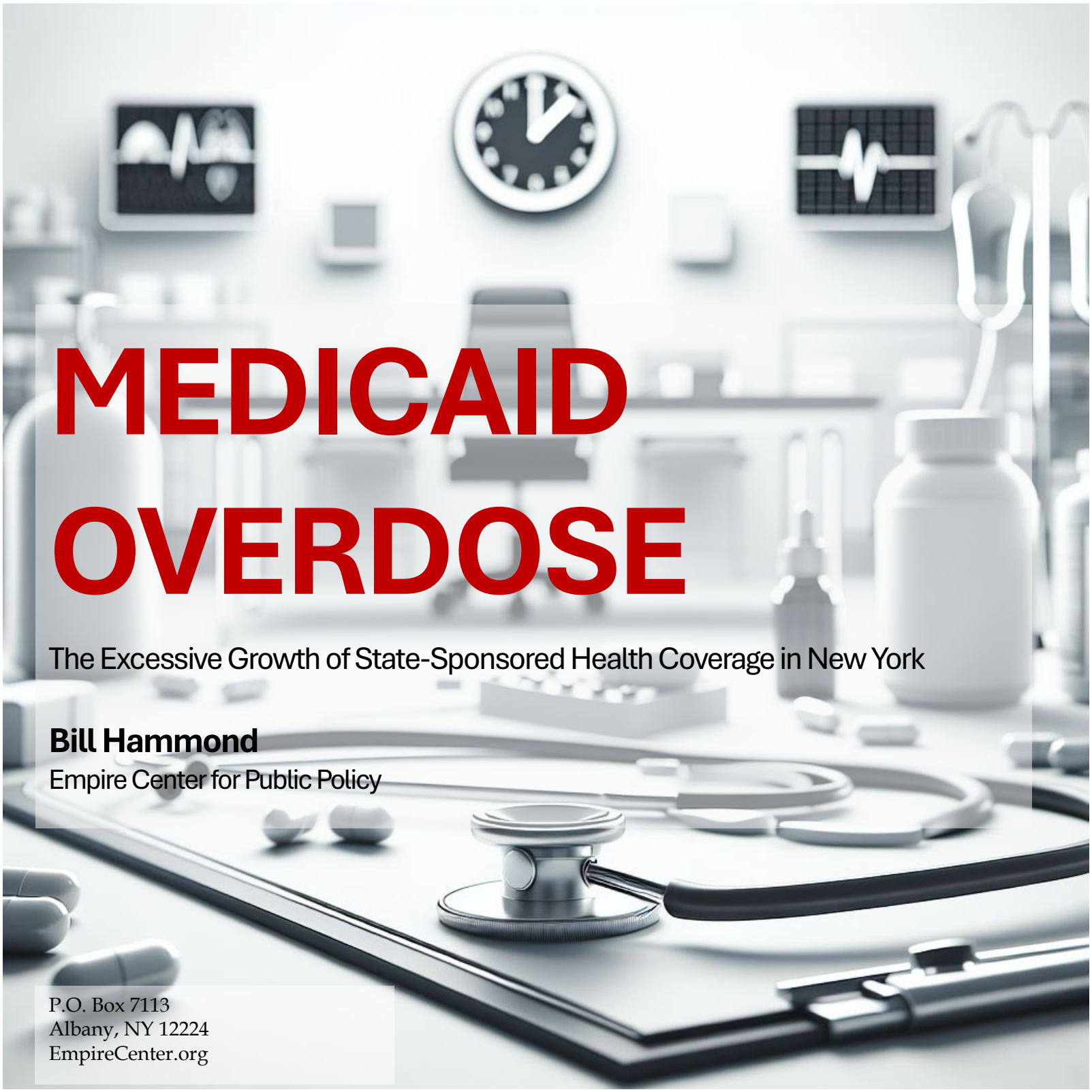
EMPIRE CENTER



MEDICAID OVERDOSE

The Excessive Growth of State-Sponsored Health Coverage in New York

Bill Hammond
Empire Center for Public Policy

P.O. Box 7113
Albany, NY 12224
EmpireCenter.org

What you will learn in this report

- Forty-four percent of the state's population, including 60 percent of New York City residents, were enrolled in state-sponsored coverage through Medicaid or the Essential Plan as of September 2024
- New York's 44 percent coverage rate was seven points higher than any other state, and 20 points higher than the national average
- More than 3 million enrollees appear to have incomes above the eligibility limits for either Medicaid or the Essential Plan, based on analysis of census data
- For every one person who stopped being counted as uninsured over the past decade, the state added more than three people to either Medicaid or the Essential Plan.
- New York offers zero-premium health coverage to residents up 250 percent of the poverty level, the highest eligibility threshold in the U.S.
- Over the past decade, total spending on Medicaid and the Essential Plan has nearly doubled, from $60 billion in fiscal 2015 to a projected $113 billion in fiscal 2025

Table of Contents

Executive summary

Medicaid enrollment has surged nationwide over the past decade, and no state has taken the trend farther than New York.

New York provides Medicaid and Medicaid-like health coverage to 44 percent of its population, which is 15 points higher than a decade ago and seven points above any other state.[1]

Within New York City, a remarkable 60 percent of residents are enrolled in state-sponsored insurance.[2]

Some of this growth reflects deliberate policy choices by state officials – especially the establishment of the Essential Plan, which has extended Medicaid-like coverage up to 250 percent of the federal poverty level, the highest income threshold in the U.S.

A close look at the numbers, however, indicates that New York's state-sponsored insurance programs have expanded beyond those elevated guidelines – and enrolled millions of people with incomes above the stated limits.

The evidence of this overflow starts with demographic data from the U.S. Census Bureau, which show that about 5.5 million New Yorkers have incomes low enough to meet the standard eligibility limits for Medicaid or the Essential Plan.[3] Yet enrollment in the two programs stands at about 8.5 million – pointing to a surplus of 3 million.

In other words, roughly one-third of the people receiving taxpayer-funded coverage from New York appear to be earning too much to qualify.

This excess enrollment over census data first appeared in 2015 and grew quickly. It hit 1.6 million by 2019 and peaked at 3.6 million during the pandemic, when emergency rules caused Medicaid rolls to temporarily swell. The excess has diminished since those rules lapsed, but it remains almost double what it was before the coronavirus arrived.[4]

Other states have developed similar enrollment surpluses in recent years, but New York's is proportionally the largest.[5]

The drivers of this over-enrollment include eligibility rules that were loosened under the Affordable Care Act, runaway demand for a popular form of home care known as the Consumer Directed Personal Assistance Program and the widespread use of "estate planning" maneuvers that allow well-to-do individuals to qualify for Medicaid long-term care coverage while protecting their wealth.

Above all, there has been a change in the politics around Medicaid. A generation ago, both major political parties would have viewed growing Medicaid rolls as a problem to be solved – a sign of rising poverty and social dysfunction and an unwelcome burden on taxpayers. Now, the state's leaders treat record-high enrollment as an accomplishment to be celebrated, a benchmark of progress toward universal coverage.

This is only partly true. The number of New Yorkers without health insurance dropped by 1.2 million over the past decade,[6] but enrollment in state-sponsored coverage increased by 3.7 million – a sign that most new sign-ups were people who otherwise would have been insured elsewhere.

The overuse of taxpayer-funded insurance harms the state in multiple ways.

Most obvious is the added burden on taxpayers. Even assuming most of the 3 million excess enrollees are non-disabled adults and children, they could be costing Medicaid $20 billion or more per year.[7] That expense would be roughly split between the state and federal governments, and New Yorkers pay taxes to both.

The share of Medicaid costs financed by state taxpayers has jumped by 53 percent over the past five years and currently consumes about 28 percent of all state operating funds.[8]

Overuse of state-sponsored health insurance also weakens the commercial insurance market by drawing away millions of potential customers who might otherwise be paying premiums and bolstering the risk pool. At the same time, the state is imposing cost-increasing coverage mandates and levying billions in taxes on health plans. Albany is simultaneously making it too hard to afford private insurance and too easy to get into public insurance.

Most importantly, adding millions of less needy, healthier enrollees to Medicaid rolls tends to divert resources from what should be program's core mission: providing decent care to people who cannot help themselves.

People with serious, lifelong mental and physical disabilities are a shrinking fraction of Medicaid enrollment, and the not-for-profit agencies that keep them alive and healthy account for a shrinking fraction of its spending.

When state lawmakers annually divide up the available money, providers serving the disabled – which are almost entirely dependent on Medicaid – must compete with hospitals and health-care labor unions, which are some of the most influential and deep-pocketed lobbying forces in Albany.

The signs of large-scale Medicaid over-enrollment in New York should be a red flag for state leaders – a warning that they have lost proper control over one of their most important and costly programs.

Reform begins with tightening eligibility rules and strengthening enforcement, to more effectively screen out applicants with incomes above the limits. At the same time, the state should do what it can to make commercial coverage more accessible and affordable, which starts with rolling back its excessive taxes and regulations.

New York should stop abusing Medicaid as a catch-all insurance plan for almost half the state's population. Instead, it should refocus the program on its original and most important purpose, which is to provide care for those who cannot help themselves.

Enrollment trends

Unusual surges

Medicaid was established in 1965 as a nationwide safety-net health plan for the indigent and disabled. States are charged with managing the program and have flexibility to customize eligibility rules and benefits within guidelines set by Washington. The federal government pays half or more of the expenses, depending on a state's relative wealth. New York is one of 10 states with the lowest possible standard matching rate of 50 percent.

In 1997, Medicaid was expanded to cover a larger share of children, with the federal government contributing at the Medicaid matching rate plus 15 points. New York's version is called Child Health Plus.

The past decade has seen two unusual surges in Medicaid enrollment: the first beginning in 2014 after the federal Affordable Care Act (ACA) took effect, and the second during the coronavirus pandemic that struck in 2020.

The ACA, enacted during the Obama administration in 2010, aimed to reduce the nation's uninsured population through a mix of public and private insurance coverage.

