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Keeping People Covered after the OBBBA: How to Prevent New York's Health Insurance Crisis

One of the most significant impacts of H.R. 1, the "One Big Beautiful Bill Act" (OBBBA), on New York's healthcare system will be the imposition of work requirements on two million New Yorkers who are covered by the ACA's Medicaid expansion. The bureaucratic hurdles created by these new requirements are expected to result in significant loss of coverage, with the State's Department of Health estimating that up to 1.2 million New Yorkers could lose their health insurance.

Healthcare advocates have proposed that the State directly provide insurance coverage to this population, while our elected leaders have consistently argued that the State simply cannot afford to cover people—they will just need to go without healthcare. But this is a simplistic way of thinking about the issue. After all, denying health *insurance* to this population will not cause their healthcare *costs* to simply disappear. Uninsured people continue to use healthcare services, and those with life-threatening illnesses are entitled to hospital care regardless of insurance status. If government-funded insurance does not pay for their care then it will be paid for in some other way—at first, hospitals (especially safety net hospitals) will have to absorb the costs of uncompensated care; in the long-term, the State, which already spends billions of dollars annually bailing out hospitals for uncompensated care, will need to increase these payments.

Thus, the policy question confronting New York is not really *whether* to increase state health spending to compensate for federal cuts, but *how* to do so. Should the State step in to provide health insurance to the newly uninsured? Or should it pay for this healthcare through increased bailout payments to safety-net hospitals?

In this piece, I will offer a rough financial model of these alternatives. I find that disenrollment is likely to be substantial, but significantly lower than the State estimates—800,000 rather than the Department of Health's widely cited 1.2 million.[1] The disenrolled are likely to be disproportionately healthier and less expensive to cover than the average expansion enrollee. I estimate that New York could provide state-funded replacement coverage for the newly disenrolled at a cost of approximately $3.1 billion per year, but savings from reduced bailout costs would make the *net* expense only $2.3 billion annually.

[1] Internal DOH analysis cited in Francis, Paul and Adrienne Anderson, "How Many New Yorkers Will Become Uninsured Due to the One Big Beautiful Bill Act?," November 12, 2025, accessed at https://www.steptwopolicy.org/post/how-many-new-yorkers-will-become-uninsured-due-to-the-one-big-beautiful-bill-act

Given the significant uncertainties associated with nearly every aspect of work requirement implementation, the State should use next year's budget to mitigate the immediate impacts of coverage loss while exploring policy alternatives, such as a pilot program to extend temporary state-funded coverage for people disenrolled from federal Medicaid while providing assistance in meeting the new federal work requirements.

Introduction

Modeling the impact of these policy alternatives requires making some estimates subject to significant uncertainty. Specifically, we need to estimate:

1) **How many people are at risk of losing coverage?** Two million New Yorkers currently receive health insurance through the ACA Medicaid expansion (out of a total State Medicaid population of 6.9 million). Estimates of how many might lose coverage under OBBBA range as low as 500,000 and as high as 1.2 million.
2) **Which people are most likely to lose coverage?** Changes in eligibility don't impact all enrollees equally. To estimate the fiscal impact of disenrollment, we must estimate the health status and associated healthcare costs of those who will be disenrolled.
3) **How will disenrollment impact charity care costs?** Uninsured people don't simply stop using healthcare—but their healthcare use shifts. On the one hand, the uninsured are far less likely to seek primary care than people with insurance. On the other hand, when they do need care, they may be forced to seek it in high-cost settings such as emergency rooms. People with serious or life-threatening health issues will go to the hospital regardless of insurance status—and without primary care, people may be more likely to face such medical emergencies. Thus, it is unclear how loss of insurance will impact overall healthcare spending.
4) **How will savings and costs be split among providers, the State and the federal government?** The bulk of the cost of covering the ACA expansion population is currently borne by the federal government, which provides a 90 percent match for this population. If this population were to be shifted to a state-funded insurance program, then 100 percent of the cost of their care would be paid for by the federal government. If the cost was shifted to Medicaid-matched supplemental payments to safety net hospitals, this care would be federally matched at a lower rate than that of the ACA expansion population, with the exact match rate to be determined by the specific supplemental payment program.

Red Tape Maze: Understanding the Enrollment Impact of Work Requirements

A Closer Look at Work Requirements

To fix the problem, though, we need to understand it. The State has estimated that 1.2 million New Yorkers may lose Medicaid coverage due to the OBBBA's coverage provisions. Who will those people be, and why will they lose coverage?

