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Issue Brief

Shifting Shares

The Costly Challenge of a State Medicaid Takeover

by Bill Hammond

New York shifts more of its Medicaid costs to local government than any other state.[1] The 57 counties and New York City currently fund 12 percent of the overall program, or almost $8 billion a year.[2]

There is little dispute that requiring local governments to shoulder a large share of Medicaid costs—based not on ability to pay, but on historic patterns of need—is outmoded, dysfunctional and unfair. This system puts a disproportionately high burden on localities with poorer residents and weaker tax bases. Even for wealthier counties, Medicaid is one of Albany's most onerous unfunded mandates—a major, ongoing expense over which local officials have no control.

Over the decades, state lawmakers have mitigated the burden by gradually lowering the counties' share of total spending, which was initially 25 percent. They capped the annual growth of local payments in 2006, and froze the payments as of 2015. If not for those steps, local governments would be paying $3.3 billion more per year than they do now.[3]

To date, however, the counties' longstanding plea for full relief from Medicaid costs has been stymied by the price tag: The local share now stands at $7.6 billion, including $5.3 billion from New York City and $2.3 billion from the other 57 counties.[4]

Offsetting the loss of that much revenue would require either an enormous tax hike, deep cuts to health care

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spending or, most plausibly, a concerted, multi-year push to squeeze efficiency from the Medicaid program.

Further complicating the task is the lopsided regional distribution of the burden. New York City accounts for fully two-thirds of the local cost, and poorer upstate areas pay proportionally more than the wealthier downstate suburbs. A comprehensive solution would necessarily skew in the opposite direction, with New York City residents reaping most of the benefit, and downstate suburban taxpayers taking a financial hit.

Table 1. Impact of Local Medicaid Cost by Region

Region	Medicaid Per Capita	Per $1,000 of: Personal Income	Property Value
Long Island	$174	$2.50	$1.04
Capital	$190	$3.63	$2.18
Southern Tier	$192	$4.81	$3.14
North Country	$203	$5.16	$2.79
Mid-Hudson	$205	$2.99	$1.61
Central New York	$214	$4.88	$3.90
Finger Lakes	$215	$4.72	$3.79
Western New York	$233	$5.21	$4.28
Mohawk Valley	$241	$6.12	$3.97
New York City	$630	$9.82	$5.02

Sources: Empire Center calculations using data from the NYS Association of Counties, the Census Bureau, the Bureau of Economic Analysis and the Office of the State Comptroller

In the past two years, county leaders' perennial call to be relieved from Medicaid costs has gained new momentum. State takeover plans have been put forward by members of Congress, state legislators and at least two candidates for governor. However, these proposals either exclude New York City or offer it only partial relief—which would be hard to justify as a matter of fairness—and none fully addresses the question of financing.

This issue brief explores the financial considerations and policy challenges associated with eliminating the local Medicaid share and reviews the major options for implementing a state takeover.

Regardless of how approached, such a takeover would represent a major change in a program affecting the lives and livelihoods of millions of New Yorkers. The cost and complexity of the task should not be underestimated, and all options would require difficult trade-offs.

Background

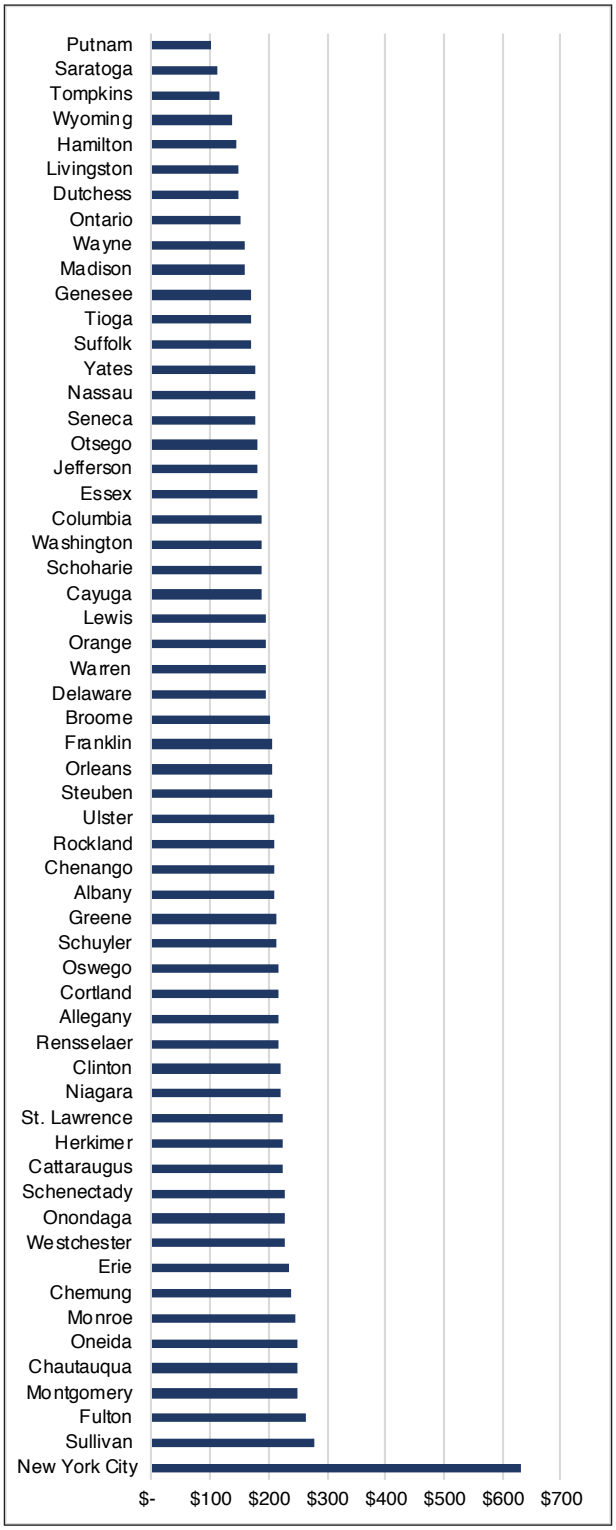
Medicaid is a government-run health plan for the poor and disabled that is managed by states under federal guidelines, and was significantly expanded as part of the Affordable Care Act. New York's version is one of the largest, most generous and costliest Medicaid programs in the country. It currently covers more than 6 million New Yorkers, or about one-third of the population, with a total budget for fiscal year 2019 of $70 billion.

The program is financed with a mix of federal and state-based money, with the federal share varying according to a state's per capita income. In New York, Washington pays a bit more than half of overall costs.

States also have the option of shifting costs to local government, which New York does more than any other. This policy dates back to the program's inauguration in 1966, when it replaced pre-existing health programs that were shared between New York City, the other 57 county governments and the state.[5]

Local governments originally paid half of the non-federal share, or 25 percent of total costs, for medical bills incurred by their low-income or disabled residents. This percentage declined over the years as the state reduced

Figure 1. Local Medicaid Contribution Per Capita



Sources: Empire Center calculations using data from the NYS Association of Counties and the Census Bureau

or limited the local share of certain portions of the program.

Starting in 2006, then-Governor George Pataki successfully pushed the Legislature to cap the growth of counties' Medicaid expenses at 3 percent per year, shifting more costs to Albany. In 2012, in a measure advanced by Governor Cuomo, lawmakers phased the cap down to 0 percent, freezing the local share as of 2015.

