FEDERAL CHANGES, LOCAL IMPACTS

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New York City Independent Budget Office

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How Federal Budget Changes Could Impact New York City's Public Hospital System

IBO's *Federal Changes, Local Impacts* series is a collection of short reports that examine areas of New York City's budget, economy, and operations that are particularly reliant on federal funding, subject to notable federal policy changes, or both. These reports are intended to inform public discussion by objectively highlighting how federal decisions may affect the City. IBO encourages readers to visit its website to explore additional topics covered in this series.

Introduction

New York City Health + Hospitals (H+H) is the City's public hospital system, a public benefit corporation created by New York State in 1969. H+H's stated mission is to serve all New Yorkers regardless of their ability to pay. H+H is a safety net health system, as defined by the New York State Department of Health, with over 65% of the system's adult patients being either uninsured or reliant on Medicaid.[1] H+H is thus very sensitive to changes in federal healthcare policy, including changes to Medicaid.

H+H is the largest public hospital system in the United States. It consists of 11 acute care sites, 29 health centers (clinics), and 5 long-term care centers (alternately called post-acute centers). The H+H system serves over one million patients annually, employs over 43,000 workers, and operates with a budget of $13.5 billion for fiscal year 2025. For context, the second largest public hospital system in the country is the Los Angeles County Department of Health Services, which serves 750,000 patients a year, with 23,000 employees.

H+H has historically faced financial challenges which have sometimes been offset by City intervention and, in the case of the COVID-19 pandemic, federal stimulus funding. Recent federal Medicaid policy changes threaten to materially decrease H+H revenues. This paper provides an overview of the services H+H provides to New York City residents and its primary revenue sources.

About H+H

H+H serves a diverse population of patients through a range of services. H+H provides services to New Yorkers of all immigration statuses, including persons who are insured, underinsured, uninsured, and individuals in the custody of the New York City Department of Correction (DOC) through its Correctional Health Services (CHS). The H+H system includes 11 acute care sites that have a combined capacity of more than 4,500 beds. Acute care is active, short-term treatment for a severe episode or illness. As a point of comparison, New York-Presbyterian has over 3,300 beds across seven hospital campuses in New York City and the Mount Sinai Health System, also with seven hospital campuses, has upwards of 3,700 beds. H+H's acute care sites provide inpatient, outpatient, emergency department, and ambulatory surgery services. H+H operates five long-term care centers that are located in Manhattan, Brooklyn, and Staten Island, one of which has both a skilled nursing facility and a long-term acute care hospital. These centers provide care for people who need physical rehabilitation and who have long-term disabilities, as well as elderly patients who require residential nursing services. These five facilities have a combined capacity of nearly 3,000 beds. Another service that H+H provides is CHS, a division of H+H created in 2016 to manage and administer health care delivery for individuals in DOC custody. CHS provides treatment within DOC facilities on Rikers Island, as well as outpatient treatment, and inpatient treatment in secure settings in other facilities such as Bellevue Hospital.

H+H's network additionally includes Gotham Health centers, ExpressCare clinics, and Virtual ExpressCare. Gotham Health is H+H's network of 29 federally-certified health centers that provide primary and preventive care. These centers are in all five boroughs, each located in or near underserved areas. While Gotham Health sites are centered around primary care and help patients to manage chronic diseases, H+H's ExpressCare clinics are suited for urgent, but non-life threatening, care. Virtual ExpressCare, introduced at the height of the COVID-19 pandemic, is a telehealth option available to patients who are within New York State at the time of their visit.

In addition to the facilities and services that it operates, H+H also administers insurance and access plans for New Yorkers. MetroPlus is an H+H-operated health insurance plan that helps connect New Yorkers who are lawful residents to low- or no-cost insurance plans. Over 690,000 New Yorkers are enrolled in MetroPlus. H+H also offers NYC Care, a health care access program for New Yorkers who do not qualify for and are unable to afford insurance. This program is available only to people who live in New York City, do not qualify for any health insurance plan available in New York State — including MetroPlus— and are not able to afford health insurance based on federal guidelines. This could be because of immigration status, as NYC Care is available to all residents of the City. NYC Care is not an insurance program but allows individuals to receive primary and preventive care services offered by H+H. The cost of services for people enrolled in NYC Care depends on the family size and income. As of October 2024, NYC Care had over 145,000 enrollees.