The OBBBA makes a variety of changes to Medicaid eligibility and enrollment, but the most significant for our purposes are those targeting the "new adult group" of individuals enrolled in Medicaid due to the ACA's Medicaid expansion, which extended coverage to adults earning up to 138 percent of the Federal Poverty Line. This category included approximately 2 million of New York's roughly 6.9 million

Medicaid enrollees as of the end of 2024, according to the Centers for Medicare and Medicaid Services (CMS).[2]

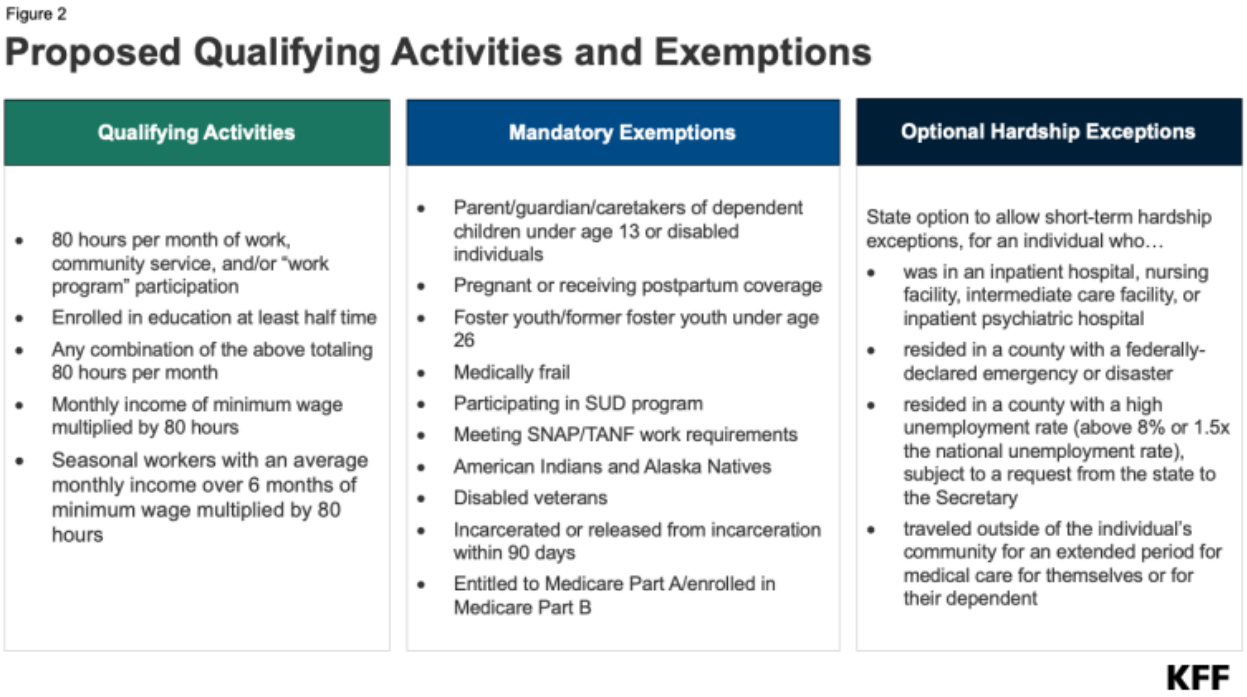
The OBBBA makes two important changes to Medicaid enrollment. First, and most importantly, enrollees will be required to show that they have worked or participated in "community engagement" activities for at least eighty hours in the past month or qualify for an exemption from work requirements. Second, the State will be required to redetermine their Medicaid eligibility every six months, rather than annually, as was previously the case.

The new work requirements come with a number of complications and exemptions.[3] Individuals can qualify by enrolling in school or job training at least part-time, participating in eighty hours per month of community service, or earning income equivalent to eighty hours of work at the federal minimum wage (i.e. $7.25 per hour). A number of groups will also be exempt from work requirements, including enrollees who are pregnant, parents of children under age thirteen, caretakers of disabled people, participants in substance use disorder (SUD) treatment programs, and those who are "medically frail"—with the latter group potentially including people with complex medical conditions. Finally, states have the option of exempting others in some circumstances—including people in economically depressed areas and, crucially, those who have received inpatient treatment or outpatient treatment related to an inpatient treatment episode in any given month.

[2] Centers for Medicare & Medicaid Services, "Medicaid Enrollment - New Adult Group" New York, October–December 2024, filtered dataset, accessed January 8, 2026, https://data.medicaid.gov/dataset/6c114b2c-cb83-559b-832f-4d8b06d6c1b9/data?conditions[0][property]=enrollment_year&conditions[0][value]=2024&conditions[0][operator]=%3D&conditions[1][property]=enrollment_month&conditions[1][value][0]=10&conditions[1][value][1]=11&conditions[1][value][2]=12&conditions[1][operator]=in&conditions[2][property]=state&conditions[2][value]=New%20York&conditions[2][operator]=%3D

[3] Elizabeth Hinton, Amaya Diana, and Robin Rudowitz, "A Closer Look at the Work Requirement Provisions in the 2025 Federal Budget Reconciliation Law," KFF, July 30, 2025, https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/.

