NEW YORK CITY COMPTROLLER
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# Risks for Medicaid and other NY State Healthcare Programs

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# Introduction

Over 5 million NYC residents receive their healthcare coverage through one of NY State's health plans – Medicaid, the Essential Plan, Child Health Plus, or the Qualified Health Plan – over 60% of the city's overall population. These plans provide healthcare coverage for many working New Yorkers as well as critical services for vulnerable populations such as mental health services for the homeless and special education services for children in foster care.

While spending on Medicaid services in New York City sits largely outside of the City's budget, if included it would dwarf any other component, including education or public safety. Medicaid and the Essential Plan made up nearly 44 percent of the State's overall spending last year. More than half the funding comes from the federal Government, with more than $32 billion flowing to New York City's healthcare providers and insurers for patient care.

The Trump Administration and Congress will likely target Medicaid spending, putting the health of NYC residents, their providers, and City and State budgets at risk. Several draconian cuts to Medicaid have already been outlined as options to pay for the extension and expansion of the 2017 tax cuts. The Medicaid cuts could total $2.3 trillion over 10 years with additional proposed cuts for ACA tax credits. If passed, any of these cuts would mean some combination of stricter eligibility, fewer covered services, lower rates for providers and/or cost shifting from the federal government to the State and on to localities. This Fiscal Note provides background on the complex financing of publicly supported healthcare coverage in NY State with a specific lens on NYC, as well as ways in which the Trump Administration could impact these important programs.

## Background

Medicaid is a federal entitlement program administered by the states but with shared financial responsibility. The federal government's share ranges from a minimum floor of 50% to a cap of 83% based on the per capita income of a state relative to national per capita income.[1] For the most part, the match is open-ended, regardless of the cost per capita or the number of people enrolled. New York State combines its own funding and a capped local contribution with the federal government's guaranteed 50% match to fund its Medicaid program. Beginning in 2014, the Affordable Care Act (ACA) enabled optional state expansions of Medicaid that increased the federal match to 90% for those populations eligible under the expansions, in addition to creating private health plan options which in NY are managed by the NY State Marketplace.[2]

According to the Office of the State Comptroller, Medicaid spending in NY State grew to $101.5 billion in State Fiscal Year (SFY) 2024, of which the federal government paid $57.1 billion (56.3%), the State paid $35.9 billion (35.4%) and localities paid $8.5 billion (8.4%).[3] New York State requires a uniquely large local contribution to its program; NYC has $6.7 billion budgeted as an expense for its contribution this fiscal year.

In addition to the Medicaid budget, an additional $9.7 billion[4], largely funded by the federal government, pays for the Essential Plan which is NYS's no-cost basic health option for non-Medicaid-eligible low-income individuals that was authorized by the ACA. In total, excluding the

local contribution, combined State and federal funds for Medicaid and the Essential Plan made up 43.7% of the State's overall spending in SFY 2024. [5]

Approximately $56.2 billion flowed to New York City's healthcare system to cover care for nearly 5 million Medicaid and Essential Plan members for the 12 months ending June 2024, of which $31.8 billion (56.6%) is federal funding.[6] These funds flow to many private physicians and dentists, community health providers, public and voluntary hospital systems, nursing homes and home care providers. Some of the funds flow directly from the State to providers through what is known as "fee for service", while other payments are made to managed care plans which then reimburse providers. Several City agencies also receive Medicaid funds to reimburse for services such as occupational and speech therapy and early intervention.