The resulting savings have been significant. Had those steps not been taken, the Division of the Budget estimates that local governments would currently be spending an additional $3.3 billion per year. The cost-shift back to the state has increased by $2.3 billion since Cuomo took office in 2011—representing 15 percent of the overall growth of state-funded spending during that time.[6]

The frozen amount now paid by local governments is $7.6 billion, including $5.3 billion from New York City and $2.3 billion from the other 57 counties combined. That amounts to about 12 percent of the total Medicaid budget, a share that gets gradually smaller as overall spending rises.

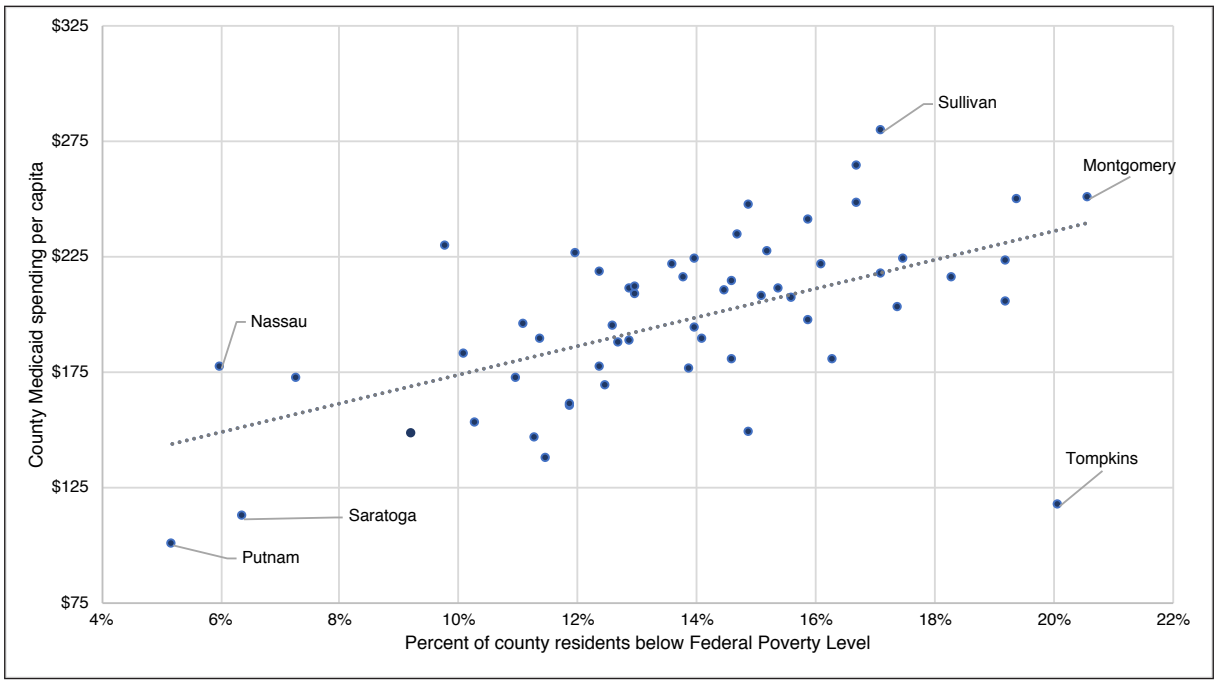
Impact on local finances

Even with the freeze, Medicaid remains one of the largest expenses faced by local governments in New York—and one they have little or no means to control. For 2016, it represented 9 percent of total expenditures for both New York City and, on average, the other 57 counties' governments.[7]

This heavy burden falls unevenly across the state—because the cost for each jurisdiction is based not on ability to pay, but on historic usage of the program by local residents.

Hardest hit by most measures is New York City, largely due to its disproportionately large population of Medicaid recipients. *(See Table 1.)* Its Medicaid costs are the highest in the state, both on a per-capita basis and as a share of

Figure 2. Per Capita Medicaid Costs and Poverty (Excluding New York City)



Sources: Empire Center calculations using data from the NYS Association of Counties and the Census Bureau

personal income, and fifth highest as a share of property value.

The burden on the other 57 counties varies widely. Per capita Medicaid costs range from $100 in Putnam to $279 in Sullivan. The cost per $1,000 of personal income ranges from $1.68 in Putnam to $6.83 in Chautauqua. The cost per $1,000 of property value ranges from 19 cents in thinly populated Hamilton to $5.63 in Montgomery. *(See Figure 1 and Appendix 1.)*

The distribution of Medicaid costs among local governments is generally regressive, in that counties with proportionally higher Medicaid payments also tend to have higher poverty rates and lower median incomes. *(See Figure 2 and Appendix 2.)*

The local share of Medicaid also contributes to the burden of property taxes, which are a principal source of revenue for counties. Outside New York City, Medicaid costs equate to 40 percent of overall county property tax revenues. Among individual counties, the ratio of Medicaid spending to property tax revenue varies widely, ranging from 8 percent in Hamilton to 79 percent in Oneida. *(See Table 2 and Appendix 3.)*

With sales taxes and other revenues factored in, Medicaid accounts for 9 percent of counties' total spending on average, ranging from 3 percent in Hamilton to 16 percent in Fulton.

Of course, property owners outside New York City pay taxes not just to county governments, but also to school districts, cities, towns, villages and fire districts. As a share of total property-tax liability—which is arguably the more relevant comparison—local Medicaid costs average 7 percent outside New York City.

This, too, varies considerably by county and region, as seen in Table 2 and Appendix 3. Regionally, the share of combined property taxes devoted to Medicaid ranges from 4 percent on Long Island to 13 percent for the Mohawk Valley and Western New York. By county, the share ranges from 2 percent for residents

of Hamilton County to 17 percent for residents of Chemung County. *(See Figure 4.)*

For New York City, which is both much larger and differently structured than other counties, Medicaid costs equate to 24 percent of property tax revenues, and 9 percent of overall revenues.

Table 2. Medicaid and County Finances By Region, 2016

	Medicaid Share of:		
Region	County Property Taxes*	County Expenditures*	Combined Municipal & School Property Taxes**
Capital	46%	10%	8%
Central NY	52%	10%	10%
Finger Lakes	45%	9%	10%
Long Island	29%	7%	4%
Mid-Hudson	36%	9%	5%
Mohawk Valley	54%	13%	13%
New York City***	24%	9%	24%
North Country	45%	9%	11%
Southern Tier	43%	9%	10%
Western NY	61%	12%	13%

*Sources: Empire Center calculations using data from the NYS Association of Counties and the Office of the State Comptroller. *Based on county fiscal data for 2016. **Includes all county, city, village, town, school and fire district property taxes. ***New York City encompasses the governmental functions of a county, a city and a school district*

Past proposals

Calls to eliminate the local share of New York Medicaid date back to its earliest years. One of the first came from Governor Nelson Rockefeller in 1967, just one year after lawmakers launched the program at his urging. Also proposing state takeovers during their terms were Governors Hugh Carey and Mario Cuomo.