Figure 1: Work requirement qualifying activities, exemptions and hardship exceptions



Source: KFF, "A Closer Look at the Work Requirement Provisions in the 2025 Federal Budget Reconciliation Law." https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/

People will not necessarily need to personally verify that they meet work requirements or qualify for an exemption. The law requires states to attempt to use third-party data, such as payroll and other state records, to verify that an individual meets the work requirement or qualifies for an exemption (e.g., that they were paid for at least eighty hours of work in the past month, or have a child under the age of thirteen). These methods may allow states to keep people covered without asking them to verify their eligibility every six months. However, it remains an open question how effectively states will be able to match Medicaid enrollment to other sources of data on enrollees.

Many other questions remain open as well. The Trump administration plans to release implementing regulations related to work requirements in June 2027; until then, many critical details of the new eligibility regime remain unclear. States do not yet know the following:

- Which data sources will states be permitted to use to verify eligibility, and under what circumstances?
- How will states be required to verify that someone meets work requirements through community service?
- Under what circumstances can states grant hardship exemptions to people who receive inpatient hospital treatment?
- Who will qualify for the "medically frail" exemption from work requirements?
- When people are disenrolled due to work requirements, how long must they wait to reapply?

These implementation details could have a dramatic impact on the ultimate consequences of work requirements.

Why Work Requirements Will Lead to Disenrollment

Most experts agree that the vast majority of new adult group enrollees either already meet the work requirements or qualify for an exemption.[4] Despite this, work requirements are expected (and indeed intended) to cause a massive loss of Medicaid coverage. Savings from disenrollment due to work requirements are the largest single Medicaid cut in the OBBBA, accounting for $326 billion of the $911 billion in total savings over ten years.[5] Existing estimates of the impact vary substantially, from the 5.2 million calculated by the Congressional Budget Office (CBO) to the 7.1 million determined by the Center on Budget and Policy Priorities (CBPP), but everyone agrees that work requirements will lead to a massive loss of coverage.

If most enrollees meet the new requirements, why will so many be disenrolled? Simply put, many enrollees will not make it through the complex process of verifying their status every six months. Many will be automatically qualified—particularly in New York and other blue states where governments will make it a priority—but many states will not have the data to automatically verify compliance, requiring enrollees to manually document their eligibility every six months.

Some enrollees will forget to reapply or will not receive notification that they need to do so; others will fail to fill in the paperwork correctly, or miss the eighty-hour monthly threshold because they were off work sick for a week, or will be unable to assemble the right documentation. Some will assume they qualify for an exemption when they do not or assume they are ineligible when they in fact meet the requirements. Even in a state such as New York, where the Medicaid program will do everything possible to support enrollees, asking millions of people to navigate these bureaucratic hurdles every six months virtually guarantees large-scale loss of coverage.

Estimating the Scale of Coverage Loss in New York

Estimating exactly *how many* people will lose coverage is quite challenging, however. Estimates for coverage losses in New York cover a wide range:

- At the high end, Governor Hochul's office has estimated a coverage loss of up to 1.5 million due to work requirements.[6] The State has not explained how it arrived at this figure or provided a clear timeline. This estimate would correspond to an enrollment decline of about 60 percent among the targeted population and is likely too high. More recently, in the Mid-Year Update to

[4] Jennifer Tolbert, Sammy Cervantes, and Gary Claxton, "Different Data Source, But Same Results: Most Adults Subject to Medicaid Work Requirements Are Working or Face Barriers to Work," KFF, June 25, 2025, https://www.kff.org/medicaid/different-data-source-but-same-results-most-adults-subject-to-medicaid-work-requirements-are-working-or-face-barriers-to-work/

[5] Rhiannon Euhus, Elizabeth Williams, Alice Burns, and Robin Rudowitz, "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package," KFF, July 23, 2025, , https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/

[6] "Stay Connected: Medicaid" NY State of Health, accessed January 8, 2026, https://info.nystateofhealth.ny.gov/stay-connected#:~:text=MEDICAID,by%20at%20least%2020%20percent.

the FY26 financial plan, the State has broadened its estimate, suggesting coverage losses in the range of 750,000-1.5 million.[7]