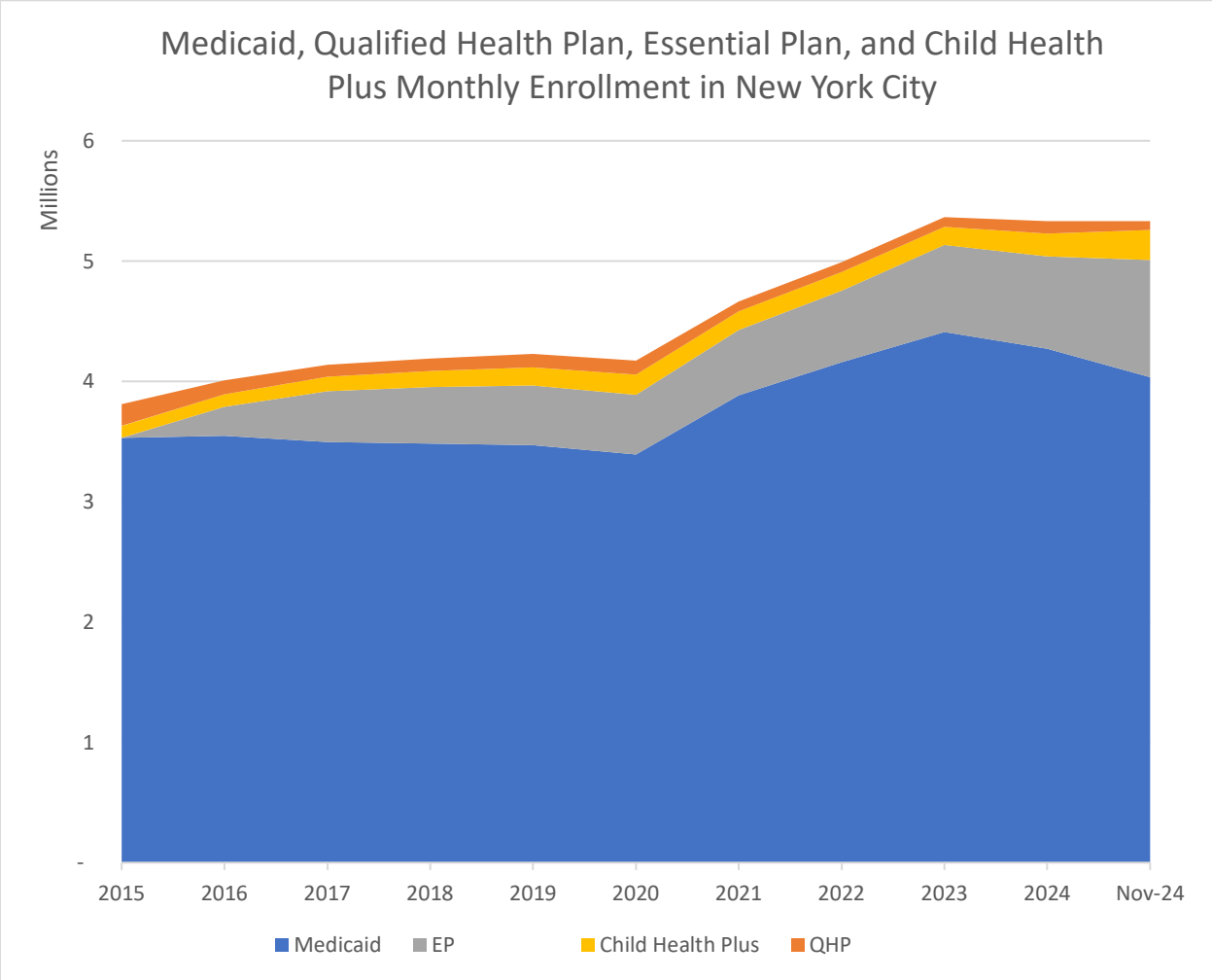
Additional funds flow to NYC hospitals in the form of Supplemental Medicaid payments to offset costs for indigent care and make up some of the shortfall for Medicaid rates relative to Medicare. Even with these additional funds, hospitals that serve a disproportionate share of Medicaid patients still struggle.

Nationwide, federal spending on Medicaid is projected to be $607 billion in federal FY 2024, with an additional outlay of $125 billion for premium tax credits and related spending; combined, this represents over 10% of total projected outlays.[7] These programs will likely end up a target for the incoming administration's efforts to cut spending. NY State – with the second highest total Medicaid cost after California and among the highest per capita spending for Medicaid in the country – would experience an outsize impact from any reductions.

# Who is eligible?

In total, more than 5.3 million NYC residents receive their healthcare coverage through Medicaid or one of the other NY State publicly supported health plans. After the ACA was enacted, enrollment in NY State plans shifted and grew in various ways as eligibility increased and new options became available to different segments of the population, as depicted in Chart 1 below.