One additional service that H+H provides, in coordination with the Fire Department of New York, is behavioral health services to support the City's $35 million per year pilot effort to provide nonviolent response to behavioral health calls. Known as the Behavioral Health Emergency Assistance Response Division (or B-HEARD), the program currently operates 16

hours a day in 31 out of 78 police precincts citywide. As of fiscal year 2025, H+H provides a total of 38 social workers to accompany emergency service personnel.

The H+H system serves over one million New Yorkers annually. According to the 2025 Preliminary Mayor's Management Report, in the first four months of fiscal year 2025, the system served almost 700,000 unique individuals. About 45% of those individuals were on Medicaid, and 20% were uninsured, including people enrolled in NYC Care. H+H also reports that over 70% of its patients are either Black/African American, Hispanic, or Asian American Pacific Islander, and approximately 30% of its patients have limited English proficiency. For comparison, at private nonprofit hospitals in New York City, Medicaid and charity care patients constitute about 25% to 28% of their client base.

H+H's Operating Budget

H+H publishes three financial plans annually – two cash-based plans following the City's January and Executive financial plans, and one accrual-based plan following the release of H+H's financial statements in the Fall. The May 2025 plan projected total revenue of $13.5 billion for 2025 (all years in this section are City fiscal years). In many ways, H+H operates as a regular hospital system, billing insurance companies and individuals for services provided, and then receiving payments. H+H is a public system, though, and the majority of its clients are either uninsured or publicly-insured (through Medicare or Medicaid). As seen in Figure 1, other third party insurance, inclusive of private insurance and Essential Plan (discussed below), comprised 11% of H+H's total revenue in 2025, compared with 36% for public insurance (Medicare and Medicaid). Comparable private hospitals, which also serve Medicaid clients, albeit at lower percentages, offset operating costs with private fundraising efforts through philanthropy.

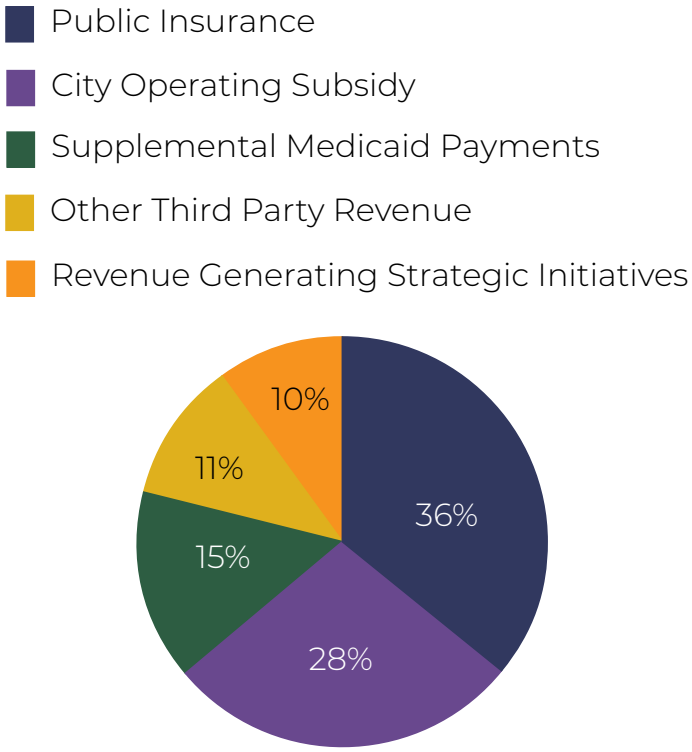
Since revenue from direct insurance reimbursements covers less than half of the H+H's operating expenses, H+H requires supplemental government support. This support takes two main forms: supplemental Medicaid payments and City funds.

