

TESTIMONY SUBMITTED TO THE JOINT FISCAL COMMITTEES OF THE
NEW YORK STATE SENATE AND NEW YORK STATE ASSEMBLY
ON 2026-2027 EXECUTIVE BUDGET PROPOSAL
HEALTH/MEDICAID

February 10, 2026

Thank you for the opportunity to submit testimony. I am Judith B. Esterquest, Healthcare Specialist for the League of Women Voters of New York State. The League is a nonpartisan, grassroots organization with a mission to educate the public to become engaged and informed voters, particularly on issues that further the public good.

The League believes every New York resident should have access to essential physical and behavioral healthcare, and that New York State in its regulation of healthcare must ensure that delivery is high quality, affordable, and equitably accessible, particularly for our most vulnerable and marginalized residents.

The League believes that both chambers need to address looming federal cuts and rule changes in this year's budget to protect residents and hospitals. Replacing up to \$13B is daunting, but it is not hyperbole to say our healthcare infrastructure could collapse, putting even more lives at stake. This testimony suggests areas where modest short-term investments this year could achieve significant on-going savings — while also improving access and quality. The League urges you to begin making these investments now.

Our healthcare is not fiscally sustainable, nor serving our health. The One Big Beautiful Bill Act (OBBBA) and other recent federal actions) will be devastating — credible authorities estimate, as the NYS Executive did last summer, a loss of \$13B in federal payments, with over 1.5B residents losing all coverage (and more opting out because they see coverage as unaffordable).¹ As the Fiscal Policy Institute concludes, "The consequences of simply allowing these cuts to happen would be nothing short of catastrophic...many hospitals will close, and preventable deaths will rise."²

The League urges legislators to budget the funds needed to keep residents insured and reimbursements sufficient to keep hospitals open. This testimony will focus on the following asks:

- Coverage for the \$1.5M New Yorkers who will lose access due to federal cuts
- Investing significant funds (\$3B) in primary care
- Direct funding to NYS Department of Health and away from private, for-profit entities

The League advocates that the best and most sustainable answer is single-payer, publicly-funded healthcare which could save up to \$20B per year while protecting patients, providers infrastructure, and taxpayers. This testimony also identifies areas for similar sorts of savings at smaller scale: in overseeing both for-profit and non-profit entities that receive public funds, NYS should maximize how much funding goes to health services and minimize what goes to overhead, private profit or excess revenue and require audit transparency.

We note below the League's highest priorities for pro-active funding and to achieve savings — both to protect the lives and health of New York residents and to ease budget pressure within a year to five years. The League appreciates that budgeting is a demonstration of values and priorities, and that this year's budget cannot fully achieve our mutual goals of accessible and quality healthcare for residents, adequate financing for

¹ Fiscal Policy Institute, " The State is Understating Threats to NYS Medicaid After OBBBA, New York can protect its Medicaid system from Trump's cuts – but it needs to act now," July 25, 2025, <https://fiscalpolicy.org/wp-content/uploads/2025/07/Protecting-Medicaid-7-26-25.pdf>

² Ibid.

hospitals/clinics, adequate compensation and working conditions for providers, and affordability for taxpayers. But the League also notes that healthcare in New York is in crisis and worsening. The Health and Medicaid Committees must budget to achieve enduring savings by focusing taxpayer funds on taxpayer needs, moving funds to invest in cost-efficient care as well as to reduce taxpayer-funded corporate profits.

1. Include coverage for 1.5M NYS residents who will lose coverage

Recent federal actions to reduce federal spending³ will eliminate or reduce health insurance eligibility for at least 1.5M NYS residents. NYS, however, has both legal and moral obligations to provide coverage. The state must also maintain its health infrastructure, the productivity of its workers, and the future health of its children. Continuing to provide coverage and maintaining reimbursement levels is not optional.

We are facing a coming crisis that could evolve into system failure in a domino-effect collapse unless much or all the \$13B in lost funding for coverage and reimbursement can be replaced. The Legislature must include in the one house budgets funding for the at least 1.5M NYS residents who will lose coverage — those who will lose coverage entirely, those who will refuse coverage that is now unaffordable and those whose coverage will move from Essential Care to Medicaid, reducing reimbursement for their care.

2. Invest \$3B in primary care services

Eliminate middlemen by increasing public control of healthcare funding — full transition to single-payer would save as much as \$60B per year, more than off-setting the recent federal funding cuts, with enough to raise reimbursement rates, particularly for primary care. The League urges legislators to invest in primary care: big savings and big health impact. Twenty states are already reaping rewards.⁴ Primary care providers (pediatricians, family care, geriatricians, OB/GYN, and therapists) focus on prevention, early diagnosis, and controlling chronic disease, significantly reducing emergency room use (especially for routine care), hospitalizations and high-cost specialists — substituting low-cost interventions for highest-cost interventions. One estimate: investing \$3B more in this budget could save \$40B each subsequent year in emergency, specialty, and hospital services.⁵

Investing in primary care means more than mandating increased spending by insurers. Keeping those we attract requires ensuring safe working conditions (e.g., with adequate staffing levels) and reducing burnout/moral injury that drives providers out of the profession.