One key provision was a Medicaid expansion that called for all states to lift their income eligibility limits to 138 percent of the federal poverty level, or FPL (Table 1). The federal government would initially pay the full cost of newly eligible enrollees, then phase down to a matching rate of 90 percent. A Supreme Court ruling in 2012 made this expansion optional,[9] but most states chose to participate, including New York.

Table 1: 2024 poverty levels and eligibility limits

Household size	Federal poverty level	138% FPL*	250% FPL**	400% FPL***	NY median annual wage (2023)	NY median household income (2023)
1	15,060	20,783	37,650	60,240	78,620	82,095
2	20,440	28,207	51,100	81,760		
3	25,820	35,632	64,550	103,280		
4	31,200	43,056	78,000	124,800		

**Standard Medicaid income limit **Essential Plan income limit ***ACA premium tax credit limit*

Table: Empire Center • Source: U.S. Department of Health and Human Services • Created with Datawrapper

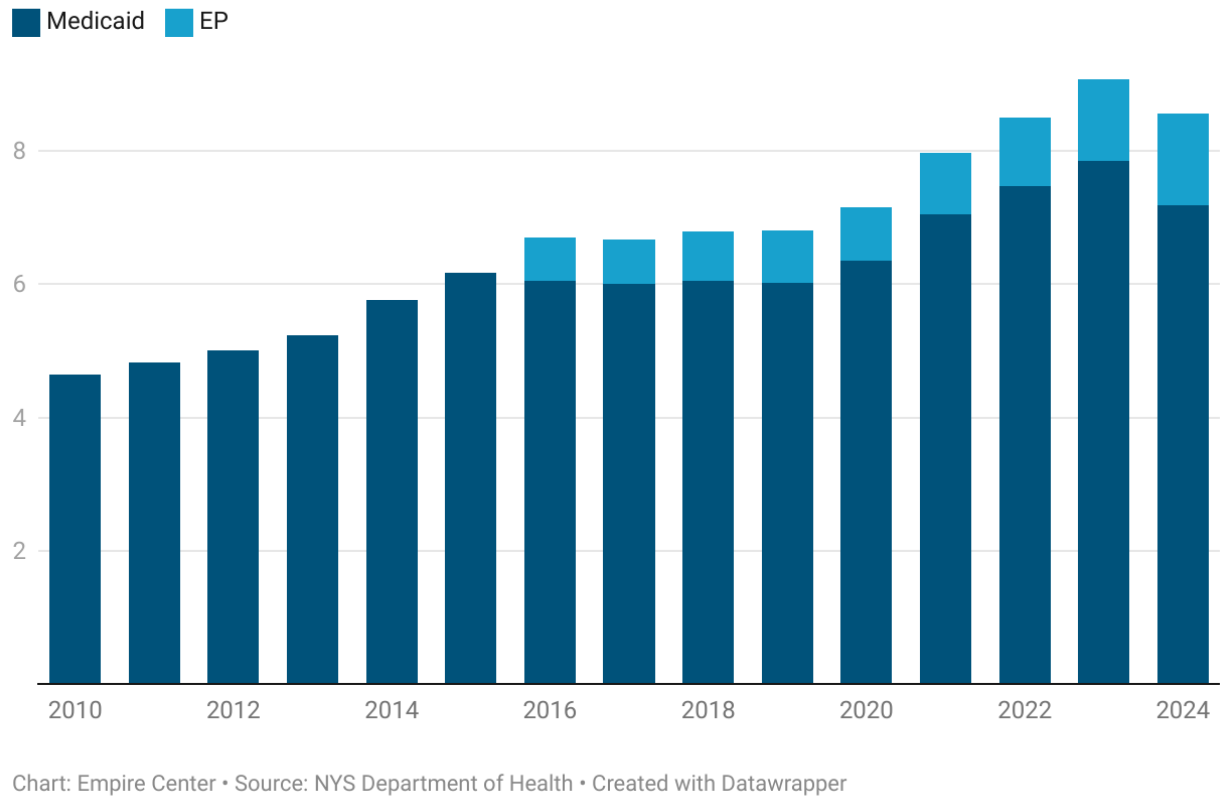
For uninsured people in the next income band, from 138 percent to 400 percent of FPL, the ACA provided premium tax credits and other subsidies to offset the cost of purchasing commercial coverage through newly established insurance exchanges.

New York entered this period with a Medicaid enrollment that was already expansive by national standards. Its enrollment rate in 2013 was 29 percent, or 11 points higher than the U.S. average.[10]

On paper, the ACA's Medicaid expansion seemed unlikely to have much effect on New York's program because the state already met the ACA's standards for most recipient categories. One exception was able-bodied adults without children, for whom the state increased its income limit from 100 percent to 138 percent of FPL as the ACA took effect in 2014.

In the first two years under the ACA, from 2013 to 2015, New York's already high enrollment jumped by almost 1 million or 20 percent (Figure 1).[11]

Figure 1: Medicaid and Essential Plan enrollment (millions)



Newly eligible adults accounted for about one-quarter of that surge.[12] The bulk appears to have been the result of the "woodwork effect," in which previously eligible people opted to sign up when they hadn't before.

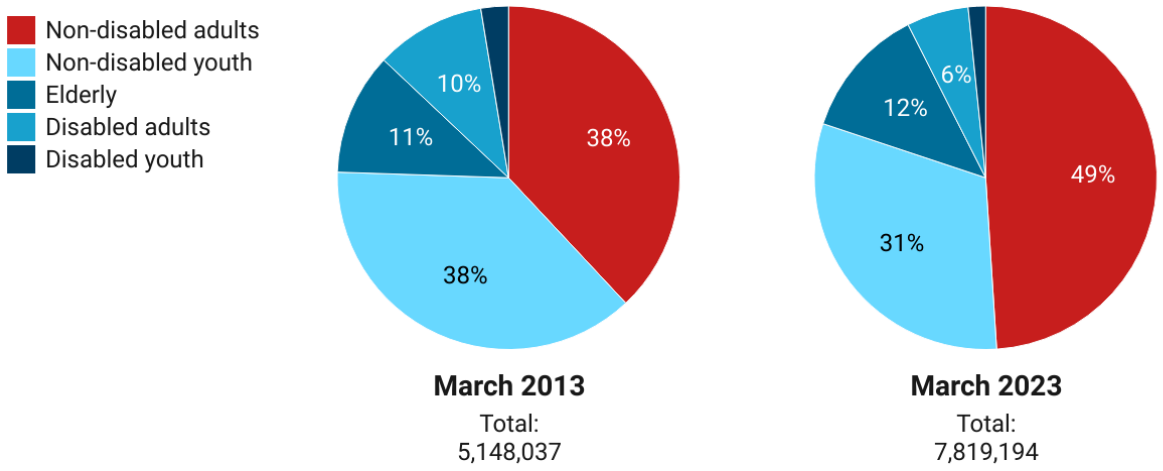
They were likely responding to structural changes associated with the ACA. First, there was a burst of publicity to notify people of newly available insurance options. Second, the law initially required people to find coverage or potentially face tax penalties – the so-called individual mandate that was repealed in 2017.[13]

Third, the state established an insurance exchange, dubbed the New York State of Health, that processed applications both for Medicaid and for the "qualified health plans" that were eligible for ACA tax credits. The exchange assigned applicants to coverage based on their income, and many were deemed to qualify for Medicaid.

The resulting growth spikes transformed the demographics of Medicaid. Seventy percent of the enrollment growth from 2013 to 2023 consisted of non-disabled adults between the ages of 21 and 64. That cohort now represents 49 percent of New Yorkers receiving Medicaid, up from 38 percent a decade earlier (Figure 2).

Over that same period, the number of disabled recipients, including those over 65, dropped to 18 percent of Medicaid rolls, down from 24 percent 10 years earlier.[14]

Figure 2: NYS Medicaid enrollment, 2013 and 2023



The Essential Plan

Another turning point came in 2015 when New York launched its Essential Plan, which initially offered Medicaid-like benefits at little or no premium up to 200 percent of FPL. It operated under an optional provision of the ACA that authorized states to establish government-operated "basic health programs."[15] To finance these programs, the federal government would provide aid equal to 95 percent of the tax credits and subsidies enrollees would have received had they purchased insurance.

New York and Minnesota were the first states to exercise this option, with Oregon becoming the third in 2024.[16]

New York's Essential Plan has proved popular, with enrollment rising to more than 1.5 million as of October 2024.[17]

New York had a unique motivation to take this option. Under a 2001 court ruling, *Aliessa v. Novello,* the state has been required to provide health coverage for several hundred thousand "legally present" immigrants who were ineligible for federal matching funds through Medicaid – putting the full cost on the state.[18] Immigrants in this category include green card holders who have been in the U.S. less than five years, people covered by President Obama's Deferred Action for Childhood Arrivals program and others with court rulings allowing them to remain.