First, supplemental Medicaid payments from the Federal government comprise 15% of the 2025 budget. Supplemental Medicaid payments are a method of funding providers above the level of standard reimbursements to make up for Medicaid shortfalls: the difference between the actual cost of administering a service and the reimbursement received for the service. There are several types of supplemental Medicaid funding: Disproportionate Share Hospital (DSH) payments that factor in the losses associated with treating Medicaid and uninsured patients; Upper Payment Limit (UPL) Supplemental payments, which provide funding for the difference between what Medicaid paid and what Medicare would have paid for services; and State Directed Payments (SDPs), which have been utilized to provide additional reimbursement to supplement Medicaid managed care rates. For more information on the history of Supplemental Medicaid payments, please refer to IBO's 2021 report.

H+H also receives operating subsidies from the City's coffers. Per an agreement with the City in 1992, the City provides a lump sum City Tax Levy payment to the system, also known as a City operating subsidy. This subsidy is calculated based on H+H's need, and is provided in addition to the supplemental Medicaid payments that are provided to H+H. The same agreement requires H+H to have an annual revenue and expense budget, approved by its Board of Directors and by the City. These City subsidy funds are reflected in the H+H

FIGURE 1

H+H 2025 Operating Budget: Revenue Sources



SOURCE: NYC Health and Hospitals FY 2026 Executive Financial Plan

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section of the City's operating budget. The rest of H+H's revenue does not appear in the City's budget. For 2025, $3.4 billion is reflected in the June 2025 City Adopted Budget, with $2.8 billion (82%) tallied as City funds. Of note, the City share of H+H funding in 2025 (28% as of H+H's May 2025 plan) is somewhat inflated due to costs related to the City's network of Humanitarian Emergency Response and Relief Centers (HERRCs), created in 2022 and jointly operated by H+H and the New York City Department of Emergency Management.

The final 10% of H+H's revenue comes from grants or other sources such as food, parking, and land ownership revenue.

H+H's operations are predominantly funded through the revenue that it generates via insurance reimbursements, not through the City subsidy it receives. Figure 2 provides a breakdown of H+H's operating budget by revenue source. In all years of the May 2025 plan, the largest portion of revenue comes from direct insurance reimbursement, with Medicaid accounting for most of this in each year. In 2025, direct insurance reimbursement accounts for 47% of total revenue and Medicaid—reimbursements, not supplemental payments—on its own accounts for 22% of total revenue. As of May 2025, these percentages are projected to remain relatively stable over the life of the financial plan – in 2029, direct insurance reimbursement makes up 51% of total revenue and Medicaid on its own is projected to make up 24% of total revenue.

In 2025, H+H's expenses break down as follows: 33% for personal services, which pertains to the compensation of employees such as salaries and wages; 16% for fringe benefits, which include health insurance and retirement contributions and are typically categorized as under personal services; 15% for affiliations, which are contracts for staff from outside entities, such as physicians employed by other hospitals; 37% for other than personal services (OTPS), which relates to supplies, equipment, utilities, and contractual services; and less than 1% for system efficiencies, which may include things such as technology and energy efficiency upgrades. (Percentages sum to more than 100% due to rounding.)

Notably, H+H currently projects approximately $1.5 billion less in OTPS expenses in future years compared with 2025, mostly driven by an anticipated reduction in spending on asylum seekers. As the asylum seeker census has steadily declined, the City has been able to close