For example, pediatricians are in severe shortage across the state, worse in rural counties. Too often they are reimbursed as little as 75% of family physicians. This is not just business as usual: a third of all pediatricians are over 60. A cliff is just ahead.

Similarly, Early Intervention therapists are in such short supply that half of eligible children, who benefit most when receiving services as early as possible, will age out of eligibility; they are reimbursed at rates lower than in the 1990's, receive no reimbursement for travel between patients, and the new payment portal, rolled out in 2024, continues to have missing data, authorization glitches, and severe payment delays.⁶

³ HHS quoted as, it "will result in reduced federal spending" in Rockefeller Institute of Government, "New Federal Health Insurance Rule to Impact Coverage in New York," August 2025, <https://rockinst.org/wp-content/uploads/2025/08/fed-health-ins-rule-change.pdf>

⁴ **This resource includes a list of action steps:** <https://nashp.org/implementing-high-quality-primary-care-a-policy-menu-for-states/>

⁵ **"Oregon found that every additional \$1 invested in primary care generated \$13 in savings across emergency, specialty, and hospital services."** in Implementation of Oregon's PCPCH Program; Exemplary Practice and Program Findings. 2016. Portland State Univ.: <https://www.oregon.gov/oha/HPA/dsi-pcpcch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf>.

⁶ <https://ritchietorres.house.gov/posts/congressman-ritchie-torres-raises-alarm-on-new-york-states-mismanagement-of-early-intervention-program>

Similarly, EMS & Paramedicine Services are usually classified as acute care but in rural areas, where the shortage of all care is at crisis levels and other access is distant, distinctions may blur. Rural areas need state funding for these services to survive: increased wages, better working conditions, more training for current EMS, funding to recruit and train replacements for those near-retirement age and older. Successfully addressing these essential services will improve public health in rural areas and reduce high-cost crisis interventions.

3. Reduce spending through in-sourced Medicaid Managed Long-Term Care and privileging nonprofit/public providers:

NYS pays private insurers to coordinate long-term care for patients who do not receive care coordination: insurers charge NYS marked-up cost to pay homecare aides. The Dept of Health could administer fee-for-service reimbursements to aides at significant savings, after minimal transition to add capacity.

When Connecticut de-privatized its entire Medicaid program in 2012, they saw billions of dollars in immediate savings, expanded savings over time, and dramatic increases in quality ratings and outcomes, not to mention transparency across the program (contrasting with prior opacity).⁷

Reduce existing for-profit and prohibit new for-profit health facilities — hospices, nursing homes, dialysis centers, etc. — research is clear that for-profit entities have more fraud, more patient complaints, higher cost, and lower quality.

- As much as 10-15% of total healthcare spending is during the final year of life, with half of that in the final 60 days, too often with patients and their families wanting release. Yet NYS utilizes less hospice care than most all other states,⁸ and average length of stay is 15 days.⁹ The answer is not to short-change dying New Yorkers by allowing additional new for-profit hospices to offer poor staffing, poor nutrition, poor environment, and poor treatment because private equity can profit from the dying. NYSDOH education for patients and providers could dramatically reduce high-cost spending that reduces patient quality of life.
- NYS currently has about 200 nursing homes, run by for-profits, nonprofits, and government (VA, H&H in NYC, and county homes). For-profits cost patients more, provide lower quality services, have higher rates of patient complications, abuse, and death, and use third-party contracts (not always at arms-length) to increase profits. NYS needs to insist on fiduciary duty to the public in healthcare.
- NYS has both for-profit and nonprofit dialysis centers. The nonprofits give better care with fewer complications and lower cost. Public funds should be directed to better, that is, lower-cost and higher quality facilities. With NYS funding gaps are so huge, the League urges legislators to stop wasting public funds on corporate overhead, investor payouts, and worse care.

Corporate Ownership of Hospitals & Corporate Practice of Medicine (CPOM) — NYS has a long and proud history of ensuring physicians, not corporations make medical decisions. Over the past decades, the private sector has engaged in increasingly complicated financialization, making corporate structures both opaque and difficult to review. Although hospitals and LLCs that provide healthcare may be NYS nonprofit corporations, their corporate owners are increasingly not. Further, and more troubling, corporate entities that exert "passive" control are affecting operations. NYS needs to insist on transparency about corporate ownership to protect healthcare as a public good for all New Yorkers

4. Direct Funding to the NYS Department of Health to rebuild and extend critical capacities

NYS needs to invest in its Department of Health. With the federal government stepping back, New Yorkers need the NYSDOH to step up, as it's been doing — NYSDOH needs more funding.