- At the low end of the spectrum, the Congressional Budget Office has estimated that coverage losses nationally from work requirements and more frequent redeterminations will reach 6 million by 2034.[8] Assuming that individual states' coverage losses are proportional to their expansion populations, New York having 10 percent of the total current expansion population implies losses of perhaps 500,000 statewide by 2034. However, the CBO projects that coverage losses would phase in gradually over time—so New York's coverage losses would be just 290,000 by 2028.
- Using Arkansas's experience with work requirements in 2018–19 as a model, the Center on Budget and Policy Priorities put the figure at 974,000 in New York by 2034.[9] The Arkansas work requirements are somewhat harsher than those likely to be implemented under the OBBBA in New York—stipulating *monthly* rather than biannual verification of compliance. Further, the state government of Arkansas was generally hostile to expanding Medicaid, while New York will likely work hard to maintain coverage. Still, the Arkansas requirements did not apply to fifty-five-to-sixty-four-year-olds, who may be less likely to work than younger enrollees and therefore more likely to be disenrolled. Additionally, while CBPP's projection is for 2034, it does not express a view on what might happen with coverage in the interim.

Clearly, coverage loss estimates vary widely, and the truth is that it's simply very hard to predict. Medicaid work requirements have never been tried on this scale before, and many details of the implementation of these work requirements remain to be determined. It seems reasonable to conclude that coverage loss is likely to be in the range from five hundred thousand to one million (or between a quarter and half the total current expansion population), while acknowledging significant uncertainty as to these estimates.

In the remainder of this piece, I will be assuming coverage losses of eight hundred thousand by the end of state fiscal year 2027, but readers should consider this estimate as involving substantial uncertainty.

Impacts of Churn: The Disenrolled Group Is Likely to Be Disproportionately Healthy

To estimate the fiscal impact of these disenrollments, it is not enough to know *how many* people will be disenrolled—we also need to know *who* will lose coverage. After all, healthcare spending is not evenly distributed across the expansion population; most enrollees use very little healthcare in any given year, while a few very sick enrollees may account for hundreds of thousands of dollars of spending. Studies

[7] Kathy Hochul and Blake G. Washington, "FY 2026 Enacted Budget Financial Plan: Mid-Year Update" New York State Division of the Budget, October 2025, 16, https://www.budget.ny.gov/pubs/archive/fy26/en/fy26fp-en-myu.pdf
[8] Phillip L. Swagel, "Distributional Effects of Public Law 119-21," Congressional Budget Office, August 11, 2025, https://www.cbo.gov/publication/61367.
[9] Gideon Lukens and Elizabeth Zhang, "Medicaid Work Requirements Could Put 36 Million People at Risk of Losing Health Coverage," Center on Budget and Policy Priorities, February 5, 2025, https://www.cbpp.org/research/health/medicaid-work-requirements-could-put-36-million-people-at-risk-of-losing-health.

show that health insurance spending follows an "80/20" pattern, where the sickest 20 percent of enrollees account for 80 percent of total spending.[10]

Here the answer is clear: While work requirements will impact people of all ages, backgrounds, and health statuses, those disenrolled are likely to be on average healthier than the general ACA expansion population, while those remaining enrolled will be on average less healthy than the ACA expansion population as a whole. That's because healthy people will be more likely to face disenrollment, while sick people will be more likely to re-enroll. There are two main reasons for this:

1) **Sick people in the expansion population are more likely to *remain* enrolled during redeterminations:** Work requirements and frequent redeterminations create bureaucratic barriers to staying covered, and enrollees with serious or chronic health conditions will prioritize navigating these barriers. A fifty-five-year-old with diabetes who needs daily insulin is more likely to respond to reminders from the Department of Health, carefully study eligibility requirements, fill out paperwork, double-check that her paperwork went through, and aggressively pursue appeals against loss of coverage than is a healthy twenty-four-year-old college student who barely uses healthcare. As a result, the former is more likely to stay enrolled than the latter.
2) **People who lose coverage are much more likely to *re-enroll* if they get sick than if they remain healthy:** Among those who do lose coverage, people with serious health issues are far more likely to find a way to re-enroll than people without health issues. Suppose that a twenty-four-year-old college student loses coverage due to work requirements, becomes uninsured, and is severely injured in a car accident six months later, requiring ICU care. That college student will immediately become eligible for a short-term hardship exemption from work requirements due to her inpatient hospital stay, and the hospital will ensure that she enrolls so that the hospital can be reimbursed for its services. The coverage will be retroactive, covering one month prior to her enrollment, so it will cover her ICU visit. Once she is out of the hospital, she will likely remain eligible as she receives follow-up care: If she remains enrolled in college she will meet the work requirement through her enrollment and she may also qualify for an exemption from work requirements as a "medically fragile" case.

