse approvals of services or new approaches to care delivery, on the basis that elements contained in the state's Medicaid waiver conflict with an administrative objective of controlling costs by eliminating fraud, waste, and abuse.

Even if this administrative approach to withdrawing the waiver is unsuccessful, the Trump administration could potentially invoke the Congressional Review Act or request that Congress enact legislation terminating the waivers, though such actions would likely be precedent-setting. The initial House and Senate Reconciliation bills (Section 44135 in the House and 71123 in the Senate), moving through Congress, includes language requiring 1115 waivers to be budget neutral, and would require HHS to develop methodologies for applying savings generated to be applied to future extensions, effective immediately if enacted. While the NYHER waiver is subject to budget neutrality, the budget neutrality test was met by CMS treating certain health-related social needs expenditures as "hypothetical" rather than applying CMS's 2018 budget neutrality policies. This change was proposed on top of recent CMS guidance limiting availability of designated state health programs DSHPs and HHS rescinding CMS prior guidance on health-related social needs. Therefore, it's unclear if Congress is looking to further restrict budget neutrality calculations from including DSHPs or other like mechanisms in current waivers or in the future. Other changes proposed in the bill modify eligibility standards, including continuous coverage for childless adults, for example, that are requirements in New York's waiver—raising questions about whether the terms of the waiver or any other amendments New York would like to pursue for the foreseeable future would need to be amended or renegotiated with the Trump administration. Additionally, any amendments to New York's 1115 waiver, prior to expiration, would be subject to the new policy, if enacted. New York's Health Equity Reform (NYHER) 1115 waiver,[51] which adds approximately $6 billion in federal funding, includes maintenance of effort provisions restricting New York's ability to modify funding for certain programs in the face of federal reductions.

Work Requirements and Other Eligibility Standards

Over the past decade, New York has taken numerous steps to both expand Medicaid benefits and streamline the process for verifying eligibility.[52] Should the New York Medicaid waiver be rescinded or allowed to expire, the state would need to renegotiate the terms and conditions of all components of the waiver, including eligibility criteria,

with the Trump administration. As a result, it's possible that elements of New York's Medicaid eligibility standards, which over time have been modified to eliminate barriers to accessing Medicaid coverage, would be viewed as in conflict with Trump administration objectives.[53]

The Trump administration may push new eligibility criteria administratively, such as by renegotiating waivers. However, in the near term, it is more probable that changes to eligibility, like new work requirements for nondisabled adults aged 19–65, may be adopted by Congress to achieve spending reduction targets more quickly and minimize litigation avenues for states. New York Congressman Mike Lawler (R-NY-17) penned an op-ed in April indicating support for "reforms like work requirements for able-bodied adults without dependents, shifting eligibility verification to a quarterly review from the current annual review system, and ensuring benefits don't go to ineligible recipients, including illegal immigrants."

For example, the Reconciliation bills (Section 44141 in the House and 71124 in the Senate) approved a proposal similar to a bill introduced in the House of Representatives in February 2025 entitled *The Jobs and Opportunities Act for Medicaid,* which would require "individuals who are between the ages of 18 and 65 and who are not otherwise unable to work due to a medical condition, family situation, or other listed reason to work or volunteer at least 20 hours per week, based on a monthly average [of 80 hours], in order to qualify for Medicaid." Accordingly, those who do not meet this work requirement would be determined ineligible for Medicaid under the proposal. The bill is sponsored by Senator Kennedy (R-LA) and has four cosponsors in the House, including Congresswoman Tenney (R-NY-24). Despite his written support, Congressman Lawler is not a cosponsor at present. There is another version of the bill in the House, also with four cosponsors, none of whom are from New York, and there is currently no analogous bill in the Senate. Congressman Bean, the sponsor of the second House bill, indicated that similar bills (in the past) have been scored (evaluated) by the Congressional Budget Office as saving $109 billion over the next decade, though there is no score on either of the current bills. The CBO projections assume that, on average, 1.5 million adults would lose federal funding for Medicaid coverage, with 900,000 or 60 percent remaining on state-only programs, and 600,000 or 40 percent becoming uninsured.[54] The House Reconciliation bill initially delayed implementation of work requirements until October 2029; however, in exchange for certain amendments,[55] including a change to the SALT deduction, the final bill approved by the House modified the implementation date to require HHS to issue rules by July 2027. The Senate version accelerated the community engagement timeline, but did not expand the SALT deduction.

Estimates of how many adults on Medicaid in New York are working are inconsistent. A February 2025 report by The Center for Budget and Policy Priorities (CBPP) suggests that 48 percent (3.3 million) of all adults enrolled in Medicaid in the state could lose coverage if work requirements were a condition of eligibility. While it is difficult to model the impacts of such a proposal, it is fair to say this action could result in a temporary coverage lapse for a large percentage of enrollees. However, it is unlikely that such a substantial portion of New York's Medicaid enrollment would be permanently disenrolled. These estimates appear to be on the higher end, and

the CBPP itself has noted that its "estimates would need to be refined pending the details of a specific proposal."[56] The Kaiser Family Foundation has, on the other hand, estimated that 57 percent of adults in New York on Medicaid are working. Nationally, Kaiser found that 68 percent of adults with no disability are working. And, the president of the state's largest healthcare employee union, SEIU 1199, has recently echoed that in stating: "The large majority of adult Medicaid recipients under the age of 65 are employed." There is also the potential that some New Yorkers enrolled on Medicaid, who are not currently counted as working, would potentially be able to maintain coverage by meeting newly imposed standards, which are not factored into any of the current estimates. A portion of any savings achieved would likely be offset by operational costs to administer the policy.

It's not just Medicaid waivers and the associated program and eligibility designs that are at risk, however. All of New York's approved benefits for enrollees, eligibility standards, and approaches to financing are subject to federal approval and could be modified through federal rulemaking, statute, or administrative review processes. Further, the new administration may seek the reinstatement of additional eligibility verification requirements. This could include reversing the prior administration's regulatory efforts to streamline eligibility determinations in Medicaid, CHP, and the Essential Plan, which could be effectuated administratively, but is included in the House bill advancing through Congress.

In fact, Congress, in its initial Reconciliation bills (both the House and Senate), included numerous eligibility changes, in addition to work requirements, including:

- Limiting coverage for noncitizens.
- Imposing administrative hurdles to maintain eligibility, such as requiring biannual eligibility verification for expansion population (100–138 percent of the FPL) adults, and requiring cost sharing, for example.
- Limiting retroactive enrollment to one month (from three) and capping the home equity exemption for seniors requiring long-term care at $1 million. New York's home equity exemption is currently $1,097,000 and indexed to inflation.
- Delaying implementation of Biden administration rules related to 1) enrolling in the Medicare savings program and 2) streamlining Medicaid eligibility determinations.

It is expected that there will be modifications to the initial proposals as the Reconciliation process unfolds, but that eligibility changes will continue to be a component of the savings package.

Financing the Nonfederal Share of Medicaid

The nonfederal share of Medicaid expenditures is funded through a variety of sources. The Social Security Act, which is the authorizing statute for Medicaid, requires that at least 40 percent of each state's share of Medicaid expenditures must be financed by the state, and up to 60 percent of the state's share may come from local governments or other sources. According to a 2024 Congressional Research Services report, "in

state fiscal year (SFY) 2024, states reported that about 68 percent of the state share of Medicaid costs was financed by state general funds (most of which are raised from personal income, sales, and corporate income taxes). The remaining 32 percent was financed by other funds (including local government funds, provider taxes, fees, donations, assessments, and tobacco settlement funds)."

New York relies heavily on healthcare-related taxes, local government contributions, and settlement funds to finance the nonfederal share of Medicaid. As discussed further below, this current funding structure may be subject to change as Congress and the new administration review healthcare taxes and county contributions.

Healthcare-Related Taxes

Congress or the new administration could choose to modify healthcare-related provider tax laws, rules, regulations, or approvals to reduce the federal budget and claim reductions to the cost of insurance. These taxes are, however, typically passed on through increases to the cost of care and ultimately premiums.

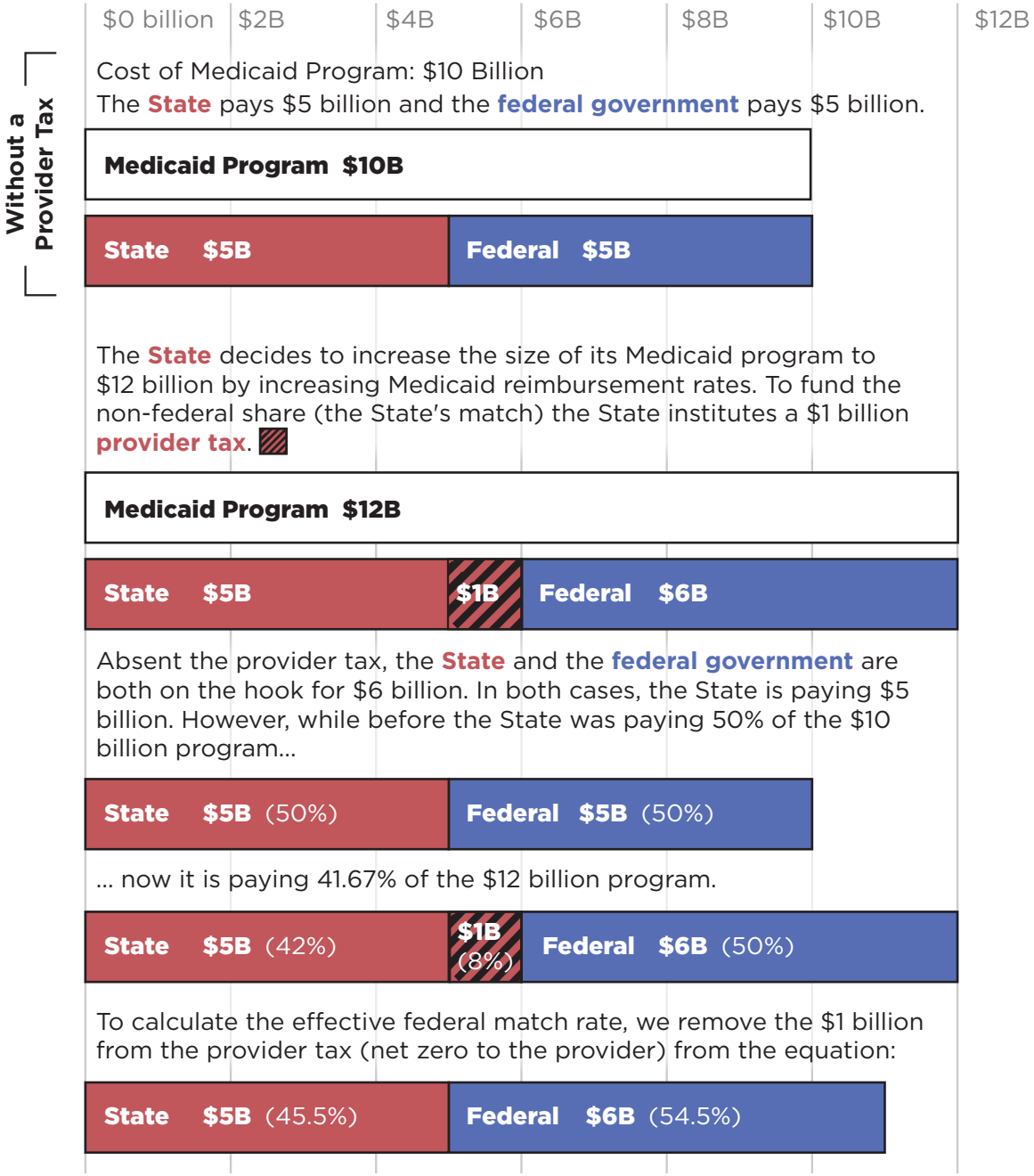
Provider taxes are fees assessed to healthcare providers or insurers to support the nonfederal share of Medicaid financing and are implemented by all states in the nation, except Alaska.[57] New York was an early adopter of provider taxes, and the debate over New York's use of provider taxes is as old as the taxes. In New York, healthcare-related taxes, including taxes on providers, known as "provider taxes or gross receipts assessments," and insurers, account for over $10 billion in funding to support Medicaid and other healthcare programs in New York, according to a review of the state's financial plan documents.[58] Most of these financial resources flow directly or indirectly through the state's General Fund, but are ultimately connected to health provider service revenue.

Limits on the use of provider taxes to fund the nonfederal share of Medicaid are among the more likely options currently under consideration by Congress and are included in the Reconciliation bills (Section 44132 in the House and 71120 in the Senate) advancing through Congress.[59] These fees may likewise be scrutinized by the administration, and are an area where the president, through CMS, has a lot of administrative discretion, though certain changes would require new law to be enacted.

As a potential option that would count towards the $880 billion spending reduction target, the Congressional Budget Office (CBO) recently scored proposals that would limit the safe harbor, which is the maximum amount of the tax that can be reimbursed, without a waiver, for provider taxes from 6 percent to lower percentages, or zero percent, which would eliminate states' ability to use provider taxes to fund the nonfederal share of Medicaid. In New York, gross receipts assessments, or provider taxes, contribute to the $10 billion in health-related taxes collected annually, with more than 75 percent of the gross receipts taxes collected from the 6.8 percent assessment on nursing homes.[60] The initial Congressional bill would freeze currently imposed taxes at existing rates and prohibit any future provider taxes from being imposed, effective immediately upon enactment. This would preserve New York's existing provider taxes, but shrink the relative value of such arrangements in reducing the state's contribution to the Medicaid program going forward.

An Oversimplified Explanation of Provider Taxes and Medicaid

Let's assume a State has: 1) a $10 billion Medicaid Program; 2) a 50% Federal Medical Assistance Percentage (FMAP). The State wants to increase its effective federal match rate (the percent of the program the federal government is paying for) using a provider tax and increase provider rates without spending any additional State funds. Here's how that works.



More recently, the Kaiser Family Foundation issued an analysis, "Five Key Facts About Medicaid Provider Taxes," detailing which states are over 5.5 percent and 3.5 percent ceiling scenarios by provider type (hospital, nursing home, and intermediate care facility). According to Kaiser, in all cases, New York is over the 3.5 percent gross receipts threshold, but not the 5.5 percent threshold. Accordingly, a proposal to limit provider taxes to less than 5.5 percent of gross receipts could impact New York's current healthcare financing structure. Additionally, New York has special federal legislation allowing it an exception to typical federal requirements, which necessitate that such taxes be broad-based and uniform. This exception allows a surcharge on certain hospital and clinic services.

Even if Congress does not ultimately modify the use of provider taxes to fund Medicaid, the Trump administration maintains significant regulatory and guidance-making authority over the use of provider taxes. One example is the hold harmless provision, which allows Medicaid providers to be reimbursed for the tax up to the safe harbor limit, which is currently 6 percent, with an additional federal share that is obtained through a separate payment to the provider, funded by the tax and the additional federal share.[61] In other words, states collect the tax and subsequently use the tax receipt to fund the nonfederal share, which is matched with a federal share in the form of a Medicaid payment, thereby reimbursing the provider who paid the tax for the Medicaid portion of their business and maximizing federal funds (without increasing the state's contribution). A provider increase funded through this strategy is worth roughly half of the total payment to the industry, but costs a state little to nothing to finance, as the increase is funded by the tax receipts and the federal government who matches the spending by the provider tax as if the state had funded the nonfederal share with general fund dollars.

Other health-related taxes include taxes on insurers. The Covered Lives Assessment in New York State imposes a per-region flat rate fee on all health insurers based on the number of lives covered by the insurance plan. In addition, the FY 2025 enacted state budget authorized a new tax on managed care organizations (MCO), modeled after a similar tax in California that CMS approved.[62] California's tax has, however, come under scrutiny recently by the Paragon Health Institute, for using it to fund (directly or indirectly), coverage expansions such as eliminating the asset test for seniors and coverage for noncitizens, which may be more specifically described as nonqualified aliens in this case (for more detail see the section on coverage for noncitizens later in this paper).

In short, this kind of tax allows Medicaid managed care plans to be taxed at a higher rate than non-Medicaid plans, leverages the hold-harmless arrangement to reimburse the Medicaid plans for the costs of the tax, and in doing so generates net proceeds of roughly half of the collected tax to be used to fund Medicaid. Importantly, in the final weeks of the Biden administration, New York received approval to implement an MCO tax. The tax "is expected to provide up to $3.7 billion in resources over two years" and would be used to fund provider rate increases, according to New York State Fiscal Year 2026 Executive Budget documents.[63] Given the late approval and that its express purpose is to generate additional federal funding for New York, this tax could be put at risk. CMS made clear, even in the Biden administration approval letter, that "this

tax disproportionately burdens the Medicaid program….CMS intends to take imminent action to develop and propose new regulatory requirements through the notice and comment rulemaking process to address this issue. Furthermore, CMS recommends that New York carefully consider how to mitigate or avoid possible budgetary and program challenges that could result from CMS's intended rulemaking." Additionally, an April report from the Foundation for Government Accountability, a conservative Florida-based think tank, detailed New York's use of the MCO tax to fund additional spending above the "$3,046 per resident in federal Medicaid funding, more than any other state." The report suggests Congress can prohibit tax revenue to fund the state's share of Medicaid, reduce the provider tax safe harbor by 1 percent annually until eliminated, or freeze existing approvals (at 2024 collections) and gradually lower the safe harbor.[64] Option one and two would restrict New York from collecting the planned MCO tax (as collections couldn't have been drawn in 2024, given the 2024 approval).

