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Paying More, Getting Less: Rising health care costs, poor outcomes, and harmful federal policy decisions are putting New Yorkers at risk

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Key Takeaways

- Health care costs are rising sharply across all forms of coverage, while federal policy decisions are worsening affordability and access.
- Enhanced ACA premium tax credits are set to expire, exposing individuals and families to sudden and severe premium increases.
- Employer-sponsored family coverage now averages nearly [\\$27,000](#) per year in the U.S., with workers paying more through higher premiums and deductibles.
- Even insured New Yorkers [increasingly delay or forgo care](#) due to cost and fear of medical debt, leading to worse health outcomes and higher long-term system costs.
- Recent federal changes threaten to reverse New York's coverage gains, shifting costs back to families, providers, and New York City's budget.

The National Picture: Coverage is becoming less affordable and less stable

Congress's failure to extend enhanced Affordable Care Act (ACA) premium tax credits coincides with the largest marketplace premium increases in years.¹ According to the [Congressional Budget Office](#), allowing the subsidies to expire would increase the number of uninsured Americans by 2.2 million in the first year, rising to 3.9 million by 2028. The loss of the enhanced tax credits as premiums are rising creates an immediate affordability crisis for millions of families.

Employer-sponsored family coverage now averages nearly [\\$27,000](#) per year in the U.S., with workers paying approximately \$6,850 toward premiums alone and facing steadily rising deductibles and cost sharing.

¹ The Affordable Care Act originally established premium tax credits to help offset the cost of Marketplace insurance. These credits were temporarily expanded by the American Rescue Plan Act of 2021, which increased subsidy amounts and removed the income cap on eligibility, and were later extended by the Inflation Reduction Act of 2022. Without further action, the enhanced credits are scheduled to expire on December 31st, 2025.

Financial distress is widespread — even among the insured

Rising premiums, deductibles, and cost sharing are pushing Americans into financial distress across income levels — including those with health insurance. National surveys consistently show that a majority of U.S. adults, including a substantial share of insured individuals, report difficulty affording health care or worry about their ability to pay for unexpected medical bills.^{2,3}

High deductibles and out-of-pocket maximums are particularly harmful because many households [lack the savings](#) needed to meet them. Nearly half of U.S. households lack even \$2,000 in readily available savings, and many do not have enough liquid assets to cover the typical deductible or out-of-pocket maximum in private insurance plans. As a result, health insurance increasingly exposes families to financial risk rather than protecting them from it.

Medical debt now totals at least [\\$220 billion](#) nationwide, with the largest balances concentrated among households owing more than \$10,000.

Importantly, these affordability challenges are not limited to low-income households. Concern about affording health care extends [across income levels](#), including middle- and higher-income families facing large deductibles, uncovered services, and unpredictable medical bills. A recent survey of [New Yorkers](#), found that nearly 80% worry about affording health care in the future and over two-thirds experienced at least one health care affordability burden in the last year, such as being uninsured due to cost (including dental, vision or medical), delaying or going without care due to cost, or struggling to pay medical bills.

High costs and fear of financial distress lead people to [forgo needed care](#), ultimately making people less healthy and driving costs up further.

One-quarter of Americans report that they [did not call an ambulance](#) during a medical emergency because they were worried about the cost. Fear of financial consequences — not medical judgment — is shaping how and when people seek urgent care.

Paying more — and getting worse outcomes

Despite spending more on health care than any other country, the United States delivers poorer outcomes on many basic measures of health. The U.S. spends nearly [twice as much per person](#) as other high-income nations, yet Americans experience [lower life expectancy](#), [fewer in-person physician visits](#), and [higher death rates for avoidable conditions](#).

The [Commonwealth Fund](#) ranks the United States last overall among high-income countries on health system performance, including access, equity, and health outcomes. When care is delayed

² Maese, E. (2025) [How Do Americans Experience Healthcare in Their State?](#), Gallup.

