



Mitigating the Impact of HR 1 on New York's Health Insurance Landscape

FOUR POLICY PROPOSALS TO PRESERVE COVERAGE

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Acknowledgements

CSS is grateful to Robin Hood for its unwavering support of the needs of low-income New Yorkers and for its generous support of CSS's health care research and advocacy. We would like to thank Laura Braslow for their analytical expertise on this project. We thank the following stakeholder organizations for their help thinking through HR 1 mitigation strategies: Make the Road New York; the New York Immigration Coalition; the Coverage4All Campaign; Health Care For All New York Campaign; Medicaid Matters New York; New York Coverage and Care Campaign; and our colleagues in State government and the Legislature. We also would like to acknowledge the assistance and support of our colleagues here at CSS: David R. Jones, Steve Krause, Jeff Maclin, Carrie Tracy, Julia Stern, Alia Winters, William Pan, Juan Pinzon, Opal Lynch, and the incredible staff of the Health Initiatives Department who tirelessly work with health care consumers on their health care affordability and coverage matters.



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Executive Summary

This paper describes options for New York State to consider in response to major cuts to the eligibility and financing of health insurance for lawfully present immigrant and citizen New Yorkers.

On July 4, 2025, President Trump signed House of Representatives Bill 1 (“HR 1”), enacting a cascading series of health care cuts that will disproportionately impact New York State. The Hochul Administration estimates that approximately 1.5 million New Yorkers are likely to become uninsured over the next few years due to HR 1. The coverage cuts imposed by HR 1 impact three types of public health insurance programs: (1) Medicaid; (2) the Essential Plan (EP); and (3) Qualified

Health Plans (QHPs) on the NY State of Health Marketplace.¹ Currently, 6.8 million New Yorkers are enrolled in Medicaid, 1.5 million are enrolled in the EP, and 220,000 purchase QHPs.

Under HR 1, eligibility for federally funded health coverage is reduced from over a dozen immigration statuses to just three (referred to here as the “HR 1 Qualified Immigrants”).² Federally funded health coverage is phased out over several years for all other categories of lawfully present immigrants. In New York, the changes to immigrant eligibility rules under HR 1 mean the loss of federal funding for approximately 670,000 people, including: 60,000 Medicaid beneficiaries; over 590,000 EP enrollees; and 20,000 QHP enrollees. *See Figure 1.*

Figure 1. Immigrant New Yorkers Losing Federal Funding Under HR 1

| | Population | Impact of HR 1 | Estimated Number of Lawful Immigrants Enrollees Losing Federal Funding |
|--|--|--|--|
| Medicaid | Medicaid (0-138% of FPL) | Lose federal financial participation for lawfully present immigrants who are not HR 1 Qualified on October 1, 2026 | 60,000 |
| Essential Plan | EP 1 (Non-Medicaid, 150%-200% FPL) | Lose federal financial participation for immigrants who are not HR 1 Qualified on January 1, 2027 | 59,000 |
| | EP 2 (Non-Medicaid, 138%-150% FPL) | Lose federal financial participation for immigrants who are not HR 1 Qualified on January 1, 2027 | 30,000 |
| | EP 3 (<i>Aliessa</i> , 100%-138% FPL) | Lose federal financial participation on January 1, 2027 | 59,000 |
| | EP 4 (<i>Aliessa</i> , < 100% FPL) | Lost federal financial participation on January 1, 2026 | 401,000 |
| | EP 5 (Non-Medicaid, 200%-250% FPL) | 1332 Waiver program will be terminated on July 1, 2026, pending federal approval. | 40,000 |
| Qualified Health Plans | | Lawful immigrants lose federal funding on January 1, 2027 | 20,000 |
| Grand Total: Number of Immigrants Set to Lose Federal Funding | | | 669,000 |

As a result of a 2001 Court of Appeals decision, *Aliessa v. Novello*, the State must offer coverage to many lawful immigrants, despite the loss of federal funding.³

This paper explores four proposals that New York State policymakers can consider to mitigate the loss of federal funding coverage for legal immigrants enrolled in Medicaid, EP, and QHPs:

1. Return to operating a Basic Health Program (BHP) to use the surplus BHP Trust Funds to retain EP coverage for 609,000 BHP-eligible lawfully present immigrants.
2. Offer State-only funded EP to the 444,000 New Yorkers (citizens and immigrants) expected to lose EP eligibility mid-2026.