The Medicaid restriction notwithstanding, the state discovered that it could enroll these immigrants in an ACA-authorized basic health program. By switching this *Aliessa* population to the Essential Plan, officials estimated the state would save about $1 billion per year.[19]

Federal funding for the Essential Plan has proven unexpectedly generous – resulting in payments to the state that far exceeded the cost of the program. The state was legally unable to spend the funds for any other purpose, causing a surplus of almost $10 billion to accumulate over its first eight years.[20] In an attempt to use more of this revenue, the state hiked Essential Plan reimbursement rates for providers and eliminated premiums, which were initially $20 a month for some enrollees.[21]

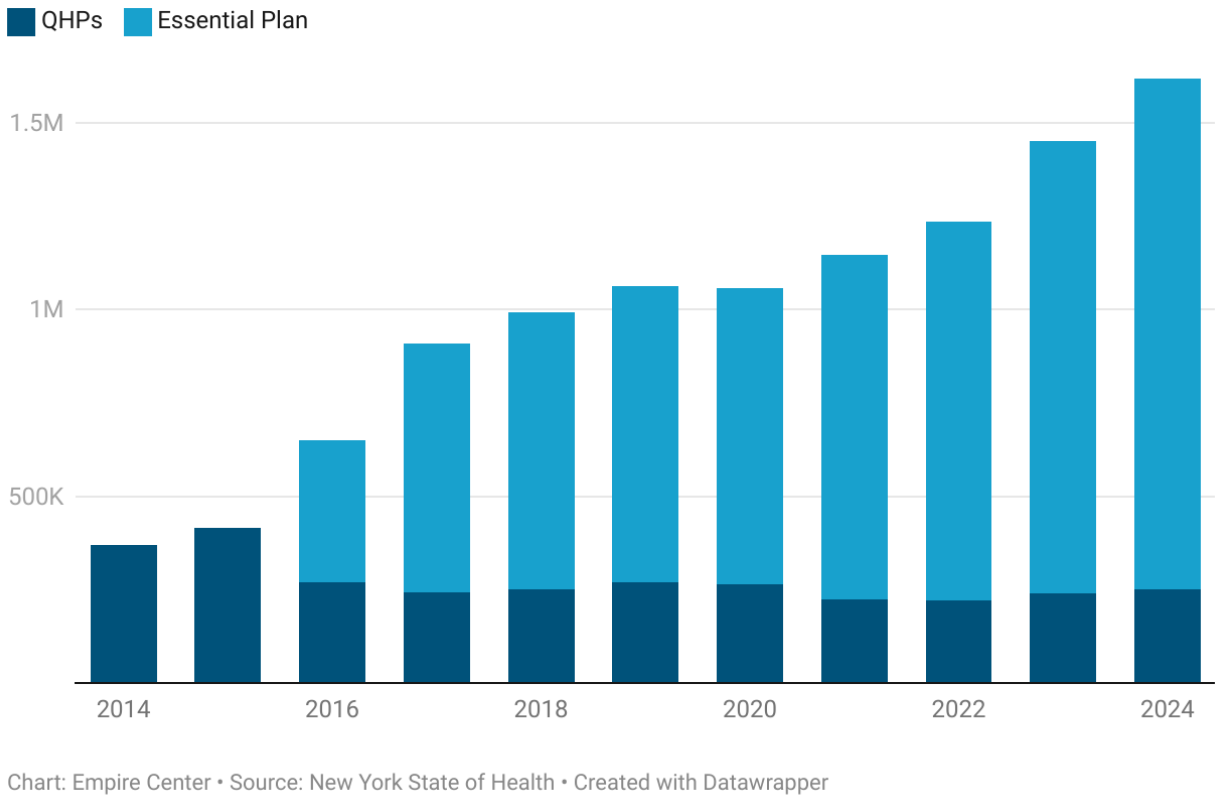
Although it's legally a separate program – and operates differently in certain ways – the Essential Plan effectively functions as an extension of Medicaid for a higher band of income: taxpayer-funded, means-tested health insurance provided at no cost to the recipient.

In early 2024, the Health Department won federal approval to expand the program even further, up to 250 percent of FPL.[22] This puts New York in the position of offering Medicaid-like coverage to the broadest income range of any state.

The plan now reaches well into the state's middle-income population. For a family of four in 2024, 250 percent of FPL equates to $78,000,[23] which is 5 percent less than the state's median family income for 2023. Many people in this range have full-time jobs and access to employer-sponsored health insurance.

The Essential Plan also reaches halfway through the eligibility range for subsidized coverage through commercial insurers, known as qualified health plans. Enrollment in those plans has accordingly declined, from a high of 415,000 in 2015 to 224,000 in 2024 (Figure 3).[24]

Figure 3: Enrollment in Qualified Health Plans and the Essential Plan



The coronavirus pandemic

The coronavirus pandemic triggered one of the largest Medicaid enrollment increases in state history, swelling the rolls by 1.9 million or 31 percent over three years.[25]

The spike was only partly due to the economic disruptions. A larger factor was a federal policy that suspended normal eligibility rules during the pandemic emergency. This so-called continuous enrollment rule required states to keep existing recipients on their Medicaid rolls regardless of changes in income. Existing enrollees stayed enrolled in Medicaid even if they found new jobs and signed up for employee health benefits.

Congress ended this rule in April 2023, and New York and other states have been gradually pruning their rolls since.[26] New York's program (excluding the Essential Plan) peaked at almost 8 million in the spring of 2023 but dropped to 7 million as of September 2024.[27] Officials are projecting that the state's post-pandemic enrollment will stabilize at about 6.7 million.[28] That would still be about 800,000 or 14 percent higher than it was when the crisis began.

Excess enrollment

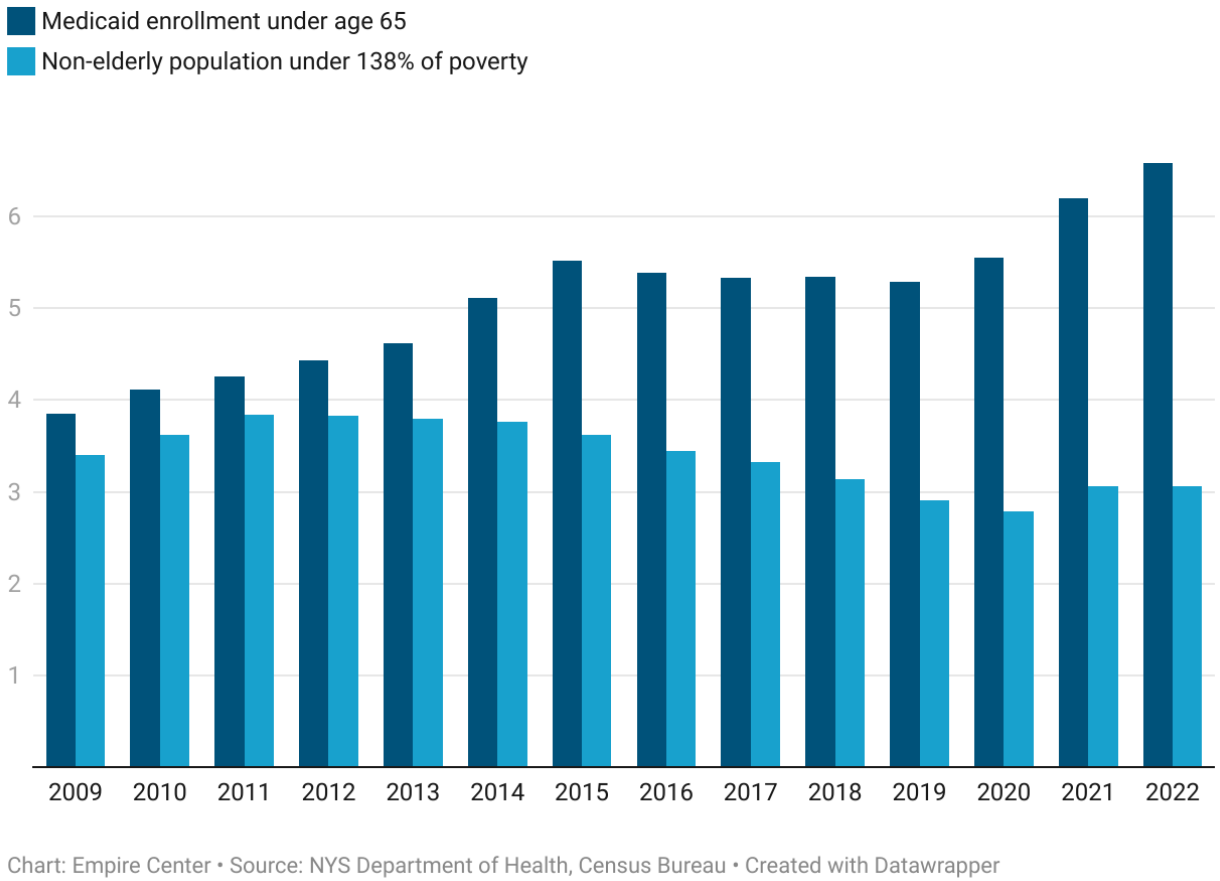
As enrollment soared in both Medicaid and the Essential Plan, the state's poverty rate was dropping – from 16 percent in 2013 down to 13 percent in 2019 before rising back to 14 percent in 2023. Over the decade, the number of New Yorkers living in poverty fell 12 percent, from 3.1 million in 2013 to 2.7 million in 2023.[29]

With those trend lines going in opposite directions, the state's means-tested health plans have become increasingly disconnected from measures of poverty. The surplus enrollment in these plans – the gap between the size of Medicaid rolls and the nominally eligible population – has ballooned into the millions.

Closer analysis of this Medicaid surplus is made possible by the Census Bureau's Small Area Health Insurance Estimates, which break down the population of each state and city according to ACA-relevant income groups.[30] These estimates omit people over 65, who are almost universally covered by the federal Medicare program.

Figure 4 shows a comparison of these Census Bureau estimates with non-elderly Medicaid enrollment as reported by the Health Department. Since enactment of the ACA, the difference between these two numbers – the surplus enrollment – has more than quadrupled. It went from 820,000 in 2013 to 3.5 million in 2022, the most recent year for which this type of Census Bureau data is available.[31]

Figure 4: Non-elderly Medicaid enrollment and poverty in New York (millions)



Proportionally, the gap between enrollment and the nominally eligible population went from 22 percent to 115 percent. As of 2022, in other words, more than half of the state's non-elderly Medicaid enrollees were living above 138 percent of FPL.[32]

This analysis is based on census estimates that are imprecise, and which might overstate the surplus enrollment to some extent. For one thing, Medicaid exempts certain forms of income, such as worker's 2 and veterans' benefits that Census Bureau surveys do not.