⁷ https://pnhp.org/system/assets/uploads/2022/03/CTManagedCare_Toubman.pdf and Health Justice Monitor post: <https://www.healthjusticemonitor.org/connecticut-medicaid-prospers-post-capitated-managed-care/>

⁸ <https://nyassembly.gov/write/upload/publichearing/001098/002567.pdf#:~:text=Hospice%20contributes%20to%20better%20care%2C,better%20performance%20in%20pain%20management>

⁹ https://researchinstituteforhomecare.org/wp-content/uploads/NY_Hospice_2024.pdf

Pro-actively provide public access to trustworthy health/science data and information on prevention, emerging diseases, medications, treatments, and public health advice. This has become an essential service since the CDC and NIH and other federal agencies have stripped information considered DEI-adjacent, begun posting health advice based on ideologies rather than evidence-based science (e.g., challenging germ theory), and lost thousands of highly trained specialist public servants. NYS may require additional DOH services TBD:

- Global Health Update Report (Jan/25) provides weekly, preliminary data to track global health threats
- Northeast Public Health Collaborative (NEPHC) is an 8-state voluntary regional coalition established 9/25 to improve coordination, share expertise, and strengthen regional readiness for public health threats
- Fact sheets and recommendations on vaccination/other medications, advice once trusted from the CDC
- Advising how to protect NYS patient rights to access to politicized treatments and medications

Protect Reproductive Rights & Eligibility of Medicaid Recipients

- Continue defending NYS providers from prosecutions (and other threats, doxxing or Comstock Act enforcement) by strengthening shield laws and planning legal defenses.
- Ensure sufficient stockpiles of drugs potentially targeted for withdrawal of FDA approval
- Require transparency by all NYS hospitals in posting policies listing any "standard medical care" the hospital refuses to offer
- Provide significant support to Medicaid-eligible New Yorkers unable to navigate the new rules

Expand capacity of DOH to oversee and manage fee-for-service reimbursement

to reduce overall cost, including fraud, and to use funds more effectively to

- Improve transparency (both fiscal and quality) and
- Reduce the cost of Medicaid managed care (MMC) by as much as 20% where NYS is paying a premium but receiving no added value, such as MLTC
- Consider more significant cost reduction options, perhaps those implemented by Connecticut¹⁰

Extend capabilities of DOH to reduce cost and stabilize supplies of generic drugs

- Perhaps licensing NYS contract manufacturers to produce prescription drugs for NYS at cost
- Perhaps partnering with other states, like California, which are doing similar things
- Despite 90% of prescription drugs being generic, they are priced like brand-name drugs
- Some commonly used generics are constantly out-of-supply, often manufactured abroad; new tariffs and trade issues may exacerbate future shortages.

Conclusion

The League greatly appreciates the healthcare reforms implemented by the Legislature and Governor in recent years. That said, disparities in access and in health outcomes reveal continuing challenges. Protecting vulnerable residents means not only ensuring affordable access to insurance and the care it allows — including by attracting more front-line providers to all areas of NYS — but also helping NYS hospitals survive.

The League opposes the further privatization of healthcare. Despite the heady optimism of the 1980s that the private sector can deliver "public goods" like healthcare at higher quality and lower cost than the public sector, four decades of credible scrutiny have concluded the opposite: The private sector, because its fiduciary duty is to investors (not the public) prioritizes profits, which means segmenting "customers" by profitability and using price and service discrimination to attract high-margin segments (wealthy and healthy) and deter low-margin segments (poorer, sicker, those needing complex care).¹¹ Because the private sector adds significant

¹⁰ Note the experience of the State of Connecticut, which replaced managed care organizations (MCOs) in its Medicaid program in 2012. The cost increases since then have risen at a significantly slower rate, with better service to patients, see Sheldon Toubman, "How Connecticut Eliminated Capitated Managed Care in Medicaid," February 2019, <https://pnhp.org/system/assets/uploads/2022/03/CTManagedCare_Toubman.pdf> CT.gov asserts a Medicaid administrative overhead of 3.8% vs a managed care state average of 9.4%: Department of Social Services, "Medicaid Landscape Analysis," December 2024, <https://portal.ct.gov/dss/home/-/media/dss/ct_dss_medicaid-landscape-analysis_final-report_1252024_v2.pdf?rev=e1eda292a7314ff086978073421447da>

¹¹ Penn LDI, "Hospital Privatization Increases Profits, at What Cost?: New Study Finds Privatized Hospitals Serve Fewer Patients — Particularly Those on Medicaid — Than Public Hospitals," 3/2/23, NBER DOI 10.3386/w30824

administrative costs on top of targeted profit levels, it cannot achieve financial sustainability without reducing access, quality, or services.¹² Privatization may also be a significant contributor to provider shortages.

We urge both chambers to address the federal cuts crisis by rebalancing where we spend our healthcare dollars, perhaps investing in pilots and demonstration projects that will test increased primary care and increased public sector control of healthcare in NYS. Some may net savings within a year or so and others may present more significant savings further down the road, but programs that focus on prevention and routine care, along with those that remove profits, excess revenues, and needless administration costs, will transform the health trajectories of all New Yorkers. They will also reduce high-cost health crises that have outsized effect on individual well-being, family health, public health, provider well-being and NYS economic productivity. Most important, we need this rebalancing this year to protect institutions we cannot let fail.

Thank you.

¹² ProPublica, "How Often Do Health Insurers Say No to Patients? No One Knows." June 28, 2023, <https://www.propublica.org/article/how-often-do-health-insurers-deny-patients-claims>