3. Offer State-only funded EP to the 6,000 DACA and other residual PRUCOL immigrants with incomes between 138-200 percent of the federal poverty level (FPL).⁴
4. Create a State-only funded premium assistance program to make QHPs equally affordable for 30,000 lawfully present immigrants as their citizen counterparts.⁵

New York can preserve coverage for 480,000 people for as little as \$2.3 billion a year under these proposals.

The History and Financing of New York's Essential Plan

In 2015, New York launched its Basic Health Program (BHP) pursuant to Section 1331 of the Affordable Care Act (ACA). This provision of the ACA provided federal funding to support coverage for citizens or lawfully present immigrants with incomes under 200 percent of the federal poverty level (FPL) who were ineligible for Medicaid because of their income or immigration status. New York State branded its BHP the “Essential Plan” (EP). Adoption of the BHP enabled New York to secure federal financing for over 300,000 lawful immigrants who at the time had State-only Medicaid and Family Health Plus coverage as a result of the *Aliessa* litigation that challenged the State’s implementation of the Personal Responsibility and Work Opportunity Act (PRWORA) of 1996.⁶

Under the BHP, the federal government finances 95 percent of the Advanced Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs) that eligible enrollees would receive in financial

assistance to purchase the second lowest cost silver plan on the marketplace instead of being enrolled in a BHP. These funds are prospectively deposited into the BHP Trust Fund on a quarterly basis to support the purchase of coverage for BHP enrollees. The BHP Trust Fund generates surplus revenue because the differential between the second lowest cost silver plan premium rate and a factor of the Medicaid premium rate can be substantial—depending on the rating factor used to set the BHP premium rate.

On April 1, 2024, New York expanded eligibility for the EP under the ACA’s Section 1332 Innovation Waiver authority.⁷ The funding methodology under a 1332 Waiver is more favorable than that provided under the BHP.⁸ Under the 1332 Waiver, EP income eligibility for consumers was increased from 200 percent to 250 percent of FPL. The 1332 surplus funds also were used to support a major health plan premium rate increase that increased provider

reimbursement rates from approximately 125 percent of Medicaid for the first 7 years of operation (between 2016-2022) to as high as 225 percent of Medicaid for the 2025 plan year.⁹ The 2025 enhanced rates helped offset Medicaid losses experienced by hospitals and other health care providers. The State reduced the EP plan rates to 220 percent of Medicaid for the 2026 plan year.¹⁰

Since its launch, EP enrollment has grown steadily—from 380,000 in 2016 to 1.7 million in 2025.¹¹ Its popularity is attributed to: the lack of monthly premiums and deductibles; comprehensive health benefits (including vision and dental); and limited cost sharing. While the 1332 Waiver is operating, the BHP Trust Fund account, which has grown to \$8.9 billion, was placed in suspension in the event the State sought to return to operating a BHP.¹² Under HR 1, many categories of lawful immigrants no longer qualify for federal financial assistance (APTCs and CSRs) to pay for coverage. This cut substantially reduces the amount of funding New York receives to operate the EP under either the 1332 Waiver or BHP programs.

However, HR 1 did not terminate the *eligibility* for lawful immigrants to participate in a BHP—only the prospective federal *funding* associated with enrolling these immigrants. The Senate Parliamentarian ruled that the BHP eligibility could not be amended through the federal budget reconciliation process under the Senate’s procedures (called the Byrd rule).¹³

On September 10, 2025, New York State notified the federal government of its intention to phase out its 1332 Waiver program and return to operating a 1331 BHP.¹⁴ Under the BHP, New York will be able to continue to cover lawfully present immigrants with incomes between 0-200 percent of FPL and citizens above the Medicaid income eligibility levels (typically 138 percent of FPL). The State intends to access the \$8.9 billion BHP Trust Fund, which had been placed in suspension during the operation of the 1332 Waiver, to fund coverage for EP enrollees who no longer have federal financing for coverage. However, 444,000 citizens and lawful immigrants with incomes between 200 and 250 percent of FPL will no longer be eligible for free EP coverage after July 2026, absent State intervention.