## Chart 1




SOURCE: New York State Department of Health

NOTE: Aside from November 2024 data, Medicaid and Child Health Plus enrollment data are from January of their respective year. QHP and EP enrollment data are from January, February, or March of their respective year. This variability is due to less consistent enrollment reporting for QHP and EP. Essential Plan coverage began January 2016.

Medicaid alone provides healthcare coverage to 4.04 million NYC residents, as of November 2024. Eligibility for Medicaid varies by age and other characteristics. NYS took advantage of the ACA's expanded Medicaid eligibility option and enhanced rates, and current income eligibility thresholds are 138% of the Federal Poverty Level (FPL) for adults under the age of 65, 223% of FPL for pregnant women and children under age 1, and 154% of FPL for children aged 1 to 18.

Pregnant women and children are eligible for Medicaid in NY regardless of immigration status. Undocumented immigrants aged 65 and over became eligible for expanded Medicaid services last year. Undocumented immigrants outside of these populations are eligible for emergency Medicaid only, which covers care for emergency conditions but not preventive care or care for chronic conditions.

The more recent growth (2020-23) and subsequent decline of Medicaid enrollees seen in Chart 1 above, largely reflects the temporary elimination of recertification requirements during the pandemic and their subsequent reinstatement. Much of the decline was offset by enrollment in the Essential Plan and Child Health Plus.

The Essential Plan, which began in 2016, now provides coverage to an additional 972,208 non-Medicaid-eligible low-income individuals. It was expanded last year to serve individuals up to 250% of FPL as well as approximately 12,000 individuals with Deferred Action for Childhood Arrivals (DACA) status.[8] In addition, the Essential Plan covers certain immigrants who would otherwise not be eligible for federal Medicaid funding (covered previously by a state-funded Medicaid program).

In addition, the State also manages the NY State Marketplace that runs the ACA options for Child Health Plus (CHP) for non-Medicaid eligible children and Qualified Health Plans (QHP) for individuals and families who are not eligible for either Medicaid or the Essential Plan. Both CHP and QHP are considered private (commercial) plans, but depending on income and household size, families and individuals may be eligible for lower premiums or tax credits. Child Health Plus offers subsidies for children up to 400% of FPL; above this level, families can still enroll a child but pay the premium in full. Families can also enroll with their children in QHP, though CHP may be more advantageous depending on their income.

Over 250,000 children and 70,000 individuals receive insurance through the CHP and QHP programs, respectively. Eligible QHP participants, depending on income and household size, can receive subsidies from the Federal government through pandemic-era tax credits to offset some or all of their premium contributions that were subsequently extended through 2025. Beginning in 2025, certain NYS QHP enrollees may be eligible for a federal cost-sharing subsidy to help reduce out-of-pocket expenditures[9]. The State contributes a smaller amount ($883 million) to subsidize the cost of CHP.[10] Although administered and funded differently, these programs are somewhat intertwined with Medicaid and the Essential Plan, and all would be impacted by changes to the ACA. As an example, the recent Essential Plan expansion to 250% of the FPL enabled some individuals to shift from QHP to the no-cost Essential Plan. Other ACA expansions to Medicaid and the Essential Plan shifted individuals out of State-funded programs.

New York City enrollees make up a more than half of overall enrollment in the State's publicly supported health plans, though the percentage varies across programs, as show in Table 1.

## Table 1. NYC's enrollment as a share of NY State's

| Plan | NYC Enrollment | NYS Enrollment | NYC Share |
|---|---|---|---|
| **Medicaid** | 4,036,284 | 6,976,942 | 57.85% |
| **Essential Plan** | 972,208 | 1,590,833 | 61.11% |
| **Child Health Plus** | 251,547 | 575,194 | 43.73% |
| **Qualified Health Plans** | 70,560 | 171,941 | 41.04% |
| **All** | **5,330,599** | **9,314,910** | **57.23%** |

Source: NYS Department of Health; November 2024 enrollment

Note: QHP and CHP include enrollees who may pay full premiums as well as those who receive subsidies and tax credits.