Those early plans typically called for some version of a tax swap. In 1994, for example, Mario Cuomo called for counties to forfeit a portion of their sales tax revenue—and for New York City to give up part of its income tax revenue—in return for the state taking over the local Medicaid share. This would have been advantageous for counties at the time, because Medicaid costs were rising more rapidly than sales tax revenue.

"In the first couple of years the swap would be nearly even," *The New York Times* wrote in 1994. "But if Medicaid costs continue to explode, the city and counties would eventually come out ahead."[8] However, Mario Cuomo's plan was not taken up by the Legislature.

The debate over a state takeover was rekindled in 2017 with the election of U.S. Rep. John Faso (R-Columbia County), a former Assembly minority leader, who had campaigned on the issue. In March 2017, Faso and Rep. Chris Collins (R-Erie County) cosponsored federal legislation requiring New York to eliminate the local share of Medicaid for counties outside New York City within two years.[9] Faso and Collins later added the same provision as an amendment to several GOP bills aimed at repealing and replacing the Affordable Care Act—one of which came within a single vote of passage in Congress.

In March 2018, the Assembly's minority Republicans unveiled a proposal to eliminate the 57 counties' Medicaid contributions gradually over 10 years, along with half of New York City's contribution over 20 years.[10]

This plan was part of a broader package that called for a mix of spending cuts, spending increases and revenue raisers—the latter including a 50 percent reduction of what are now $420 million a year in state tax credits for film and TV production, which are due to expire in 2022, and the elimination of a $1 billion

property tax relief credit that is due to sunset at the end of 2019. However, the proposed revenue increases and program savings would not fully offset the cost of the Medicaid takeover and other spending increases.[11]

In May 2018, majority Republicans in the state Senate introduced and quickly passed two variations of a takeover. The first called for a five-year phase-out of the local share for counties outside New York City only. The second called for a 10-year phase-out that fully eliminated payments by the 57 counties and partially eliminated New York City's share, limiting the city's savings to $2.3 billion. Neither bill included a plan to replace or offset the lost revenue.[12]

The Senate bills would mandate that local governments dedicate their savings to reducing local taxes, but provide no specifics for how compliance would be defined or enforced.

Although recent proposals have been advanced by Republicans, there is some bipartisan support for the underlying goal. Assemblywoman Crystal Peoples-Stokes (D-Buffalo) is lead sponsor of a bill that would phase out the local share of Medicaid over a five-year period. Originally introduced in 2011, the bill is currently cosponsored by a fellow Democrat, Phil Steck of Albany County, along with Republicans Joseph Giglio of Cattaraugus County and Andrew Goodell of Chautauqua County.[13]

A state takeover of local Medicaid costs has also been advocated by two gubernatorial candidates: Dutchess County Executive Marcus Molinaro, a Republican, and former Syracuse Mayor Stephanie Miner, a Democrat seeking to run as an independent. As of early July, neither had released a detailed plan.

The primary goal of all such proposals is property tax relief. A full state takeover would equate to a 24 percent reduction in property taxes imposed by New York City, and an average 40 percent reduction in county taxes elsewhere in the state. As discussed, however, the potential relief as a share of *total* property taxes outside New York City would average a relatively modest 7 percent—lower in downstate suburbs, higher in upstate counties.

Policy options

As it now stands, the local share of Medicaid is an unfunded mandate that imposes disproportionate costs on poorer jurisdictions while contributing to New York's high local tax rates across the board. It's unlikely that state lawmakers would approve such a system if they were designing the program from scratch.

Worthy as it is, however, the goal of eliminating the local share is expensive and must compete with other priorities. If Albany had an extra $8 billion per year to spend, it's not clear that local tax relief should take precedence over, say, an investment in infrastructure.

Assuming the state does commit to a takeover, it should take care to do so in way that does not create equally problematic tax burdens and inequities somewhere else.

A review of the major policy options follows:

Excluding New York City

One strategy for reducing the cost of a takeover would be to limit is applicability to New York City, which accounts for 70 percent of local spending on Medicaid.

The Assembly minority's plan would eliminate only half of the city's contribution, and do so over twice as long a period as for other counties. One of the two bills passed by the Senate would phase out $2.3 billion of the city's share, which is less than half of its $5.3 billion tab. The second Senate bill would omit the city entirely, as would the Collins-Faso amendment in Washington.

While this would expediently reduce the cost of a takeover, excluding New York City would be hard to justify on policy grounds.

Creating such an exception would arbitrarily limit or deny relief to the group of local taxpayers shouldering by far the heaviest cost. Plus, it would put city residents (and a large number of Connecticut and New Jersey commuters with jobs in the city) in the position of subsidizing relief for others, because they pay a disproportionately large share of the state taxes redistributed from Albany.

The effect would be to make the state's Medicaid financing system more inequitable than it already is.

A more constructive way to limit cost would be to provide partial relief to all jurisdictions based on need. For example, the state could commit to take over the portion of each county's contribution that exceeds a certain share of its residents' incomes, or of the local property value.

Table 3. Regional Impact of Medicaid-for-Sales Tax Swaps, Including and Excluding NYC

	Gain (Loss) from a Swap	
Region	Excluding NYC[1]	Including NYC[2]
Capital	$(17,752,273)	$(212,935,500)
Central NY	$29,139,426	$(91,787,522)
Finger Lakes	$43,994,765	$(144,566,659)
Long Island	$(186,382,794)	$(782,346,619)
Mid-Hudson	$(10,588,915)	$(436,037,222)
Mohawk Valley	$38,221,112	$(19,484,991)
New York City	N/A	$3,934,508,705
North Country	$15,791,922	$(45,016,300)
Southern Tier	$19,045,886	$(82,040,852)
Western NY	$68,530,870	$(153,038,687)

[1] 1.2% of taxable sales [2] 2.2% of taxable sales

Sources: Empire Center calculations using data from the NYS Assn. of Counties and the NYS Dept. of Taxation and Finance

Under any such scenario, however, New York City would likely receive the bulk of the benefit.

Swapping for a share of sales tax

One takeover approach that has been floated repeatedly in the past—by Mario Cuomo and others—would take the form of a sales tax "swap": The state would assume responsibility for the counties' share of Medicaid costs in return for counties giving up a portion of their revenue from sales taxes.

This has the potential advantage of spreading costs less regressively—at least among counties outside New York City.

Table 3 and Appendix 4 show the effects of two tax swap scenarios.

The first assumes that New York City would be excluded. To offset the Medicaid payments of the other 57 counties, the state would need to divert 1.2 percentage points of the counties' taxable sales. Counties with relatively more Medicaid recipients and less retail business—mostly upstate—would generally save money, at least in the short term. The mid-Hudson suburbs and Long Island, with relatively few Medicaid recipients and stronger retail economies, would pay more.

Under the second scenario, which includes New York City, the share of sales tax necessary to finance the swap would rise to 2.2 percentage points. The city would reap the vast majority of savings and most other counties would experience a net loss.

A swap made more sense years ago, when counties' Medicaid costs were typically growing faster than sales tax revenue—meaning the trade almost certainly would have saved money for all counties in the long run.

Now that the local share is frozen, however, the dynamic has reversed. Sales taxes generally rise and local Medicaid costs are fixed, meaning a swap would eventually leave all counties worse off than before.