Thus, work requirements will likely leave the Medicaid expansion population much less healthy (and therefore more expensive to insure) than the current population. The people who lose coverage will be on average healthier than the current population, while those who enroll or re-enroll will be on average sicker. This is by no means an absolute pattern; many chronically ill people will undoubtedly lose coverage. But *on average,* the population will become sicker.

The Fiscal Impact of Disenrolling the Healthy

This pattern, combined with the 80/20 rule described above, has important fiscal implications. The implications of this 80/20 pattern on the Medicaid expansion population are stark. New York currently enrolls two million adults in the expansion population. Enrolling a non-disabled adult cost $6,235 per

[10] Es Nash, Mark Bethke, and Ken Abrams, "The 80/20 Rule: Is it still true? And what can it tell us about Population Health in 2018 and beyond?" Deloitte, accessed January 8, 2026, https://www.deloitte.com/us/en/Industries/life-sciences-health-care/articles/is-80-20-rule-of-health-care-still-true-population-value-based.html.

year in 2023, according to a Kaiser Family Foundation analysis of federal data.[11] This implies a total cost (including state and federal dollars) of $12.5 billion. But the 80/20 pattern suggests that a small share of these enrollees (around four hundred thousand) account for the vast majority of this spending (nearly $10 billion), while the remaining 1.6 million enrollees account for just $2.5 billion in spending. To put it another way, average health spending for the "healthy" 80 percent is just $1,559 per year, while average spending for the "unhealthy" 20 percent is nearly $25,000 per year.

Table 1: Distribution of Medicaid Costs Among High-Cost and Low-Cost Enrollees

	Population	Average Cost	Total Cost (State + Federal)
Total	2,000,000	$6,235	$12,470,000,000
Healthy	1,600,000	$1,559	$2,494,000,000
Sick	400,000	$24,940	$9,976,000,000

The implications of these figures for New York's fiscal options are significant. Imagine a simplified model where New York's 2 million expansion enrollees are neatly divided between "sick" enrollees who cost $25,000 per year to insure and "healthy" enrollees who cost $1,559 per year. Now suppose that 40 percent of all enrollees become uninsured (a total of 800,000), but that "healthy" enrollees are slightly more likely to become uninsured than sick enrollees—for example, suppose healthy enrollees become uninsured at a rate of 45 percent.

As shown in Table 2, in this scenario New York would lose 40 percent of its expansion enrollees—but since the remaining enrollees would be on average sicker than the current population, average costs per enrollee would increase substantially, from $6,235 per person per year to $7,794. As a result, while enrollment would shrink by 40 percent, *expenditure* would shrink by far less—just 25 percent.

Table 2: Estimating Average Cost of Coverage Post-Disenrollment

	Pop.	Avg Cost of Coverage	Total Cost	Share Disenrolled	Remaining Population	New Total Cost	Change in Total Cost	New Avg Cost of Coverage
Healthy	1.6 mn	$1,559	$2.5 bn	45%	880,000	$1.4 bn		
Sick	400k	$24,940	$10 bn	20%	320,000	$8.0 bn		
Total	2 mn	**$6,235**	$12.5 bn	40%	1,200,000	$9.4 bn	-25%	**$7,794**

[11] See "Medicaid Spending per Enrollee (Full or Partial Benefit) by Enrollment Group," KFF, last modified October 3, 2025, accessed January 8, 2026, https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/. NYS Medicaid Amir Bassiri's presentation to the United Hospital Fund reported annual spending per adult Medicaid enrollee (on non-disabled, non-senior adults) of $5,800 in FY25. This is by far the most recent public data, but it covers *all* non-disabled adults in Medicaid, not only the ACA expansion population, and is significantly lower than estimates from other sources. MACStats provides data for federal FY22 which gives somewhat higher numbers: an annual cost of $6,914 for expansion adults and $6,120 for non-expansion, non-disabled, non-senior adults in New York. The Medicaid Financial Management Report for federal FY24 puts total state and federal spending on expansion enrollees in New York at over $20 billion, implying annual expenditures per enrollee of nearly $10,000, which is almost certainly too high. It is not clear what explains these discrepancies. I am using the $5,800 figure as the most recent, but my argument holds regardless of the figure selected.

Of course, this calculation also suggests that it would be less expensive for the State to keep people covered than a naïve calculation might indicate. Since the population at risk of disenrollment is significantly healthier than the population that will remain covered, the average cost of providing state-funded coverage for the disenrolled group on this model would be just $3,897 per enrollee per year.