# What is at stake?

NY State's Medicaid program has the fourth highest per capita cost in the country and has been growing at a pace of over 10% per year in recent years.[11] [12] Some of this recent growth is due to the Consumer Directed Personal Assistance Program (CDPAP) which allows recipients in need of services to choose their caregivers. The cost increase also reflects the pause in certification requirements that led to increases in Medicaid enrollment during the pandemic, as noted above.

The State has made efforts over the years to restrain costs. In 2012, it implemented a cap on Medicaid spending, known as the Global Cap, which initially limited growth to the rate of inflation. While successful at first, per-recipient costs began to rise again after 2014.[13] The State modified the growth rate in SFY23 to the five-year rolling average of the federal Centers for Medicare and Medicaid Services (CMS's) annual projections of health care spending, essentially allowing for greater growth.

More recently, the State has begun to tackle the rising costs of its home health services in the CDPAP program. The State is in the process of consolidating the management and payment of these services from over 600 fiscal intermediaries to a single intermediary in April 2025.

The State has also employed or is planning other reforms and cost-control mechanisms that may be at particular risk under the Trump administration. Other more aggressive changes are also possible, such as block grants and changes to the federal matching formula, which could greatly exacerbate the funding challenges for the State, and potentially in turn, the City. The following sections describe some of the ways that the Trump Administration and Republican Congress could alter the administration and public financing of Medicaid and NY State's other health plans.

# Medicaid Waivers

States can apply to the federal government for waiver approval to implement demonstrations and pilot innovative approaches to improve their State Medicaid programs. These waivers, known as Section 1115 waivers, must be budget neutral and promote the objectives of the Medicaid program.[14] [15] The authority to grant waivers rests with the federal Secretary of Health and Human Services after what are usually extensive negotiations between the Centers for Medicare and Medicaid Services (CMS) and the requesting state.[16] Because of the inherent flexibility of these waivers and with decision-making authority resting with the executive branch, waivers allow presidential administrations to implement their priorities without going through the legislative process. While states are not *required* to implement these priorities, an incoming administration can quickly change which waivers are encouraged, approved or renewed.

The first Trump administration allowed states to implement work requirements as part of their Section 1115 waivers, though many of these were litigated or not implemented due to the pandemic. The Biden administration rescinded most of these waivers, concluding that they were not in conformance with the Medicaid program's objectives (e.g., such as promoting coverage for low-income people), although some of the rescindments are under litigation.[17] [18] The Trump administration also emphasized the implementation of eligibility restrictions and raising costs for beneficiaries, and reduced transparency in the waiver approval process.[19] [20]

The Biden administration, conversely, looked to expand coverage, improve continuity of care and allow states more flexibility to use Medicaid funding to pay for non-medical expenses to address social determinants of health such as access to food and housing.[21] One example is the April 2023 guidance from CMS to State Medicaid directors for the opportunity to apply for Section 1115 demonstration projects to support community reentry and improve care transitions for individuals who are incarcerated.[22] In addition, the Biden administration had returned to greater transparency and use of public notice requirements.[23]

NY State received CMS approval for its New York Health Equity Reform (NYHER) Section 1115 waiver amendment in January 2024. The NYHER waiver amendment includes several components, the largest of which is to provide the State a mechanism to cover health-related social needs. New York is authorized to spend over $3 billion (half funded by the federal government) through Social Care Networks across the State to pay community-based organizations for limited housing supports, mold remediation services, nutrition supports, and other services not normally covered by Medicaid. This amendment also includes a global budget initiative for private safety net hospitals and funding for loan repayment and workforce training.[24]

The implementation of the Social Care Networks program begins in January 2025 and has approval until March 31, 2027. Whether the incoming Secretary will extend this or other aspects of the waiver beyond that date is uncertain. While Project 2025 specifically called out eliminating the use of Medicaid for non-medical services, these types of programs could be in line with the nominated Secretary's perspectives on chronic health disease prevention. However, even the threat of a funding expiration may reduce the incentive for community-based organizations to

invest in the necessary infrastructure to benefit from the new waiver, potentially undermining its success.