In May, HHS proposed regulations to sunset the use of broad-based and uniform waivers that permit an MCO tax, calling it a "loophole… exploited by states to inflate federal payments to states, and free up state funds for non-Medicaid purposes."[65] The proposed regulations would terminate such waivers upon enactment of the rule for any state that has been approved for such a waiver within the past two years, which includes New York. With regard to the potential for disruption, CMS declared:

> States … obtained their most recent approval knowing that CMS intended to undertake rulemaking in this area, as was communicated in a companion letter with the approval. We believe it has been incumbent upon States to assess the risk of having a waiver deemed prospectively impermissible in the future if related policy changes are finalized (including within a short timeframe) when determining whether to submit a waiver request that exploits the loophole.

Accordingly, CMS believes states, such as New York, that were notified of their intent to modify rules should have planned accordingly.

Further, the House approved and the Senate proposed a similar ban on taxes such as the MCO tax (Section 44134 in the House and 71122 in the Senate), which would be effective immediately, with a transition period of up to three years, subject to the discretion of the Secretary of Health and Human Services. Even if the MCO tax is not rescinded in the final Reconciliation bill, the proposed regulations make the availability of this financing arrangement uncertain, with approximately $2 billion of the $3.7 billion at risk.[66] Thus, any rate increases supported by this arrangement will need to be considered in conjunction, at a minimum, with other reductions and CMS's decision to not extend the financing mechanism supporting the state's 1115 waiver.

County (Local Government) Contribution

According to the National Association of Counties, as of 2020, counties contribute to State Medicaid spending in 26 states, of which 18 states mandate such contributions. According to a report by the nonpartisan and New York-based Citizens Budget Commission, in New York, county contributions to Medicaid were authorized as part of the adoption of Medicaid in 1966 under Governor Nelson Rockefeller. At the time, local governments administered the Medicaid program somewhat uniquely in each county

of the state. Growth in Medicaid spending has long been an issue for local government administrators. Numerous efforts for the state to assume financial responsibility for Medicaid spending growth from the counties have occurred.

In 2005, New York State enacted a law to limit the growth of local contributions to 3 percent annually.[67] And, in 2012,[68] local contributions to the state's Medicaid program were further capped at 2015 levels or $7.6 billion annually following a three-year phase out of previously capped growth.

In the past, Congress has limited or proposed limits on the state's ability to require counties to contribute to the cost of the state's Medicaid program, including during the prior Trump administration.[69] While no such language was included in the initial Reconciliation bills, the magnitude of reductions included could evoke questions about the state's Medicaid financing arrangements or require local governments to take greater responsibility for ensuring access to safety-net providers and services in the future.

In addition to statutory contributions, county and other types of local governments participate in financing arrangements to fund local government or facility-specific initiatives, such as disproportionate share hospital (DSH) payments. This mechanism is known as an intergovernmental transfer.[70] At present, a publicly operated hospital in New York has challenged the state's practice of requiring counties, or the entity itself in the case of a county-sponsored public benefit corporation, to finance the nonfederal share that allows the state to receive enhanced federal funding. Scheduled reductions to DSH funding, that absent a change to New York State law would primarily affect the availability of DSH funding for New York City,[71] were delayed from starting in October 2026 to 2028 in the initial House Reconciliation bill (Section 44303), but not included in the Senate version.[72]

Any reduction in county funding (if limited by Congress or the courts) for the nonfederal share would, of course, shift costs to the state.

Optional Services and Unlicensed Providers

Under the authorizing legislation, the Social Security Act, and other applicable regulations, states that participate in the Medicaid program must provide all mandatory benefits. These benefits include, but are not limited to, inpatient and outpatient hospital services, nursing facility services, physician and clinic services, transportation to medical care, home health services, laboratory and x-ray services, and certain pediatric and birthing services.

Services that states provide in addition to the federal minimum requirements may be scrutinized by the new administration. These include the pharmacy and dental benefits, which are available to many New York State Medicaid enrollees. Additionally, programs like personal care services—home-based care services that help eligible individuals with activities of daily living like transportation, bathing, and meal preparation—which serve hundreds of thousands of New Yorkers, could be targeted administratively or through statute by Congress for reductions.

Based on the president's statements thus far, it appears less likely that pharmacy or dental benefits would be eliminated; however, pharmacy costs have long been a driver of cost growth in Medicaid and commercial products. In fact, changes to the way the federal government participates in reimbursing pharmaceuticals had already begun, as Biden-era drug pricing controls were rescinded in an initial omnibus executive order reversing numerous Biden-era executive orders and actions.[73] This further impacts New York's Medicaid spending as New York's program covers pharmacy-related out-of-pocket costs for people eligible for both Medicare and Medicaid (known as dual-eligible seniors).

It's also possible that rules or regulations will be imposed that limit the expansion of Medicaid benefits beyond standard licensed providers.[74] Recently, New York, along with other states, has expanded benefits to allow for the reimbursement (directly or indirectly) for services provided by nonmedical provider types such as doulas and community health workers. While the initial version of the House bill did not directly limit specific provider types, it did include additional measures (Section 44105) to eliminate any provider that has been excluded from participation in any state from all states, which would be effective January 2028. Further, the bill (Section 44106 in the House and 71104 and 71105 in the Senate) requires states to routinely check federal databases, such as death records, to disenroll ineligible or deceased providers, effective January 2028. Additionally, effective October 2030, the bill imposes a Federal Medicaid Assistance Percentage (FMAP) penalty (Section 44107 in the House and 71106 in the Senate) on states when federal entities (HHS, OIG, etc.) identify payments to ineligible individuals or services.

Long-Term Care

Unlike private coverage or Medicare, Medicaid provides support through services to children, adults, and seniors who have long-term care needs because of disability or chronic illness, making Medicaid the primary payer of long-term care nationally. These services are aimed at supporting individuals in accomplishing the necessary activities of daily living, such as bathing, toileting, and feeding.

Long-term care costs in New York represent the most expensive part of the Medicaid program. Nationally, CMS estimates that over 30 percent of all state and federal spending on Medicaid was on long-term care services. Because Medicaid is considered the target for Congressional savings and Medicaid is the payer of long-term care services, it can't be ruled out that long-term care will not be impacted.[75] The Reconciliation bills (Section 44126 in the House and 71108 in the Senate) includes a cap on home equity limits to qualify for Medicaid-funded long-term care services and supports at $1 million. New York's home equity maximum is currently $1,097,000.[76] Additionally, the proposed limit (Section 44122 in the House and. 71114 in the Senate) on retroactive coverage (from three months to one month), often used for individuals receiving long-term care, would also restrict the reimbursement of medical bills incurred for prior months of care. Some of the previously discussed proposals, such as additional eligibility checks or asset tests, limits on provider taxes, or other actions that shift costs to New York, could directly or indirectly impact funding for long-term

care, while other regulatory changes and oversight actions could have more direct implications.

Long-term care can be delivered in an institutional setting, like a nursing home, but it can also be delivered through community-based long-term care models that generally provide services in an individual's home or a home-like setting, such as assisted living, with the goal of maintaining independence. Examples of community-based long-term care services and supports include home healthcare, which relies on skilled nursing care, and personal care, which is generally considered unskilled care except in the case of the consumer-directed personal care program (CDPAP), which allows home attendants to perform skilled tasks. New York's Capitol Region newspaper, the *Times Union*, reported that "from 2017 to 2023, CDPAP spending grew 500 percent… while… overall Medicaid spending growth was 46 percent."[77] The massive growth in community-based long-term care programs in New York, like CDPAP, could make them or the terms by which residents can utilize such programs, a target of the Trump administration or Congressional scrutiny.

Nursing Home Care

Nursing homes have been around for decades, while community-based long-term care programs only became more prominent over the past two decades. New York State has over 600 nursing homes.[78] It was expected that community-based long-term care would be a substitute for institutional-based care; however, in practice, community-based care has grown over the past two and a half decades without a commensurate decline in institutional-based care.[79]

As noted in the healthcare-related taxes section of this piece, nursing home provider taxes are heavily used to finance Medicaid reimbursement nationally. New York has applied a 6.8 percent assessment on cash operating (gross) receipts for all residential healthcare providers (nursing homes) since 2012, but the tax dates back to 2002, according to the New York State Department of Health's website. Given the potential provider tax ceilings being discussed (see the healthcare-related taxes section), New York's gross receipts assessment on nursing homes would likely be impacted by a 3.5 percent net patient revenue ceiling, but not a 5.5 percent net patient revenue ceiling, according to Kaiser.[80] However, the initial Senate version of the bill, which reduces the tax threshold down from 6 percent to 3.5 percent by 2031, excludes nursing homes and intermediate care facilities.

The Biden administration's minimum staffing standards for long-term care facilities and the Medicaid institutional payment transparency rule were recently blocked by a United States District Court judge. Various bills, one of which had 37 Republican cosponsors (including Tenney (R-NY-24) and Langworthy (R-NY-23), in the 2024 Congress Protecting America's Seniors Access to Care Act, prohibit implementation of the staffing rule. The CBO scored various versions of the bill as saving $22 billion over 10 years. Interestingly, the Trump administration robustly defended the rule during court proceedings, which could be an indication that the Trump administration supports the rule, though that remains unclear.[81] While Congressional negotiations unfold in parallel with the litigation, the staffing rule is certainly a potential area to watch, as a delay until 2035 was included in the House and Senate Reconciliation bills.

Community-Based Long-Term Care Services and Supports

In New York, community-based long-term care services and supports are primarily delivered through New York's Medicaid managed long-term care (MLTC) plans. MLTC is a "system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities." Enrollment in MLTC has increased from approximately 10,000 in 2004 to over 380,000, including approximately 60,000 seniors enrolled in a fully integrated plan, such as Program for the All-Inclusive Care for the Elderly (PACE) and Medicaid Advantage Plus (MAP).

MLTC enrollment is highly concentrated in New York City. According to the *Managed Long-Term Care Reports* published by the Department of Health:

- Over 80 percent of total enrollment resides in New York City and 84 percent of partially capitated enrollment is New York City based, according to the New York State Department of Health *2023 Managed Long-Term Care Report*.
- Over 80 percent of MLTC enrollment is for seniors dually enrolled in Medicare and Medicaid, although applicants may be 18 or older with long-term nursing home level of care needs.
- The average age of MLTC enrollees has declined with a greater proportion of enrollees in the 55–74 range in 2023 compared to 2018.
- In 2018, when MLTC enrollment included long-term nursing home residents, 70 percent of MLTC enrollees required assistance with medication administration. By 2023, that percentage dropped to 4 percent.
- Similarly, in 2018, 77 percent of MLTC enrollees required assistance with dressing their lower body, whereas only 6 percent require such assistance in 2023.
- Likewise, in 2018, 69 percent of enrollees required assistance with toileting. In 2023, that percentage dropped to 26 percent.

The delivery of long-term care services and supports through MLTC was a function of New York's Care Management for All policy, referenced in the Medicaid overview section. Since 2011, a series of policy changes have been implemented to promote access to community-based care and to implement the state's Care Management for All policy, including but not limited to:

Functional Eligibility: Functional requirements are limited to adults in need of various home and community-based care services for at least 120 days at the time of evaluation.[82]

Financial Eligibility: The level of income and assets an MLTC recipient and or their spouse can retain is significantly more generous than other Medicaid enrollees, in part, due to eligibility changes at the federal level in the Affordable Care Act[83] and the transition of former Nursing Home Transition and Diversion Waiver (Lombardi program) members into MLTC.[84] As a result, the state rescinded its MLTC spousal budgeting policy in 2014, unless it was more advantageous to the applicant. Moreover,

the federally mandated look-back period to prevent asset transfers for nursing homes does not currently apply to home and community-based care, including care delivered through MLTC.[85]

Caregivers: Who can provide care either expands or contracts access and interest in the program. Another significant policy change—allowing relatives (who are not legally responsible) to serve as personal assistants in the consumer-directed personal care program—was implemented effective April 2016. Not only did this change broaden access to caregivers, but it also allowed individuals who were providing informal care to be reimbursed by the Medicaid program.

Wages: The rate of payment to the worker is a driver of the price to deliver the service. Beginning October 2022, with a phase-in, the minimum wage for home care workers was increased by approximately $3 over the base minimum wage.[86] Another significant policy change—extending wage parity, referring to the total compensation paid to home care aids in New York City, Nassau, Suffolk, and Westchester—to consumer-directed personal care in 2017. This policy is credited with contributing to the growth of CDPAP, as agency-based aides, who are often unionized, would be paid the same rate for CDPAP services as for other home care services. Since the implementation of this change, home care services have been roughly flat, with nominal growth, while CDPAP services continued to grow.[87]

While not an exhaustive list, the above policies have significant implications, beyond the rate of inflation and or change in the aging population, for the cost and use of Medicaid-funded community-based long-term care, including through managed long-term care plans in New York. These policy changes, and others, are codified in New York's recent 1115 waiver agreement with the federal government through administrative approvals.

Therefore, the state's use of managed long-term care plans to deliver long-term care services and supports was reauthorized in conjunction with the recently approved 1115 Health Equity Reform waiver to expand benefits for services that support social determinants of health through March 31, 2027. As noted, the rules by which New York funds Medicaid long-term care and the standards for eligibility, including whether there are look-back periods and/or assets, or income tests, are all subject to federal approval. This works through the state plan amendment or waiver process, both of which are contracts the state has with the federal government detailing the terms of the program, benefit design, and financing.

Depending on the approach the Trump administration takes with New York's waiver, changes to long-term care could happen administratively through waiver negotiations or via Congressional action. Additionally, the 1115 waiver included $646 million in workforce funding to be distributed by 1199 SEIU Training and Employment Funds, Iroquois Healthcare Association, and the Finger Lakes Performing Provider System.[88] Both 1199 SEIU and Iroquois are heavily focused on long-term care workforce training and recruitment. This was funded through designated state health programs (DSHP), which CMS has stated it will not renew beyond the currently approved terms.[89]

While it may be unlikely that Congress or the Trump administration would make significant changes to long-term care nationally, as detailed by a recent report by

the Fiscal Policy Institute, New York is an outlier in long-term care spending, and its benefit design is unique and more costly in comparison to other states.

Using CMS Medicaid per capita spending on seniors as a proxy for MLTC spending, New York spends ($30,474) more than 150 percent of the median national spend ($19,079) and California ($18,338). The only comparable "peer" state that outspends New York is Minnesota ($34,055), who also has generous program and eligibility standards. Home care and personal care workers are unionized in Minnesota[90] and there are minimum home care wage standards,[91] as is the case in New York. Also like New York, personal care in Minnesota is an entitlement, so there are no waiting lists, like in other states.[92] Minnesotans can also hire friends and relatives to provide self-directed personal care and income and asset requirements bear similarities to New York standards, including the use of trusts to protect income and assets from being counted in Medicaid eligibility determinations.

In New York, the Medicaid program spending trajectory, which has been cited as unsustainable, has been primarily driven by MLTC growth. In 2020, when the state reengaged the Medicaid Re-design Team to address a structural imbalance in the program, MLTC, including personal care services, was identified as the primary driver of the structural deficit:

> Spending on long-term care—more specifically, personal care and consumer directed personal care services (CDPAS)–is growing at an unsustainable rate and is the single largest cause of the State's Medicaid structural deficit....In recent years, enrollment in MLTC plans has increased by 13 percent annually, with annual spending growth totaling approximately $1.3 billion. In calendar year 2018, CDPAP accounted for approximately 50 percent of year over year spending growth in MLTC plans and 68 percent of year-over-year personal care utilization growth.

A review of state administrative data on MLTC enrollment indicates that despite a brief period of suppressed enrollment growth in MLTC during the COVID -19 pandemic and immediately thereafter, in fiscal year 2024, annual MLTC growth was over 10 percent, averaging one percent monthly. By fiscal year 2025, average growth increased for the first part of the year reaching a peak of over 320,000 enrolled in partial capitation MLTC plans to roughly 318,000 in March of 2025. Between April and December of fiscal year 2025, monthly growth was approximately 2 percent. For January through March, growth was roughly -1 percent, corresponding with the implementation of the state's transition to a single fiscal intermediary for consumer directed personal care and partially offsetting growth in fully integrated plan enrollment. Historical MLTC enrollment growth has exceeded the growth in seniors in New York associated with the aging of baby boomers, though the aging of this population can be expected to continue to account for a portion of growth in Medicaid spending in New York through the next decade or more.

Given the scope and size of the program, and that multiple levels of government are involved with the administration of and determination of eligibility for long-term services and supports, extensive auditing could identify improper payments despite the best of intentions. One particular area of focus includes the consumer directed

personal care program. The Enacted Budget Financial Plan notes that "Utilization of CDPAP grew by 1,200 percent since 2016… [and in] response to this expansion, hundreds of for-profit private businesses, known as Fiscal Intermediaries (FIs), have emerged that provide payroll functions and administrative support for an administrative fee that is paid by the Medicaid program… The State is in the process of finalizing its transition to a single FI administrator, consolidating the administrative and payroll functions from hundreds of existing FIs to administer the program in a more cost-effective manner." According to a Department of Health fact sheet, the state expects to save over $1 billion annually from enacted CDPAP reforms.

In response to outreach from advocacy groups in New York, the secretary for health and human services directed CMS "to continue its careful review of the New York Consumer Directed Personal Assistance Program [CDPAP], with particular review of program integrity, consumer choice, and taxpayer value. CMS will continue to engage with New York as the state works towards submitting necessary documentation." Additionally, the HHS OIG website indicates further reviews of CDPAP are underway. Not only does this indicate that HHS and CMS is looking at how New York provides consumer-directed care, but that the extent and scope of CMS's review may go beyond the current confines of the debate at the state level about how to best manage CDPAP.