Health Insurance Coverage Options that Mitigate the Impact of HR 1

This report investigates four coverage proposals for preserving access to health insurance in the wake of the federal cuts to funding and eligibility under HR 1: (1) return to operating a BHP under the ACA and use the surplus BHP Trust Funds to retain EP coverage for 609,000 BHP-eligible lawfully present immigrants; (2) offer State-only funded EP to the 444,000 New Yorkers expected to lose EP eligibility mid-2026; (3) offer State-only

funded EP to the 6,000 DACA and other residual PRUCOL immigrants with incomes between 138-200 percent of the FPL; and (4) create a State-only funded premium assistance program to make QHPs equally affordable for 30,000 lawfully present immigrants as their citizen counterparts.

Proposal 1: Return to Operating a Basic Health Program to Retain Essential Plan Coverage for 609,000 BHP-Eligible Lawfully Present Immigrants

HR 1 destabilizes the financing for the State’s 1332 Waiver by cutting federal Medicaid and APTC/CSR eligibility for many categories of lawful immigrants in three phases: (1) on January 1, 2026, for lawful immigrants with incomes below 100 percent FPL who were not eligible for federally funded Medicaid; (2) on October 1, 2026 for lawful immigrants who were previously eligible for federally funded Medicaid; and (3) on January 1, 2027, for lawful immigrants with incomes above 100 percent FPL. Under HR 1, just three groups of immigrant categories will retain federal funding for coverage (the “HR 1 Qualified Immigrants”): (1) people with Lawful Permanent Residence status (Green Card holders) for more than five years; (2) Cuban and Haitian entrants; and (3) people from the Compacts of Free Association States (citizens of Micronesia, Palau, and the Marshall Islands).

As noted above, the language in HR 1 that was initially included to terminate *eligibility* for BHP for nearly all lawful immigrants was rejected. Accordingly, most lawfully present immigrants are still eligible for BHP, but no new *federal funding* associated with their coverage will be generated.

To maximize the number of New Yorkers able to access EP coverage, New York submitted a request to terminate its 1332 waiver and re-activate its BHP on October 21, 2025. If granted, the termination of the 1332 Waiver and return to BHP would occur on July 1, 2026. Under the BHP,

eligibility will be reduced to New Yorkers with incomes up to 200 percent of FPL (down from 250 percent). This change will render 444,000 citizen and immigrant New Yorkers with incomes between 200 and 250 percent of FPL ineligible for the EP. *See* Proposal 2 for coverage options for this group.

Under the renewed BHP, two groups will be enrolled in EP: (1) revenue-generating citizens and HR 1 Qualified Immigrants (described above); and (2) lawfully present immigrants who will not generate new BHP revenue (but would still be enrolled). *See* Figure 2. New York currently has an \$8.9 billion surplus in its BHP Trust Fund. The State can use the BHP Trust Fund to cover individuals enrolled in the EP program and help recoup some of the losses in federal funding. But the setting of EP health plan premium rates will determine how long the BHP Trust Fund will last. *See* Figure 2.

Once New York State returns to a BHP in mid-2026, there will be two groups of individuals generating revenue. In 2026, individuals generating revenue for the EP program will be: (1) citizens and HR 1 Qualified Immigrants with incomes between 138 and 200 percent of FPL; (2) lawfully present immigrants with incomes between 100 and 200 percent of FPL (between July 1-December 31, 2026). As of January 1, 2027, after all the immigrant eligibility cuts have been phased in, the number of BHP enrollees generating revenue will be around 693,000

Figure 2. BHP Enrollees by Federal Revenue Generation

| | January 2026 | Mid-2026 (Average enrollment) | 2027 and beyond (Projected enrollment) |
|-------------------------------------|---------------------|---|--|
| Revenue-generating enrollees | 1,285,000 | 841,000 | 693,000 |
| Non-revenue-generating enrollees | 401,000 | 461,000 | 609,000 |
| Total estimated EP enrollees | 1,686,000 | 1,303,000 | 1,303,000 |

(citizens and HR 1 Qualified Immigrants). The number of BHP enrollees who will *not* be generating revenue will be around 609,000. See Figure 2.

To calculate the annual revenue generated for the BHP Trust Fund, the number of revenue-generating enrollees is multiplied by the amount of federal financial participation attributed to them (95 percent of what they would have received in APTC and CSR if they were enrolled in the second-lowest cost silver plan).¹⁵ See Methodology. This value was added to the baseline of \$8.9 billion already in the BHP Trust Fund to estimate the BHP Trust fund value, with no expenditures. See Figure 3.