Table 4. Using Personal Income Tax to Replace County Medicaid Payments (In Millions)

Region	Current Medicaid Payment	Share of $7.6B Increase in PIT	Savings (Loss)
NYS Residents	$7,634	$6,377	$1,257
Nonresidents	$0	$1,257	($1,257)
New York City	$5,378	$3,168	$2,210
Capital	$206	$223	($17)
Central NY	$168	$127	$40
Finger Lakes	$260	$209	$51
Long Island	$497	$1,194	($697)
Mid-Hudson	$477	$1,025	($548)
Mohawk Valley	$104	$50	$54
North Country	$86	$42	$43
Southern Tier	$135	$97	$38
Western NY	$323	$227	$96

Sources: Empire Center calculations using data from the NYS Assn. of Counties and the NYS Dept. of Taxation and Finance

Increasing state taxes

Even in the context of a $170 billion all-funds state budget, finding another $7.6 billion in revenue would be no small matter.

The cost of a full takeover would equate to a 15 percent hike in the state's personal income tax, which is projected to bring in $50 billion in fiscal year 2019.[14]

The state's total tax collections—including levies on personal income, business income, retail sales, cigarettes and gasoline—are projected to be $78 billion.[15] The cost of a takeover equates to an across-the-board increase in all of those taxes of almost 10 percent.

The revenue needed to finance a takeover would be much more than the amount to be raised by other state tax hikes currently on the table. The Assembly Democrats' proposed hike on New Yorkers with incomes of $5 million or more—earmarked for spending on schools and health care—would raise $5.6 billion, or three-quarters of the amount necessary for a takeover.[16] Mayor Bill de Blasio's proposed tax on the wealthy, intended to finance repairs to the subway system, would raise $1 billion or less.[17]

Financing a takeover through the state income tax would shift the tax burden rather than reducing it. Poorer parts of the state would generally pay less, while richer areas would pay more. (*See Table 4 and Appendix 5.*) One group that clearly stands to lose is out-of-state commuters, who would go from contributing nothing toward Medicaid's local share as of now, to carrying 17 percent of the cost post-takeover.

Assuming the increase is weighted toward higher income groups—as such proposals usually are—this approach would further increase the state's heavy reliance on revenue from high earners, and from the financial sector in particular. This would heighten the state's fiscal vulnerability to volatility on Wall Street and the broader economy.

Any move in this direction would also aggravate New York's status as a high-tax state. The enactment of federal tax changes last year—which capped the deductibility of state and local tax payments—effectively increased the marginal cost of residing in New York compared to states with lower taxes. The net combined state-and-city income tax rate on New York City's highest earners has jumped to almost 13 percent, its highest level ever, and second only to California among the 50 states.

In this context, any significant income tax hike would further damage New York's economic competitiveness and undermine the benefit of tax relief at the local level.

Especially counterproductive would be any increase in taxes on health care itself. The state already raises $4.5 billion per year from taxes on health insurance.[18] A takeover that excludes

New York City would entail a 51 percent increase in these surcharges, which are already among the largest levied by any state. A statewide takeover would require an increase of 169 percent.

This approach would further drive up the cost of health insurance for New Yorkers, who already pay some of the highest premiums in the U.S. This would cause more people lose or drop coverage and ultimately drive up Medicaid enrollment and costs.

Cutting state spending

While there is certainly waste in the state budget, financing a Medicaid takeover through spending reductions would require much more than belt-tightening.

The price tag for a takeover, at $7.6 billion, equates to 8 percent of all spending funded by state taxes. It's more than the entire budgets for major functions such as parks and the environment ($1.6 billion), economic development ($2.1 billion), mental health ($2.9 billion), prisons ($3 billion), the state-funded portions of transportation ($5 billion) and the State University of New York ($7.2 billion).[19]

Realistically, a cost-cutting effort on this scale would have to consider the two largest items in the state budget: school aid and Medicaid itself.

A takeover could hypothetically be funded by a 29 percent cut in school aid. But that would likely backfire if local districts responded by raising their property taxes, which are much costlier for most homeowners than county taxes.

The most logical place to look for cuts would be Medicaid, both because it is the original source of the counties' expense, and because New York's program is so expensive. Its per capita cost in 2015 was $3,054, the highest of any state and 76 percent above the national average.[20]

Finding sufficient savings from the program would be complicated by the federal aid formula, which matches state and local spending on a roughly dollar-for-dollar basis. As a result, the state would have to cut overall Medicaid spending by $15 billion—or 22 percent—to achieve net savings of $7.6 billion for itself.

Even after a 22 percent cut, however, New York would still rank among the top 10 states in terms of per capita Medicaid spending.

Cutting the Medicaid budget

The least painful way to cut Medicaid spending would be rooting out waste, fraud and abuse—which certainly remains a significant factor in New York's program. To cite one example, a recent audit by the office of state Comptroller Thomas DiNapoli found that the Health Department spent $1.3 billion over six years on Medicaid managed care premiums for recipients who already had other health insurance.[21]

Another desirable approach would be improving the efficiency of care delivery—for example, by encouraging patients to use clinics and urgent-care centers instead of emergency rooms for non-emergency issues, or better managing chronic illnesses such as diabetes and asthma to avoid hospitalizations. If successful, these steps would have the added benefit of improving outcomes for recipients.

However, the state already devotes considerable resources to eliminating waste through the comptroller's office, the Health Department, the Office of the Medicaid Inspector General and various law enforcement agencies.

The state is also currently improving efficiency by enrolling most recipients in managed care plans and increasing coordination among providers through the Delivery System Reform Incentive Payment program.

Given those existing efforts, it's unlikely that additional anti-fraud and efficiency efforts, by

themselves, would generate $15 billion in savings in the short term.

To quickly lower spending by 22 percent, the state would have to consider more politically difficult steps, such as cutting fees to providers, trimming benefits for recipients or reducing enrollment. Each of those steps comes with drawbacks.

Medicaid fees are generally lower than those paid by Medicare and commercial insurance, and many providers report losing money when they treat Medicaid recipients. Among other consequences, this discourages doctors from participating in the program and strains the finances of hospitals who serve the needy, potentially compromising the quality of care for all patients. A further significant reduction in fees would aggravate all of these problems.

Another cost-cutting option would be trimming the benefits that Medicaid provides, some of which are optional under federal law. Theoretically, for example, New York could end Medicaid coverage for adult dental care, eyeglasses, hospice care, prosthetics or even prescription drugs.[22]

Such steps would affect the range of Medicaid recipients, from low-income able-bodied adults to severely disabled children and frail residents of nursing homes. Many would have no other way of paying for the services, and their health and quality of life might be compromised as a result.

Eliminating even major benefits would not necessarily generate sufficient savings. For example, Medicaid's total prescription drug spending for 2016 was $3.3 billion, less than a quarter of the amount necessary to finance a takeover.[23]

A third approach to cutting Medicaid costs would be reducing enrollment. New York's unusually expansive program covers 6.1 million people, or a third of the population, which as of 2015 was the second-highest share of any state after New Mexico.[24]

The state could potentially trim the rolls by, for example, restricting eligibility for the "medically needy," who live above the poverty line but have medical or nursing-home bills that exceed their income.