While the state continues to implement its CDPAP reforms, which are expected to reduce spending significantly, its possible that further conversations about eligibility and benefits for community-based long-term care will be necessitated due to federal action or simply due to the magnitude of reductions potentially impacting New York. As was the case in 2020, New York's Medicaid spending trajectory cannot be materially modified without continuing to address long-term care spending growth.

Changes to Federal Funding Formulas

Like every state, New York is hugely reliant on federal funding to support its Medicaid program. In fact, federal funding for Medicaid and other health programs accounts for over 75 percent of the total federal funding received by New York.

According to Kaiser, "the amount of federal payments to a State for medical services depends on two factors. The first is the actual amount spent that qualifies as matchable under Medicaid and the second is the Federal Medical Assistance Percentage (FMAP). The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average."

As noted in the Rockefeller Institute of Government's 2024 report, *Giving or Getting?: New York's Balance of Payments with the Federal Government*, "due to its high per capita income, New York, along with nine other states, is granted the lowest allowable FMAP of 50 percent, independent of the state's need." Absent the FMAP floor of 50 percent, New York's FMAP rate would be approximately 37 percent, using 2023 and 2024 data.[93]

In large part, any proposals to give block grants or limit matching rates would require Congressional action and are less likely. However, other proposals that limit spending growth for the enhanced match for childless adults, particularly the expansion population, may be more likely. The Cato Institute, for example, recently advocated

strongly for a block grant to eliminate the disincentives to control spending created by an open-ended matching program.[94] Importantly, however, unlike waivers and other administrative payments or program design elements, any variety of block grants, per capita caps, or matching rate changes would require legislation and were not included in the House or Senate Reconciliation bills.

Block Grants Using Per Capita Caps or Per Enrollee Average Spending

There are numerous options to significantly reduce the federal government's contribution to state Medicaid programs. This includes establishing a block grant or using a set amount of funding from the federal government, based on per capita spending or per-enrollee average spending (trended forward at the medical component of the consumer price index).

While many of these options, at least in broad format, have appeared to be on the back burner and were not included in the initial House or Senate Reconciliation bills, conservative advocacy groups have more recently been publishing blogs, posts, and articles keeping such proposals in the conversation.[95] And, should Congress and the Trump administration propose reducing federal spending on Medicaid to the national per capita or per enrollee average, the cost to New York could be significant.[96]

According to the Step Two Policy Project, "because per capita Medicaid spending in New York is higher than any state in the nation and is currently growing at a rate of roughly 10 percent per year, New York is particularly vulnerable to any type of block grant or per capita spending cap program." Further, on a per-enrollee basis, New York exceeds the national average by more than $2,000 per enrollee. This is largely because of higher per-enrollee spending on seniors (for which New York is ranked 6th, among the 18 ranked states for which there is comparative data), those with disabilities (ranked 6th), and the ACA expansion population (ranked 8th).[97]

On a per capita basis, New York is estimated to be higher than the national average by 40 percent.[98] Kaiser estimates that New York could lose up to $48 billion over 10 years if a per capita cap model were implemented. If combined with the elimination of enhanced matching for childless adults under the ACA, that impact was estimated to double. Kaiser's assumptions are based on administrative data rather than survey data, which is more reliable for this population. The analysis does not, however, assume any changes to existing state policies, which could be necessary, given the estimated funding reductions.

More recently, Kaiser evaluated the impact of a per capita cap on the expansion population only. The report found that if a per capita cap on the expansion population (using a 2025 baseline per enrollee spend grown by inflation [CPI-U]) was implemented in 2027 and New York maintained coverage and spending for the expansion population, New York's spending on Medicaid would increase by $24 billion over the next 10 years, or 5 percent. The analysis "assume [s] that all states experience the same growth rates for Medicaid enrollment and spending; and that total spending grows at the same rate as federal spending;" however, in New York, Medicaid growth, depending on how you look at it, is more than double that of inflation.[99] But, because New York spending is

growing faster than inflation, if we presume the state is unlikely to eliminate coverage for the expansion population (New York had already expanded coverage prior to the ACA), the impact of this proposal in combination with others would not only compound in the out years, but it could also significantly crowd out available resources for other priorities within the Medicaid program after 2027.

Federal Match Rates

As previously noted, New York already receives the lowest federal match possible, despite the relative concentration of poverty in New York, so any changes to federal funding formulas, like that for the Federal Medical Assistance Program (FMAP), or distributions would further exacerbate New York's existing imbalance and could result in significant losses in federal funding.

There are certain circumstances when the FMAP rate is higher than the base rate, including in the case of public emergencies and achieving certain specified policy goals. The most notable policy goal of increasing FMAP to states is the ACA Medicaid expansion, which authorized enhanced FMAP for coverage of childless adults up to 138 percent of the federal poverty limit (nearly $22,000 in 2025). New York receives enhanced FMAP on its entire childless adult population through two distinct sections under the ACA. FMAP can also be enhanced for administration, particularly as it relates to fraud, waste, and abuse activities and systems development. Or it can be reduced to penalize states for failure to comply with CMS requirements. The Congressional Research Service's FMAP report includes a detailed summary of all of the FMAP exceptions.

Proposals that have been floated include: reducing the federal Medicaid matching floor, otherwise known as the statutory base federal match, from 50 percent to 40 percent; reducing or eliminating the enhanced ACA funding for childless adults; or reducing administrative funding more generally. In its initial iteration, the House did not include any universal changes to FMAP, but did include an FMAP penalty on enhanced funding for the expansion for states that cover noncitizens, such as New York. This proposal, which may not be the final iteration on this topic, is discussed in more detail later in the paper.

As noted above, despite the relative concentration of poverty in New York, the FMAP calculation persistently generates only a 50 percent base FMAP match, or the floor. This is due to the fact that New York also has a significant number of extremely high earners. For every 1 percent that the floor is reduced, the state contribution would increase by more than $700 million—so a reduction from 50 to 40 percent could result in an increased state contribution of over $7 billion. This would not only impact New York, however, as it is one of 10 states at the statutory base FMAP rate.[100]

Of additional significance would be a legislative change reducing the enhanced match for childless adults authorized under the ACA (see the discussion of a per-enrollee cap on the expansion population in the Block Grants Using Per Capita Caps or Per Enrollee Average Spending section). According to Kaiser, all but 10 states have implemented the Medicaid expansion as of 2025, including New York. The expansion is widely

touted as a major contributor to reducing the number of uninsured, both nationally and in New York, where 95 percent of the population is estimated to have health insurance.

Less frequently discussed, but likely relevant as Congress and the Trump administration negotiate an overall fiscal plan, is how the expansion expenditures compare to projections. Using CMS administrative data, The Foundation for Government Accountability calculated that federal spending on the Medicaid expansion is more than double the projections nationally and more than 384 percent higher than was earlier estimated for New York.

These calculations do not, however, include the enhanced funding for previously eligible childless adults, which, in combination with the expanded population, accounts for over $16 billion in total federal funding in federal fiscal year 2023.[101] Any proposals that reduce the match rate, limit future growth, or restrict federal financial participation for childless adults could put a portion of that $16 billion in funding at risk for New York. Reductions to enhanced funding for expansion or previously eligible adults are particularly problematic for states like New York. The enhanced match currently applies to adults (0–138 percent of FPL) who could not be disenrolled under most any practicable circumstances, resulting in a massive cost shift to the state from the federal government in an amount equivalent to the federal cut.

Section Two—Federal Health Insurance Programs *(Medicare)*

Medicare was established in 1965 under Title XVIII of the Social Security Act to provide health insurance to people aged 65 and older, regardless of income or medical history. The program was expanded in 1972 to include people under age 65 with permanent disabilities receiving Social Security Disability Insurance (SSDI) payments and people with end-stage renal disease (ESRD). In 2001, Medicare eligibility expanded further to cover people with amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease).[102]

Medicare is divided into four parts (each with separate financing mechanisms):

1. Part A—covers inpatient hospital, skilled nursing facility, some home health visits, and hospice care.
2. Part B—or the Supplementary Medical Insurance (SMI) program, helps pay for physician, outpatient, some home health, and preventive services.
3. Part C—or Medicare Advantage, is detailed later in the paper.
4. Part D—covers outpatient prescription drugs.

According to the Medicare Enrollment Dashboard, as of March 2025, there are 3.9 million New York residents enrolled in Medicare (47 percent are enrolled in traditional Medicare (Parts A and B), and 53 percent are enrolled in Medicare Advantage (Part C). Of the 3.9 million enrolled, 79 percent, or 3.1 million, participate in prescription drug coverage, which is optional. The Kaiser Foundation estimates that two out of seven, or nearly 30 percent of Medicare enrollees, are dually enrolled in Medicaid.

While President Trump has commented that Medicare will not be harmed, and the Medicare program is largely untouched in the initial House and Senate Reconciliation bills, it is possible that the Trump administration or Congress will advance proposals that modify the structure of Medicare as it is known today, especially in the context of program integrity, and reducing fraud, waste, and abuse, similar to statements and proposals referenced prior with respect to Medicaid. Already, in February, Trump administration officials alluded to concerns regarding the integrity of the Medicare payment system, and the types of program integrity measures states would be directed to implement in their respective Medicaid programs in the House bill relating to Medicaid, such as prepayment edits, can be implemented administratively in Medicare, since the federal government is the program operator.

Like in Medicaid, Child Health Plus, and the Essential Plan, proposals to reduce funding for Medicare programs, which do not change benefits to those covered, would consequently reduce funding available for the program, but in the case of Medicare, which is not a program operated by the state, the funding impacts would be felt directly by providers, rather than the state budget in the first instance, as is the case with Medicaid. Eligibility changes would modify funding and program design commensurately, as with other public health insurance programs. While Medicare financing often does not impact the state's financial plan, it represents a significant and growing portion of healthcare providers' business in New York (covering 3.9

million or 21 percent of New York residents) and is therefore increasingly important in the context of New York's healthcare economy. The Reconciliation bills moving through Congress, as drafted, avoids the most drastic changes to Medicare financing and eligibility that could have been implemented (and are detailed below). The bills do include various other changes, not limited to: delaying the Biden-era Medicare Savings Program rule until 2035 (Section 44101 in the House and 71101 in the Senate), restricting eligibility for noncitizens similar to Medicaid, with a one year grace period for disenrollment (Section 112104 in the House and 71201 in the Senate), updating the physician fee schedule (Section 44304 in the House only. Not in the Senate version.), and various pharmacy related reforms, some of which are detailed below.

Graduate Medical Education Funding

Medicare provides formulaic payments to hospitals to reimburse for the costs of approved Graduate Medical Education (GME) programs. Essentially, payments are based on a methodology that determines a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period and indexed for inflation. For most hospitals, the base period is 1984.

GME funding is, and has long been, of particular relevance to New York. Since 1987, the New York State Council on Graduate Medical Education (NYS CGME) "provide[s] advice to the Governor and Commissioner of Health on the formulation and implementation of State policies relating to medical education and training." According to a 2021 report published by the Center for Health Workforce Studies, New York is the leading state in the nation for the number of physicians trained annually, at over 18,000 or 12 percent of the national total. Therefore, any GME reductions under Medicare would disproportionately impact New York and the network of medical schools and academic medical centers that train these physicians in the state.[103] So far, neither house has modified GME funding in their respective Reconciliation bills.

Relatedly, but not specific to Medicare, limits on or the elimination of research funding through the National Institutes of Health (NIH), for example, would also have an outsized impact on New York, given its disproportionate share of this research, which is often conducted at academic medical centers participating in the GME program. New York joined 22 state attorneys general challenging the Trump administration's plans to reduce funding. It's estimated that New York currently receives nearly 20 percent of the more than $5 billion in NIH grants. A 15 percent cap on administration, as proposed, could eliminate $850 million in funding to New York.

Site of Service and Site of Care

Site of service and site neutrality refer to a model that would require the same payment regardless of the setting in which care is provided. Because each type of service currently has its own payment methodologies that are site-dependent, in many cases, services provided at hospital outpatient departments are reimbursed at a different rate than the same services provided in free-standing physician offices or ambulatory care surgery centers.[104]

As reported widely in the media, site-neutral payments are considered among the more probable changes to Medicare. For example, a January 2025 Paragon Health Institute report recently identified opportunities to implement site-neutral payment policies in Medicare. If such changes advance, they would eliminate the existing reimbursement differential across sites, perhaps within a framework that sees such changes as promoting more efficient and cost-effective care. Proponents of site-neutrality argue there is significant potential to save money without cutting benefits.

However, as a recent *Health Affairs* article highlighted, site-neutral payments are controversial, bringing not only potential benefits but also negative impacts:

> Site-neutral payment policies offer significant potential to reduce costs for patients, payers, and taxpayers while also reducing the incentives for health care consolidation. While the positive impacts of these policies are evident, there are concerns from key stakeholders about the potential negative impacts of site-neutral payment policies.

Further, the article noted that these impacts could "increase financial instability" and reduce "access [to care in] underserved areas." According to New York State Fiscal Year 2026 executive budget documents, 29 percent of hospitals in New York are already distressed.[105]

Hospital associations oppose site neutrality policies. In 2023, the Greater New York Hospital Association (GNYHA) estimated the loss of funding under a site-neutral policy to New York hospitals for all hospital outpatient departments at $9.7 billion.

Further, the Trump administration, through changes to where a surgery may or may not be performed if it is to receive federal reimbursement, may reform how Medicare pays for services through what's referred to as the Medicare inpatient-only list. New York also has its own inpatient-only list. Under these lists or policies, certain surgeries, for example, can only be performed in a hospital in New York, though they may, in certain cases, be authorized by Medicare to be performed in an alternate location such as a surgery center.

In the final days of the previous Trump administration, regulations were finalized to "give patients more choice around surgery" by phasing out around 300 procedures from the Medicare inpatient-only list, which defines what surgeries must be performed in an inpatient setting to be eligible for Medicare reimbursement. In 2021, the Biden administration issued a rule restoring the 300 procedures to the inpatient-only list and creating a process to remove such procedures going forward.

Not only could the Trump administration reinstate its rule to reduce the inpatient only list for Medicare, but the federal government could also, through administrative actions, tell New York that it will no longer pay the higher cost to perform surgeries in a hospital in New York that are being performed at lower cost in a nonhospital setting in other states.

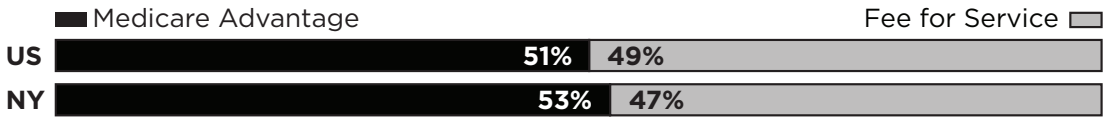
Medicare Advantage

Medicare Advantage is an insurance option that people who are eligible for Medicare can choose. It is administered through private managed care organizations that receive a set monthly payment per enrollee, rather than on a traditional Medicare fee-based schedule.

The prior Trump administration significantly expanded the Medicare Advantage program through the "Protecting and Improving Medicare for Our Nation's Seniors" executive order in 2019. The executive order also emphasized site neutrality, expanded the scope of practice and telemedicine, and expanded networks. It further authorized Medicare savings accounts, emphasized patient choice, and expanded access to Medicare data on cost and quality.

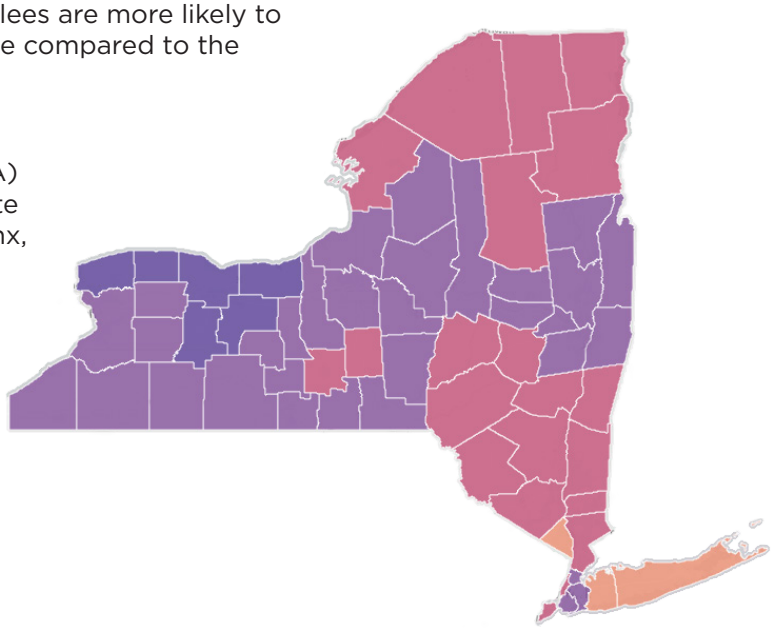
Since 2019, according to the Medicare Enrollment Dashboard, participation in Medicare Advantage has declined nationally, dropping from 58 percent of enrollment to 49 percent of enrollment. In New York, the opposite has occurred; Medicare Advantage enrollment has grown from 41 percent of total Medicare enrollment to 53 percent. Accordingly, funding methodologies within the Medicare Advantage program, like the wage equalization factor, have a disproportionate impact on New York, which has higher-than-average Medicare Advantage participation, particularly upstate.

Proposals related to expanded enrollment in Medicare Advantage plans, through a health maintenance organization (HMO) model rather than the traditional fee-for-service structure, would be a continuation of prior Trump administration priorities.



New York Medicare enrollees are more likely to be in Medicare Advantage compared to the national average.

Medicare Advantage (MA) is more prominent upstate and in Brooklyn, the Bronx, and Queens.



