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Let me start by giving credit where credit is due: Thanks to better management here in Albany, New York's Medicaid program has become measurably more efficient over the past six years.

The Budget Division reports that spending per recipient fell by more than \$1,000 between 2011 and 2016, a drop of 11 percent. As recently as 2007, New York's per-recipient Medicaid spending was the highest of any state. Now, by my own estimate, it ranks about 10th.

This progress was the result, in large part, of constructive actions taken by the Legislature and the Cuomo administration. Among those steps were switching to two-year budgets, ending automatic yearly hikes in provider fees, establishing the Medicaid Redesign Team, granting the health commissioner additional authority to limit spending, and expanding enrollment of recipients in managed care plans.

These and other reforms helped make it possible to add about 1 million enrollees – a 40 percent increase – while holding state spending on the program close to flat when adjusted for medical inflation. This was a welcome change from the program's historic pattern of unsustainable growth.

However, the job of streamlining New York's Medicaid program is far from finished. Not when spending per recipient remains much higher than the national average. Not when President Trump and Congress are contemplating changes that would limit or reduce federal funding.

If anything, the state needs to double down on rooting out waste and dysfunction.

Which brings me to the Health Care Reform Act.

The major parts of this 20-year-old law – which is riddled with waste and dysfunction – are due to expire this year. Although the governor did not highlight the issue in his budget presentation, he is proposing to extend HCRA through 2020 with virtually no changes. That would be a mistake.

HCRA started out as real reform. It ended the state's heavy-handed system of price controls for hospitals, in hopes that exposure to market pressure would help tame rising costs – which did, in fact, happen.

To smooth the transition, the law continued subsidizing hospitals for providing two so-called public goods: free care for the poor and uninsured and training for young physicians. To finance those programs, HCRA imposed a pair of taxes on health insurance – a surcharge on

patient services delivered by hospitals and clinics, and per-member fee known as the covered lives assessment.

Some of you will also remember the HCRA expansions of 2000 and 2002, which raised cigarette taxes, reaped billions in proceeds from tobacco lawsuits and insurer conversions, and launched or expanded programs like Child Health Plus, Family Health Plus, Health New York and EPIC.

But the law as it existed back then is no more. HCRA has morphed from a vehicle for positive change into a revenue generator for the status quo.

Fourteen times over the past two decades, the state either increased the original HCRA taxes or added new ones. Their combined annual revenue has tripled – so that HCRA now ranks as the state’s third-largest tax, behind income and sales taxes.

In fact, a straight extension of the insurance surcharges alone would bring in \$13.3 billion over the next three years – which is \$700 million more than the millionaire’s tax.

As a major source of revenue, the HCRA surcharges are problematic for at least four reasons.

First, they fail to adjust for ability to pay. They equally affect all New Yorkers with private health insurance, whether they stock shelves at Walmart or trade stocks on Wall Street.

Second, one of the surcharges, the covered lives assessment, varies dramatically – and unfairly – by ZIP code, ranging from \$9 per individual in Utica to \$185 in New York City, a difference of 2,000 percent. This is a throwback to when HCRA subsidized teaching hospitals, a program that ended in 2009.

Third, they’re hidden from public view. Few consumers have any idea that HCRA exists, let alone how much it adds to their premiums.

Fourth, the surcharges undermine the goal of making coverage more affordable. They add approximately 6 percent to a typical premium in the New York City market, or about \$1,000 a year for a family of four – which is one reason why the state’s premiums are the second-costliest in the country.

The spending side of HCRA has drifted in undesirable ways, too.

Most of the law’s big-ticket, marquee programs, such as Family Health Plus, Healthy New York and EPIC, became largely redundant with the advent of the Affordable Care Act and Medicare Part D, and have been eliminated or scaled back.

What HCRA does now, mainly, is balance the state budget. Fully two-thirds of HCRA revenues, about \$3.5 billion a year, flow into Medicaid. HCRA accounts for about one-fifth of the state contribution for the program – in effect, freeing up General Fund money for other programs.

Much of the remaining third goes toward questionable purposes. One such program subsidizes malpractice insurance for doctors, which may buy political peace but makes little sense from a

policy point of view. Whether you blame high premiums on doctors, lawyers or insurance companies, shifting the burden to taxpayers only enables the dysfunction.

Another seriously flawed program is the Indigent Care Pool, which, at about \$1 billion a year, is HCRA's largest non-Medicaid expenditure. This pool is supposed to finance free hospital care for the poor and uninsured. Yet under the current distribution formula, how much money a hospital receives usually has little to do with how much free care it provides.

An analysis of 2015 distributions found that the pool reimbursed some safety-net hospitals for as little as 14% of their uncompensated care costs. At the same time, some hospitals serving better-off areas received as much as three times their costs.

For 2015, in fact, there was a small negative correlation between the percentage of a hospital's patients who were on Medicaid versus the percentage reimbursement that hospital received from the Indigent Care Pool. In other words, the more poor patients a hospital served, on average, the less charity-care funding it received.

Needless to say, that's the opposite of how this program should work.

So here is what HCRA has come to mean: New Yorkers struggling to afford insurance are paying billions in regressive taxes to finance programs that do little to improve healthcare – and, in some cases, enable dysfunction.

Without doubt, simply allowing HCRA to expire – and giving up \$5.5 billion overnight – would be a non-starter, both fiscally and politically, especially given the situation in Washington.

But there are smaller steps the Legislature can take to begin putting “reform” back in the Health Care Reform Act.

You can stop treating HCRA as a slush fund – and phase out programs such as the taxpayer subsidy for malpractice insurance.

You can find a fairer, more sensible way of distributing funds for indigent care.

And you can come up with plan for weaning the state budget off its dependence on health insurance taxes, in recognition that they are regressively and counterproductively adding to the already too-high cost of coverage. Repealing the unfair covered lives assessment would be a good start.

To read the Empire Center's full report on the Health Care Reform Act, go to www.empirecenter.org/publications/hooked-on-hcra/ or call (518) 434-3100 for a hard copy.