This would come at the cost of allowing more New Yorkers—especially the elderly, disabled and seriously ill—to be impoverished by medical expenses. It would also be difficult politically: For 28 years in a row, governors of both parties have proposed ending "spousal refusal"—a legal strategy that allows long-term care patients to qualify for Medicaid while protecting the income and assets of their spouses—and they were turned down by the Legislature every time.[25]

Strengthening the Medicaid 'global cap'

The challenge of eliminating counties' Medicaid costs becomes more manageable if the change can be phased in over a period of 10 to 20 years. This opens the door to an existing cost-cutting strategy with a record of success: the "global cap" on Medicaid spending growth.

If the existing cap were broadened and strengthened, it could potentially generate enough savings to finance a gradual takeover.

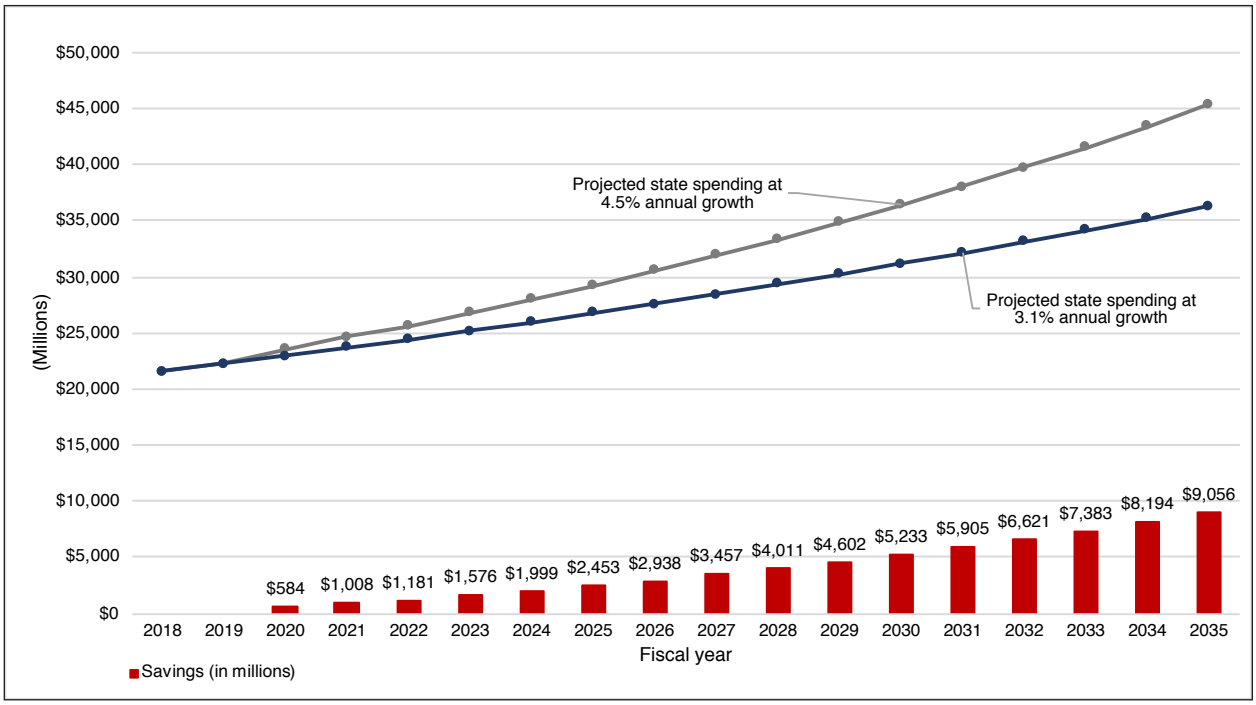
The current cap was enacted in 2011 as part of Governor Andrew Cuomo's first budget. It limited year-to-year growth of state Medicaid spending to the 10-year rolling average of the medical inflation rate.[26]

To find the necessary savings, the governor empaneled a Medicaid Redesign Team representing various stakeholders in the health-care system. If the team's efforts fell short, the health commissioner was empowered to cut Medicaid fees as necessary to meet the cap.

This system largely worked as intended, especially in its early years.

Under Medicaid director Jason Helgerson, the Redesign Team advanced dozens of reform

Figure 3. Potential Savings from Tightened 'Global Cap' on Medicaid Spending



Source: 2018-2022 Medicaid spending figures from the NYS Division of the Budget

ideas intended not just to save money, but also to improve care and broaden access. Perhaps most importantly, the state enrolled a far greater share of Medicaid recipients into managed care plans, including groups that had previously been exempt, such as the mentally ill and nursing home residents.

Meanwhile, state Medicaid outlays stayed at or below the global cap, even as enrollment surged with enactment of the Affordable Care Act. Per-recipient spending dropped significantly—from $12,000 in 2011 to $9,700 in 2015—and measures of care quality generally held steady or improved.[27]

Over time, however, weaknesses in the global cap became apparent. It restrained spending on the bulk of the program, known as Department of Health (DOH) Medicaid, but did not cover services provided through the Office of Mental Health, the Office for People with Developmental Disabilities or the Office of Alcoholism and Substance Abuse Services. Certain expenses were also exempted, such as labor costs associated with a Cuomo-sponsored hike in the minimum wage.

As of 2017, the cap governed 97 percent of DOH Medicaid. That dropped to 93 percent for 2019, and is projected to fall to 88 percent by 2022.[28]

Meanwhile, enrollment leveled off, rendering the cap significantly less restrictive. Per-recipient spending climbed back to more than $11,000.

The result of these trends is that overall state spending on Medicaid is growing substantially faster than the medical inflation rate. The state's latest financial plan shows increases of 4.2 percent in the current fiscal year, 6.3 percent for 2020, 5.4 percent for 2021 and 4.2 percent for 2022—whereas medical inflation is projected to continue at about 3.1 percent.[29]

If the growth rate could be lowered by 1.4 points—the difference between medical inflation and the current trend—the annual savings would be substantial. As shown in Figure 3, they would reach $1.2 billion by fiscal year 2022, and $8.2 billion—enough to eliminate the local share—by 2034.

To achieve those savings, the global cap could be strengthened in two ways:

First, it could be expanded to cover all Medicaid spending, including the portions managed by OMH, OPWDD and OASAS and minimum wage-related costs for all providers.

Second, the global cap should be supplemented with a per-recipient cap, to protect against excessive spending growth when enrollment is flat or declining.

State officials would still face the hard work of removing waste and improving efficiency and, possibly, the hard choices to cut fees, benefits or enrollment. But they could do so gradually and carefully, without sudden or severe changes.

Local tax relief

If the goal of a state takeover is property tax relief—as opposed to giving local officials more money to spend—the state will need to set guidelines for how the savings are used.

A readily available mechanism is the state's property tax cap.* Enacted in 2011, this law limits the year-to-year growth of each jurisdiction's property tax collections to 2 percent or the inflation rate, whichever is less. The cap applies to the total amount to be raised by property taxes, known as the "levy," with certain limited exceptions.

The cap can be overridden only with approval by a 60 percent majority of the decision-making body—which, for counties, would be a legislature or board of supervisors. The law does not currently apply to New York City.

In enacting a takeover plan, the state could require that the annual savings accruing to each county be subtracted from its current levy before calculating the capped amount for the next year.