The 1332 Waiver was projected to spend \$12.6 billion for calendar year 2026, or \$6.3 billion for the first six months. The revenue associated with this period was projected to be \$13 billion for the year, or \$6.5 billion for the first six

months of 2026.¹⁶ Accordingly, there would not be adequate funding to operate the 1332 Waiver over time as additional federal funding associated with lawfully present immigrant enrollees is eliminated.

Figure 3 describes the new annual BHP Trust Fund revenue (first row) and its overall value with no expenditures (second row), including the previously suspended \$8.9 billion BHP Trust Fund, for the period July 1, 2026 through December 31, 2032.

To determine how long the BHP trust fund would remain solvent, the cost to cover both revenue-generating and non-revenue-generating enrollees at the current premium rate (220 percent of the Medicaid rate) is subtracted from the BHP trust fund value with no expenditures. Without reducing EP rates, the BHP trust fund would be on a trajectory to become insolvent by 2032. See Figure 4.

Figure 3. BHP Trust Fund Revenue Generated by Year (in millions)

| | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 |
|---|----------|----------|----------|----------|----------|----------|----------|
| BHP Trust Fund new revenue generated | \$5,000 | \$8,650 | \$9,120 | \$9,630 | \$10,160 | \$10,710 | \$11,300 |
| BHP Trust Fund value with no expenditures | \$13,900 | \$22,540 | \$31,670 | \$41,290 | \$51,450 | \$62,160 | \$73,460 |

Figure 4. Net BHP Trust Fund Value with No EP Rate Adjustment (in millions)

| | | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 |
|---|---------------------------------|----------------|----------------|----------------|----------------|----------------|--------------|-------------------|
| No rate intervention (220% of Medicaid) | BHP Trust Fund Spending | \$4,200 | \$10,330 | \$10,860 | \$11,420 | \$12,000 | \$12,620 | \$13,280 |
| | Net BHP Trust Fund value | \$9,700 | \$8,020 | \$6,280 | \$4,490 | \$2,640 | \$730 | (-\$1,240) |

However, the State can ensure the long-term sustainability of the BHP Trust Fund by tweaking the EP health plan premium rates. Notably, the BHP Trust Fund ran up a substantial surplus for the first seven years of the program, when the premium rates were set at 125 percent of Medicaid.

Four scenarios of EP rate interventions are modeled through 2032: (1) reducing the EP premium to 200 percent of the Medicaid premium rate; (2) reducing the EP premium to 175 percent of the Medicaid premium rate;

(3) reducing the EP premium to 150 percent of the Medicaid premium rate; and (4) returning to the baseline EP premium, or 125 percent of the Medicaid premium rate. Depending on the health plan premium rate, the cost for running the program for six and a half years would range from \$46.3 billion to \$74.7 billion.

In all four scenarios, reducing the EP rate would keep the BHP Trust Fund solvent through 2032. The net value of the Trust Fund would range from \$5.5 to \$27 billion, depending on the magnitude of the rate reduction. *See* Figure 5.

Figure 5. Net BHP Trust Fund Value with EP Rate Adjustments (in millions)

| | | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 |
|--|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Small rate intervention (200% of Medicaid) | BHP Trust Fund Spending | \$3,820 | \$9,390 | \$9,870 | \$10,380 | \$10,920 | \$11,480 | \$12,070 |
| | Net BHP Trust Fund value | \$10,080 | \$9,340 | \$8,590 | \$7,840 | \$7,080 | \$6,310 | \$5,550 |
| Moderate rate intervention (175% of Medicaid) | BHP Trust Fund Spending | \$3,340 | \$8,220 | \$8,640 | \$9,080 | \$9,550 | \$10,040 | \$10,560 |
| | Net BHP Trust Fund value | \$10,560 | \$10,990 | \$11,480 | \$12,020 | \$12,620 | \$13,290 | \$14,040 |
| Significant rate intervention (150% of Medicaid) | BHP Trust Fund Spending | \$2,860 | \$7,040 | \$7,400 | \$7,790 | \$8,190 | \$8,610 | \$9,050 |
| | Net BHP Trust Fund value | \$11,030 | \$12,640 | \$14,360 | \$16,200 | \$18,170 | \$20,270 | \$22,530 |
| Return to BHP Baseline rate (125% of Medicaid) | BHP Trust Fund Spending | \$2,600 | \$6,400 | \$6,730 | \$7,080 | \$7,440 | \$7,830 | \$8,230 |
| | Net BHP Trust Fund value | \$11,300 | \$13,540 | \$15,930 | \$18,480 | \$21,190 | \$24,080 | \$27,160 |