SOURCE: "Medicare Enrollment For February 2025," Medicare Enrollment Dashboard, https://data.cms.gov/tools/medicare-enrollment-dashboard.

Section Three—Commercial Insurance Markets and New York State of Health (NYSOH)

According to CMS, "health care coverage is often grouped into two general categories: private and public. The majority of people in the US have private insurance, which they receive through their employer, who buys directly from an insurance company, or through a Health Insurance Marketplace. While other people have public health care coverage through government programs such as Medicare, Medicaid, or the Veterans Health Administration."

New York residents who are not eligible for public insurance (Medicaid, Child Health Plus, the Essential Plan (1332), or Medicare) are insured through a variety of different products, which are often considered private health insurance or commercial coverage. Within commercial coverage, there are two options. There are fully insured plans, which are regulated by the Department of Financial Services (DFS) who set the requirements of the coverage, and the associated premium paid by the employer or the individual and there are self-insured plans, which are essentially employers paying for services on a fee-for-service basis, with an entity acting as the third-party administrator. This can be commercial insurance companies or independent third parties.

Under the Employee Retirement Income Security Act of 1974 (ERISA), companies that self-insure are exempt from state health insurance mandates and laws,[106] including reserve requirements, mandated benefits, consumer protections, and premium taxes.[107]

For employers with employees working in multiple states, the ERISA exemption means those large employers can offer the same benefit package company-wide and save money by not covering some of the state-level health insurance benefits. Such coverage is often combined with stop-loss coverage, which protects the employer against catastrophic claims.

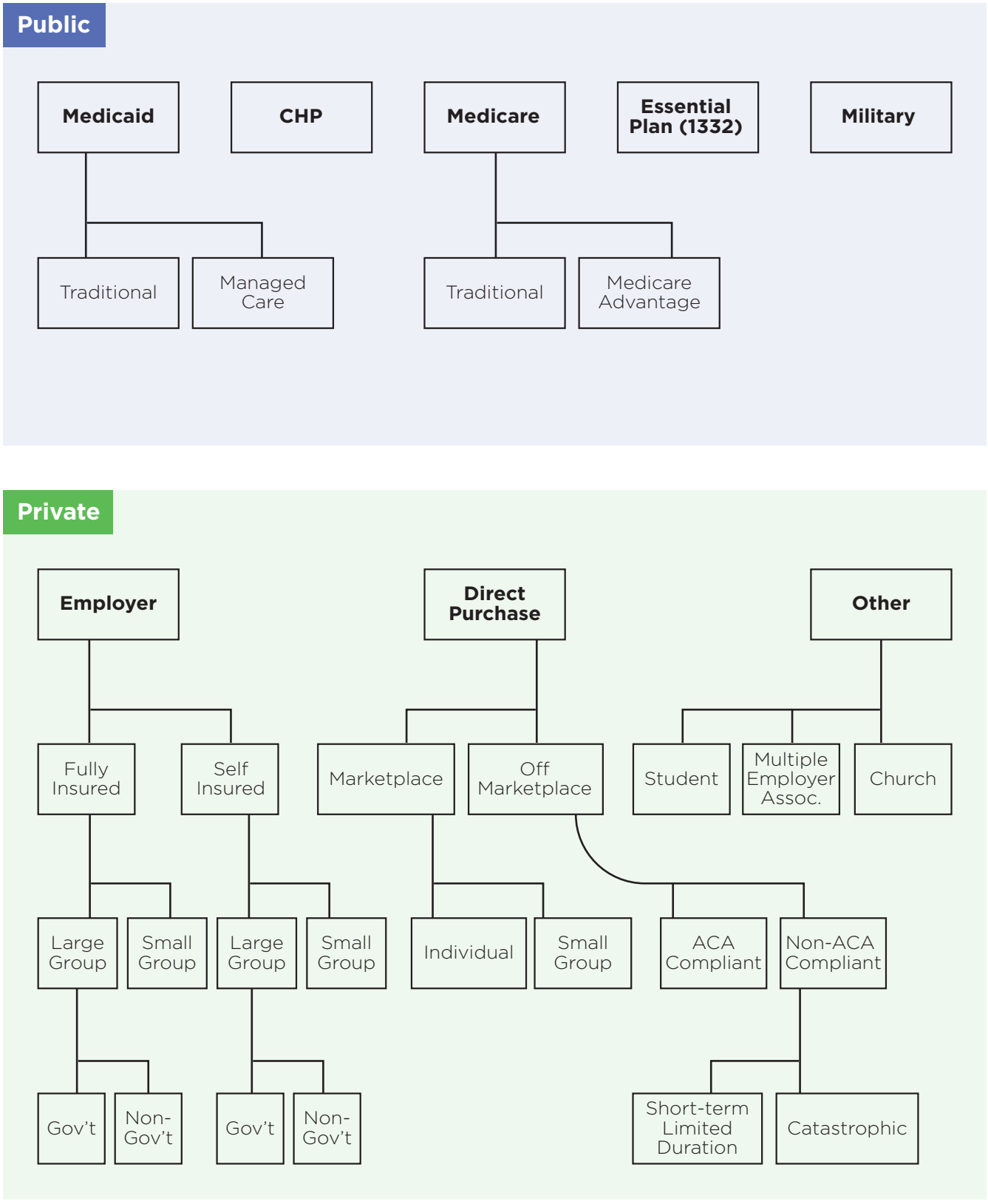
Typically, stop loss coverage is a separate product, though Kaiser notes that more recently:

> a complex funding option, often called level-funding, has become more widely available to small employers. Level-funded arrangements are nominally self-funded options that package together a self-funded plan with extensive stop-loss coverage that significantly reduces the risk retained by the employer. Thirty-eight percent of covered workers in small firms (3-199 workers) [were] in a level-funded plan in 2023.

The Kaiser Foundation's 2023 Employer Health Benefits Survey further suggests that in 2023, 65 percent of all employer-based health insurance was self-funded, with an increasing propensity at larger firms (83 percent), as opposed to small firms (18 percent), which they define as having fewer than 200 employees. Most self-insured plans are employer-based.[108]

Fully insured plans represent a smaller segment of the New York nonpublic insurance marketplace. Fully insured products can be purchased in a large group, small group,[109] or an individual market, meaning they can be employer-based (large and small group)

95% of New Yorkers are insured. Here's how.



NOTE: Related insurances such as vision, dental, pharmacy, and long-term care are not represented, as applicable.

or not (individual). Small group and individual coverage can be purchased on New York State of Health, the state's official health plan marketplace. As of January 2025, nearly 218,000 residents purchased qualified health plan coverage that was not Medicaid, Child Health Plus, or the Essential Plan on NYSOH (discussed further below).

In the commercial market, because the insureds are responsible for all or a part of the cost of coverage, premium increases (the rate at which the monthly cost to be insured increases) are of particular interest to consumers.[110] Likewise, it is generally consumers who bear the brunt or benefit of financing and eligibility changes. Unlike with Medicaid and other public programs, most aspects of commercial coverage financing and eligibility are neutral to the state's financial plan; however, in certain circumstances, due to the previously discussed *Aliessa* litigation, eliminating or adding financing for subsidies could shift costs on or off public health insurance programs. As expected, the Congressional Reconciliation bills promotes patient choice and expand access to high-deductible plans.

Marketplace Coverage

Health insurance marketplaces were created in the ACA to provide a one-stop shopping experience for individuals and small businesses to purchase coverage and to determine eligibility for federal, or in some cases, state subsidies to purchase coverage. In New York, the state health insurance marketplace is called New York State of Health (NYSOH). NYSOH also verifies eligibility for Medicaid, Child Health Plus, and Essential Plan (1332) coverage for most enrollees in those programs.

The Trump administration first modified funding for federal navigators, which help individuals sign up for coverage on the marketplace, as part of federal funding reductions announced in February 2025. While the federal navigator reduction is unlikely to have a major impact on New York, which does use navigators, it signals a shift in federal policy from expanding coverage to reducing costs. The announcement cited that the new administration was unsatisfied with the return on investment associated with the number of sign-ups, which they estimated resulted in a cost of over $1,000 per sign-up.

Following the navigator announcement, on March 10, 2025, the Trump administration issued a proposed rule to make significant changes to eligibility and enrollment on exchange-based health insurance products. According to CMS, the proposed rule includes the following:

> Revised standards relating to strengthening income verification processes; modifying eligibility redetermination procedures; removing Deferred Action for Childhood Arrivals (DACA) recipients from the definition of "lawfully present" for eligibility and enrollment in Marketplace and Basic Health Program (BHP) coverage; and adopting pre-enrollment verification for special enrollment periods (SEPs), aimed at reducing improper enrollments and improving the risk pool. Additionally, the rule proposes to adopt in regulation the evidentiary standard CMS uses to assess whether to terminate an agent's, broker's, or web-broker's Marketplace Agreements for cause; prohibit issuers from providing coverage of sex-trait modifications as an essential health benefit

(EHB); revise actuarial value standards for health plans; require Marketplaces to deny eligibility for advance payments of the premium tax credit (APTC) upon a tax filer's failure to reconcile APTC for one year; revise the automatic reenrollment hierarchy; change the annual Open Enrollment Period (OEP); eliminate the SEP for persons with annual household incomes below 150 percent of the federal poverty level (FPL); and revise the premium adjustment percentage methodology.

Several of the changes are addressed elsewhere in this summary or are incredibly complicated regarding the rules for coverage offered on exchanges. The Trump administration finalized the proposed rule in June, 2025.[111] The House Reconciliation bill largely replicated the rule's changes, with a significant exception relating to further limiting the availability of advance premium tax credits for noncitizens, which is discussed later in the paper. The Kaiser Family Foundation compiled a detailed summary of the Marketplace changes included in the House bill, which replicated in the Senate's version.

The primary changes in some cases are included in both Reconciliation bills, which are not discussed elsewhere in this piece, include a requirement for documentation when electronic income verification doesn't match information supplied by an applicant, and a limitation on enrollment periods to prevent individuals from waiting to enroll in coverage when they are sick. The proposals aim to reverse Biden administration policies aimed at making it easier to enroll in coverage and reducing the cost of providing coverage. As with other current proposals that have already been advanced or are expected to be advanced, the proposed rule has been framed in the context of reducing fraud, waste, or abuse regarding exchange-based health insurance.

Following the announcement of the proposed rule in March, New York State of Health and the New York State Department of Financial Services issued formal comments on the proposed rule. The comments were largely technical and related to operational timelines, but also identified the potential for premium increases (related to the premium adjustment calculation), loss of coverage (not attributed to a particular action), and implementation costs. The comments do not address the cost to the state associated with the DACA change.

Short Term, Limited Duration, and Association Health Plans

To counter expansions of publicly funded coverage—as a healthcare financing vehicle—Congress and/or the Trump administration may look to expand private health insurance markets by reimplementing regulations expanding access to certain types of plans, which require greater patient responsibility for healthcare costs than public coverage would.[112]

Short-term, limited duration (STLD) health insurance is coverage that is primarily designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another. Association health plans (AHPs) function as multiple employer group health plans, especially in circumstances where the employers are all

operating in the same trade, to take advantage of the better pricing available to large group purchasers relative to the small group market.

In 2017, then President Trump issued an executive order directing the US Department of Labor to issue regulations, which were issued in 2018, to expand access to both STLD and AHPs. Following separate tracts, both policy types were expanded under the previous Trump administration and then jointly through an additional rule in 2019, which allows individuals participating in STLD and AHPs to also use individual coverage health reimbursement arrangements in conjunction with the newly created coverage offerings and for purchasing coverage on the exchange. New York led litigation by 11 states and the District of Columbia to block the AHP rule, which was largely invalidated. The Biden administration took steps to reverse the remaining elements of the prior Trump administration's expansions of STLD and issued a full rescission of the 2018 rule on AHDs in 2024.

The House Reconciliation bill moving through Congress codifies the 2019 rule (Section 110201) and renames individual health savings accounts to Custom Health Option and Individual Care Expense (CHOICE) arrangements (Section 110202) that can be used to contribute pretax dollars for an employee's share of premium expense, if purchasing an exchange plan. It also creates a two-year credit for small businesses with fewer than 50 employees that provide such arrangements to their employees, for the first time (Section 110203).[113] These changes were not included in the Senate bill.

Enhanced Subsidies

Existing subsidies for Americans not enrolled in Medicaid, Medicare, or other coverage that provide additional financial assistance above and beyond what was authorized under the Affordable Care Act (ACA) are set to expire in 2025.[114] Not only have those subsidies for purchasing health insurance coverage increased (for those who were already receiving a subsidy) through advance premium tax credits, but eligibility for subsidies was expanded to include those above 400 percent of the federal poverty limit ($62,600 for an individual and $128,600 for a family of four in 2025).

These subsidies were initially authorized during COVID-19, but it is unclear if they will be renewed by Congress. An extension was not included in the House or Senate Reconciliation bills. The impending expiration this year creates a potential "subsidy cliff" by producing a sudden and steep increase in premiums for those purchasing coverage in the individual or small group market. Absent legislative action, it is estimated by the Kaiser Foundation that the cost to purchase health insurance in the individual market could increase by over 75 percent due to the subsidy expiration. While subsidies have the greatest impact in the 10 remaining non-Medicaid expansion states,[115] New York and other states would be impacted as well.

In 2022, the last time the subsidies were set to expire, New York State estimated that the expiration would increase premium costs for qualified health plan enrollees by 58 percent and reduce funding to the Essential Plan by $600–$700 million.[116] New York recently estimated the impact at 38 percent following passage of the House bill, which

did not include the extension. Using January 2025 enrollment data, that estimate would jump from $1 billion to $1.2 billion.[117] The subsidy benefits nearly 140,000 New Yorkers and reduces coverage costs by $1,453 per person annually. Given that this estimate predates the comprehensive redetermination of Medicaid eligibility, which increased participation in exchange-based products since 2022, it can be assumed that the 2022 estimated impacts are a floor, and not a ceiling, on how the subsidy expiration might affect New York.[118, 119] Additionally, New York has experienced higher-than-average premium increases in recent years, so reductions to subsidies may make it more difficult for people to afford to buy coverage and could further exacerbate the shrinking New York individual and small group health insurance markets.

Reinsurance

Expanded availability of short-term or association health plans and the expiration or phase-out of the COVID-19-era subsidies would create changes to the way risk is segmented in the insurance market by shifting the enrollment landscape.[120] The Trump administration may look to reinsurance waivers, as did the first Trump administration, with the intention of moderating the impact of adverse selection and reducing the risk to insurers, which would otherwise be passed on to consumers in the form of premium increases.[121]

Services Covered

According to CMS, the Affordable Care Act requires non-grandfathered health insurance coverage in the individual and small group markets to cover essential health benefits (EHB), which includes items and services in at least the following 10 benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance-use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

A benchmark plan represents the second-lowest-cost silver plan (SLCSP), which covers the required essential health benefits, available on the exchange, and other plans offered on the exchange are compared (or "benchmarked") to the cost and benefit design of the services provided by that plan.

The federal government maintains administrative discretion to establish what can and cannot be covered in a benchmark plan, and the Trump administration is already taking action to modify existing benefits where they do not align with Trump administration policies. For example, in a March 10th proposed rule, CMS "proposes a policy that would add sex-trait modification to the list of items and services that may not be covered as essential health benefits beginning in plan year 2026." This prohibition was proposed to be codified in the initial House Reconciliation bill, but not the Senate.

The Trump administration could also administratively require states to "defray" the cost of state-mandated expansions of coverage enacted since the ACA. Current

regulation prohibits states from drawing enhanced federal subsidies by expanding the set of services authorized in the state's benchmark plan.[122] Coverage expansions shift a portion of the associated cost to the federal government in the form of increased advanced premium tax credits (APTCs).[123] Accordingly, a reduction in federal subsidies for coverage expansions authorized in New York would shift costs back to New York State.[124]

Separately, the Supreme Court is expected to rule in the case of *Kennedy v. Braidwood Management* related to the ACA requirement for insurance plans (and Medicaid expansion plans) to cover certain preventative services with no cost sharing.[125, 126] According to Kaiser:

> In this case, Braidwood Management, Christian owned businesses and six individuals in Texas, have challenged the Affordable Care Act's (ACA) requirement to cover preventive services. The Supreme Court is narrowly considering whether the structure of the US Preventive Services Task Force (USPSTF [or "the taskforce"])—an independent entity convened by the federal government that makes recommendations for preventive services that nearly all private insurances must cover without cost-sharing—violates the US Constitution's Appointments Clause. That provision states that "officers of the United States" may only be appointed by the president, subject to the advice and consent of the Senate and the litigants are claiming that the USPSTF does not have the authority to set coverage requirements.[127]

According to the SCOTUS blog,

> the task force is made up of 16 volunteers, each of whom serves a four-year term. Members of the task force and their recommendations are required by law to be "independent, and to the extent practicable, not subject to political pressure."
>
> The task force's recommendations for required preventive-care services include contraception, cancer screenings, statin medications, and human-papilloma-virus vaccines. In June 2019, the task force recommended that preexposure prophylaxis, known as PrEP, medicine that is highly effective at preventing HIV, be included as a mandatory preventive-care service.
>
> The plaintiffs in this case are four individuals and two small businesses that have religious objections to the requirement that insurers and group health plans provide coverage for PrEP.