FIGURE 2

H+H Operating Budget, 2025-2029: Revenue Source

Dollars in Millions

Revenue Source	2025	2026	2027	2028	2029
Direct Insurance Reimbursement					
Medicaid	$2,980	$2,882	2,932	$2,966	$2,985
Medicare	1,897	1,871	1,927	1,976	2,015
Other Third Party Revenue	1,420	1,261	1,289	1,313	1,333
Other Government Support—Through New York City's Budget					
New York City Operating Subsidy	$3,780	$1,703	$1,677	$1,722	$1,722
Supplemental Medicaid Payments	2,032	2,493	2,888	2,864	2,880
Other Revenue					
Other Direct Revenue and Grants	$1,145	$1,355	$1,047	$1,043	$1,043
Revenue Generating Strategic Initiatives	222	504	507	531	545
Total Revenue	**$13,474**	**$12,069**	**$12,277**	**$12,415**	**$12,524**

SOURCE: NYC Health and Hospitals FY 2026 Executive Financial Plan

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response sites operated by entities other than the Department of Homeless Services. The number of HERRCs in New York City has also been shrinking with the decrease in new arrivals.

Expenses outpace revenue in each year of the financial plan with the exception of 2025. This presents a challenge as H+H operates with shrinking cash reserves. For context, in a 2026 Preliminary Budget hearing, Dr. Mitchell Katz, President and CEO of H+H, testified that the system had 15 days' worth of reserves on hand, while private hospital systems typically operate with far more. For context, according to a Single Approval Transaction Summary published by the Dormitory Authority of the State of New York in 2023, New York-Presbyterian consistently recorded over 100 days' cash on hand. Historically, the City has intervened in various ways to assist H+H when cash flow shortfalls have arisen. For example, in 2015, the City agreed to take on additional personnel costs associated with collective bargaining increases.

FIGURE 3

H+H Operating Budget, 2025-2029: Expenses

Dollars in Millions

Expense Category	2025	2026	2027	2028	2029
Personal Services	$4,375	$4,493	$4,618	$4,719	$4,771
Fringe Benefits	2,100	2,198	2,259	2,319	2,322
Affiliations	1,961	1,911	1,982	2,041	2,102
Other than Personal Services	5,031	3,521	3,517	3,620	3,719
System Efficiencies	(10)	(30)	(51)	(73)	(116)
Total Expenses	**$13,458**	**$12,092**	**$12,325**	**$12,626**	**$12,796**

SOURCE: NYC Health and Hospitals FY 2026 Executive Financial Plan

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(For more on City supports for H+H, see IBO's 2022 Fiscal Brief.) As the financial pressure on H+H increases, there will be more pressure on the City's budget to respond accordingly.

Federal Changes and Implications

Over the past several months, proposals and discussions about the Federal budget have included substantial cuts to the Medicaid program through restructuring and limiting eligibility criteria. On July 4, 2025, President Trump signed the One Big Beautiful Bill Act (OBBBA). This legislation is expected to result in over $1 trillion in reduced healthcare spending over the next decade, most of which is related to Medicaid. This is particularly relevant to H+H as a significant portion (approximately 45%) of the patients that the system serves are enrolled in Medicaid and, consequently, 51% of the system's operating revenue stems from public insurance reimbursement and supplemental payments.

A June 2025 letter published by the Congressional Budget Office (CBO) quantifies anticipated changes to the uninsured population as a result of policies outlined in the OBBBA as passed by the House of Representatives in May 2025. CBO estimates that, in 2034, there will be a total of 16 million fewer people who have health insurance nationwide and, more specifically, 5.2 million fewer adults enrolled in Medicaid. According to CBO's analysis, those who no longer qualify for Medicaid will be unlikely to receive employer-based health insurance and will likely not be eligible for the premium tax credit, a benefit created by the Affordable Care Act that lowers healthcare premiums. Statements released by Governor Hochul's office estimate that 1.5 million New Yorkers will lose insurance coverage due to changes made by OBBBA.[2] An analysis by KFF, a health policy research organization, similarly projects that the uninsured population in New York State could increase by up to 1.2 million. Based on KFF's mid-point estimate of 920,000, 850,000 of those losing insurance would be attributable to changes in Medicaid and the remainder to changes in the Affordable Care Act (ACA). The Fiscal Policy Institute has estimated that there also could be impacts on the State healthcare labor markets due to OBBBA, with up to 78,000 jobs directly lost (a greater than 4% decrease), and 136,000 jobs lost through economic spillovers.