Also, Medicaid rules in New York – as in some other states – make exceptions to income limits for some categories of applicants, such as pregnant women and children and people with certain disabilities (Table 2).[33]

Table 2: Medicaid income eligibility limits in New York State

	Percent of federal poverty level
Adults	138
Children 1-18	154
AIDS insurance	185
Pregnant women and infants	223
Buy-in for working people with disabilities	250
Essential Plan*	250

**Expanded from 200% as of April 2024*

Table: Empire Center • Source: NYS Department of Health • Created with Datawrapper

However, these eligibility exceptions have existed in some form since before the enactment of the ACA, and their numbers are too small to explain the growth spurt of the past decade.

Medicaid covered 101,000 births in 2021, suggesting that it covered a similar number of pregnant women of all incomes in that year. That figure has been declining since 2015.[34]

Another exception is a Medicaid "buy-in," which allows working people with disabilities up to 250 percent of FPL to purchase coverage by contributing a percentage of their income. About 12,500 people are currently enrolled through this program. (In November 2024, the state proposed to expand this option up to 2,250 percent of FPL, or $338,850 for an individual, and projected that an additional 2,195 people would enroll.)[35]

Similar surpluses have developed in other states, especially during the pandemic emergency. New York's Medicaid surplus was larger than average, but lower than those in 10 other states.[36]

What has set New York apart is the Essential Plan, which covered a broader demographic group – up to 200 percent of FPL from 2015 to 2023, rising to 250 percent of FPL in 2024.

For this demographic group, population-wide data are available as recently as 2023.[37] The Census Bureau's count of New Yorkers under 200 percent of FPL – the eligibility range for the Essential Plan and most Medicaid recipients – was 5.5 million, while

combined enrollment in 2023 was 8.9 million (Figure 5). That translates to a combined enrollment excess of 3.4 million or 61 percent above the targeted income group.[38]

Over the past year, Medicaid rolls have diminished in New York and other states due to the end of temporary rules in place during the pandemic emergency. At the same time, Essential Plan enrollment has been rising since the expansion to 250 percent of FPL took effect in April 2024.

These data indicate that more than 3 million people – one out of every seven New Yorkers – continue to receive means-tested, taxpayer-funded health coverage despite having incomes of more than double the poverty rate.

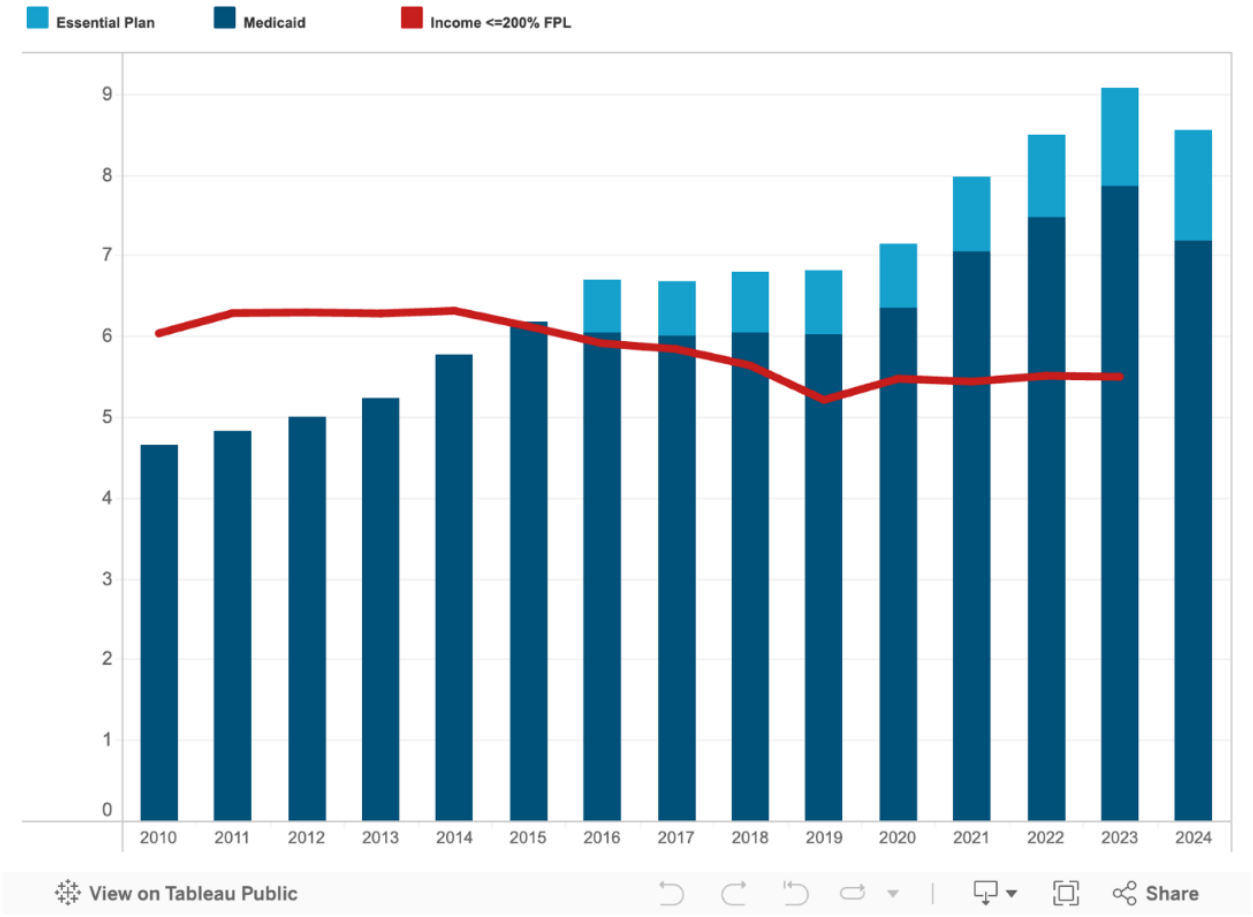
Previous reports have documented evidence of similar over-enrollment nationwide, especially in states that opted to expand Medicaid under the ACA.

One study found that Medicaid expansions "led to a 3.0 percentage point increase in Medicaid enrollment among working-age adults with incomes at or above 138 percent of the FPL, a sizable effect from a baseline rate of 2.7 percent."[39]

A follow-up study found that the growth of Medicaid enrollment above income eligibility thresholds varied from place to place, suggesting that it was driven in part by state policies and procedures. "There are some areas, such as New York City and Los Angeles, where the problem is so egregious that it may be a sign of purposeful abuse of the program rules and potentially of fraud," the authors wrote.[40]

The trends in New York indicate that enrollment above the 138 percent threshold has gotten significantly larger since those papers were published in 2019.

Figure 5: Medicaid and Essential Plan (millions)



Contributing factors

Fully explaining the scale of New York's surplus enrollment in means-tested health plans would require access to data about enrollees' income and other personal information that are not readily available to the public.[41]

However, certain important factors can be identified.

Exceptions to the 138 percent limit

Most enrollees are subject to an income limit of 138 percent of FPL, but the state has set higher thresholds for certain groups.[42]

For example, the income limit for pregnant women and infants under age 1 is 223 percent of FPL. For people living with AIDS the limit is 185 percent of FPL. And

disabled people with jobs can qualify for Medicaid while retaining income up to 250 percent of FPL (Table 1).

As discussed above, most of these exceptions have existed in some form since before the enactment of the ACA, and the numbers involved appear to be too small to explain the rapid growth of the past decade. None of the exceptions apply to the non-disabled adults who made up the bulk of enrollment growth.

Asset protection maneuvers

People with higher incomes and assets can evade Medicaid's eligibility limits by using specialized legal maneuvers to transfer or shield assets. One common strategy is to place assets and income into a special established trust fund managed by an independent person on behalf of the would-be Medicaid enrollee. Money in such a trust fund does not count as an asset for Medicaid eligibility purposes, but it can be spent on certain living expenses of the person receiving Medicaid.[43]

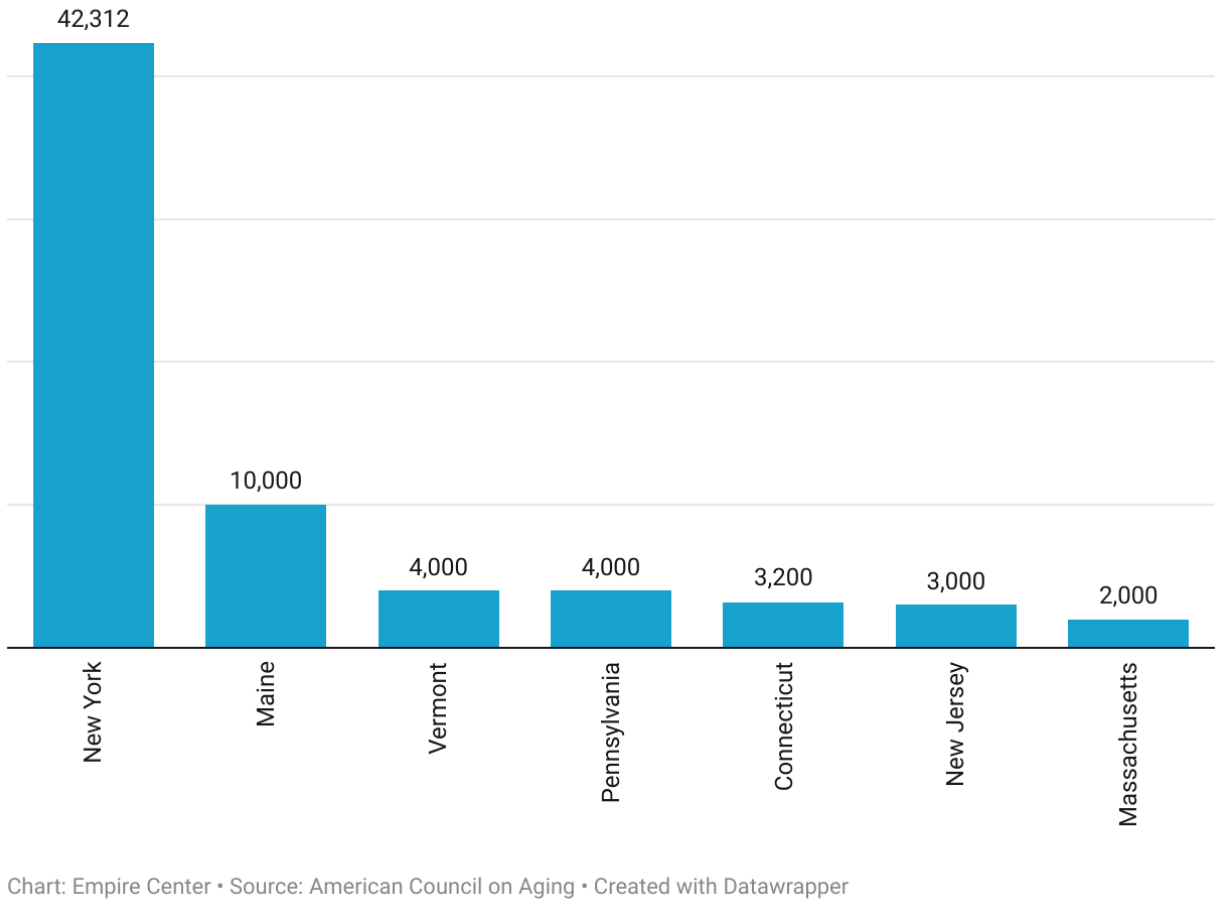
For people seeking coverage to enter a nursing home, Medicaid enforces a so-called lookback period. Assets placed in a trust or otherwise transferred within the previous five years are counted as if they still belong to the applicant, resulting in a "penalty period" during which Medicaid benefits are limited or denied.