The Impact of Managed Care

The previous section assumed that the State pays the healthcare costs of Medicaid enrollees directly. This is a simplification. In practice, New York State's Medicaid program is operated under managed care, and the State pays a flat "capitation rate" or premium per enrollee to managed care organizations (MCOs) which in turn use this funding to pay healthcare costs. Thus, in the first instance, if the Medicaid population becomes dramatically less healthy the State's cost would not change: The State would continue to pay the same capitation rate, but the MCOs would have to use this rate to provide for a much less healthy enrolled population and would begin to lose money. Some might argue, then, that changes to the average health status and cost of the Medicaid population wouldn't impact the state budget—only the MCOs would be affected.

This would only be true only in the very short term, if at all. The State is required under federal law to pay capitation rates that are "actuarially sound" (i.e. sufficient to cover the healthcare costs of the enrolled population), and in any case private MCOs will not continue to participate in the State's Medicaid program if they are paid below cost. A significant increase in population healthcare costs will require the State to almost immediately raise capitation rates to cover the increase. For our purposes, then, it is reasonable to ignore the intermediating impact of the MCOs and treat changes to average healthcare costs among the enrolled population as impacting the state budget directly.

The Impact of Disenrollment on Charity Care Costs

A massive loss of insurance coverage will increase the cost to providers (especially hospitals) incur when they are required to provide treatment to uninsured patients. These costs are referred to as "charity care" expenses. How large an increase in charity care can we expect due to the OBBBA? To pose the question quantitatively: How much will charity care spending need to increase for every dollar of decreased Medicaid spending in New York? The question is complex. We can imagine treatments falling into the following categories:

- Some forms of care will occur regardless of whether the patient is insured, and in these instances every dollar of decreased Medicaid spending will be matched by a dollar of increased charity care. For instance, if a person is hit by a car and receives life-threatening injuries, she will certainly be taken to a hospital and treated, regardless of insurance status, even if that requires hundreds of thousands of dollars' worth of ICU care. If Medicaid doesn't pay for this treatment it will take the form of charity care.
- Some forms of care will not occur, and will not need to be paid for, if the patient is uninsured. For instance, an insured patient with strep throat might visit a primary care doctor and receive antibiotics, while an uninsured patient may avoid seeking treatment to avoid medical bills. In the latter case, one dollar of Medicaid payment will be replaced with zero dollars of charity care.
- On the other hand, some forms of care will not occur if the patient is uninsured and will be replaced with more expensive forms of care. For example, an uninsured patient with Type 2 diabetes may not seek treatment or use insulin if he is uninsured—but because he is not able to

> manage his disease, he may become much sicker than he would otherwise, requiring emergency care and even surgery. In this instance, a one-dollar decrease in Medicaid spending corresponds to an increase in charity care of much more than one dollar.

It is important to note that these dynamics may play out differently on different time horizons. A newly uninsured person who stops seeking primary care may cause an immediate decrease in total spending, but the health consequences of this lack of primary care may cost more in the long run.

Can we estimate the net impact of decreased Medicaid spending quantitatively? One effort to do so, by MIT economist Amy Finkelstein and colleagues, suggests that every dollar of decreased Medicaid spending leads to 60 cents in increased charity care.[12] This estimate is based on a limited two-year study of Oregon enrollees, and importantly it does *not* take into account any potential increased healthcare costs associated with loss of access to primary care among the uninsured. It should be treated as conservative—increases in charity care may well be higher than this figure suggests.

Who Pays for Charity Care?

Charity care costs are born in the first instance by providers themselves. A hospital that treats an uninsured patient may attempt to bill the patient, but most uninsured patients cannot pay any appreciable fraction of the total cost of a significant healthcare episode, so care provided to them becomes a loss for the hospital.

Some hospitals can simply bear the costs of increased charity care out of profits from insured patients. The NYU-Langone hospitals system, for example, which earned a net income of $240 million in its most recent quarter alone, can afford to treat some patients for free.[13] However, the safety net hospitals where uninsured patients tend to receive care are in a different situation—they lose money overall and are heavily dependent on state supplemental payments to sustain operations. The State currently subsidizes nearly one-third of New York's hospitals at a total annual cost of $3.5 billion per year. Since these hospitals provide most charity care in the State, it seems reasonable to assume that the marginal cost of increased charity care will need to be paid entirely by the State. That is, we assume that a $1 decrease in spending on Medicaid coverage will result in a $0.60 increase in State spending on charity care.

What Does the Federal Government Contribute?