In November, the Biden administration approved an amendment, also valid through March 2027, allowing continuous eligibility for children until the child's 6th birthday, enabling them to maintain coverage regardless of fluctuations in their family's income.

NYS previously submitted a waiver request to provide a limited package of re-entry services to incarcerated individuals within 30 days in December 2022. This amendment would have allowed NYS to use Medicaid funding to cover certain services prior to release, such as care management and discharge planning, and certain medications to better transition individuals – particularly those with substance abuse and mental health disorders. NYS had not yet resubmitted an application under the new April 2023 guidance by the end of Biden's term, an opportunity that may not be extended in the Trump Administration.[25] [26]

# Provider Taxes

In late December, CMS approved NYS's Managed Care Organization (MCO) tax proposal through another waiver under Section 1903 of the Social Security Act. At the time that the NY State legislature approved this proposal, in April 2024, it was expected to increase federal funding by $4 billion, based on a similar tax implemented in California. The Governor's recently released Executive Budget includes $1.6 billion in federal funding from this assessment in State FY 2026 ($3.7 billion over the next two years).[27] [28]

In essence, New York will levy a tax on its managed care plans (Commercial, Essential Plan, and Medicaid) on a per member per month basis. Commercial (or private) plans, including QHP, will be taxed at the lowest rate, with the cost paid by the plans or passed on to consumers. Essential Plans will be taxed at slightly higher rates with their cost mostly covered by the federal government. MCOs serving Medicaid enrollees face the highest tax rates per member per month, with the cost reimbursed evenly by the federal and state governments.[29] However, the State will pay itself back using tax proceeds and use the federal matching aid to increase hospital and nursing home rates and expand the Safety Net Transformation program.

Provider taxes such as these are likely targets for the incoming administration.[30] Most states tax providers including hospitals, nursing homes and managed care organizations, to help cover the state share of Medicaid expenses. Proposals to lower or eliminate provider taxes are expected to reduce state spending, resulting in a lower federal match. [31] [32]

In addition to the MCO tax described above, New York State relies on several provider taxes, largely authorized under the Healthcare Reduction Act (HCRA), to fund healthcare expenses, with approximately 80 percent of these taxes used to pay for Medicaid (a small portion goes to support the Child Health Plus Program as well).[33] In SFY 25, HCRA is projected to contribute $5.5 billion, or 17.7% of NYS's Medicaid share.[34]

# The Affordable Care Act

The enhanced ACA subsidies are set to expire at the end of 2025. The American Rescue Plan Act (ARPA), passed in 2021 in the wake of the COVID-19 pandemic increased the subsidy amount received by those already eligible under ACA. ARPA also expanded subsidies to families with incomes over 4 times the FPL. The enhanced subsidies were extended through 2025 by the Inflation Reduction Act (IRA). Allowing the enhanced subsidies to expire would increase premium payments for nearly everyone who receives care through the ACA Marketplace.[35]

Fortunately for New Yorkers, ACA enrollees under 250% FPL, who are most vulnerable nationally, are instead covered by the no-cost Essential Plan in NY – protecting them from what would otherwise be the steepest increase in premiums. In March 2024, NYS received the approval (through another waiver under Section 1332 of ACA) to extend eligibility from 200% to 250% of FPL as well as to DACA recipients, through December 21, 2028. Subsequently, in September 2024, NY received approval through December 2029 to use some of its pass-through savings[36] to provide subsidies for people with incomes up to 400% FPL, as well as those receiving diabetes and/or pregnancy/postpartum care services, further protecting low-income New Yorkers should the enhanced ACA subsidies expire.[37] Finally, on January 15, 2025, CMS approved an extension of the March approval, maintaining the threshold increase to 250% of FPL through December 2029, beyond the end of Trump's second term.

New York has used the Essential Plan (its Basic Health Plan option under the ACA) to expand populations receiving coverage without increasing costs to the State. The ACA's favorable reimbursement formula for this plan was challenged unsuccessfully by the first Trump administration. With the increase in Essential Plan members and the expansion of eligibility thresholds, even more would be at stake for NYers if the federal government were to challenge the program again.