Proposal 2: Offer a State-Only Funded Bridge Program for the 444,000 New Yorkers (citizen and immigrants) Slated to Lose Essential Plan Coverage in Mid-2026

On July 1, 2026, pending federal approval, EP coverage for 444,000 New Yorkers with incomes between 200 and 250 percent of FPL will end with the termination of the 1332 Waiver. As a result, this population will need to find alternate health insurance coverage for the remainder

of 2026 and subsequent years or go without insurance entirely. Citizens, lawful immigrants for the remainder of 2026, and HR 1 Qualified immigrants in this program will be eligible for financial assistance through the NY State of Health Marketplace. But for many, these plans

will be unaffordable or a poor value proposition. This is because a typical “silver” plan for these individuals would cost around \$200 a month, after subsidies, and come with a \$2,450 deductible for the remaining coverage year.

The State could consider offering a transition bridge to this group of people by providing State-only funded coverage through the end of 2026, until open enrollment for 2027. Depending on the EP premium rate, this would cost between \$960 million and \$1.7 billion. See Figure 6.

Between July 2026 and December 2032, the costs of the State paying for EP premiums for six and a half years would range from \$14.8 billion to \$26 billion depending on the EP premium rate paid to the health plans. See Figure 7.

Alternately, the State could charge a modest \$50 premium to EP enrollees with incomes over 200 percent of FPL. Charging consumers a monthly premium would substantially suppress enrollment. Before the State adopted its 1332 Waiver, just 78,000 individuals with incomes between 200-250 percent of FPL paid premiums to enroll in QHPs through the NY State of Health Marketplace, for a 17 percent take up rate.¹⁷

A State-funded EP program with a \$50 monthly premium would cost between \$468 million and \$824 million annually (2027), or \$3.4 to \$6.1 billion over six and a half years. This assumes a conservative 25 percent take up rate, or that 113,000 out of the current 444,000 EP enrollees would pay a \$50 month premium to enroll into coverage. See Figure 8.

Figure 6. Proposal 2A: Cost of Continuing a Free EP 5 Program for Six Months, with Rate Adjustments

| | 2026 Per Member Per Month Premiums | Six-Month Cost to the State (in millions) |
|---|------------------------------------|---|
| No rate intervention (220% of Medicaid) | \$636 | \$1,700 |
| Small rate intervention (200% of Medicaid) | \$578 | \$1,540 |
| Moderate rate intervention (175% of Medicaid) | \$506 | \$1,350 |
| Significant rate intervention (150% of Medicaid) | \$434 | \$1,160 |
| BHP Baseline premium rate (125% of Medicaid) | \$361 | \$960 |

Figure 7. Proposal 2A: Cost of Continuing a State-Only Funded Free EP 5 Program, with Rate Adjustments (in millions)

| | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | Total |
|---|----------|---------|---------|---------|---------|---------|---------|-----------------|
| No rate intervention (220% of Medicaid) | \$1,700 | \$3,560 | \$3,750 | \$3,940 | \$4,140 | \$4,360 | \$4,580 | \$26,030 |
| Small rate intervention (200% of Medicaid) | \$1,540 | \$3,240 | \$3,410 | \$3,580 | \$3,770 | \$3,960 | \$4,170 | \$23,660 |
| Moderate rate intervention (175% of Medicaid) | \$1,350 | \$2,840 | \$2,980 | \$3,140 | \$3,300 | \$3,470 | \$3,640 | \$20,700 |
| Significant rate intervention (150% of Medicaid) | \$1,160 | \$2,430 | \$2,560 | \$2,690 | \$2,830 | \$2,970 | \$3,120 | \$17,750 |
| BHP Baseline premium rate (125% of Medicaid) | \$960 | \$2,030 | \$2,130 | \$2,240 | \$2,350 | \$2,480 | \$2,600 | \$14,790 |