Modeling the impact of this increase in charity care requires taking into account the way the federal government matches various types of Medicaid spending. Disenrollment of ACA expansion adults will be fiscally costly for New York in part because this population currently receives an especially generous federal match of 90 percent. New York's standard Medicaid match is 50 percent, although various specific populations and forms of care receive a higher match. Thus as the State shifts from paying for expansion adults' care through Medicaid coverage to paying for it through supplemental payments to providers, it is also shifting from a form of payment with a generous federal match to paying for it with a much lower federal match—greatly accentuating the fiscal impact on the State.

[12] Amy Finkelstein, Nathaniel Hendren, and Erzo F. P. Luttmer, "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," NBER Working Paper no. 21308 (Cambridge, MA: National Bureau of Economic Research, 2015), https://www.nber.org/papers/w21308.
[13] Amanda D'Ambrosio, "NYU Langone earns quarterly profit as hospital discharges, surgeries increase," July 25, 2025, https://www.crainsnewyork.com/health-pulse/nyu-langone-earns-strong-profit-third-quarter.

What exactly will the federal match for charity care be? This, too, is a complex question. The State operates a variety of supplemental programs under a variety of federal authorities, but the two largest are Disproportionate Share Hospital (DSH) and State Directed Payment (SDP, known in New York as Directed Payment Template or DPT). DSH receives a 50 percent match, while the federal government has approved SDP payments at approximately a 60 percent match. For the purposes of our model, we will assume that New York's supplemental payments are matched at 55 percent.

The Impact of Doing Nothing: Modelling New York Costs for a Surge in the Uninsured

To summarize, we assume that under federal work requirements:

- 800,000 New Yorkers will lose insurance.
- The average cost of insuring the ACA expansion population is $6,235.
    - However, the average cost of insuring those who will retain coverage after work requirements is significantly higher, at approximately $7,794 per year, while that of insuring those who will lose coverage is lower, around $3,897 per year.
- Every dollar in decreased Medicaid spending on insuring the expansion population will result in an increased charity care cost of 60 cents.
    - This increase will be paid for by the State through increased supplemental payments to hospitals.
- The federal government matches spending on insurance for the expansion population at 90 percent but matches supplemental payments for charity care at 55 percent.

Given these assumptions, the fiscal impact of coverage loss on the State and federal governments can be seen in Table 3.

Table 3: Estimating the Annualized Cost of Work Requirement Disenrollments Including Safety Net Costs

	Enrollment	Average Cost per Enrollee	FMAP	Total Program Cost/(Savings)	State Share of Total	Federal Share of Total
Current Cost of ACA Expansion Population	2,000,000	$6,235	90%	$12.5 bn	$1.3 bn	$11.2 bn
Apparent Savings from Coverage Loss	-800,000	$6,235	90%	-$5.0 bn	-$0.5 bn	-$4.5 bn
Adjusted Savings from Coverage Loss	-800,000	$3,897	90%	-$3.1 bn	-$0.3 bn	-$2.8 bn
Cost of Reimbursement to Healthcare System ("Charity Care")			55%	$1.9 bn	$0.8 bn	$1.1 bn
Actual Cost/Savings from Coverage Loss				**-$1.2 bn**	**$0.5 bn**	**-$1.7 bn**

Table 3 begins with a naïve calculation: If 800,000 New Yorkers become uninsured due to work requirements at an average cost of $6,235 per enrollee per year, this will result in apparent savings to the state Medicaid program of nearly $5 billion. Since the federal government pays 90 percent of the cost of coverage for this population, the bulk of savings (nearly $4.5 billion) will go to the federal government—but the State, too, will recoup significant savings of nearly $500 million annually. New York's economy and healthcare system will experience a massive loss of federal funding, but the *state budget* will see savings in the first instance as the State avoids its share of the cost of covering 800,000 New Yorkers.

But this estimate does not incorporate two critical factors: The relative health status of those who lose coverage and the increase in charity care costs associated with the newly uninsured.

To model the first factor, we assume that the average cost of the newly uninsured is $3,897, as discussed above. In this scenario, total savings shrink to just $3.1 billion, and these savings are shared by the State ($312M) and the federal government ($2.8B).

To model the second factor, we assume that charity care costs will increase by $0.60 for every dollar saved through disenrollment. Thus, New York will need to increase supplemental payments by 60% of $3.1B, or approximately $1.9B. Since these payments will be matched at the lower Federal Medical Assistance Percentages (FMAP) of 55 percent, the cost will fall heavily on the State, which will need to assume an extra $842M in charity care costs as compared to the federal government's $1.05B.