If Congress were to go further and re-open the ACA, other significant impacts are also possible. As mentioned in November's Spotlight Protecting New York City, reconfiguring risk pools and making insurance cheaper for the young and healthy would conversely drive premiums much higher for older Americans and those with chronic diseases.

Congress could also target the enhanced match under the ACA that incentivized states to expand eligibility. If the higher 90% federal share were eliminated for the expansion population and restored to 50%, New York State could lose approximately $4 billion according to one estimate.[38] However, 40 other states, including Washington D.C., expanded Medicaid as a result of the ACA, which could make such a measure hard to pass, even in a Republican Congress.

A final potential impact on NYC stemming from the ACA would be its treatment of cuts to Medicaid Disproportionate Share Hospital (DSH) funding, a form of Supplemental Medicaid. The ACA reduced DSH funding dramatically beginning in 2014. Each year since then, Congress has voted to defer the cuts to DSH funding. The latest cuts were scheduled to begin in January 2025 but delayed again in the recent Continuing Resolution passed in late December to avert the government shutdown, though only until April 2025. If the ACA were reconfigured in the future, it would provide Congress an opportunity to permanently repeal these reductions, or further

enshrine them. If the ACA remains in effect as-is, the ongoing, repeated effort to postpone these cuts would still be required. In the past, these postponements have received bipartisan support, but it is uncertain if that will continue. In NY, these cuts fall first on NYC's Health + Hospitals (H+H), the city's public hospital system. If enacted, these DSH cuts could reduce federal funding to H+H by approximately $622 million a year.[39]

## More Aggressive Changes

Other efforts could more significantly limit federal Medicaid spending by restructuring the financing into a block grant or a per capita cap, or changing the guaranteed federal matching rate. NY would be particularly vulnerable under any of these options.

Currently the federal government's matching rate is not capped, regardless of the number of enrollees, the range of services provided to them, or the rates paid to providers. Converting this entitlement to a block grant would limit overall program growth.[40] The impact on NY would largely depend on how the formula is set and at what level of spending, but a block grant, by definition, would not provide the same guaranteed federal share regardless of growth trends that the State currently enjoys. Similarly, a per capita cap would also limit growth and might force immediate reductions for New York given its current high per capita spending relative to many other states. While both these proposals are mentioned in the Project 2025 playbook, they are seen as politically difficult for the administration to achieve.[41] [42] [43]

The proposal to reduce or eliminate the floor of the guaranteed federal match below 50% would more directly target higher income states like New York and California. The traditional federal matching rate varies by state with a minimum floor of 50% up to a maximum cap of 83% based on a state's per capita income relative to the nation's, with wealthier states receiving lower matching rates. New York is one of 10 states who are at the floor. Applying the same formula without the floor would lower these states' respective matching rates. According to one analysis, reducing the floor to 40 percent would cost NY State $10.3 billion each year, rising to $13 billion if the floor were removed entirely.[44] Because such a proposal would impact a smaller number of states (and many blue ones at that), this may be a more politically feasible proposal than block grants or per capita caps.

# Conclusion

House Republicans have already signaled their intention to target Medicaid, proposing $2.3 Trillion in cuts, nearly half of the savings from a recently released list of spending reforms. These proposals represent a nearly one-third reduction over ten years from currently projected federal Medicaid spending.[45] While not all the proposals are likely to pass given their Party's narrow margins, Medicaid will undoubtedly be a significant focus of the Trump administration's savings and efficiency plans over the next four years and is unlikely to remain unscathed.

Given the size and scope of Medicaid and other publicly supported health programs in New York and the sheer number of people who receive their healthcare coverage through these programs, any cuts or changes to these programs would have a substantial impact to the State and City budgets, and to New Yorkers. Reductions to federal funding could result in a combination of reducing the number of people receiving benefits, limiting the array of covered benefits and services, cutting rates paid to providers for delivering healthcare services, and/or shifting costs to State and City budgets which would need to be offset by alternative sources of savings and revenues.

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