For people seeking home-based long-term care, New York does not enforce a lookback period – which until recently was unique among the 50 states. The only other state with that policy is now California, which abolished lookbacks as of January 2024. New York lawmakers voted in early 2020 to establish a home care lookback of 30 months, but federal rules prevented New York from implementing that requirement during the pandemic emergency and it had not yet been put into effect as of late 2024.[44]

The lack of a lookback for Medicaid home care likely helps explain why demand for those services has grown so rapidly in recent years.

Another factor for people seeking Medicaid long-term care coverage is the "resource limit," the maximum amount of assets that an applicant can retain. New York's limit is set at 150 percent of the income limit, or $42,312 for a family of two. This is by far the highest such cap of any state except California, which has no limit. Maine has the second-highest asset limit of $10,000 (Figure 6).[45]

Figure 6: Asset limits for Medicaid long-term care coverage



Runaway home care demand

People receiving long-term home health services represent a tenth or less of total enrollment, but their numbers have been rising fast.

Enrollment in Medicaid's managed long-term care plans – which primarily provide home care – jumped by 144,000 or 85 percent from 2016 to 2024.[46]

Although precise utilization numbers for home health care aren't available, the state budget director recently said that enrollment in one form of home care, the Consumer Directed Personal Assistance Program, had soared 1,200 percent in eight years.[47]

The overall 65-plus category of Medicaid enrollment increased by 64 percent over the past decade, compared to 50 percent growth for the younger groups.[48] That was also more than double the growth of the state's overall 65-plus population, which was 28 percent.[49]

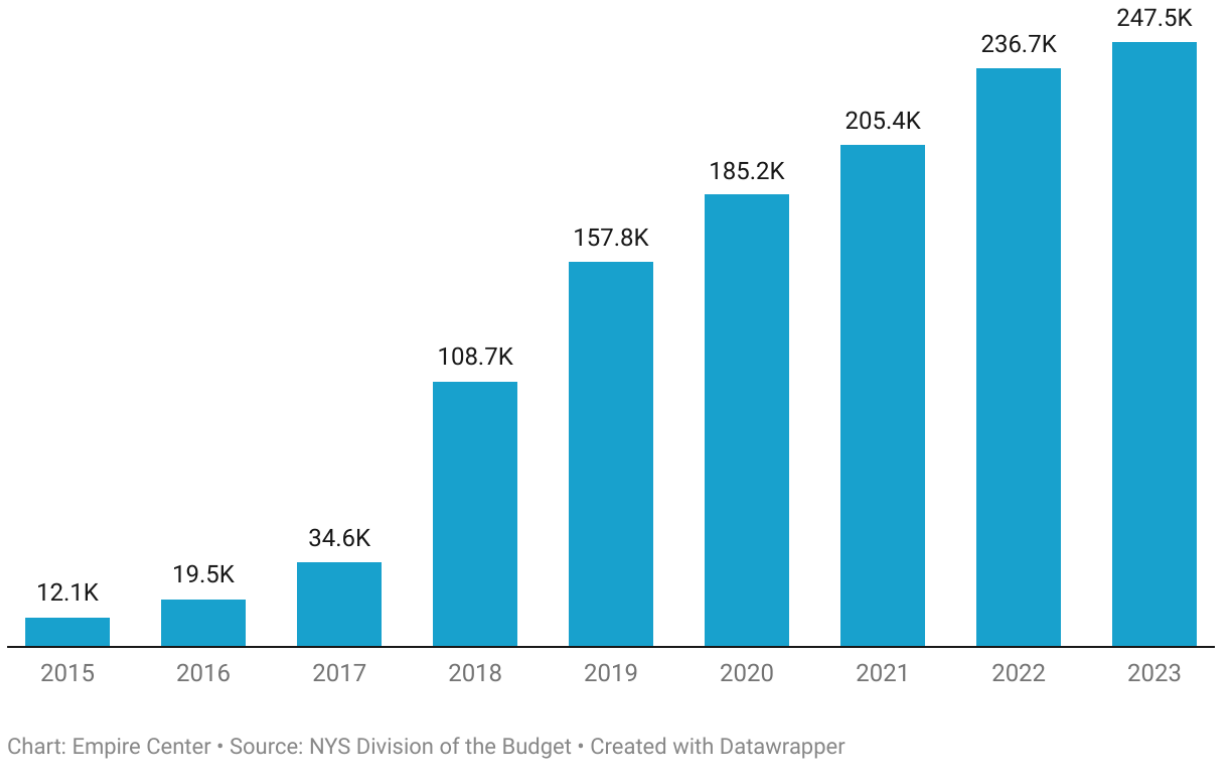
Among the drivers of growth in this area were structural reforms enacted in the middle of the previous decade. As part of then-Governor Andrew Cuomo's Medicaid "redesign," the state moved most elderly and disabled Medicaid enrollees into managed long-term care plans. In return for monthly premiums from the state, these privately operated plans took responsibility for the cost of their members' long-term care expenses.

The state further encouraged these plans to offer their members the Consumer Directed Personal Assistance Program, or CDPAP, as an option. Under this program, the clients hire and manage their own caregivers, with a company called a fiscal intermediary taking care of administrative tasks such as processing paychecks.

Because it was less expensive on a per-hour basis than traditional home care provided by an agency, the state directed the long-term care plans to offer CDPAP as an option for their members. The program proved unexpectedly popular, and hundreds of new fiscal intermediaries opened for business. They in turn started advertising the benefits of CDPAP, and that encouraged hundreds of thousands to sign up.

The number of people using the program soared from 12,000 in 2015 to 250,000 in 2023 (Figure 7).

Figure 7: CDPAP enrollment



In hopes of reining the program in, the Hochul administration is currently trying to replace the hundreds of small fiscal intermediaries with a single statewide provider.[50] Although that change is being challenged in court and faces opposition in the Legislature, it is currently due to take full effect on April 1, 2025.

Fiscal incentives

The Affordable Care Act included enhancements in federal matching rates for certain categories of enrollees, which reduced the financial incentive for state officials to be stringent about eligibility screening.

For states that participated in the Medicaid expansion, the federal government paid 100 percent of the cost of newly eligible enrollees in the ACA's first year, 2014, with that rate phasing down to 90 percent by 2020.

States with broad eligibility rules that predated the ACA, including New York, have received enhanced matching funds for all non-disabled childless adults under 100 percent of FPL. For New York, this enhancement translated to the federal government picking up 75 percent of costs in 2014 (25 points above its usual matching rate), phasing up to 90 percent in 2020.[51]

This latter enhancement proved to be a windfall for New York. The state's enrollment of "non-newly eligible adults" has jumped by more than 1 million, accounting for three-quarters of its total enrollment growth.[52] Over the ACA's first 10 years, New York has accounted for more than half of the total federal spending on this category – resulting in approximately $36 billion in additional federal aid flowing into the state.[53]

Critics have charged that these enhanced matching rates have led to over-enrollment and improper payments of federal aid.

In 2018 and 2019, federal audits found evidence that New York was incorrectly screening both newly eligible[54] and non-newly eligible enrollees[55] in the early years of the ACA. Based on a sample of 130 cases reviewed, the 2019 audit estimated that New York's procedural errors "could have resulted in up to $1.3 billion in potentially improper Federal Medicaid payments over the 6-month audit period."

A 2020 report by the Centers for Medicare & Medicaid Services found that the state had correctly determined eligibility for the adult expansion group in 2017 and 2018 – suggesting that the state had improved its procedures.[56]

The finances of the Essential Plan have created another powerful incentive for New York to expand enrollment.

For each Essential Plan enrollee, the state collects federal aid equal to 95 percent of what that enrollee would have received in tax credits and other subsidies had he or she purchased commercial insurance through an exchange.[57] Unexpectedly, this formula has generated federal funding that exceeds the operating costs of the plan – generating billions in surpluses.[58]

For each New Yorker enrolled in the Essential Plan, in effect, the state has been collecting more federal money than it has been able to spend.