³ Sparks, G., Lopes, L., Montero A., Presiado M., and Hamel, L. (2025) [Americans' Challenges with Health Care Costs | KFF](#).

due to cost, conditions worsen, preventable complications increase, and long-term spending rises—leaving the U.S. paying more for worse results.

What this means for New York City

New York had been successful in pushing reforms to expand access to care through Medicaid expansion, the Essential Plan, and state-funded coverage for certain immigrant populations. Its uninsured rate was [4.8% versus the national average of 7.9%](#) in 2023, even before the recent Essential Plan expansion for those between 200% to 250% of the Federal Poverty Level (FPL) in April 2024. In New York City alone, more than 4 million residents are enrolled in Medicaid and another 1 million in the Essential Plan.

Federal changes now threaten to reverse these gains. An estimated [725,000](#) NYC Medicaid enrollees are expected to lose Medicaid coverage through more stringent work reporting requirements and more frequent recertifications enacted as part of the so-called One Big Beautiful Bill Act (OBBBA).⁴ And in response to federal limits on immigrant eligibility, the Governor has proposed rolling back the Essential Plan expansion for individuals with incomes between 200% to 250% FPL in order to free up [reserve funds](#).⁵ Approximately 450,000 New Yorkers, including an estimated 230,000 in NYC, are expected to lose access to their no-cost care in July 2026, pushing them into the individual Marketplace just as the enhanced tax credits expire and higher premiums go into effect. While they may still be eligible for some subsidies and cost-sharing reductions, depending on immigration status, premium payments could still be prohibitive for this income group.⁶ Many may no longer be able to afford insurance; unmet health needs and uncompensated care will rise, placing growing financial pressure on NYC Health + Hospitals and community health providers.

New York’s insurance plans continue to increase rates, even higher than the national average. One of NYC’s two premium-free plans for its municipal employees, the Health Insurance Plan of Greater New York HMO Preferred (HIP-HMO), requested a 12.7 percent increase to take effect in FY 2026 with the State Department of Financial Services (DFS) ultimately approving a 12.2%

⁴ NYC estimates are based on Congressional Districts 5 – 15.

⁵ New York accumulated approximately \$10 billion under the Essential Plan’s precursor, the Basic Health Plan, that the State can access once it reverses its recent Essential Plan (EP) expansion. These one-time funds will be used by the State to cover those immigrants losing EP eligibility because of the OBBBA’s eligibility changes, for whom the State is required by the Aliessa court ruling to provide state-only funded Medicaid (income under 138% FPL).

⁶ Individuals in this tier who lose Essential Plan coverage and who enter the Marketplace can still receive the ACA’s initial “Advance Premium Tax Credits”. Their premium contributions will be capped at 6.3% to 8.05% of their income, on a sliding scale (as opposed to 2% to 4% under the Enhanced Premium Tax Credits. See this [description](#) for more details. In addition, individuals will still receive a small amount of cost-sharing reductions that reduce deductibles and limit the the out-of-pocket maximum. See this [description](#) for more details on cost-sharing reductions.

increase.^{7,8} Similarly, NY insurers statewide requested individual insurance premiums to increase by an average of [13%](#), with DFS approving an average increase of [7.1%](#).

Federal policy changes are driving coverage losses and compounding rising health care costs, placing the City government under growing fiscal strain, increasing both demand for publicly funded care and the cost of health insurance for City employees.

Why costs keep rising

Prices, not utilization, are the primary driver of excess U.S. health care spending. Americans receive fewer services than peers but pay far higher prices for the same care, reflecting the absence of systematic price regulation throughout most of the U.S. health system.⁹

Prescription drugs are a key contributor. While public programs like [Medicaid](#) and [Medicare](#) increasingly negotiate prices, private plans often pay significantly more for the same drugs, widening the gap between public and private spending and driving up premiums and out-of-pocket costs.