Should the authority of the USPSTF be invalidated, there could be implications for New Yorkers about what services are covered without cost sharing, but even if the task force is upheld, this case is likely to open up additional questions related to services covered and HHS authority.[128]

Section 4—Cross-Insurance Issues

Program Integrity

Based on an overwhelming number of statements and media reports, the Trump administration, including the Department of Government Efficiency (DOGE) in particular, as well as Congressional Republicans are heavily focused on program integrity—which, as is noted above, includes reducing fraud, waste, and abuse—to achieve spending targets and reform existing programs. The health component of the Reconciliation bills are organized into four sections:

A. Reducing Fraud and Improving Enrollment Processes

B. Preventing Wasteful Spending

C. Stopping Abusive Financing Practices

D. Increasing Personal Accountability

Reducing spending through actions that promote program integrity is a central paradigm through which federal proposals are being evaluated by the Trump administration and Congress. Proposals that can be framed in this context are therefore generally expected to continue to be prioritized by the federal government to advance policy shifts as the Reconciliation process unfolds and the Trump administration takes further action through additional executive orders, policy directives, and a rescission bill, which is expected to include additional cuts.[129]

It's hard to know exactly how much of national spending on healthcare falls under the category of fraud, waste, or abuse. According to CMS:

- "**Fraud** is when someone knowingly deceives, conceals, or misrepresents to obtain money or property from any health care benefit program. Medicare or Medicaid fraud is considered a criminal act.
- **Waste** is overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program. Examples of waste are conducting excessive office visits, prescribing more medications than necessary, and ordering excessive laboratory tests.
- **Abuse** is when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards. Examples of abuse are billing for services that aren't medically necessary, overcharging for services or supplies, and misusing billing codes to increase reimbursement."

The March 25th executive order cites a recent US Government Accountability Office (GAO) report on "fraud risk management," which found that the federal government "loses an estimated $233 billion to $522 billion annually to fraud." In that 2024 report, the GAO estimated that more than 50 percent of the total amount (in dollars) of improper payments estimated across the federal government were associated with Medicare (34 percent) and Medicaid (19 percent). For Medicaid itself, the 2024 national

Fraud, Waste, and Abuse—Answers from the Centers for Medicare and Medicaid Services (CMS)

What's the difference between health care fraud, waste, and abuse?

Fraud is when someone knowingly deceives, conceals, or misrepresents to obtain money or property from any health care benefit program. Medicare or Medicaid fraud is considered a criminal act.

Waste is overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program. Examples of waste are conducting excessive office visits, prescribing more medications than necessary, and ordering excessive laboratory tests.

Abuse is when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards. Examples of abuse are billing for services that aren't medically necessary, overcharging for services or supplies, and misusing billing codes to increase reimbursement.

The difference depends on circumstances, intent, and knowledge.

Who determines if something is fraud, waste, abuse, or a simple error?

Usually, it's not possible for a casual observer to distinguish between intentional fraud, waste, abuse, and errors (mistakes made without intent or knowledge of the error). Improper payments, for example, are often mistakes. If a situation raises a flag, it will need to be properly investigated to determine if it's more than a mistake. The government has systems in place to investigate and determine whether it's actually fraud or something else. Since fraud is ultimately determined by the judicial system, the Centers for Medicare & Medicaid Services (CMS) typically notes "potential fraud" until the judicial system has made a decision.

These answers taken from the Centers for Medicare & Medicaid Services – National Training Program document, "Frequently Asked Questions (FAQs): Medicare & Medicaid Fraud, Waste, and Abuse Prevention Mini-Course & Podcast Series," available at https://cmsnationaltrainingprogram.cms.gov/sites/default/files/shared/C-10_FAQ_Medicare_%26_Medicaid_Fraud_Waste_Abuse_Prevention_12-8-2022.pdf.

improper payment rate, according to CMS, was 5.09 percent (based on reviews in 2022, 2023, and 2024). Such improper payments may have increased significantly during the COVID-19 period before beginning to decrease. A 2024 Rockefeller Institute of Government report, for example, identified a 40 percent surge in improper payments between 2019 and 2022. According to CMS, "improper payments are payments that do not meet CMS program requirements. They can be overpayments, underpayments, or payments where insufficient information was provided to determine whether a payment was proper." This may be an intentional or unintentional error, such as a data entry error or a missed administrative step in the process.[130]

The Trump administration has already begun a renewed focus on leveraging data analytics and program integrity efforts to prevent improper payments *before* they are made. The second Trump administration has continued prior efforts under the first Trump administration to expand access to health data and make healthcare pricing more transparent. This was reflected in a February 25, 2025, executive order, which focused more specifically on prices paid by insurers to hospitals and for prescription drugs. Additionally, the president's Make America Healthy Again Commission includes a broader requirement for "ensuring the transparency of all current data."

The Trump administration also issued an executive order in March 2025, "Protecting America's Bank Account Against Fraud, Waste, and Abuse," that focused on imposing further controls before federal payments are made for all programs and federal spending. A concurrent article in the *Wall Street Journal* referenced a review of Medicaid payment records, which identified duplicate payments to managed care plans for Medicaid recipients who moved between states within an eligibility year. In other words, the review found that the federal government was paying the nonfederal share to cover one person in two different states, which is impermissible under current requirements.

Access to current data is a limiting factor, however, in states' ability to monitor recipient changes if the recipient doesn't self-report, as states do not have access to other state eligibility data. The executive order and the article above reference the need to verify payments against existing federal data sets prior to payment. A March 20th executive order, "Stopping Waste, Fraud, and Abuse by Eliminating Information Silos," requires the Department of Health and Human Services (HHS), the Department of Treasury, and other federal agencies to "rescind or modify guidance that restricts access to unclassified records, data, software systems and information technology systems," essentially allowing the federal government to do data matching across federal databases, including for health insurance programs like Medicaid, Medicare, Child Health Plus, the Essential Plan, and federally subsidized insurance purchased through state health insurance marketplaces. It can be expected that the Trump administration and associated entities will implement additional spending controls to prevent the kinds of duplicate payments highlighted in the *Wall Street Journal* review going forward.[131] And, at the close of April 2025, the Centers for Medicare and Medicaid Services (CMS) announced the establishment of a new Fraud Detection Operations Center, which has identified a series of improper or potentially fraudulent payments.[132]

It's possible that the Trump administration will declare via executive order an effort to reduce healthcare costs,[133] in part by applying an expanded definition of fraud, waste, and abuse to Medicaid, by modifying or adhering more literally to CMS's current interpretation of these terms. Of these three terms, the existing definition of waste appears to be the broadest: "overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program." Already, in a June 6th memorandum, the president directed the Health and Human Services Secretary to take action to reduce fraud, waste and abuse in the Medicaid program, citing examples of currently approved financing mechanisms such as provider taxes and directed payment template as examples of arrangements subject to HHS review under the memo.

New York already has oversight processes in place to ensure program integrity standards are met. The Office of the Medicaid Inspector General (OMIG) works to ensure the integrity of the Medicaid program by conducting and coordinating fraud, waste, and abuse control activities for all New York State agencies responsible for Medicaid-funded services. Nonetheless, the topic remains center stage and remains a topic of focus in current publications about healthcare, given the prominence assigned to the topic by the Trump administration and in Congress. For example, Kaiser recently issued "5 Key Facts about Medicaid Program Integrity – Fraud, Waste, Abuse and Improper Payments." Analysis published by the Center on Budget and Policy Priorities has argued that the more the Trump administration and Congress can declare policy shifts as improving program integrity, the more they can deflect claims that they are eliminating benefits or reducing coverage as they modify the policies regarding health insurance.

Coverage of Care for Noncitizens

New York finances healthcare for certain noncitizens in a variety of circumstances. During the Clinton administration, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which limited "alien eligibility for federally funded public assistance benefits (including Medicaid) and authorized States to follow suit with their own programs."[134] The PWORA created a distinction between 1) qualified aliens,[135] such as green card holders, who are largely ineligible for federal Medicaid funds for five years, known as the "five-year ban," and 2) nonqualified aliens, who are generally ineligible for federal programs (both documented and undocumented, including expired documents). Within the nonqualified alien group, for the purposes of certain public benefits, a new subcategory of persons was created, for the purpose of public benefits, who are legally residing in the United States under the color of law (PRUCOL).[136]

Following the enactment of the PRWORA, New York terminated Medicaid eligibility, with the exception of emergency coverage, for most qualified aliens—such as green card holders, and PRUCOLs—who were otherwise financially eligible.[137] In 2001, however, a group of 11 immigrants was successful in challenging the state's policy as in violation of the equal protection clause in both the United States and state constitutions (*Aliessa v Novello*). Accordingly, under court order, New York has financed the healthcare of

qualified aliens (documented) within the five-year ban, as well as those recognized as PRUCOLS through Medicaid and the Essential Plan (1332 waiver). The House and Senate Reconciliation bills potentially modify the circumstances surrounding that case.

Additionally, with regard to nonqualified aliens who are not recognized as PRUCOL (undocumented persons), as of January 2024, New York authorized state-only Medicaid coverage to undocumented persons who are 65 years old or older. Additionally, undocumented pregnant persons are covered in state-only Medicaid, and undocumented children are fully insured through the state's Medicaid and Child Health Plus programs.[138] While more states offer coverage to either lawfully present and/or undocumented children or pregnant persons,[139] New York is one of only seven states (California, Oregon, Washington, Colorado, Minnesota, Illinois, New York) that offer coverage to undocumented adults.[140]

Based on initial activity directing federal agencies to act,[141] the Trump administration will further seek to limit the use of Medicaid funds coverage for noncitizens (both qualified and nonqualified aliens), and such language is included in the Reconciliation bill moving through Congress (Section 44110 in the House and 71110 in the Senate). Already, the Trump administration has made clear in executive orders that it intends to challenge states and providers that use federal funds in conflict with the administration's policies regarding immigration. For example, one proposed rule (in March 2025) would reverse a Biden-era rule allowing for federal funds to be used for coverage provided to deferred action childhood arrivals (DACA). The proposed rule, eliminating eligibility for subsidies, would be codified by the House and Senate Reconciliation bills. New York's approved 1332 waiver application included covering an estimated 16,000 DACA recipients, effective August 1, 2024. The prohibition on using federal funds for programming that benefits noncitizens conflicts with New York's recent legislative efforts to expand coverage for undocumented persons.[142] The Senate's Reconciliation bill (Section 71112) also limits the availability of federal matching funds for emergency Medicaid to the base rate (50 percent in New York) rather than the enhanced rate for childless adults (90 percent), which would nearly double state costs for those currently eligible for enhanced funding.

There is a bill—the No Medicaid for Illegal immigrants Act of 2025—pending in Congress, in the House Energy and Commerce Committee, that would prohibit states from making Medicaid available to any alien who is "not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law," with the exception of emergency Medicaid.

In addition to numerous bills impacting the availability of federal funding to cover noncitizens, there is also currently legislation pending in Congress to prohibit the use of any federal Medicaid funding or funding structures to support coverage for noncitizens. The bill was first introduced in February 2025 by Representative Hudson of North Carolina and has since gained the support of 15 additional cosponsors as recently as April 2025. The companion is sponsored by Senator Cassidy (R-LA) in the Senate. Two New York representatives, Tenney (NY-24) and Langworthy (NY-23), are cosponsors, and the bill is referred to the House Energy and Commerce Committee,

which is charged with finding Medicaid savings.[143] Similar language was included in the House and Senate Reconciliation bill (Section 44111 in the House and 71111 in the Senate), moving through Congress. That language would impose a 10 percent penalty on expansion FMAP (currently at 90 percent) for any state, such as New York, that uses its Medicaid systems to operationalize state-funded healthcare for noncitizens (specifically nonqualified aliens, with the exception of pregnant women and children), effective October 2027. As of 2023, New York received $16 billion in ACA enhanced FMAP, of which $2.7 billion was directly related to the expansion population.[144]

Additionally, the House and Senate Reconciliation bills (Section 44110 in the House and 71109 in the Senate) moving through Congress would prohibit the use of extensions for reasonable opportunity periods, which allows applicants for Medicaid, Child Health Plus, the Essential Plan, and those purchasing coverage on the Exchange with subsidies 90 days to verify his or her citizenship. Current regulations provide for "good faith extensions" as follows:

> The agency may extend the reasonable opportunity period beyond 90 days for individuals declaring to be in a satisfactory immigration status if the agency determines that the individual is making a good faith effort to obtain any necessary documentation or the agency needs more time to verify the individual's status through other available electronic data sources or to assist the individual in obtaining documents needed to verify his or her status.[145]

The 2024 Biden-era rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," removed the optional limitation on the number of reasonable opportunity periods, if the state "demonstrates that the lack of limits jeopardizes program integrity." The application of the rule was delayed to January 2035 in both Reconciliation bills. However, the bills (Section 44110 in the House and 71109 in the Senate) moving through Congress would not only prohibit implementation of the removal of the optional limit on reasonable opportunity periods, it statutorily limit the reasonable opportunity period to document citizenship to 90 days.

Eliminating any federal funding available for noncitizens, including as it pertains to healthcare, is a cornerstone of the Trump administration's priorities, as evidenced by a February 19th executive order directing "Federal departments and agencies to identify all federally funded programs currently providing financial benefits to illegal aliens and take corrective action."[146] Accordingly, in pursuit of spending reductions, Congress has also proposed (Section 112101 and 112103 in the House and 71301 and 71302 in the Senate) legislation to prohibit the availability of advanced premium tax credits to persons who are neither citizens, nor lawfully admitted for permanent residence, but who are residing under the color of law (PRUCOL) or who are lawfully present, such as a green card holder. Some of such persons are unqualified for federal financial participation in Medicaid because of the five-year waiting period required for federally-funded Medicaid benefits, but such adults under 65 currently are eligible for healthcare financed through the Essential Plan and 1332 waiver successor program in New York State. Currently, New York uses such federal funds to finance healthcare

for this group in a Basic Health Plan (the Essential Plan in New York) and 1332 waiver programs (the Essential Plan's successor in New York).

If enacted, the pending federal legislation would impact nearly 494,000 people in New York, according to January 2025 Department of Health enrollment data.[147] This subset of noncitizens eligible for the Essential Plan represents approximately one-third of total Essential Plan enrollment as of January 2025 (40 percent of total enrollment, excluding the 200–250 percent 1332 waiver expansion group). According to the New York State *Financial Plan*, Essential Plan expenditures are estimated to be $13.2 billion in FY 2026. If one assumes that federal funding received is equivalent to what is spent, one could presume that such legislation would result in a loss of at least $4–5 billion in federal funding to New York State.[148] The state could be required to continue providing Medicaid-equivalent care to this population due to previous litigation at a cost of approximately $3 billion;[149] however, the proposed bill substantially revises the circumstances surrounding the previous decision, necessitating conversations between the governor, the legislature, and stakeholders, if enacted. Eliminating funding for noncitizens obtaining coverage through the Essential Plan, or its 1332 waiver successor, cannot be accomplished entirely administratively, as the authorization for both the Essential Plan and the eligibility for PRUCOL individuals to receive ACA subsidies is in federal statute.

Additionally, the federal government is currently required to share in the financing of emergency Medicaid services for persons with life-threatening or organ-threatening conditions. According to New York State Department of Health data provided to the Empire Center for Public Policy, a think tank, as of March 2024, there are 480,000 noncitizens enrolled in the emergency Medicaid program.[150] These are largely undocumented, unqualified aliens who are otherwise not eligible for Medicaid or the Essential Plan as a qualified alien, PRUCOL, or through an undocumented program, as described above. Absent federal funding, hospitals would still be required to provide care in an emergent situation under the Federal Emergency Medical Treatment and Labor Act (EMTALA) without federal money to reimburse those hospitals for that care.[151]

Coverage for Gender-Affirming Care

According to the New York State Attorney General, "private health insurance plans bought in New York State and New York Medicaid must cover medically necessary gender-affirming care. They are subject to state law." This means New Yorkers are "entitled to receive sex specific procedures regardless of your sex assigned at birth or your gender identity."

Already, the Trump administration has made clear through executive orders that it intends to challenge states and providers that use federal funds in conflict with the administration's policies regarding gender. On March 5, 2025, CMS issued a letter to hospitals to provide "notice that CMS may begin taking steps in the future to align policy, including CMS-regulated provider requirements and agreements" with the priorities and perspectives espoused under the EO.

Additionally, the Centers for Medicaid and Medicare Services (CMS) sent a letter to Medicaid directors in April, which, according to a statement by CMS administrator, Dr. Oz, informs states that: "Medicaid dollars are not to be used for gender reassignment surgeries or hormone treatments in minors."[152] In May, the Department of Health and Human Services followed up the guidance with a report on the treatment for pediatric gender dysphoria.

Also in May, Representative Tenney (R-NY-24) and Senator Marshall (R-KS) introduced the No Subsidies for Gender Transition Procedures Act, which would eliminate taxpayer-funded transgender procedures on both minors and adults. Similar language (Section 44125), for minors, was initially approved by committees in the House through the Reconciliation process. However, in exchange for other amendments, including SALT, the final language approved by the House, which is also in the Senate version, extended the prohibition on federal payments for gender-affirming care to both minors and adults.[153] Notably, the Senate did not include language that was passed by the House (Section 44201) to remove gender-affirming care procedures from the list of essential health benefits for Affordable Care Act compliant plans.

Abortion and Family Planning Services

The history surrounding abortion dates back nearly two centuries, with laws defining the permissibility or impermissibility of abortions dating back to the 1880s. New York legalized abortion in 1970, three years prior to the 1973 *Roe v. Wade* Supreme Court decision. Since then, access to abortion and family planning services remains a controversial issue at the federal level, with several further court cases, including *Dobbs v Jackson* (2022), unfolding in the last decade.[154]

On January 25, 2025, the Trump administration issued an executive order limiting the availability of federal funding for abortions and the promotion of abortion services. The executive order rescinds two Biden administration executive orders: Protecting Access to Reproductive Health Services and Securing Access to Reproductive and Other Healthcare Services, which were issued by the Biden administration, in part, as a response to abortion-related litigation.