The state initially responded by making the plan more generous for both recipients and providers. It eliminated premiums, which had been up to $20 per month. It also increased reimbursement payments to providers – setting Essential Play hospital fees at 225 percent of the standard rates paid by Medicaid.[59]

In 2024, the state received a federal waiver to expand eligibility for the plan from 200 to 250 percent of FPL. Its waiver application projected that this would lead to a 10 percent increase in enrollment and a 26 percent in spending, largely due to increased payments to providers.[60]

So far, however, enrollment has jumped 25 percent in the first seven months of the expansion.[61] Spending in fiscal year 2025 is projected to be $12.3 billion, up from $6.3 billion in 2023.[62]

Harmful effects

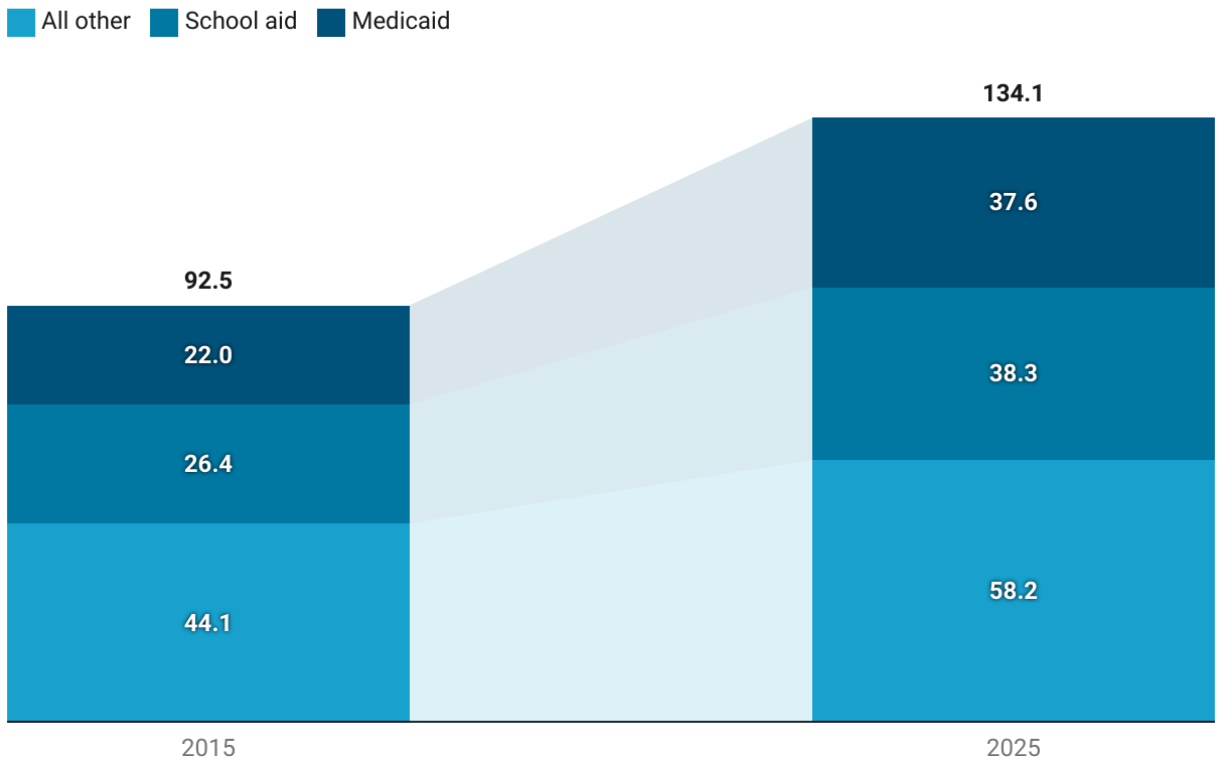
Medicaid covers vital and life-enhancing services for the indigent and disabled recipients who were its original intended beneficiaries. For the millions of others who have enrolled in the past decade, receiving comprehensive medical coverage without paying a premium is undoubtedly a valuable benefit. However, extending safety net-style coverage to almost half the population has negative effects for the larger health-care system and the state as whole.

Burdening taxpayers

Even with the federal government paying half the costs, Medicaid ranks as one of the biggest drivers of New York's high taxes at both the state and federal levels.

State government's contribution in fiscal year 2025 is expected to be $38 billion, which has soared by $10 billion or 36 percent in just the past three years. It is on track to eclipse state support for public schools, previously the largest portion of the state budget.[63]

Figure 8: State operating funds spending, billions*



**Does not include federal matching funds or payments from local governments*

Chart: Empire Center • Source: NYS Division of the Budget • Created with Datawrapper

On top of that amount, the state requires New York City and the 57 other county governments to contribute $8.6 billion.[64] This amount has been essentially frozen since 2015, but it is the largest expense for many county budgets and often outstrips their total revenue from property taxes.

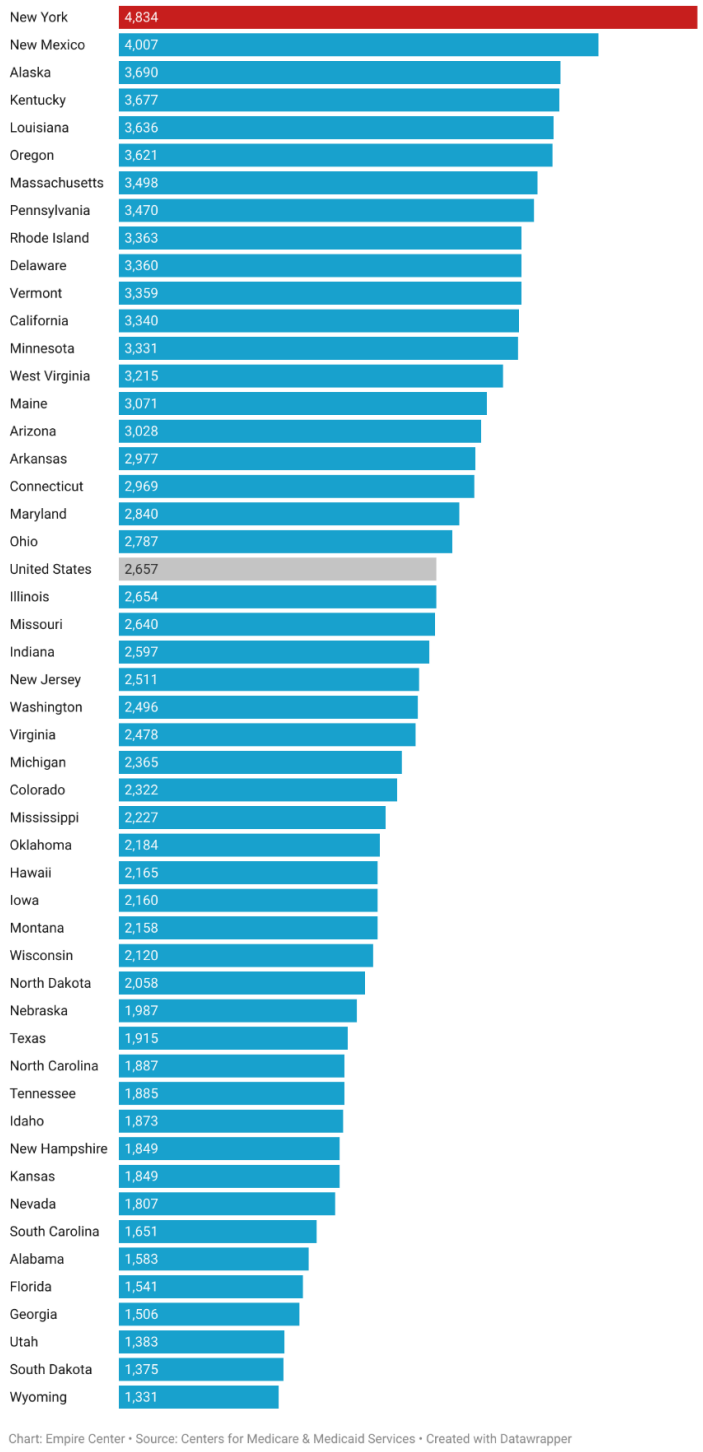
The state and county payments taken together amounted to almost $1,800 per state resident in 2023, which was the highest per capita non-federal share of any state. New York's total Medicaid spending per capita also ranks No. 1 (Figure 9).[65]

If New York could reduce its per capita costs to those of the No. 2 state, New Mexico, it would save state and local taxpayers more than $16 billion annually – and still spend 51 percent more than the U.S. average.[66]

Excess enrollment contributes substantially to these expenses. The surplus likely consists primarily of adults without disabilities, who cost the program an average of $6,600 each in 2021.[67] At that rate, a surplus of 3 million would translate to almost $20

billion in Medicaid spending – roughly half of which would be paid by state funds. That equates to about $500 for each resident of the state.

Figure 9: Per capita Medicaid spending, FFY 2023



Weakening the insurance market

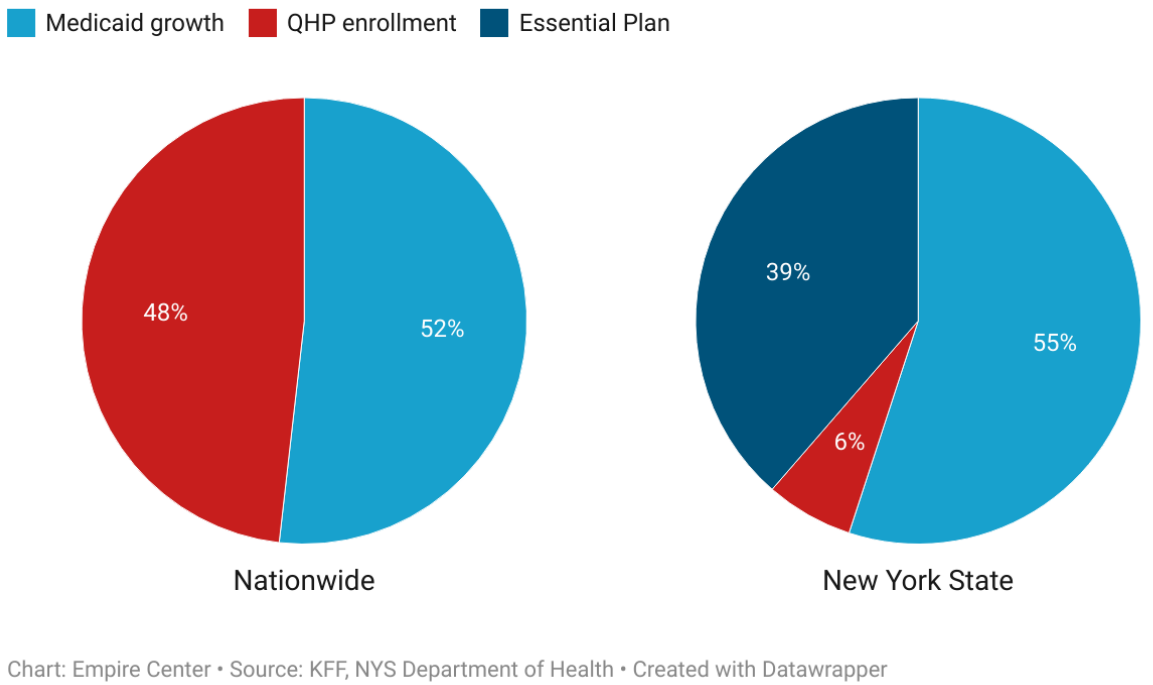
As originally designed, the Affordable Care Act was meant to reduce the uninsured population with a mix of public and private coverage. People under 138 percent of FPL would be enrolled in Medicaid, and those above that line but under 400 percent of FPL would be offered subsidized commercial coverage known as qualified health plans, or QHPs.