Take, for example, a hypothetical county with a property tax levy of $100 million and Medicaid takeover savings of $5 million. As things stand now, it would be allowed to increase the levy by as much $2 million, to raise a total of $102 million in the following year—plus spend the $5 million as it wished.

Under a modified cap, the county's current levy would be reduced by the $5 million in savings, to $95 million. The county would then be allowed to increase taxes by no more than 2 percent of that reduced base, or $1.9 million, for total collections of $96.9 million in the ensuing year. Instead of increasing by $2 million, tax collections would decrease by $3.1 million.

Under this plan, a county would have the flexibility to override the cap, but only with 60 percent approval by its legislature in a separate vote preceded by a public hearing. This would put the public on notice of the decision and encourage local officials to prioritize tax relief.

The tax cap, as modified, could be expanded to include New York City—requiring the City Council to clear at least one additional hurdle before adding to the city's already enormous tax burden.

Using the savings to reduce the city's income tax—as contemplated in one of the Senate GOP proposals—would be more complicated. While property tax rates are controlled by the City Council, changing city income tax rates would require further action by the state Legislature.

Conclusion

The local share of Medicaid has evolved into something that's hard to defend, but also hard to unwind. Eliminating it entails either the reallocation of almost $8 billion in state resources, or $15 billion in cuts to a program that pays medical bills for one in three New Yorkers and serves as a financial mainstay of the state's entire health care system.

Because the current system distributes costs so

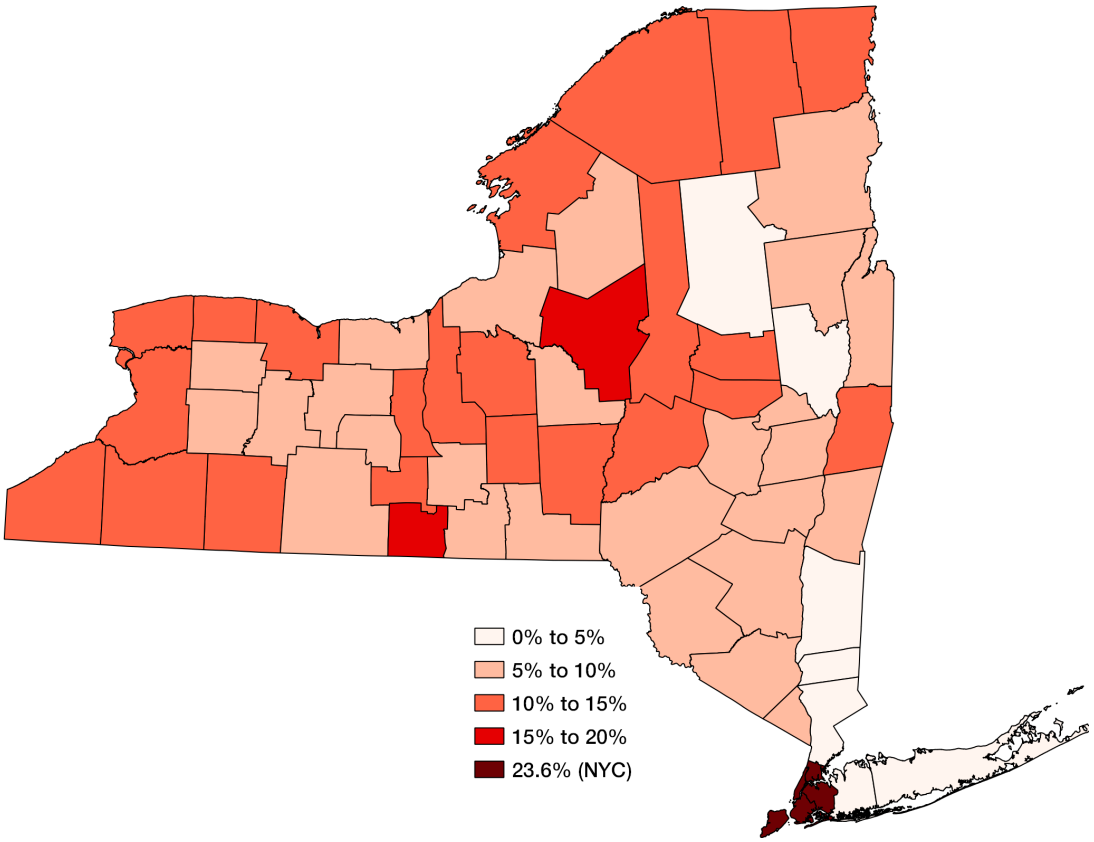
* This mechanism was suggested to the author by Charles Brecher of the Citizens Budget Commission.

unevenly, any solution must therefore distribute relief unevenly. Including New York City more than triples the cost, from $2.3 billion to $7.6 billion, but excluding it would be manifestly unfair and politically impractical.

The most plausible approach is to slowly phase out the local share over a period of 10 years or more, and make up for the lost revenue with savings squeezed from the Medicaid program itself—which, despite efficiency improvements, remains much costlier than national norms. The state effectively began that process more than a decade ago, when it capped and then froze local payments, causing them to gradually shrink in real terms due to the effects of inflation.

Committing to full elimination, however, would be a major escalation, both in dollars and in difficulty. Leaders committing to this path must be prepared to grapple with tough choices for years to come.

Figure 4.
Medicaid Local Share as a Percentage of Combined Local Property Tax Levies, 2016



Sources: Empire Center calculations using data from the NYS Association of Counties and the Office of the State Comptroller. Combined levies include county, city, village, town, school and fire district property taxes.

Measured as a percentage of combined county, municipal and school property taxes, the local share of Medicaid costs adds the most to property tax burdens in upstate counties with large low-income populations, the more darkly shaded areas above. Medicaid has the least impact on total property taxes in affluent suburban counties on Long Island and in the Hudson Valley, which are lightly shaded. Two outliers at opposite extremes: New York City, whose Medicaid share equates to nearly one-quarter of property taxes, and Hamilton County in the North Country, which has a tiny year-round population and low Medicaid property tax impact. See Appendix Table 3 for detailed county percentages.