Since the main OBBBA changes do not directly impact reimbursement rates, the biggest impact for H+H will likely be the potential increase in the number of uninsured clients seeking care. Because H+H's mandate is to serve all New Yorkers regardless of their ability to pay, the decline in the size of the insured population will reduce revenues. The system may have to rely more heavily on funding sources outside of insurance reimbursement or implement new strategies to generate revenue. A significant Medicaid-related element of OBBBA is the imposition of work requirements for eligibility. As of December 31, 2026 individuals must work or participate in qualifying activities for a minimum of 80 hours per month.[3] Before, Medicaid eligibility was largely not linked to employment, and only one state had such requirements in place at the time that OBBBA was signed. Of note, these changes will begin taking place after the next State and federal election cycles and also fall at differing points in the City, State, and federal fiscal years.

Another major change is the potential loss of federal funds to support the New York State Essential Plan for individuals who are not citizens. The Essential Plan is New York's Basic Health Program (BHP). BHPs, created by the ACA, are a health insurance option for people who do not qualify for Medicaid or the Children's Health Insurance Program. If

these individuals lose coverage, it will be up to the State and City to decide how to provide different coverage options for them, or otherwise find a way to reimburse H+H for the increased cost of care that it will likely incur.

Impacts for the New York City budget will depend on how New York State responds to the changes noted above and other changes to health-related policy. For example, due to restrictions on the use of managed care taxes outlined in OBBBA, New York State may lose more than a year's worth of managed care organization (MCO) tax revenue. The State was set to receive an estimated $3.7 billion in revenue over a two-year period and funds were to support new health care delivery investments. For more details on the impacts of OBBBA on healthcare in New York State more broadly, see the Rockefeller Institute of Government's report "An Analysis of the One Big Beautiful Bill Act (OBBBA's) Impact on Healthcare for New York."

Conclusion

The degree to which the City can step up support for H+H over the next decade will depend on how the City prioritizes budget needs. When the Medicaid changes take effect, particularly the loss of federal reimbursement for Essential Plan individuals who are not citizens, a large amount of H+H's revenue could disappear unless the State takes action. How the State and City choose to either insure or otherwise pay for medical care (for example through NYC Care) for the over 1 million people in New York State who stand to lose federal Medicaid coverage will ultimately determine the impact on the H+H system. On September 10th, Governor Hochul announced plans to revert the eligibility criteria for the State's Basic Health Program to the previous limit of 200% of the Federal Poverty Line. This would allow more than one million Essential Plan members to remain insured. Another 450,000 former Essential Plan members whose incomes are between 200% and 250% of the Federal Poverty Line are likely to lose coverage. Beyond the funding implications discussed above, there are other far-reaching impacts that may be felt. First, H+H employees or contractors could lose their jobs if the system is forced to downsize. Second, uninsured individuals are likely to delay getting care due to cost barriers or forego care altogether. Health outcomes for the population overall are likely to worsen as: 1.) fewer people are able or willing to access preventive screening; 2.) medication nonadherence rates increase due to inability to buy medication out-of-pocket and/or obtain prescriptions; and 3.) mortality rates increase because of a combination of these factors.

Endnotes

1 The State Department of Health states that a safety net provider must have at least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals and at least 30 percent of inpatient treatment associated with these populations, or the provider must serve at least 30 percent of this population type in the proposed county or multi-county community.

2 New York State Governor Kathy Hochul (accessed 2025, August 18, 2025) Governor Hochul Joins U.S. Representative Ritchie Torres to Warn of Crippling Effects of Republicans' 'Big Ugly Bill'; New York State Governor Kathy Hochul (accessed 2025, July 17, 2025) Governor Hochul Convenes Cabinet Meeting on Devastating Impacts of Republicans' 'Big Ugly Bill' on New York State

3 States that demonstrate good faith efforts to comply with the requirements may be granted an extension until December 31, 2028.

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