Additionally, a more recent executive order and a subsequent letter reinstated the "Mexico City Policy," which requires foreign NGOs to certify that they will not "perform or actively promote abortion as a method of family planning" using funds from any source (including non-US funds) as a condition of receiving US funds.

Beyond the actions already taken, it's expected that the Trump administration will seek to restrict medication-induced abortions through limitations on access to the drug mifepristone and through reductions in funding for Planned Parenthood and Title X.[155] Already, some funds related to abortion have been withheld. Further limits on abortion coverage could be extended to Medicaid and Child Health Plus, as well. The Supreme Court will decide (*Medina v Planned Parenthood South Atlantic*) whether states have the right to exclude abortion providers from their Medicaid programs, which could bear on the federal government's actions.[156] The Reconciliation bills (Section 44126 in the House and 71118 in the Senate) appear to speak directly to the case, prohibiting Medicaid funds from being paid to providers that are engaged in family planning or

reproductive services, or provide for abortion services other than Hyde Amendment exceptions, and receive more than $1 million in funding annually.

Governor Hochul and the New York State Legislature have enacted protections in recent years[157] related to abortion access and enhanced reimbursement to providers in New York and, in the past, supported backfilling lost funding, which would minimize any impacts to New Yorkers should the federal government take further action.[158] Additionally, New York voters recently adopted an amendment to the state's constitution to make "pregnancy, pregnancy outcomes, and reproductive healthcare and autonomy" a protected class under the Equal Rights Amendment. The governor recently affirmed her commitment to supporting access to abortion in a June op-ed in which she stated, "My promise… is that we will continue to stand as a safe harbor for anyone who needs abortion care." The op-ed coincided with the announcement of $25 million in abortion access grants.

Hospital Consolidation

What it means to be a hospital and how hospitals are financed have changed over time due to advances in medicine and technology, financing, and patient choice.[159] The health policy changes at the federal level are likely to evoke questions about hospital financing, as the proposals described above would dictate who and what is covered. Over the last two decades, nationally, hospitals have consolidated rapidly, while such consolidation has occurred to a lesser extent in New York. Hospital consolidation includes affiliations and/or partnerships with a parent hospital or system; it is not limited to closures and is often an alternative to outright closure when a hospital is financially insolvent.

Accordingly, a central component of Governor Hochul's healthcare agenda has been to promote the sustainability of struggling hospitals through partnerships with stronger, high-quality affiliates through the Safety-Net Transformation Program (SNTP). The SNTP "aims to support the transformation of safety net hospitals (as defined under PHL 2825-i(2)) to improve access, equity, quality, and outcomes while increasing the financial sustainability of safety net hospitals by encouraging collaborative partnerships between safety net hospitals and partner organizations." New York State Fiscal Year 2026 executive budget documents stated that: "75 of 261, or 29 percent, of New York's hospitals are financially distressed, and overall distressed hospital spending has increased over 600 percent since FY 2017. While reforms supported by the 1115 Waiver and Safety Net Transformation program mergers may help support some of these facilities, need has continued to grow at unsustainable levels."[160] Further, such documents indicate New York spends over $3 billion annually to help nearly one-third of its hospitals remain solvent.

Availability of federal funding to support, and likewise the state's ability to continue or expand its current support for, distressed hospitals going forward is at risk under current proposals in the House and Senate Reconciliation bills. A portion of the $3 billion in distressed hospital funding is paid through a directed payment template (DPT), which allows the state to leverage a federal share on approximately $2 billion in distressed hospital payments. Reversing a Biden administration rule, the bills

(Section 4413 in the House and 71121 in the Senate), progressing through Congress, cap the maximum payments through the DPT program at the Medicare rate, rather than the average commercial rate allowed in the 2024 Biden rule, for any future DPT payments. While the House version includes a grandfathering provision for previously approved rates, the Senate version requires that previously approved rates would need to be adjusted downward incrementally by 10 percent until such rates do not exceed the approved Medicare rate. The majority of New York State's DPTs expired on March 31, 2025, including the approximately $2 billion for distressed hospitals and $15.7 million for improving pregnancy outcomes. Both of these payments are set above the proposed limit, with the pregnancy outcomes DPT detailing that it is set at 156 percent of Medicare; therefore, assuming similar ratio for other DPT payments, approximately one-third of federal funding ($500–$600 million) currently available is uncertain and potentially at risk under the proposal, as the grandfathering clause (in the House bill), which would essentially freeze current payments, may not allow for adjustments to respond to changes in facility or community needs, and the Senate bill would substantially reduce available federal funding going forward.

Additionally, the Advancing All-Payer Equity Approaches and Development (AHEAD) Model, which the New York State Department of Health indicates will provide $2.2 billion in funding to "stabilize and transform targeted financially distressed voluntary hospitals," is financed through designated health state programs (DSHP) that CMS indicated it would not continue beyond 2027.[161]

Prospectively, hospital mergers and/or consolidations, which may be necessary to modernize and stabilize New York's healthcare delivery system, especially in the face of significant proposed reductions to federal funding that supports New York's distressed hospitals may also be at risk. The recent House FY 2025 Budget Resolution includes a reference to limiting hospital consolidations in the name of avoiding unnecessary price growth. Additionally, some healthcare executives have recently expressed that they expect a slowdown in hospital merger activity, even if there aren't explicit limitations: "Hospitals are worried about how much federal aid they will get from the federal government. They're concerned about President Trump's tariffs, which have been paused on most countries but are in effect on China, a major producer of medical supplies. And there's uncertainty in the markets, which could impact health systems' investments." In other words, despite there not being an executive order or proposed rule outright limiting mergers and or consolidations, there may be a chilling effect, at least in the short-term, on the potential for hospital consolidation in New York in response to Trump administration policies and funding reductions, as proposed by Congress.

A Kaufman-Hall analysis of hospital merger activity in the first quarter of 2025 shows that such activity had fallen to its lowest level reported in the eight year history of the analysis, with only five mergers announced, compared to 20 in the first quarter of 2024. The Kaufman Hall analysis substantiates that "Not only was the number of transactions low in Q1; the size of the transactions was as well. There were no "mega mergers" (mergers in which the smaller party has annual revenues in excess of $1 billion), and the average size of the smaller party, measured again by annual revenues, was $279.3 million. This is roughly half of the average seller size of $559 million

recorded for 2024, and well below the recent high in average seller size of $852 million in 2022."

New York has a legacy system of many small hospitals, some of which are operating at 50 percent or less of certified bed capacity, based on a review of publicly available administrative data. New York also has the most hospitals in the nation, relying on approximately $3 billion in financial assistance from the state, and in some cases the federal government, to maintain operations.[162]

By experience and review of public data, many of the financially "distressed" hospitals serve patients reflecting a predominant mix of Medicare and Medicaid funded care and are independent or affiliated with only a few other small hospitals. Such hospitals, with some exceptions, often do not have the broad outpatient and physician networks necessary to drive volume and compete in a marketplace where a handful of insurers control most covered lives in each region.[163] According to the American Medical Association, 95 percent of United States health insurance markets are highly concentrated and in 48 percent of the regions one health insurer has a market share of at least 48 percent.[164]

Further, not a single New York-based hospital system qualifies as among the largest 35 hospital systems nationally. The state's largest hospital system, also the state's largest private employer, ranks 38th. One hospital system, which operates in New York, ranks sixth on the list, but is headquartered outside of New York. Places like Rochester, Minnesota; Birmingham, Alabama; and St Louis, Missouri all have hospitals far bigger than the largest hospital in New York City and more than double the size of any upstate New York hospital. Many of New York's hospitals were built in the 1950s or even earlier, when a community-based general hospital was the standard.

The challenge with community-based hospitals is particularly felt in rural communities. In 2023, the Congressional Research Service produced a report on the status of rural hospitals. According to the Rural Health Information Hub, New York has 20 critical access hospitals (out of 1,377 nationally) and one rural emergency hospital (out of 38 nationally). With the exception of urban centers, much of New York's landscape north of the Hudson Valley is not designated as a "non-rural area" according to the Census Bureau.[165] Rural hospital designations allow designated facilities to leverage enhanced funding. New York State also has a "rural hospital" classification that is more expansive than the national standard, which makes such hospitals eligible for rural health access and development grants, one objective of which is to "integrate services with other hospitals and community-based providers."

Step Two Policy Project's "Healthcare in Rural New York: Current Challenges and Solutions for Improving Outcomes" details how the challenges facing rural hospitals differ from those of urban hospitals:

> It is difficult to deliver sustainable, high-quality healthcare services to an older, sicker, and poorer population in geographies with low population density, widely distributed housing and services, limited public transportation, and a declining labor force. These challenges impact the delivery of healthcare services in ways that differ from many of the challenges in urban areas and

contribute to the worsening disparities in health outcomes, including mortality, observed between rural and urban New Yorkers.

According to a 2024 report by Chartis, a healthcare consulting firm, nationally, 58 percent of rural hospitals are affiliated with a system, and 50 percent of rural hospitals are in the red: "In 2019. The median operating margin for these affiliated hospitals is 1.7%, compared to -2.2% for independent rural hospitals. Additionally, only 42% of health system-affiliated rural hospitals are operating in the red, compared to 55% of independent rural hospitals."[166]

While there have been limited hospital closures in New York over the past decade, closures have been more likely in nonurban centers.[167] Interestingly, the House Reconciliation bill includes language (Section 111201) that would extend eligibility for rural emergency hospitals to hospitals that were open between January 1, 2014, and December 26, 2020, but have since closed, to reopen as emergency hospitals. Hospitals that could potentially meet such criteria are in or in close proximity to New York Congressional delegation districts, including, but not limited to: Langworthy (NY-R-23), Tenney (NY-R-24), and Riley (NY-D-19). Similar language was not included in the Senate version.

While there is a legitimate argument that excessively large systems could result in higher prices, and that for-profit chains are not necessarily associated with better quality,[168] this is typically not the case regarding New York's safety-net hospitals, given the current environment. Insurer pricing is volume-based,[169] and except in limited instances, small independent hospitals cannot offer the volume needed to garner the same rate offered to large, high-quality systems, which, unlike nationally, in New York, must be not-for-profit.

Hospital consolidation is an important element to consider with respect to reducing the future level of subsidies provided to New York hospitals. The reductions in funding proposed by Congress could significantly shift costs to the state or require new conversations about the future organization of New York's healthcare delivery system.

As referenced above, New York hospital systems are generally smaller than other states and prohibitions on the ability of the state to promote transformations of safety-net providers could not only prevent the market from normalizing, but also potentially create unintended access issues, as closure is not the only solution in current efforts to promote consolidation through partnerships. However, given proposed funding reductions, maintaining the status quo would significantly increase costs to the state.[170] The magnitude of reductions proposed by Congress and the Trump administration could put at risk the state's ability to finance providers at existing levels. This could be particularly detrimental to safety-net providers supported through extraordinary financial assistance programs, who are, serving vulnerable populations. The state's SNTP program could provide a soft landing for patients, workers, and communities with distressed hospitals impacted by the proposed federal reductions.

Prescription Drugs

The rescission of the Biden administration's executive orders related to pharmaceuticals in January 2025 brought back into focus the issue of pharmacy pricing for life-sustaining medications. Pharmacy spending is arguably the fastest growing segment of healthcare, fueled by wider use of Glucagon-Like Peptides (GLP-1) such as Ozempic, Munjero, and Wegovy.[171] And, the next class of blockbuster drugs, such as gene therapies, are likely to be even more expensive, driving further spending growth.[172]

In February, the Trump administration further signed an executive order to expand its influence over the Federal Trade Commission (FTC), including ongoing litigation filed by the FTC regarding dramatically varied pricing for and access to insulin by pharmacy benefit managers (PBMs). This follows other cases filed by the FTC against PBMs in the past, as the topic is of continued focus for the agency, Congress, and the White House.

Accordingly, it's been generally expected that the Trump administration will resume focus on the pharmaceutical industry, not only through actions aimed at reducing chronic disease, with the potential to decrease the need for pharmaceuticals, but also through continued efforts to negotiate and leverage lower prices with drug manufacturers.

Already, in April, the Trump administration issued an executive order to:

- Expand the Medicare Drug Pricing Negotiation Program.
- Align Medicare payments for certain prescription drugs with the cost hospitals paid to acquire them.

- Standardize payments for prescription drugs.
- Require discounts for insulin and epinephrine for low-income and uninsured patients.
- Facilitate drug importation programs.
- Expand Medicaid discounts for sickle-cell medications.
- Expand access to generics and biosimilars.
- Require the disclosure of fees that pharmaceutical benefit managers (PBMs) pay to brokers.
- Direct the administration to promote a more competitive, transparent, efficient, and resilient prescription drug chain.

Congressional support for some of the proposals identified in the executive order, particularly those relating to price-setting, is controversial, and the Speaker of the House has recently expressed concerns.[173] In December 2024, Speaker Johnson put together a package of PBM reforms, which he has continued to discuss publicly.[174]

Unsurprisingly, given the Speaker's interest, the Reconciliation bills (Section 44124 in the House and 71116 in the Senate) included a federal ban on spread pricing (the difference between the acquisition cost and the drug cost) in Medicaid. New York has long tried to limit the gaming of pharmaceutical pricing by eliminating spread pricing in the Medicaid program in 2019 and recently issued regulations on commercial PBMs through the Department of Financial Services. The Trump administration may also attempt to control pharmacy costs through further regulation of PBMs. Vertical integration (of insurers, pharmacies, and other healthcare providers) in the market and opaque contractual arrangements leave the true benefits and costs associated with the use of PBMs, which in many cases are publicly traded companies with a primary obligation to generate a profit for the shareholders, unknown by decision-makers and the public.

It's clear that more changes to policies related to pharmaceuticals can be expected, as the Reconciliation bills included several pharmacy-related sections. Additionally, in April, after announcing a ban on certain chemicals in foods, Health and Human Services Secretary Robert F. Kennedy, Jr. was asked if he planned to ban certain additives in pharmaceuticals, to which he responded: "We're going to start on that next."[175] As for other potential changes, some health experts believe the Trump administration is considering a ban on pharmaceutical advertising.[176] And, prior to the executive order in April, there was focus on whether tariffs would apply to offshore drug manufacturing, though they've initially been exempt. Additionally, in May, the Trump administration issued an executive order to limit pharmaceutical prices to those paid by developing nations.[177]

Conclusion

The size and scope of the potential federal changes and cuts to healthcare and healthcare funding are significant. New York's residents and the state's $300 billion healthcare economy stand to be impacted by the potential federal policy changes summarized here. Once more, New York's healthcare sector is inextricably linked with New York's overall economy and broader employment, which includes the nation's financial markets.

Not only does the federal government maintain considerable authority over New York's healthcare sector with respect to both its financing and delivery, but the combination of proposals and scale of changes under consideration by Congress and at the discretion of the Trump administration could have a particularly significant impact on New York's healthcare sector compared to other states, as well as on the state's budget.

Based on an initial review of the proposals included in the House and Senate Reconciliation bills moving through Congress, the magnitude of financing changes to publicly funded health insurance programs—those proposals that reduce funding to New York without a commensurate eligibility change—are significant. Additionally, and not insignificantly, there are substantial eligibility changes proposed in the bill.

Moreover, we have already seen significant movement with regard to executive orders, regulatory proposals, and letters to states outlining the Trump administration's policies. When considering administrative actions, which may be layered on top of Congressionally enacted funding reductions, the impact to New York is sizeable and are outsized in relation to other states, as many of the proposals impact New York and a handful of other states. Republican Congressional leadership and the Trump administration are framing many of these significant changes in the context of fraud, waste, and abuse to achieve their policy objectives, reduce spending, and finance the federal government. Bills effectuating many of the proposals under consideration have already been introduced, and more bills and variations on pending legislation are expected as the budget Reconciliation process moves forward. Likewise, additional continued actions by the Trump administration are expected.

The actions, policies, and proposals outlined in this piece are meant to summarize the existing and shifting landscape, so that as more details emerge, there is a reference for how the proposals debated in Congress and that are subject to executive discretion by the new administration might affect New York. At present, the actions already taken by the Trump administration and the Reconciliation bills moving through Congress significantly alter New York's healthcare programs and funding. It's likely that litigation and implementation delays will cause the changes to occur over time, rather than all at once. Some of the changes, if enacted, will necessitate substantial changes to the state's financing of healthcare through conversations between the governor and legislature on program design and funding. The Rockefeller Institute will continue to study and monitor these developments closely as they unfold and to provide relevant and timely analysis.

ENDNOTES

1 In FY 2023, federal Medicaid spending totaled $880 billion in the United States, with the federal government paying 69 percent ($606 billion) and states paying 31 percent ($274 billion). This share is slightly higher than historic shares due to the enhanced pandemic match rate, but there is variation across states. New York ranks in the top five states that receive federal Medicaid assistance, with 63.8 percent in 2023, which covers an average of $9,688 per enrollee.

2 After the Medicaid expansion from the Affordable Care Act in 2014, Medicaid eligibility removed income levels as a category for access. Additionally, it altered eligibility thresholds for adults without dependents and defined whether lawful permanent residents or migrants without legal status could join a state Medicaid program.

3 New York has the largest GME infrastructure in the United States, with approximately 5,200 physicians completing their training in one of the GME programs in New York. In 2022, New York ranked first in percentage of all active physicians who completed GME in the state of New York (77 percent).

4 A 2025 fact sheet published by the Centers for Medicare & Medicaid Services described proposed rule changes to establish a standard for enrollment in healthcare marketplaces. Changes included DACA recipients from eligibility, verifying individual income levels, reworking plan options, altering premiums, and shortening enrollment periods.