Figure 8. Proposal 2B: Cost of State-Only Funded \$50 Monthly Premium EP Buy-In Program, with Rate Adjustments (in millions)

| | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | Total |
|--|----------|-------|-------|-------|-------|---------|---------|----------------|
| No rate intervention (220% of Medicaid) | \$390 | \$824 | \$870 | \$919 | \$969 | \$1,023 | \$1,079 | \$6,075 |
| Small rate intervention (200% of Medicaid) | \$355 | \$750 | \$791 | \$835 | \$881 | \$930 | \$981 | \$5,522 |
| Moderate rate intervention (175% of Medicaid) | \$311 | \$656 | \$692 | \$731 | \$771 | \$814 | \$858 | \$4,832 |
| Significant rate intervention (150% of Medicaid) | \$266 | \$562 | \$593 | \$626 | \$661 | \$697 | \$736 | \$4,142 |
| BHP Baseline premium rate (125% of Medicaid) | \$222 | \$468 | \$495 | \$522 | \$551 | \$581 | \$613 | \$3,451 |

Proposal 3: Offer State-Only Funded Essential Plan Coverage to the 6,000 DACA and Other Residual PRUCOL Immigrants with Incomes Between 138-200 percent of FPL

Under the *Aliessa v. Novella* case, New York must provide public health insurance coverage to immigrants who are deemed to be permanently residing under color of law (or “PRUCOL”). Most PROCUL immigrants are classified as “lawfully present” under the ACA and the BHP. However, a small group of immigrants, including those with Deferred Action for Childhood Arrivals (DACA) status, are not classified as “lawfully present,” but are considered to have PRUCOL status for *Aliessa* purposes. This group is referred to as the “residual PRUCOLs.”¹⁸

In 2023, New York State sought and received permission from the federal government to fund EP coverage for approximately 3,000 individuals with DACA status and incomes under 250 percent of FPL through the 1332 Waiver. In July 2026, when the State returns to operating a BHP, enrollment in EP for the DACA immigrants will end absent State intervention.

Altogether there are approximately 6,000 DACA and residual PRUCOL immigrants with incomes between the State Medicaid income eligibility level (138 percent of FPL) and the BHP income eligibility level (200 percent of FPL). The State could provide EP coverage to this population to ensure that they have equivalent coverage as their citizen and lawfully present counterparts.

Since 2001, New York State has provided coverage (i.e., Medicaid or Family Health Plus) for immigrants determined to have residual PRUCOL status on the same basis as other lawfully present immigrants.¹⁹

The cost of covering this group of people would be between \$29-\$50 million annually (2027), or between \$206-\$362 million for six and a half years through 2032, depending on the rate set for their premiums. See Figure 9.

Figure 9. Cost of State-Only Funded EP Coverage for DACA and Residual PRUCOL Immigrants (in millions)

| | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | Total |
|---|----------|------|------|------|------|------|------|--------------|
| No rate intervention (220% of Medicaid) | \$24 | \$50 | \$53 | \$55 | \$57 | \$60 | \$63 | \$362 |
| Small rate intervention (200% of Medicaid) | \$22 | \$46 | \$48 | \$50 | \$52 | \$55 | \$57 | \$329 |
| Moderate rate intervention (175% of Medicaid) | \$19 | \$40 | \$42 | \$44 | \$46 | \$48 | \$50 | \$288 |
| Significant rate intervention (150% of Medicaid) | \$16 | \$34 | \$36 | \$37 | \$39 | \$41 | \$43 | \$247 |
| Return to BHP baseline rates (125% of Medicaid) | \$14 | \$29 | \$30 | \$31 | \$33 | \$34 | \$36 | \$206 |

Proposal 4: Create a State-Only Funded Premium Assistance Program to Make Qualified Health Plans Equally Affordable for 30,000 Lawfully Present Immigrants as to Their Citizen Counterparts

Under HR 1, for the first time since the enactment of the ACA, lawfully present immigrants with incomes between 200 and 400 percent of FPL will lose eligibility for financial assistance, APTCs, to purchase QHPs through the ACA Marketplaces. In New York, there are approximately 20,000 lawfully present immigrants purchasing QHP coverage. In addition, there are an estimated 40,000 lawfully present immigrants who were enrolled in the 1332 Waiver’s EP expansion who will lose eligibility for APTCs and a small amount of CSRs.

Without financial assistance, the cost of a silver plan in the Marketplace is over \$850 per member per month, or \$10,200 a year. Immigrants enrolled in the Marketplace tend to be younger and healthier. Retaining their enrollment benefits their citizen counterparts because the enrollment of healthier and younger individuals brings

down the costs of coverage for all enrollees due to New York’s pure community rating rules.

The State could establish a State-funded premium assistance program to provide equivalent financial assistance to immigrants as the amounts received by their citizen counterparts to purchase coverage.