On net, then, if work requirements take effect as expected, overall Medicaid spending will decrease by $1.25B—but the *State's* share of Medicaid will move in the other direction, *increasing* by nearly $530M. The cost of providing Medicaid coverage will decrease by $3.1B while charity care costs will increase by $1.9B—but because the cost of coverage is mostly borne by the federal government (while the cost of charity care is shared more evenly between the State and the federal government) the State will see costs increase.

Crucially, even if the State refuses to "backfill" federal cuts—allowing disenrollment to take place as planned—it will still need to invest an additional $500 million in the Medicaid program to pay for charity care. In this scenario, the State's uninsured population will increase by 800,000, while its Medicaid costs will go up too.

The Alternative to Doing Nothing: How to Keep People Covered After OBBBA

What other choices does the State have? How can we prevent loss of coverage?

Most straightforwardly, the State could simply continue coverage for those disenrolled from federal Medicaid by shifting all 800,000 newly disenrolled ACA expansion adults to State-only coverage. This could be done without the intervention of enrollees and without disruption in care: Enrollees would remain enrolled in the same managed care plan with the same network and benefits, but the cost of this enrollment would be borne entirely by the State rather than split between the State and the federal government.

As we have seen above, this newly disenrolled population will be significantly healthier than the average ACA expansion adult, costing less than $4,000 per person per year to cover, or approximately $3.1B in total. Since New York already pays 10 percent of the cost of covering this population, the increased cost would be only around $2.8B.

This is a substantial amount of money, but it must be compared to the alternative described above. New York will face an additional $842M in increased State charity care costs if it allows 800,000 people to become disenrolled. Because avoiding disenrollment would prevent these costs, the *net* cost of this option, relative to simply letting this group lose insurance, would be less than $2.3 billion. (See Table 4.)

Table 4. Estimating the Net Cost of State-Provided Alternative Coverage

Measure	Estimate
Enrollment	800,000
Cost per Year	$3,897
Total Cost to Provide Coverage	$3.2 bn
Current State Spending on Covered Population	-$312 mn
Total Cost Relative to Status Quo	$2.8 bn
Baseline Cost (See Table 3)	$530 mn
Net Cost Relative to Baseline	$2.3 bn

A $2.3 billion price tag is significant—but it is manageable in the context of New York's $110B Medicaid program and is a small price to pay for avoiding a doubling of the State's uninsured population. Note that this is the *annualized* cost. Because work requirements don't begin until the final quarter of FY27, and coverage loss will happen only gradually during that quarter as Medicaid enrollees come due for redetermination, costs in FY27 would be far more modest, approximately $284 million.

This option creates a significant risk, however. It is in the State's interest to incentivize enrollees to qualify for *federally funded* Medicaid by meeting work requirements if possible, since the federal government pays 90 percent of the cost of federal Medicaid for this population but pays nothing for State-only Medicaid. Automatically enrolling people in state Medicaid as they cycle off federal Medicaid would reduce their incentive to pursue federal coverage—potentially shifting a growing share of the ACA expansion population onto State-funded Medicaid and raising costs for the State.

Conclusion: Policy Options for Fiscal Year 2027

The OBBBA changes to Medicaid eligibility are unprecedented and their impact is difficult to predict. The above analysis relies on assumptions and estimates about which reasonable people may disagree. A few facts are not in doubt, however:

1) Work requirements will lead to a massive loss of insurance coverage beginning in calendar year 2027, erasing much of the coverage expansion New York has achieved since the passage of the Affordable Care Act.
2) This loss of coverage will significantly increase the cost of charity care, and much of the burden of this increase will fall on the State budget. Any evaluation of fiscal alternatives for New York must clearly account for this charity care cost.
3) It is within the fiscal capacity of New York State to provide alternative coverage for New Yorkers disenrolled due to bureaucratic federal work requirements. The State could choose to mitigate or indeed fully eliminate the impact of work requirements on coverage.

A number of policy options are available to prevent an insurance crisis. For example, the State could offer *temporary* state-only coverage, say for three to six months. The State could also incentivize enrollees by charging a small premium for state-only coverage—say, $25 per month—with the fee to be automatically refunded if they re-enroll in federal coverage. Alternatively, enrollees could be offered a

small cash bonus if they meet federal work requirements. Any of these options would significantly decrease the total cost of the proposal, though precise costs are difficult to model.

This paper's estimates of the costs of keeping New Yorkers insured all reflect full annualized costs—but work requirements will be in effect for only the final quarter of FY27 (January–March 2027). This offers the State an opportunity to pilot State coverage options at relatively modest fiscal cost. The cost of enacting such a pilot program in FY27 would be less than a quarter of the cost of fully replacing coverage—perhaps as little as $250M—and would represent a smart investment in the long-term future of New York's Medicaid program.