5 In 2022, approximately 6.6 million New Yorkers were enrolled in free or low-cost coverage under the NY State of Health. Without ARPA tax credits or subsidies, the estimated average annual cost for New Yorkers would average a $1,453 increase in cost, along with 58 percent of enrollees would see an increase in personal premiums.

6 A 2020 Report to the Congressional Committee on Energy and Commerce dictated that the effects of hospital consolidation, which has increased since 2003, had significant negative effects on small medical practices, which were incentivized into large hospital conglomerates, and increases in 340B Drug Pricing Programs.

7 In the FY 2025 budget from the US House of Representatives, several proposals were included to regulate healthcare markets by "combating consolidation" through lowering federal healthcare spending for the fiscal year and eliminate incentives for hospitals to acquire local healthcare practices in both rural and metro areas, estimating $150 billion over the next 10 years.

8 Outline for Letters of Interest of Safety Net Transformation Program for consideration by New York hospitals, which detailed a way for state healthcare systems to proactively create a "safety net" of options for accessible healthcare to patients throughout New York.

9 A January 2025 executive order titled "Protecting Children from Chemical and Surgical Mutilation" directed federal agencies to limit access to gender affirming care in DHS, DoD, and shifts under the Affordable Care Act (ACA).

10 Trump administration executive orders have covered the memorandum of the Mexico City Policy, enforcement of the Hyde Amendment, and limiting further investment in medication abortion.

11 In November 2024, voters approved Proposition One, an amendment to the New York Constitution that protects abortion rights and access to reproductive healthcare. The approved amendment establishes constitutional protections against discrimination based on ethnicity, national origin, age, disability, and sex, including sexual orientation, gender identity, gender expression, pregnancy and pregnancy outcomes, and reproductive healthcare and autonomy. These protections are in addition to explicit protections against racial and religious discrimination that were already included in New York's Constitution. The amendment went into effect on January 1, 2025.

12 Exec. Order No. 14273 (April 15, 2025).

13 The proposed budget resolution outlined approximately $2 trillion in mandatory cuts to federal spending, including a cut of $880 billion from Medicaid and Medicare.

14 According to a bulletin from the American Hospital Association, this new "skinny" budget issued from the Trump administration in May 2025 that outlines reductions in spending for federal agencies including CDC, HRSA, NIH, SAMHSA, CMS, ASPR, AHRQ, and put forth $500 million for the Make America Healthy Again (MAHA).

15 The *New York Times* reviewed areas of possible spending cuts to reach $880 billion over the next decade as dictated under a budget resolution. The Energy and Commerce Committee oversees approximately $25 trillion in total spending, which would require repeals to existing statutes or cuts to Medicare which makeup the largest portion.

16 These budget resolutions were set under Reconciliation, a rule that only requires a simple majority for passage in the US Senate, allowing it to differ slightly from the House version, which set similar spending outlines and affirmed $880 billion in spending cuts.

17 *Politico* reports this proposal ranges from $500–$600 billion in healthcare spending, some coming from energy and telecommunication policies, and a potential $230 million to agriculture spending.

18 Multiple sources expressed concerns that a decade-long change to Medicaid will undermine social safety nets and deter nonprofit providers from providing services to vulnerable populations, such as 71 million people considered low-income. Opposition exists for potential policy changes including requiring recipients to work for Medicaid, eliminating tax loopholes, and citizenship verification.

19 Some estimates from other sources contradict the potential loss of spending will be minimal in the long-term and federal healthcare programs need to be regulated and reduced to increase efficiency. Various resources cite instances where past changes in Medicare and Medicaid to account for a new number of low-income and newly eligible recipients amounted to an increase in overall use by the programs.

20 From an article by *Politico*, the expansion of federal programs like Medicare and Medicaid since its inception in 1965, the programs cover so much more types of enrollees and state level support. Given this level of complexity, it could be a political liability and a legislative battle to create fundamental changes to programs with cuts.

21 This letter from Rep. Chip Roy (TX) urged the House budget reconciliation package not to include structural Medicaid reform out of concern for setting up massive tax increases and benefit cuts in the future.

22 According to the Center on Budget and Policy Priorities, research shows that Medicaid currently covers one in every five people across the country and covers an average of 41 percent of births annually. The rationale that this and other safety net programs are not cost-effective and fraudulent lacks substantial evidence for widespread elimination.

23 See *Aliessa v. Novello*.

24 Using NYSOH 2022 estimates, adjusted for January 2025 enrollment.

25 The penalty was revised three times in the House, with the final version appearing to exclude penalties for covering children and pregnant women (though there are some drafting inconsistencies in application to Child Health Plus). The final version appears to be limited to nonqualified aliens (undocumented persons) and certain parolees.

26 Using 2023 CMS 64 data from the automated Medicaid Budget and Expenditure System.

27 Additional details available in a recent Empire Center blog post: "Feds Move To Close Medicaid's 'MCO Tax' Loophole, Spelling Trouble for New York."

28 Summary provided in "An Overview of New York's 1115 Medicaid Research and Demonstration Waiver Amendment" by Courtney Burke, senior fellow for health policy at the Rockefeller Institute of Government.

29 According to the National Association of Counties, as of 2020, counties contribute to state Medicaid spending in 26 states, of which 18 states mandate such contributions. Per Part F of Chapter 56 of the Laws of 2012, local contributions to the state's Medicaid program in New York were capped at 2015 levels or $7.6 billion annually following a phase-out of previously capped growth. Chapter 58 of the laws of 2005 limited the growth of local contributions to 3 percent annually.

30 Compared to neighboring states, New York receives a vast amount of Medicaid reimbursements than others due to poverty metrics which resulted in vast disparities. For example, according to *Forbes*, in 2013 New York received about $3,200 more in federal Medicaid spending per person in poverty than New Jersey.

31 As of 2023, $62.4 billion in federal funding was provided to New York out of $606 billion in total, or 10.3 percent.

32 Local governments include the 63 counties and New York City, sometimes referred to as county governments.

33 Based on a 2024 estimate analysis of the Medicaid Program in New York State.

34 According to a 2021 KFF study of Medicaid spending by full-benefit enrollment, New York ranks 8th with an average of $9,872 per person.

35 NAMD roadmap distinguishes how the Medicaid program differs under various directors and state systems

36 MedPac estimates that at least 40 states use directed payment arrangements. New York leverages approximately $2 billion in payments to safety-net hospitals.

37 Ongoing litigation from the 233 legal challenges, along with possible Supreme Court cases, have added further uncertainty to the direction of health policies in federal legislation.

38 Terminology by the National Library of Medicine on managed care.

39 With the exception of administration costs.

40 Health-related social needs include services such as housing navigation, rental assistance, and utilities support, medically tailored meals, food and pantry stocking, air conditioners, furniture, and home accessibility modifications.

41 According to the Centers for Medicare and Medicaid Services (CMS), "Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations."

42 Complementary changes were made to New York's Essential Plan through an amendment to the 1332 waiver program to authorize social determinants of health grants to address food insecurity (through medically tailored meals, food pharmacies, and personalized coaching), preparing for climate change (through air conditioners for persons with asthma), and knowledge sharing (through provider training on mental health services and social determinants of health).

43 Five states include: New York, Colorado, Hawaii, Minnesota, and Pennsylvania. Oregon had a previously approved waiver.

44 According to Kaiser's State Health Facts as of 2022.

45 According to Step Two Policy Project, "Immediately upon taking office in 2011, Gov. Andrew Cuomo created MRT I, which was co-chaired by Dennis Rivera, the popular former leader of 1199 SEIU, and Michael Dowling, the CEO of what is now called Northwell Health and formerly a top aide to Gov. Mario Cuomo. At the staff level, MRT I was guided by the talented new Medicaid director, Jason Helgerson, and the highly experienced Deputy Secretary for Health, Jim Introne, who had also served as the Deputy Secretary for Health under Gov. Mario Cuomo and had decades of involvement with long-term care.

MRT I was perhaps the most strategic and ambitious healthcare initiative in New York State to date. Among MRT I's core strategies was the adoption of "Care Management for All," which required mandatory enrollment in managed care for almost all populations. Although programmatic arguments in favor of managed care were the primary driver for the policy's architects, cost containment was also viewed by many as an important objective. The policy of mandatory enrollment in managed [long-term care] plans represented a shift from fee-for-service reimbursement and administration by the Counties, of much of the State's [long-term care] program."

46 From an April 2025 press release, the Centers for Medicare & Medicaid Services outlined new directives from federal agencies and informed states on new funding parameters.

47 This policy change was implemented after the New York deputy commissioner at the Department of Health sent a letter in December 2024 with approval for the Health-Related Social Needs Implementation Plan for the New York 1115 demonstration project in the state.

48 This blog post outlines how these changes would potentially affect 1115 Medicaid waivers under the Trump administration.

49 To implement the rescissions, the Biden administration began by issuing an executive order to outline his policies and charge Health and Human Services (HHS) with reviewing all agency actions for consistency with the Biden administration's policy to expand health insurance coverage, including in relation to demonstrations and waivers. The Biden administration focused on *expanding* health insurance coverage. Then, the HHS secretary issued a brief outlining policies that conflicted with the administration's objectives, for example work requirements.

The Biden administration then sent letters to approximately 10 states, in one example, rescinding approvals provided by the Trump administration on the basis that the approval conflicted with the administration's stated policy goals. Specifically, the Biden administration argued that work requirements reduce enrollment in public health insurance programs, thereby conflicting with the overarching goal of coverage expansion. There was only one significant case, in Texas, where the Biden administration was not successful in rescinding Trump-era approvals, and that case has to do with the Biden administration failing to provide notice (i.e., letters) of its intent to rescind the prior approval.

50 On March 25, 2025, the Trump administration issued an executive order, "Protecting America's Bank Account Against Fraud, Waste, and Abuse," which promotes "conduct improper payment and fraud prevention screening prior to disbursing funds on behalf of agencies."

51 Summary provided in "An Overview of New York's 1115 Medicaid Research and Demonstration Waiver Amendment" by Courtney Burke, senior fellow for health policy at the Rockefeller Institute of Government.

52 At least Arkansas and South Dakota have already taken action to seek federal approval to implement work requirements.

53 For example, refer to DOH documents here and here.

54 A 2023 estimate from the Congressional Budget Office on H.R. 2811, also named the Limit, Save, and Grow Act of 2023, would put caps on discretionary funding on things from student loan spending to energy tax provisions to work requirements for Medicaid.

55 *The Hill* article detailing key amendments to the Reconciliation bill.

56 The CBPP relies on June 2024 enrollment data—before enrollment redeterminations following the pandemic were completed—and compared to previous estimates compiled by CBPP they now "include a larger group of enrollees who could be subject to the requirements, and we make different assumptions about the degree to which states would automatically exempt enrollees when they implement the requirements. If in the future an analysis tied to a single specific proposal seems warranted, **the estimates here can be refined**." (emphasis added).

57 "The most common Medicaid provider taxes in place in FY 2024 were taxes on nursing facilities (46 states) and hospitals (45 states), intermediate care facilities for individuals with intellectual disabilities (32 states), MCOs (20 states), and ambulance providers (17 states)."

58 Detailed list of financial plans for the Division of the Budget.

59 According to *Wall Street Journal*, this maneuver to meet budgetary goals could be the most politically viable option to cut up to $600 billion in the US House of Representatives.

60 New York State financial plan. Cash combining statement by account: 339.22187-Provider Assess. 75 percent is a conservative author estimate.

61 Figure 2 in this report shows the changes in fiscal support under this potential plan for hospitals.

62 Used by 21 states: Alaska, California, District of Columbia, Iowa, Illinois, Kansas, Louisiana, Maryland, Michigan, Minnesota, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Washington, and West Virginia. Florida is not reporting. List of participating states updated by the author to include New York.

63 Governor Hochul FY 2026 Executive Budget Financial Plan.

64 In addition, FGA advocated that the sharp increase in federal spending on these programs is not fiscally sustainable, and a projected $8.6 trillion over the next decade is also unattainable.

65 CMS press release on the proposed managed care organization tax regulations.

66 A May Empire Center blog post described the loss of this revenue stream as a "fiscal cliff."

67 Per Chapter 58 of the laws of 2005.

68 Per Part F of Chapter 56 of the Laws of New York.

69 H.R.6201—Families First Coronavirus Response Act: "(c) Requirement for Certain States.—Section 1905(cc) of the Social Security Act (42 U.S.C. 1396d(cc)) is amended by striking the period at the end of the subsection and inserting 'and section 6008 of the Families First Coronavirus Response Act, except that in applying such treatments to the increases in the Federal medical assistance percentage under section 6008 of the Families First Coronavirus Response Act, the reference to 'December 31, 2009' shall be deemed to be a reference to 'March 11, 2020.''

70 The New York State comptroller provides an illustration of the flow of funds during an IGT.

71 The Citizen's Budget Commission's 2018 blog post on "DSH Cut Delayed" provides details regarding the hierarchy of New York State DSH payments and the impact of the scheduled reductions.

72 The Greater New York Hospital Association was publicly lobbying for a two year elimination and/or delay, according to a September 2024 advocacy document.

73 Initiative is referred to as "most favored nation" policy for a selection of drugs covered under Medicare and would push producers of these drugs to lower prices domestically in the US to match other international markets prices.

74 According to a review conducted by the CATO Institute, Medicaid's longstanding grant mechanisms have provided more grant money than necessary, and even modest reforms would lead to a reduction in the program's output along with potentially a net savings of $612 billion over 2025–34.

75 Analysis conducted by The Commonwealth Fund noted that long-term services and supports (LTSS), including in-home care, nursing homes, and disability care, could be especially affected negatively by severe cuts to Medicaid, given that in 2022, over half of $415 billion spent nationally for LTSS was provided under Medicaid.

76 Per NYSDOH, the home equity limit for Medicaid coverage of nursing facility services and community-based long-term care is $1,097,000, as detailed in the cover memo to the New York Income and Resource Standards for 2025.

77 Refer to the February 2025 opinion piece by the *Times Union*.

78 Based on data extracted from the New York State Department of Health.

79 Linear graph of time data extracted from the Nursing Home Weekly Bed Census from 2009–25; shows fluctuation over time from just under 110,000 available nursing home bed count in 2009 to a little more than 90,000 count in 2025.

80 The Kaiser Foundation Fact Sheet 2017 noted current statistics on state and Medicaid provider taxes or fees.

81 Under the Trump administration, the Department of Justice submitted an appellate brief in April 2025 supporting a continuation of a rule change to the Medicare and Medicaid healthcare centers requiring staffing levels per the Department of Health and Human Services, begun from the Biden administration.

82 Examples of such services include nursing services in the home, therapies in the home, home health aide services, personal care services in the home (Level 2), adult day healthcare, private duty nursing, or Consumer-Directed Personal Assistance Services. A detailed overview of eligibility criteria is available here. MRT II included a prospective requirement to need assistance with two or more activities of daily living as a condition of MLTC enrollment; however, the requirement has not yet been implemented. The chairs of the Health Committees in the respective houses are carrying a bill to repeal the requirement, but it did not pass in the most recent legislative session.

83 Sec. 2404. Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment. "During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) shall be applied as though ''is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)'' were substituted in such section for ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)." Per CMS Informational Bulletin, this protection is extended through September 30, 2027.

84 When the Lombardi program was phased out between 2012–14, and all of its members were required to join Managed Long-Term Care plans, the state agreed to give spousal impoverishment protections not just to married persons transitioning to MLTC from Lombardi, but to ALL married couples where one spouse receives MLTC services.

85 The MRT II required the state to implement a 30-month look-back period for all community-based long-term care services and supports. Such a look-back was delayed by maintenance of effort requirements during the COVID-19 pandemic and thereafter due to requirements for enhanced federal funding.

86 Details regarding the phase-out are available here.

87 Michael Kinnucan, "How Fast is New York's Home Care Program Growing?," Fiscal Policy Institute, December 12, 2024, https://fiscalpolicy.org/how-fast-is-new-yorks-home-care-program-growing.

88 In August 2024, Governor Hochul awarded three workforce investment organizations $646 million over three years to establish programs that train workers to become mental health, healthcare, and social care workers.

89 In April 2025, the US Centers for Medicare & Medicaid Services notified states that it did not intend to approve new or extend existing requests for federal matching funds for state expenditures on designated state health programs (DSHP) and designated state investment programs (DSIP). The letter informed states would need to shoulder more of any future funding for these specific programs.

90 "SEIU Healthcare Minnesota & Iowa," SEIU Healthcare MN & IA, accessed June 24, 2025, https://www.seiuhealthcaremn.org/#:~:text=About%20SEIU%20Healthcare%20MN%20&%20IA,a%20voice%20on%20the%20job.

91 Governor Tim Walz, "Governor Walz Spends Time as a Home Care Worker to Highlight Increased Wages for Health Care Workers," news release, January 24, 2024, https://mn.gov/governor/newsroom/press-releases/?id=1055-607752.

92 "Minnesota Medicaid Personal Care Assistance (PCA) Program/Community First Services & Supports (CFSS) Program," American Council on Aging, updated June 4, 2025, https://www.medicaidplanningassistance.org/minnesota-personal-care-assistance/.

93 Formula: 1-0.45*(ypcpiny/ ypcpius)^2, where ypcpi is per capita personal income as calculated by BEA.

94 The Cato Institute argued that the current Medicaid matching-grant systems were fiscally wasteful, falling short of expectations, and without realignment were unstable in the long term.

95 Publications from Georgetown and KFF have advocated in favor of Medicaid and Medicare program restructuring by introducing per capita caps for federal spending and changing the rule regarding the federal medical assistance percentage for states.