A 2013 estimate from the Congressional Budget Office projected a roughly one-third, two-thirds split between these options, with 13 million people joining Medicaid and 24 million signing up for QHPs.[68]

Nationwide over the past decade, the breakdown turned out to be closer to 50-50, with Medicaid enrollment increasing by 23 million and 21 million signing up for QHPs.

In New York, however, the split has been almost 15-1, with 3.3 million added to state-sponsored coverage over 10 years and 225,000 enrolled in QHPs (Figure 10).

Figure 10: Distribution of insurance coverage under the ACA



This is almost entirely due to the creation of the Essential Plan, which covers half the income range otherwise set aside for QHPs. New Yorkers under 250 percent of FPL are now effectively required to choose state-sponsored coverage because they are no longer eligible for premium tax credits through the ACA.

Although the Essential Plan is portrayed as part of a "safety net" for the uninsured, in many cases it has diverted already insured New Yorkers away from other coverage.

This became especially clear when the state applied for federal permission to expand eligibility from 200 percent to 250 percent of FPL.

In its application submitted in February 2023, the state estimated that 91,000 additional people would enroll in the Essential Plan – but acknowledged that 68,000 of them would be switching from private insurance.[69]

Diversions such as these tend to remove younger, healthier workers from the commercial insurance pool, which drives up premiums for those left behind. The Health Department acknowledged this effect in its 2023 application, estimating that expanding the Essential Plan would add 3 percent to commercial premiums in the non-group market, causing 3,000 consumers to drop insurance, resulting in a net increase in coverage of just 20,000.[70]

In one case, a benefit fund for unionized home health care workers directly shifted a portion of its members to the newly expanded Essential Plan by changing its eligibility rules.

In early 2024, as the Essential Plan expansion took effect, the 1199SEIU-affiliated benefit fund began barring members under 250 percent of FPL – and then directing them to enroll in the Essential Plan. Because the plan's eligibility is based on household income rather than individual income, enrollees had to provide details about their family members' finances, a requirement that applied to everyone seeking benefits, not just those entering the state plan.[71]

Diverting resources from the neediest

The state's Medicaid law declares that the program is meant to serve "needy persons."[72] For most of the program's history, this was understood to mean the indigent and the severely disabled – people with no means to pay for their own care.

Those especially needy recipients have become a minority of Medicaid enrollment, increasingly outnumbered by the able-bodied and employable people with incomes closer to the statewide median.

As a result, providers serving the severely disabled – such as nursing homes and organizations working with the mentally ill and developmentally disabled – find themselves increasingly in competition for resources with the larger health-care industry.

In the annual process of setting a state budget, groups representing hospitals, nursing homes and their unionized health-care workers – who rank as the biggest lobbying spenders in Albany[73] – often command proportionally larger increases in Medicaid funding than providers who serve the mentally and developmentally disabled.

In the final budget for fiscal year 2024, for example, hospitals secured a Medicaid rate increase of 7.5 percent[74] while mental health workers received a cost-of-living adjustment of 4 percent.[75]

Recommendations for reform

Enrollment in the state's means-tested health plans has grown to be millions higher than the population of the targeted income groups, raising a red flag that something has gone wrong.

Either the program's eligibility rules have become too lax, they are being poorly enforced or a combination of both.

As a result, New York is relying on taxpayer-funded health coverage more than Congress or the state Legislature intended – and more than is healthy for the state and its residents.

State officials should tighten enrollment rules and procedures to assure that safety-net health plans are focused on the truly poor and disabled residents who have no other choice – and that those who have the means to pay their own way are doing so.

Officials should also do what they can to make commercial coverage more affordable – by rolling back the billion-dollar taxes and ill-conceived regulations that have resulted in some of the highest insurance premiums in the nation.

This, in turn, will make the health-care system less focused on influencing Albany and more focused on giving consumers what they want: higher-quality care at reasonable prices.

Investigate the enrollment surplus

The burgeoning enrollment surplus demands closer examination in the form of an audit or study, which should document the demographics of the enrollees and how they comport with the programs' eligibility guidelines.

At a minimum, the Health Department should release more data about the income profiles of enrollees to allow better public understanding of how the rolls have gotten so large.

As part of the research for this paper, the Empire Center asked the Department to provide a breakdown of Medicaid enrollment by eligibility category over the past 10 years – information that would help clarify the drivers of over-enrollment.[76] Although the center submitted its request under the Freedom of Information Law in May 2024, the Department had not yet provided the records as of the date of publication.

Shrink the safety-net rolls

The state should bring actual enrollment in its means-tested health plans more in line with the stated income limits.

It should strengthen enforcement of existing eligibility rules and, if necessary, tighten those rules.

Officials should rethink the various exceptions and waivers that have been added over the years, some of which have been overused and abused.

They should also draw a harder line against estate planning practices – while also giving consumers with means better options to insure against their own long-term care costs.

Rethink the Essential Plan

Although the Essential Plan has generated a windfall of federal aid for the state, it has done so at the expense of weakening the commercial market for non-group insurance.

If it did not exist, most of its 1 million-plus enrollees would be shopping for plans through the state's ACA exchange – and would be qualifying for tax credits and other subsidies to cover most of their costs, in some cases reducing their net premiums to zero.

By pulling those enrollees out of the risk pool, the Essential Plan has driven up premiums for those left behind – causing some people just above the plan's income range to forgo coverage completely.

Fostering a healthy insurance market should be a higher priority than maximizing federal aid. The state should scale back or eliminate the Essential Plan – or, at a minimum, tighten enrollment to cause a minimum of distortion.

Congress should also adjust the funding formula for this part of the ACA to make it less wasteful for taxpayers and less tempting for state officials.

Refocus on safety-net population

Although New York's overall Medicaid spending is high by national standards, the rates it pays to hospitals, doctors and other providers are typically lower than those paid by commercial insurance plans – and many providers complain that they lose money on Medicaid patients.

Scaling back the state's Medicaid rolls could help to resolve those gaps in two ways – by reducing the volume of service covered by the rates hikes, and by generating savings that could be reinvested into higher fees.

As mentioned above, even a relatively modest downsizing could free up a lot of money. Reducing New York's per capita Medicaid spending to the level of the No. 2 state, New Mexico, would save state and federal taxpayers about $16 billion per year.

Improve affordability of commercial plans

State officials have acknowledged that increasing premiums leads to fewer people choosing to pay for health insurance.[77]

New York consumers and their employers pay some of the highest insurance premiums in the U.S. In 2023, the average premium for employer-sponsored single coverage was almost $1,000 or 12 percent above the national norm.[78]

This is partly due to the state's high health-care costs, which a more robust insurance market would help to control.

State policy makes things worse through heavy taxation and over-regulation of health insurance.

A pair of surcharges levied under the state's 1996 Health Care Reform Act add about $440 per person to the annual cost of health insurance, or about $1,760 for a family of four.[79] Projected to bring in $5.2 billion in fiscal 2025,[80] they rank as one of the state's biggest sources of revenue.

As it happens, most of the money from these taxes goes to pay for Medicaid – meaning that downsizing the program would make it easier to reduce or repeal them.

Meanwhile, the state imposes dozens of mandates requiring insurers to cover specific procedures, or medications or types of care. Few have been subject to careful cost-benefit analysis and nearly all add incrementally to costs.

Reducing taxes and mandates on insurance could make coverage more affordable – and move New York toward a better balance between the public and private sectors in its health-care system.