Appendix 1. Local Medicaid Payments by County

	Local Medicaid Payment	Per Capita	Per $1,000 of Personal Income	Per $1,000 of Property Value
New York State	$7,633,673,109	$387	$6.49	$3.43
New York City	$5,378,022,327	$630[a]	$9.82[a]	$5.02
Albany	$65,153,487	$211	$3.70	$2.73
Allegany	$10,236,935	$217	$6.39	$5.18
Broome	$39,624,111	$203	$5.05	$4.07
Cattaraugus	$17,371,071	$224	$5.96	$4.21
Cayuga	$14,734,435	$189	$4.90	$3.20
Chautauqua	$32,343,192	$250	$6.83[b]	$4.64
Chemung	$20,748,386	$240	$6.02	$4.90
Chenango	$10,218,715	$210	$5.48	$4.30
Clinton	$17,937,879	$221	$5.40	$3.76
Columbia	$11,419,246	$187	$3.68	$1.58
Cortland	$10,355,510	$215	$5.72	$4.51
Delaware	$8,945,565	$197	$5.40	$1.56
Dutchess	$43,750,481	$149	$2.96	$1.49
Erie	$215,758,575	$234	$4.93	$4.15
Essex	$6,937,297	$182	$4.41	$1.03
Franklin	$10,323,790	$205	$5.61	$2.87
Fulton	$14,194,376	$264	$6.73	$4.39
Genesee	$9,880,283	$169	$4.21	$3.58
Greene	$10,062,792	$212	$5.01	$1.82
Hamilton	$663,757	$146	$2.78	$0.19[3]
Herkimer	$13,978,850	$223	$5.94	$3.00
Jefferson	$20,563,032	$180	$4.13	$2.60
Lewis	$5,203,749	$194	$4.82	$2.56
Livingston	$9,539,179	$148	$3.88	$2.80
Madison	$11,475,963	$161	$4.01	$2.87
Monroe	$184,837,175	$247	$5.13	$4.53
Montgomery	$12,307,071	$250	$6.43	$5.61[a]
Nassau	$240,813,962	$177	$2.23	$1.13
Niagara	$46,872,407	$221	$5.28	$4.55
Oneida	$57,338,984	$248	$6.16	$5.44
Onondaga	$105,614,117	$227	$4.73	$4.02
Ontario	$16,736,310	$152	$3.08	$1.95
Orange	$73,757,613	$195	$4.11	$2.45
Orleans	$8,542,627	$207	$5.90	$5.17
Oswego	$25,614,052	$215	$5.84	$4.41
Otsego	$10,811,129	$180	$4.65	$2.48
Putnam	$9,905,951	$100[c]	$1.68[3]	$0.75
Rensselaer	$34,834,303	$218	$4.81	$3.43
Rockland	$68,516,660	$210	$3.78	$1.95
Saratoga	$25,396,222	$112	$1.80	$1.09
Schenectady	$34,978,252	$226	$4.82	$3.77
Schoharie	$5,903,803	$189	$5.13	$2.62
Schuyler	$3,865,285	$214	$5.36	$2.86
Seneca	$6,152,710	$177	$5.06	$3.06
St. Lawrence	$24,548,788	$223	$6.49	$4.37
Steuben	$20,077,343	$207	$5.12	$3.54
Suffolk	$256,134,440	$172	$2.82	$0.96
Sullivan	$20,897,591	$279[b]	$6.57	$2.79
Tioga	$8,363,335	$172	$4.21	$3.26
Tompkins	$12,297,913	$117	$2.88	$1.77
Ulster	$37,366,146	$208	$4.63	$2.12
Warren	$12,591,527	$195	$4.03	$1.19
Washington	$11,608,683	$188	$5.12	$2.47
Wayne	$14,534,805	$160	$3.84	$3.03
Westchester	$223,035,011	$229	$2.43	$1.37
Wyoming	$5,584,596	$137	$3.66	$2.57
Yates	$4,391,315	$176	$4.91	$1.84

Sources: Empire Center calculations using data from the NYS Association of Counties, the Census Bureau, the Bureau of Economic Analysis and the Office of the State Comptroller. [a]Highest, [b]Highest outside NYC, [c]Lowest

Appendix 2. Poverty Rate and Median Income By County

	Medicaid Per Capita	Poverty Rate	Median Household Income
New York State	$387	15.5%	$60,741
New York City	$630[a]	20.3%	$55,191
Albany	$211	12.9%	$60,904
Allegany	$217	17.1%	$44,085
Broome	$203	17.4%	$47,744
Cattaraugus	$224	17.5%	$43,884
Cayuga	$189	11.4%	$53,114
Chautauqua	$250	19.4%	$43,211[c]
Chemung	$240	15.9%	$49,578
Chenango	$210	15.4%	$46,979
Clinton	$221	16.1%	$50,502
Columbia	$187	12.7%	$59,916
Cortland	$215	13.8%	$50,910
Delaware	$197	15.9%	$46,055
Dutchess	$149	9.2%	$72,706
Erie	$234	14.7%	$52,744
Essex	$182	10.1%	$53,244
Franklin	$205	19.2%	$49,782
Fulton	$264	16.7%	$46,090
Genesee	$169	12.5%	$52,641
Greene	$212	13.0%	$51,013
Hamilton	$146	11.3%	$52,708
Herkimer	$223	14.0%	$48,893
Jefferson	$180	14.6%	$49,911
Lewis	$194	14.0%	$49,976
Livingston	$148	14.9%	$52,724
Madison	$161	11.9%	$55,858
Monroe	$247	14.9%	$53,568
Montgomery	$250	20.6%[a]	$44,455
Nassau	$177	6.0%	$102,044[a]
Niagara	$221	13.6%	$50,094
Oneida	$248	16.7%	$49,838
Onondaga	$227	15.2%	$55,717
Ontario	$152	10.3%	$58,070
Orange	$195	12.6%	$71,910
Orleans	$207	15.6%	$48,731
Oswego	$215	18.3%	$49,571
Otsego	$180	16.3%	$49,689
Putnam	$100[c]	5.2%[b]	$97,606
Rensselaer	$218	12.4%	$61,754
Rockland	$210	14.5%	$86,134
Saratoga	$112	6.4%	$74,080
Schenectady	$226	12.0%	$59,959
Schoharie	$189	14.1%	$50,607
Schuyler	$214	14.6%	$47,229
Seneca	$177	12.4%	$50,073
St. Lawrence	$223	19.2%	$46,313
Steuben	$207	15.1%	$48,823
Suffolk	$172	7.3%	$90,128
Sullivan	$279[b]	17.1%	$52,027
Tioga	$172	11.0%	$58,115
Tompkins	$117	20.1%	$54,133
Ulster	$208	13.0%	$60,393
Warren	$195	11.1%	$57,174
Washington	$188	12.9%	$51,449
Wayne	$160	11.9%	$51,627
Westchester	$229	9.8%	$86,226
Wyoming	$137	11.5%	$53,612
Yates	$176	13.9%	$50,105

Source: 2016 poverty rates and median household income, Census Bureau.
[a]Highest, [b]Highest outside NYC, [c]Lowest

Appendix 3. Medicaid and County Finances

	Medicaid Share of:		
	County Property Taxes*	County Expenditures*	Combined Property Taxes**
New York State	27%	9%	14%
New York City***	24%	9%	24%[a]
Albany	67%	11%	8%
Allegany	32%	11%	12%
Broome	52%	7%	10%
Cattaraugus	32%	8%	11%
Cayuga	36%	10%	11%
Chautauqua	51%	12%	13%
Chemung	58%	10%	17%[b]
Chenango	37%	11%	11%
Clinton	73%	10%	11%
Columbia	27%	7%	7%
Cortland	30%	9%	11%
Delaware	27%	10%	7%
Dutchess	37%	9%	5%
Erie	76%	13%	13%
Essex	30%	7%	6%
Franklin	57%	10%	12%
Fulton	49%	16%[a]	14%
Genesee	35%	6%	9%
Greene	37%	10%	7%
Hamilton	8%[c]	3%[c]	2%[c]
Herkimer	48%	15%	13%
Jefferson	35%	10%	13%
Lewis	29%	4%	9%
Livingston	32%	6%	8%
Madison	31%	10%	8%
Monroe	51%	10%	11%
Montgomery	40%	11%	13%
Nassau	24%	7%	4%
Niagara	52%	12%	12%
Oneida	79%[a]	13%	15%
Onondaga	71%	9%	11%
Ontario	30%	8%	7%
Orange	55%	9%	7%
Orleans	49%	12%	13%
Oswego	41%	13%	9%
Otsego	78%	11%	10%
Putnam	22%	6%	2%
Rensselaer	51%	10%	10%
Rockland	40%	10%	6%
Saratoga	43%	9%	5%
Schenectady	46%	11%	10%
Schoharie	25%	8%	7%
Schuyler	32%	9%	12%
Seneca	61%	9%	10%
St. Lawrence	50%	13%	14%
Steuben	43%	11%	10%
Suffolk	38%	8%	4%
Sullivan	32%	9%	8%
Tioga	32%	11%	9%
Tompkins	27%	7%	5%
Ulster	46%	11%	6%
Warren	29%	8%	7%
Washington	34%	11%	10%
Wayne	34%	8%	8%
Westchester	32%	8%	5%
Wyoming	28%	4%	9%
Yates	26%	10%	9%