96 The American Hospital Association estimates the impact on the hospital sector in New York would be $1.3 billion in the first year, or $14.2 billion over 10 years.

97 Only 18 states provided usable data for this state comparison.

98 Section 1905(b) of the Social Security Act specifies the formula for calculating FMAPs as "Federal medical assistance percentage" for any state shall be 100 percent less the state percentage; and the state percentage shall be that percentage which bears the same ratio to 45 percent as the square of the per capita income of such state bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that the federal medical assistance percentage shall in no case be less than 50 percent or more than 83 percent, except as otherwise proscribed such as in the case of ACA enhanced FMAP for childless adults or Medicaid administration, for example. There are many FMAPS depending on the services or function, but the base FMAP for each state, excluding the territories, is calculated pursuant to the above formula and adjusted annually.

99 A February 2025 report by the Fiscal Policy Institute underscored that while overall enrollment in New York Medicaid has decreased over the past few years the projected spending is estimated to increase by 3.7 percent of the state budget. Although the State Budget Forecast projected at 17.1 percent growth in state Medicaid, this number does not include potential changes in federal support and generalizes individual programs in its breakdown.

100 California, Colorado, Connecticut, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Washington, and Wyoming.

101 According to CMS's Medicaid Financial Management report (2023).

102 Report from the Kaiser Foundation that defines each program, its history, and what types of groups its covers for healthcare related issues.

103 The Center for Health Workforce Studies also predicted that by 2030, the growth in the demand for physicians will outpace the growth in the supply of physicians.

104 KFF report lists five areas describing Medicare site-neutral payment reforms.

105 Refers to a number of hospitals in New York that are unable to provide services in the long term without financial changes, due in part to a lack of available, affordable services for potential patients. In FY 2026, New York is estimated to have 75 of 261 hospital systems that meet this definition.

106 ERISA primer provides an overview of the act and how it relates to state health policy.

107 This is very significant in New York, which imposes both premium taxes (1.75 percent of premium) on insurers, a covered lives tax (ranging from $10/per individual $33/per family in Utica to $189/per individual and $623/family in New York City) and surcharges (7.04 percent for Medicaid payors and 9.63 percent for all others, except self-pay) on services provided in inpatient hospital, outpatient hospital and diagnostic and treatment centers.

108 Health insurance as a component of employee benefit packages dates back to the 1920s with public employees like teachers and postal workers, and expanded into private employers in the 1940s when the federal government imposed wage freezes to fight inflation. By the 1950s, health insurance benefits became a tax-free employee benefit.

109 New York is one of four states (California, Colorado, New York, and Vermont) that chose to enact an optional expansion of the small group pool for employers with 51–100.

110 Because New York State operates a basic health plan through the Essential Plan (1332) program, premium increases drive additional funding to that program, because the funding is benchmarked to 95 percent of the second-lowest cost silver plan.

111 For additional information and analysis: https://www.healthaffairs.org/content/forefront/hhs-finalizes-aca-marketplace-rule-part-1-enrollment-restrictions-premiums-actuarial.

112 There are no out-of-pocket expenses for Medicaid enrollees in New York State under 100 percent of the federal poverty limit, children, pregnant persons, members of tribal nations, or those receiving many of the state's long-term care or services to specialized populations. Copays are capped at $50 per quarter. Essential Plan enrollees have limited cost sharing. Child Health Plus enrollees pay a portion of the premium, depending on income, but there are no copays.

113 Summary of major healthcare reforms in the Ways and Means Reconciliation bill.

114 The American Rescue Plan Act (ARPA) and then subsequently extended in the Inflation Reduction Act (IRA) authorized subsidies to reduce consumers' cost of purchasing coverage on state health exchanges.

115 States that have not increased their Medicaid eligibility limit to 135 percent of the federal poverty limit (FPL), as authorized in the Affordable Care Act: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming. Note: the ARPA provided an additional incentive in the form of a 5 percent increase in federal Medicaid match for two years following the expansion for states to expand (Arkansas and South Dakota, but both have a pop up to withdraw should the enhanced ACA funding be modified and intend to apply work requirements to their program) or who planned to expand (Missouri and Oklahoma) to 138 percent of FPL.

116 May 2022 enrollment data, which this analysis is based on, indicates total EP enrollment was 986,054 at that time. Therefore, NYSOH estimated the impact of the subsidy reduction for EP enrollees to be between $608 and $710 per enrollee.

117 EP enrollment as of January is 1,652,160. Approximately 30 percent of the estimate for the subsidy expiration overlaps with the estimates for prohibiting certain noncitizens from eligibility for federal funding in the Essential Plan.

118 As part of the COVID-19 public health emergency, Congress authorized a temporary 6.2 percentage point federal medical assistance percentage (FMAP) increase under the Families First Coronavirus Response Act (FFCRA) of 2020 and required states to maintain enrollment of nearly all Medicaid recipients through March 31, 2023. New York State began the process of redetermining eligibility for all Medicaid enrollees in June 2023.

119 In addition to the completion of the "unwind," New York expanded its Essential Plan program through a 1332 waiver, which could mitigate the impact for some consumers; however, the subsidy expiration would reduce funding available to support coverage and benefits offered through the 1332 waiver. This waiver is discussed in more detail in the Medicaid, CHP, and Essential Plan (1332 waiver) section.

120 Each health insurance market (Medicaid, Medicare, small group, individual, etc.,) is priced differently, so shifts of enrollment from one market to the next changes the risk profile of each group and thus the associated pricing, which is set based on actuarial estimates, consistent with applicable laws, rules and regulations.

121 Reinsurance waivers were implemented by the previous Trump administration.

122 States are required to identify which benefits are in addition to the EHB.

123 Over time, New York has enacted a number of insurance coverage expansions to impose new benefits or reduce out-of-pocket costs. Individually, these actions are relatively minor, and while such changes have reduced costs for consumers accessing healthcare, in combination, these changes have been incorporated into premium rate setting and the costs associated with the savings achieved for consumers are spread across the entirety of insurer's risks pools in the form of increased premiums.

124 By executive order, the Trump administration, however, requires the Assistant to the President for Domestic Policy shall submit to the president a list of policy recommendations on protecting IVF access and aggressively reducing out-of-pocket and health plan costs for IVF treatment. IVF is an example of coverage expansion in New York.

125 According to Kaiser, "Section 2713 of the ACA requires most private health insurance plans and Medicaid expansion programs to cover a range of recommended preventive services without any patient cost-sharing. Preventive services include a range of services such as screening tests, immunizations, behavioral counseling, and medications that can prevent the development or worsening of diseases and health conditions. Preventive services that must be covered are those receiving an A or B grade by the U.S. Preventive Services Task Force (USPSTF), vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA) recommendations issued by the Women's Preventive Services Initiative and the Bright Futures for Children program. All of these entities review new recommendations and conduct periodic updates of existing recommendations."

126 For more information, see also: "Explaining Litigation Challenging the ACA's Preventive Services Requirements: *Braidwood Management Inc. v. Becerra*."

127 KFF report on the Supreme Court Case *Kennedy v. Braidwood Management*, which challenges whether the ACA requirement to cover preventative services violates the First Amendment of religious protection. Also, narrowly, if the US Preventive Services Task Force violates existing laws.

128 Preview of Supreme Court case from the O'Neill Institute at Georgetown Law.

129 *CBS News* article outlined that "The rescission process is a way for Congress to cancel funds it previously appropriated but that the federal government has not yet spent, rendering the funds no longer available to departments, agencies and offices. Those funds can then be redirected elsewhere or sent to the Treasury general fund." The president's Office of Management and Budget is expected to advance a rescission package in the coming days. Relevant committees would have 25 days to act, and then the package would go to the House and Senate for a floor vote.

130 Centers for Medicare and Medicaid Services, "Fiscal Year 2024 Improper Payments Fact Sheet," Fact Sheets, November 15, 2024, https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2024-improper-payments-fact-sheet.

131 *Wired Magazine* article outlines the possibility that these agencies would be subject to scrutiny from the Department of Government Efficiency (DOGE). Moreover, the Trump administration would examine the vast amount of data under HHS for these programs.

132 Post on X from CMS on April 28, 2025.

133 "FACT CHECK: President Trump Will Always Protect Social Security, Medicare," The White House, March 11, 2025, https://www.whitehouse.gov/articles/2025/03/fact-check-president-trump-will-always-protect-social-security-medicare/.

134 Immigrant eligibility for health insurance programs is also impacted by the following (not exhaustive): Illegal Immigration Reform and Immigrant Responsibility Act of 1996, the Omnibus Consolidated Appropriations Act of 1996, the Federal Balanced Budget Act of 1997, the 1998 Agriculture Research Extension and Education Reform Act, Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998, the Food Stamp Reauthorization Act of 2002, the SSI Extension for Elderly and Disabled Refugees Act, the Children's Health Insurance Program Reauthorization Act of 2009, and the Affordable Care Act of 2010.

135 Qualified aliens are lawfully admitted for permanent residence (generally green card holders), granted asylum, designated refugees, paroled into the United States for at least one year, having their deportation withheld, granted conditional entry, Cuban and Haitian entrants or victims of battering or extreme cruelty by a spouse or other family member (see, 8 USC § 1641 [b]-[c]).

136 According to New York City documents, "PRUCOL means Permanently Residing Under Color of Law, and is a category that was created by courts and is used for public benefits eligibility, including Medicaid. It is not recognized as an immigration status by the US Citizenship and Immigration Services (USCIS). For a person to be residing "under color of law," the government must know about the person's presence in the US, and has indicated that it is not contemplating the individual's departure or planning deportation. A person residing under PRUCOL status cannot directly apply for U.S. citizenship or sponsor family members to obtain U.S. Citizenship. Though some of these individuals do not have SSNs, if financially eligible, PRUCOL individuals can get Medicaid, Child Health Plus, or the Essential Plan in New York State. Depending on their particular immigration status, they may also be eligible for QHPs with or without the Premium Tax Credits or Cost Sharing Reductions."

137 Social Services Law § 122 [1] [c].

138 Kaiser Foundation Fact Sheet on immigrants' health coverage.

139 Summary of noncitizen health programs by state from the National Immigration Law Center.

140 Interactive map from the National Immigration Law Center on health coverage for immigrants by states.

141 Executive actions include a declaration of national emergency at the US-Mexico border, ending birthright citizenship, designating cartels as terrorists for national security, and limiting refugee admissions.

142 Senate Bill S3425, which establishes a New York Health Fund Trust and New York Health Program.

143 HR 1195—Protect Medicaid Act: To amend title XIX of the Social Security Act to prohibit Federal Medicaid funding for the administrative costs of providing health benefits to individuals who are unauthorized immigrants.

144 According to CMS-64 data.

145 Title 42 Chapter IV Subchapter C Part 435 Subpart J Income and Eligibility Verification Requirements §435.956.

146 Trump administration February executive order for HHS to identify this as a program requiring "corrective action."

147 This includes enrollees eligible through the Deferred Action for Childhood Arrivals (DACA) program.

148 Essential Plan revenues and expenditures have not always aligned and are not reported discreetly in the state's financial plan; New York has roughly $10 billion in Essential Plan trust fund dollars temporarily held in abeyance through December 31, 2028 to implement the most recent expansion of the Essential Plan through the 1332 waiver to 250 percent of the federal poverty limit (FPL).

149 *Aliessa v. Novello*, held Social Services Law §122 unconstitutional to the extent it denied Medicaid to qualified immigrants who were formerly subject to the five-year ban and persons permanently residing in the United States Under Color of Law (PRUCOL) immigrants.

150 Empire Center report "Immigrant Enrollment in 'Emergency Medicaid' Surges to 480,000."

151 The limits of EMTALA were disputed under the Biden administration. Texas sued the federal government (HHS Secretary Becerra), challenging HHS's guidance that mandates providers must provide an abortion when that care is the necessary stabilizing treatment for an emergency medical condition. The Texas plaintiffs alleged that the guidance mandates providers to perform elective abortions in excess of HHS's authority and contrary to state law and sought to enjoin its enforcement. The courts enjoined the HHS guidance based on the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228, 2279 (2022), holding "that the Constitution does not confer a right to abortion." The Supreme Court heard a second case in 2024. The Trump administration issued an executive order reversing the Biden administration guidance on EMTLA regarding abortions.

152 CMS Administrator Mehmet Oz's statement on the letter to state Medicaid agencies.

153 *The Hill* article on key amendments included in the House Reconciliation bill.

154 For more information, see a primer on the issue of abortion here.

155 *Politico* article about plans to cut or withhold federal funding to nine Planned Parenthood state affiliates in the upcoming budget under Title X funding.

156 At issue is whether a state—in this case, South Carolina—can remove Planned Parenthood clinics from its state Medicaid program, even though Medicaid funds cannot generally be used to fund abortions.

157 A 2024 interview from Governor Hochul discussed her efforts to push an Equal Rights Amendment in New York, reallocation of state funding, and seeking to ensure out-of-state providers can provide to residents.

158 A *New York Times* article about the 2024 State Ballot Proposal No. 1, which amended Article 1, Section 11 of the New York State Constitution to protect against "unequal treatment."

159 According to *The Role of the Hospital in a Changing Environment*, "examines the evolving role of the hospital within the health care system in industrialized countries and explores the evidence on which policymakers might base their decisions."

160 Subsection of the FY 2026 executive budget on the Department of Health budget for New York.

161 HSG Global reported that the removal of DSHPs as a source for "matching" federal Medicaid funds will require states to adjust to new rules outlining access to federal support, but some states are better situated to backfill lost funds through other state-level programs.

162 For more information, see "The Challenge of Distressed Hospitals" here.

163 A 2024 report from the US Government Accountability Office noted how market concentration has skyrocketed from 2011 to 2022, with three or fewer insurers holding at least 80 percent of the market share in public health marketplaces.

164 For more information, see *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2024*.

165 See the map of select rural healthcare facilities in New York.

166 *Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory*, 2024.

167 A list of hospital closures in New York since 2000 compiled by the New York State Nurses Association.

168 National research indicating larger health systems are not associated with better healthcare quality generally cannot be extrapolated to New York, as such studies are skewed by the inclusion of large for-profit national chains, which are prohibited in New York.

169 A 2024 report by the American Medical Association assessed the degree of competition in US healthcare markets versus the amount of health insurers' control over markets. The data used was based on commercial enrollment in PPO, HMO, POS, and public exchange plans, including participation in consumer-driven health plans, as well as enrollment in MA plans. The study found that the vast majority of US health insurance markets are highly concentrated and have remained so for the past decade. The high cost of access to these markets, as well as the monopolization of large insurance companies, have contributed to this continuation of low competition.

170 Sean May, Monica Noether, Ben Stearns, "Hospital Merger Benefits: A Econometric Analysis Revisited," American Hospital Association, August 2021, https://www.aha.org/system/files/media/file/2021/08/cra-merger-benefits-revisited-0821.pdf. Joanna Jiang, et al., "Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals," JAMA Network, September 20, 2021, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342. Susan Ridgely, "Does Vertical Integration Improve or Imperil U.S. Health Care?," Rand, November 16, 2021, https://www.rand.org/pubs/commentary/2021/11/does-vertical-integration-improve-or-imperil-us-health.html. Tu-Uyen Tran, "Hospital chains try to gain financial and market power without inviting antitrust action," Federal Reserve Bank of Minneapolis, October 2, 2023, https://www.minneapolisfed.org/article/2023/hospital-chains-try-to-gain-financial-and-market-power-without-inviting-anti-trust-action. Trelysa Long, "Why the U.S. Needs More Consolidation, Not Less," Information Technology & Innovation Foudation, May 6, 2024, https://itif.org/publications/2024/05/06/why-us-economy-needs-more-consolidation-not-less/.

171 Among healthcare goods and services, the acceleration in total national health spending growth in 2023 was primarily driven by faster growth in the three largest categories: hospital care, physician and clinical services, and retail prescription drugs. Hospital spending increased 10.4 percent in 2023, following much slower growth of 3.2 percent in 2022, and spending for physician and clinical services increased 7.4 percent in 2023, following growth of 4.6 percent in 2022. In both instances, the acceleration reflected an increase in nonprice factors, such as the use and intensity of services, after notably slower growth in 2022. Retail prescription drug spending also contributed to the acceleration, increasing 11.4 percent in 2023 from a rate of 7.8 percent in 2022, largely because of changes in the mix of drugs dispensed toward higher-cost, newer brand-name drugs and faster growth in retail prescription drug prices.

172 Gene therapies are defined as medical procedures that attempt to modify the expression of genes that cause mutations in genetic structure, which lead to genetic diseases. These treatments add, silence, or edit genes into a body to treat diseases like hemophilia, sickle cell disease, inherited neurological disorders, and severe combined immunodeficiency. Some estimates are that by 2026, annual spending on gene therapy in the US will surpass $25.3 billion annually.

173 According to *Politico*, legislative solutions face uphill prospects due to reservations on potential cuts to Medicaid benefits under a sweeping reform bill package.

174 By the end of the 118th Session of Congress, a bipartisan healthcare policy package that would implement new reforms on pharmacy benefit managers was crafted but was not passed through the House or Senate.

175 April 23, 2025 post on X about HHS Secretary Robert F Kennedy, Jr.

176 Whilst the American Medical Association has come out in favor of, and most countries around the world have prohibited direct-to-consumer marketing, many experts believe a ban on this advertising would at most affect a 0.1 percent to 1 percent reduction in drug costs, according to a 2024 CBO report.

177 A May 2025 executive order by the president directed drug manufacturers to lower prices to align with what other countries pay in pursuit of affordable medicine policies. The Inflation Reduction Act of 2022 provided that power to renegotiate with pharmaceutical companies, and was long thought to be a potential policy option for the administration.

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