Endnotes

[1] Author's analysis of data from New York State Department of Health, the U.S. Centers for Medicare & Medicaid Services (CMS) and the U.S. Census Bureau.
[2] Ibid.
[3] U.S. Census Bureau, American Community Survey 1-year Estimates for 2023 accessed at https://data.census.gov/all.
[4] Author's analysis of Census Bureau estimates and enrollment figures from the New York State Department of Health.
[5] Author's analysis of data from the Census Bureau and CMS.
[6] Census Bureau American Community Survey, op. cit.
[7] Based on KFF Medicaid Spending per Enrollee for 2021. https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[8] Author's analysis of data from the New York State Division of the Budget, accessed at https://openbudget.ny.gov/budgetArchives.html.
[9] *National Federation of Independent Business v. Sebelius,* 567 U.S. 519 (2012). https://supreme.justia.com/cases/federal/us/567/519/
[10] New York State Department of Health enrollment data, accessed at https://health.data.ny.gov/.
[11] Ibid.
[12] CMS data on "new adult group" enrollment, accessed at https://data.medicaid.gov/dataset/6c114b2c-cb83-559b-832f-4d8b06d6c1b9.
[13] The Tax Cuts and Jobs Act of 2017. See https://taxfoundation.org/taxedu/glossary/tax-cuts-and-jobs-act/.
[14] Authors analysis of enrollment data from the New York State Department of Health, accessed at https://health.data.ny.gov/.
[15] See https://www.medicaid.gov/basic-health-program/index.html.
[16] Ibid.
[17] New York State of Health enrollment data for October 2024. https://info.nystateofhealth.ny.gov/sites/default/files/EP%20and%20QHP%20Total%20Enrollees%20October%202024%20Combined.pdf.
[18] *Matter of Aliessa v. Novello,* 96 N.Y.2d 418 (2001). See https://law.justia.com/cases/new-york/court-of-appeals/2001/96-n-y-2d-418-1.html. Immigrants covered by the ruling include green card holders who have resided in the U.S. for less than five years, people covered by President Obama's Deferred Action for Childhood Arrivals program and others with court orders allowing them to stay in the country.
[19] New York State of Health, "Essential Plan Annual Report to the Governor and Legislature," December 2016. https://www.health.ny.gov/health_care/managed_care/essential/docs/2016_basic_health_program.pdf.
[20] See Bill Hammond, "The Wacky Math of New York's Essential Plan," Empire Center, Nov. 30, 2023. https://www.empirecenter.org/publications/the-absurd-math-of-new-yorks-essential-plan/
[21] New York State of Health, "Health Insurance Coverage Update," September 2021. https://info.nystateofhealth.ny.gov/sites/default/files/Health%20Insurance%20Coverage%20Update%20-%20September%202021_0.pdf
[22] Governor's office press release, "Governor Hochul Announces Federal Approval to Expand Access to High-Quality, Affordable Health Insurance," March 4, 2024. https://www.governor.ny.gov/news/governor-hochul-announces-federal-approval-expand-access-high-quality-affordable-health
[23] See Table 1.
[24] New York State of Health enrollment data, accessed at https://info.nystateofhealth.ny.gov/enrollmentdata.
[25] New York State Department of Health enrollment data, op. cit.
[26] Jennifer Tolbert and Meghana Ammula, "10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision," KFF, June 9, 2023. https://www.kff.org/medicaid/issue-brief/10-things-to-

know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/#:~:text=The%20Consolidated%20Appropriations%20Act%2C%202023%20decoupled%20the%20Medicaid%20continuous%20enrollment,states%20could%20resume%20Medicaid%20disenrollments.

[27] New York State Department of Health enrollment data, op. cit.

[28] New York State Division of the Budget, "FY 2025 Enacted Budget Financial Plan," May 2024, p. 101. https://www.budget.ny.gov/pubs/archive/fy25/en/fy25fp-en.pdf

[29] Census Bureau American Community Survey, op. cit.

[30] Census Bureau Small Area Health Insurance Estimates Program, accessed at https://www.census.gov/programs-surveys/sahie.html.

[31] Author's analysis of data from the New York State Department of Health and the U.S. Census Bureau.

[32] Ibid.

[33] See Legal Assistance of Western New York, "What Is Medicaid?", accessed at https://www.lawny.org/node/21/what-medicaid.

[34] New York State Department of Health, "Vital Statistics of New York State 2021," accessed at https://www.health.ny.gov/statistics/vital_statistics/2021/.

[35] Information on the Medicaid Buy-In Program for Working People with Disabilities was drawn from the state's November 2024 waiver application to CMS, available at https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/mbi-wpd_cpt_draft_amend_request.pdf.

[36] Author's analysis of data from the Census Bureau and CMS.

[37] Census Bureau American Community Survey, op. cit.

[38] Author's analysis of data from CMS and the Census Bureau.

[39] Charles J. Courtemanche et al., "Medicaid Coverage Across the Income Distribution Under the Affordable Care Act," National Bureau of Economic Research, August 2019. https://www.nber.org/system/files/working_papers/w26145/w26145.pdf?utm_campaign=PANTHEON_STRIPPED&amp%3Butm_medium=PANTHEON_STRIPPED&amp%3Butm_source=PANTHEON_STRIPPED

[40] Brian C. Blase and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments," Mercatus Center at George Mason University, Arlington, Va., November 2019.

[41] In May 2024, the author requested further relevant records from the New York State Department of Health under the Freedom of Information Law. As of publication, those records had not been released.

[42] See income and resource standards posted by the New York State Department of Health in January 2024. https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/24ma01_att1.pdf

[43] American Council on Aging, "How Medicaid Planning Trusts Protect Assets and Homes from Estate Recovery," Feb. 1, 2024. https://www.medicaidplanningassistance.org/asset-protection-trusts/

[44] Ibid.

[45] Ibid.

[46] New York State Department of Health Medicaid Managed Care Enrollment Reports, accessed at https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

[47] Vaughn Golden et al., "How NY's $6 billion CDPAP Medicaid program has been abused, overused for years," *New York Post*, Feb. 14, 2024. https://nypost.com/2024/02/14/us-news/how-nys-6-billion-cdpap-medicaid-program-has-been-abused-overused-for-years/

[48] New York State Department of Health enrollment data, op. cit.

[49] Census Bureau American Community Survey, op. cit.

[50] Governor's office press release, "Governor Hochul Announces Next Steps in Plans To Strengthen Home Care Services for New Yorkers," Sept. 30, 2024. https://www.governor.ny.gov/news/governor-hochul-announces-next-steps-plans-strengthen-home-care-services-new-yorkers

[51] Robin Rudowitz, "Understanding How States Access the ACA Enhanced Medicaid Match Rates," KFF, Sept. 29, 2014. https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/#:~:text=Newly%2DEligible%20Matching%20Rate.,percent%20in%202020%20and%20beyond.

[52] CMS data on Medicaid enrollment in the new adult group, accessed at https://data.medicaid.gov/dataset/6c114b2c-cb83-559b-832f-4d8b06d6c1b9.
[53] CMS data on Medicaid new adult group expenditures, accessed at https://data.medicaid.gov/dataset/00505e90-f8ac-5921-b12f-5e23ba7ffcf3.
[54] U.S. Department of Health and Human Services Office of the Inspector General, "New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Eligible Beneficiaries," January 2018. https://oig.hhs.gov/documents/audit/6322/A-02-15-01015-Complete%20Report.pdf
[55] U.S. Department of Health and Human Services Office of the Inspector General, "New York Did Not Correctly Determine Medicaid Eligibility for Some Non-Newly Eligible Beneficiaries," July 2019. https://oig.hhs.gov/documents/audit/6355/A-02-16-01005-Complete%20Report.pdf
[56] Centers for Medicare & Medicaid Services, "New York Medicaid Eligibility Determinations for the Adult Expansion Population," September 2020. https://www.cms.gov/files/document/new-york-medicaid-beneficiary-eligibility-review-report.pdf
[57] See https://www.medicaid.gov/basic-health-program/index.html.
[58] Amanda D'Ambrosio and Jacqueline Neber, "State's hands tied in using $10B Essential Plan surplus to cover more New Yorkers," Crain's New York Business, March 9, 2023. https://www.crainsnewyork.com/health-pulse/states-hands-tied-using-10b-essential-plan-surplus-cover-more-new-yorkers
[59] New York State Department of Health Essential Plan Guidance 2.0, June 25, 2021. https://www.health.ny.gov/health_care/managed_care/essential/docs/guidance_2.0.pdf
[60] New York State Department of Health, "New York Section 1332 Innovation Waiver Essential Plan Expansion," Feb. 9, 2023. https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Draft_Application_Actuarial.pdf
[61] New York State of Health enrollment data, op. cit.
[62] New York State Division of the Budget financial plan tables. https://openbudget.ny.gov/budgetArchives.html
[63] Ibid.
[64] Ibid.
[65] Author's analysis of CMS Medicaid expenditure reports 2023, accessed at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.
[66] Ibid.
[67] KFF, "Medicaid Spending per Enrollee (Full or Partial Benefit) by Enrollment Group," accessed at https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[68] Congressional Budget Office, "Effects of the Affordable Care Act on Health Insurance Coverage," May 2013. https://www.cbo.gov/sites/default/files/recurringdata/51298-2013-05-aca.pdf
[69] Section 1332 Innovation Waiver Essential Plan Expansion, op. cit.
[70] Ibid.
[71] Bill Hammond, "State Offers Taxpayer-Funded Health Coverage to Unionized Home Care Workers," Empire Center, July 3, 2024. https://www.empirecenter.org/publications/state-quietly-offers-taxpayer-funded-health-coverage/
[72] Social Services Law, Title 11, Section 363.
[73] See for example the 2023 annual report of New York State Commission Lobbying and Ethics in Government, "Top 10 Client Spenders," p. 122.
[74] Governor's press release, "Governor Hochul Announces Investments to Create a Stronger Health Care System for the Future," May 23, 2023. https://www.governor.ny.gov/news/governor-hochul-announces-investments-create-stronger-health-care-system-future

[75] Governor's press release, "Governor Hochul Announces Passage of $1 Billion Plan to Overhaul New York State's Continuum of Mental Health Care," May 3, 2023. https://www.governor.ny.gov/news/governor-hochul-announces-passage-1-billion-plan-overhaul-new-york-states-continuum-mental

[76] The Empire Center's request sought "a count of the enrollees in each of the program's income- and resource-related eligibility categories in each of the state's 10 regions" as of March 31 from 2015 through 2024.

[77] "New York Section 1332 Innovation Waiver Essential Plan Expansion," op. cit.

[78] U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, accessed at https://datatools.ahrq.gov/meps-ic/.

[79] Bill Hammond, "Hooked on HCRA: New York's 24-Year Health Tax Habit," Empire Center, March 11, 2020. https://www.empirecenter.org/publications/hooked-on-hcra-new-yorks-24-year-health-tax-habit/

[80] FY 2025 Enacted Budget Financial Plan, op. cit.