*Sources: Empire Center calculations using data from the NYS Assn. of Counties and the Office of the State Comptroller. *Based on 2016 county fiscal data, **Includes all county, city, village, town, school and fire district property taxes, ***New York City encompasses the governmental functions of a county, a city and a school district, [a]Highest, [b]Highest outside NYC, [c]Lowest*

Appendix 4. Impact of Medicaid-for-Sales Tax Swaps Including and Excluding New York City

	Gain (Loss) from Swap	
	Excluding NYC*	Including NYC**
New York City	N/A	$1,967,254,353
Albany	$(10,113,927)	$(75,758,020)
Allegany	$5,246,030	$893,238
Broome	$4,301,078	$(26,505,725)
Cattaraugus	$5,590,822	$(4,683,262)
Cayuga	$1,955,514	$(9,189,556)
Chautauqua	$14,803,581	$(493,502)
Chemung	$4,774,651	$(9,156,760)
Chenango	$3,757,662	$(1,877,313)
Clinton	$3,389,144	$(9,299,461)
Columbia	$702,906	$(8,643,295)
Cortland	$2,268,468	$(4,784,604)
Delaware	$2,662,828	$(2,816,629)
Dutchess	$(11,435,087)	$(59,564,900)
Erie	$33,159,781	$(126,092,828)
Essex	$(1,147,051)	$(8,197,773)
Franklin	$3,933,560	$(1,639,646)
Fulton	$6,326,277	$(535,846)
Genesee	$(875,034)	$(10,255,229)
Greene	$1,305,354	$(6,332,401)
Hamilton	$(349,817)	$(1,233,800)
Herkimer	$5,910,092	$(1,127,035)
Jefferson	$(944,062)	$(19,701,365)
Lewis	$1,792,278	$(1,183,018)
Livingston	$569,116	$(7,254,078)
Madison	$2,647,071	$(5,053,003)
Monroe	$46,635,785	$(73,895,855)
Montgomery	$4,127,792	$(3,005,725)
Nassau	$(67,813,661)	$(336,981,672)
Niagara	$9,730,656	$(22,662,334)
Oneida	$20,551,168	$(11,533,139)
Onondaga	$8,547,584	$(76,108,498)
Ontario	$(9,778,439)	$(32,903,142)
Orange	$(8,954,202)	$(81,090,890)
Orleans	$4,084,409	$196,197
Oswego	$13,720,789	$3,348,140
Otsego	$302,234	$(8,863,045)
Putnam	$(6,363,852)	$(20,553,478)
Rensselaer	$11,597,588	$(8,668,194)
Rockland	$10,253,875	$(40,559,716)
Saratoga	$(24,289,488)	$(67,622,626)
Schenectady	$7,051,598	$(17,304,492)
Schoharie	$1,655,601	$(2,049,447)
Schuyler	$924,028	$(1,641,174)
Seneca	$(757,831)	$(6,784,824)
St. Lawrence	$8,768,051	$(4,995,038)
Steuben	$4,868,968	$(8,394,938)
Suffolk	$(118,569,133)	$(445,364,948)
Sullivan	$9,801,303	$123,732
Tioga	$2,724,796	$(2,192,828)
Tompkins	$(5,270,360)	$(20,592,441)
Ulster	$5,118,216	$(23,006,653)
Warren	$(8,360,036)	$(26,632,836)
Washington	$4,353,732	$(1,973,637)
Wayne	$2,530,593	$(7,938,820)
Westchester	$(9,009,168)	$(211,385,317)
Wyoming	$489,533	$(3,954,100)
Yates	$1,096,632	$(1,776,808)

Sources: Empire Center calculations using data from the NYS Association of Counties and the NYS Department of Taxation and Finance. Based on taxable sales for SFY 2014.
**1.2% of taxable sales, **2.2% of taxable sales.*

Appendix 5. Using Personal Income Tax to Replace County Medicaid Payments (In Millions)

	Current Local Medicaid Share	Share of $7.6B PIT Increase	Savings (Loss)
NYS Residents	$7,634	$6,377	$1,257
Nonresidents	-	$1,257	$(1,257)
New York City	$5,378	$3,168	$2,210
Albany	$2,256	$3,195	$(940)
Allegany	$65	$70	$(4)
Broome	$10	$5	$6
Cattaraugus	$40	$29	$11
Cayuga	$17	$8	$10
Chautauqua	$15	$10	$5
Chemung	$32	$13	$20
Chenango	$21	$12	$9
Clinton	$10	$5	$5
Columbia	$18	$10	$8
Cortland	$11	$13	$(2)
Delaware	$10	$5	$5
Dutchess	$9	$5	$4
Erie	$44	$70	$(26)
Essex	$216	$172	$43
Franklin	$7	$5	$2
Fulton	$10	$5	$6
Genesee	$14	$6	$8
Greene	$10	$8	$2
Hamilton	$10	$7	$3
Herkimer	$1	$1	$0
Jefferson	$14	$6	$8
Lewis	$21	$10	$10
Livingston	$5	$3	$3
Madison	$10	$8	$1
Monroe	$11	$10	$1
Montgomery	$185	$145	$39
Nassau	$12	$5	$7
Niagara	$241	$679	$(439)
Oneida	$47	$30	$17
Onondaga	$57	$29	$29
Ontario	$106	$88	$17
Orange	$17	$22	$(5)
Orleans	$74	$71	$3
Oswego	$9	$4	$5
Otsego	$26	$14	$12
Putnam	$11	$8	$3
Rensselaer	$10	$33	$(23)
Rockland	$35	$27	$8
Saratoga	$69	$83	$(14)
Schenectady	$25	$10	$14
Schoharie	$25	$59	$(34)
Schuyler	$35	$28	$7
Seneca	$6	$4	$2
St. Lawrence	$4	$2	$2
Steuben	$6	$4	$2
Suffolk	$20	$13	$7
Sullivan	$256	$514	$(258)
Tioga	$21	$9	$12
Tompkins	$8	$6	$2
Ulster	$12	$18	$(6)
Warren	$37	$32	$5
Washington	$13	$12	$0
Wayne	$12	$6	$5
Westchester	$15	$12	$3
Wyoming	$223	$728	$(505)
Yates	$6	$5	$1

Sources: Empire Center calculations using data from the NYS Association of Counties and the NYS Department of Taxation and Finance. Based on income tax collections for SFY 2014.

ENDNOTES

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