Administrative waste is a major cost driver. The fragmented U.S. system requires providers to navigate thousands of insurance plans with different rules, billing practices, and appeals processes. Administrative costs borne by insurers and providers together account for [roughly 30 percent](#) of excess U.S. health care spending.

Workforce constraints further limit access and increase costs. The U.S. already has [fewer physicians and nurses](#) per capita than peer nations, particularly in primary care. Recent [federal student loan caps](#) adopted under the Trump Administration risk worsening shortages by making medical and [nursing](#) education less accessible, especially for non-traditional and lower-income students.

Industry consolidation across insurers, hospitals, pharmacy benefit managers, and physicians has continued. Concentration has increased in many markets, reducing competition. The three largest pharmacy benefit managers now control roughly [80%](#) of the market. Evidence suggests that consolidation shifts revenues and power away from providers, and does not reliably lead to

⁷ Brindisi, F. [Fiscal Note 3-2025 - Health Care Costs: The Hidden Risks in the Financial Plan](#), Office of the NYC Comptroller.

⁸ In June 2025, the City selected EmblemHealth/United Healthcare to replace GHI-CBP with a self-funded plan (NYCE PPO) effective January 1, 2026. While the Office of Labor Relations estimates up to \$900 million in annual gross savings, the City's required contribution is tied to the HIP-HMO premium rate under the Health Insurance Stabilization Fund agreement, meaning any savings may accrue to the HISF rather than reduce City costs.

⁹ Tevis, D., McGough, M., Cubanski, J., Rae, M. and Cox, C. (2025) [How do healthcare prices and utilization in the United States compare to peer nations?](#), Peterson-KFF.

lower insurance premiums or prices.^{10,11} Over time, pressure on provider reimbursement can contribute to workforce strain and reduce access to care rather than improve efficiency.¹²

Policy considerations going forward

Immediate federal action is needed: Congress should extend enhanced ACA premium tax credits to prevent families from facing sudden and severe increases in health insurance costs beginning January 1, or at least do so retroactively. A three-year extension would reduce household financial strain and avoid destabilizing insurance markets.

Durable federal reform is ultimately needed. Temporary fixes leave families and states exposed to recurring policy cliffs. A federal Medicare for All-type program would achieve greater administrative simplification and purchasing leverage than any state-level approach, guaranteeing universal access while more effectively controlling prices across the entire health care system, and would provide uniform, continuous coverage nationwide.

State-level approaches are needed in the absence of federal action. In the absence of comprehensive federal reform, New York should adopt a state-level approach to achieve many of the same goals. For example, the [New York Health Act](#) (NYHA) aims to consolidate coverage into a single statewide program, eliminating premiums, co-pays and deductibles, while simplifying financing and administration, and use savings to provide medical, mental health, dental, prescriptions, medical devices and long-term care benefits. By replacing today's fragmented system, the NYHA intends to substantially reduce administrative complexity and significantly increase the State's purchasing power.¹³ Depending on the funding mechanism, the NYHA could reduce health care costs for businesses that currently provide health coverage and

¹⁰ Levinson, Z., Godwin, J., Hulver, S., and Neuman, T. (2024) [Ten Things to Know About Consolidation in Health Care Provider Markets](#) | KFF

¹¹ Dicken, J. (2024) [Health Insurance Costs Are Increasing As Markets Become More Concentrated with Fewer Insurance Companies \(interactive map\)](#) | U.S. GAO

¹² Anderson, G., Hussey, P., and Petrosyan, V. (2019) [It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt](#) | Health Affairs

¹³ Liu, J., White, C., Nowak, S., Wilks, A., Ryan, J. and Eibner, C. (2018) [An Assessment of the New York Health Act: A Single-Payer Option for NY State](#), Rand.

for low-income households.^{14,15} And, the City could spend approximately \$3 billion less annually for health insurance for its active employees.¹⁶

Administrative simplification is a major source of potential savings.¹⁷ Analyses of the NYHA and similar single-payer models suggest that eliminating the complexity of the current insurance-based, multi-payer system could substantially reduce health care costs. This complexity includes insurer overhead, marketing, and profits, contract and price negotiations between multiple payers and providers; prior authorizations, denials and appeal processes; provider billing (with different contract language and coding schemes depending on the payer); and pharmacy intermediaries. Together, removing these inefficiencies, could reduce *overall* health spending by roughly 13% or more, with administrative costs themselves reduced by 50%-70%.^{18,19} **Additional savings could be achieved through negotiated prescription drug prices.**

De-linking health insurance from employment would improve economic efficiency.²⁰ Tying coverage to jobs creates job lock, limits worker mobility, and imposes rising and unpredictable costs on employers unrelated to their core business functions. De-linking insurance from employment would improve labor market efficiency, support entrepreneurship, and reduce cost shifting to public systems, including New York City's. Providing universal, portable coverage, such

¹⁴ Liu, J., White, C., Nowak, S., Wilks, J., Ryan, J., and Eibner, C. (2018) [Estimating the Effects of a Single-Payer Proposal in New York State](#), Rand.

¹⁵ The NYHA does not specify a specific funding or revenue structure, thus it is not possible to ascertain the impact on specific categories of individuals or businesses. Analyses typically use illustrative or proposed frameworks to model the effects.

¹⁶ Financing proposals associated with the New York Health Act have generally assumed that employers would contribute the majority of any payroll-based assessment, replacing current employer premium costs. NYC currently offers no-cost coverage options to its employees and would likely cover 100% of any payroll tax. While the Act does not specify the funding structure's details, an initial analysis associated with the Act proposed payroll taxes of 10% for salaries between \$28,500 and \$148,200 and 20% for salaries greater than \$148,200. Additional (non-payroll) taxes are proposed to cover remaining funding gaps. The estimates of potential savings for the City government use the payroll tax framework applied to FY 2025 employee salaries against the FY 2025 year-end health insurance cost. Retiree health insurance costs are excluded.

¹⁷ Galvani, A., Parpia, A., Foster, E., Singer, B., and Fitzpatrick, M. (2020) [Improving the prognosis of health care in the USA](#), The Lancet. Vol. 395.

¹⁸ Rodberg, L. (2021, Updated 2024) [Updated Analysis of the Economics of the New York Health Act](#).

¹⁹ Woolhandler, S., Campbell, T., Himmelstein, D. (2003) [Costs of Health Care Administration in the United States and Canada | New England Journal of Medicine](#) and Himmelstein, D., Woolhandler, S., and Wolfe, S. (2004) [Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States, and the District of Columbia, with State-Specific Estimates of Potential Savings](#), International Journal of Health Services, Volume 34.

²⁰ In the U.S., employer-sponsored health insurance is incentivized by federal tax policy. Employer contributions for employee health insurance are excluded from employees' taxable income and are deductible as a business expense for employers under the Internal Revenue Code, creating one of the largest federal tax expenditures. This preferential tax treatment encourages employers to provide health insurance as a workplace benefit and ties coverage to employment.

as through Medicare for All or the NY Health Act, would ensure **continuous access to care and financial protection regardless of job changes, hours worked, or other life circumstances.**

In the meantime, New York City government can provide additional support to improve access and fill gaps created by recent federal and state actions. The City should invest in [NYC Care](#) and bolster NYC Health + Hospitals so every New Yorker has access to care, regardless of ability to pay. The City should also leverage the Office of Healthcare Accountability and its recent [report](#) to identify further savings opportunities.

Bottom Line

New Yorkers are paying more for health care while receiving less financial protection. Federal instability, rising premiums, and growing cost sharing are straining households, providers, employers, and New York City's budget. Addressing these challenges will require immediate action to prevent harm—and longer-term reforms to deliver stable, affordable, and efficient coverage.

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