The costs of providing a State-funded premium assistance program for 30,000 lawfully present immigrants beginning 2027 would start at approximately \$244 million per year, or over \$1.7 billion for six years. *See* Figure 10. These estimates conservatively assume that 25 percent of lawfully present immigrants previously enrolled in the 1332 Waiver’s EP expansion would enroll in QHPs at a premium equivalent to their citizen counterparts.

Figure 10. Cost of a State-Only Funded Premium Assistance Program for Lawfully Present Immigrants Between 200-400 percent of FPL (in millions)

| | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | Total |
|--|-------|-------|-------|-------|-------|-------|----------------|
| State-Funded Premium Assistance Program | \$244 | \$260 | \$277 | \$295 | \$313 | \$333 | \$1,721 |

Conclusion

New York has an opportunity to mitigate the impact of HR 1 on its citizens and lawfully present residents. Relative to other states, New York has an important policy lever—in the form of the BHP Trust Fund—that can be used to continue to provide coverage for many lawfully present immigrants. Likewise, the State has extensive experience flexing health insurance plan premium rates to ensure that State dollars are used wisely to benefit the most people.

This paper describes four proposals for policymakers to consider: (1) returning to the BHP to preserve coverage for lawfully present immigrants; (2) establishing a temporary State-funded premium assistance program through the end of 2026 for the 444,000 citizen and immigrant New Yorkers losing EP eligibility;

(3) providing State-only funded coverage for 6,000 DACA and residual PRUCOL immigrants with incomes between 138-200 percent of FPL; and (4) establishing a State-only funded Premium Assistance Program to 30,000 lawfully present immigrants to purchase QHPs.

Assuming that New York moves forward with its plans to resume its BHP, the State is in an enviable position to have over \$3 billion to help mitigate HR 1's impact on its residents and continue to move forward with the goal of achieving affordable, quality coverage for all of its residents.²⁰ The policy proposals presented in this paper provide a flexible roadmap for New York to preserve coverage for 480,000 people for as little as \$2.3 billion a year.

Figure 11. Summary of Policy Proposals to Mitigated HR 1 on Health Care Coverage in New York State

| Policy Proposal | | Estimated Enrollment | Range of Costs (State funding unless otherwise specified) | | | |
|---|-----------------------------------|----------------------|--|-----------------------------------|-----------------------------------|-----------------------------------|
| | | | Annual (2027) | | Six-year period (Mid-2026-2032) | |
| | | | Low Premium Rate | High Premium Rate | Low Premium Rate | High Premium Rate |
| 1. Return to BHP | | 1,300,000 | \$6.4 billion Federal Funding | \$10.3 billion Federal Funding | \$46.3 billion Federal Funding | \$74.7 billion Federal Funding |
| 2. Transition for EP 5 enrollees | Option 2A No premium | 440,000 | \$960 million (six months) | \$1.7 billion (six months) | \$14.8 billion | \$26 billion |
| | Option 2B \$50 premium | 113,000 | \$222 million (six months) | \$390 million (six months) | \$3.5 billion | \$6.1 billion |
| 3. Cover DACA/RP | | 6,000 | \$29 million | \$50 million | \$206 million | \$362 million |
| 4. State-Funded Premium Assistance for QHP | | 30,000 | \$244 million | | \$1.7 billion | |

Methodology

The population counts, coverage, and cost impacts of the proposals described in this report were generated by the Community Service Society of New York. This report utilizes population and coverage cost data produced by the New York State Department of Health and its vendors. Supplemental information and modeling inputs from other recognized sources, such as the Kaiser Family Foundation.

Most population counts used in this report are based on direct observation of enrollment in current NYS coverage programs, including Medicaid, EP, and QHP. The timeframes for when populations would become eligible for the proposed coverage changes follow the timelines for changes under HR 1 and other relevant policy changes affecting each group. Given the evolving policy environment, CSS does not assume any further changes in these populations over time. These projections assume that only groups impacted by coverage and cost changes under HR 1 would participate in these coverage proposals.

- For the BHP and EP-related proposals where enrollees losing coverage would experience no changes in current cost sharing, CSS assumes that all current enrollees in the eligible coverage groups will be covered under the proposal.
- For the proposal to offer a State-only funded \$50 monthly premium EP buy-in program, CSS assumes a conservative 25 percent take-up rate among eligible enrollees.
- For the proposal to offer a State-only funded premium assistance program to make QHPs affordable, CSS assumes that all current lawfully present immigrant QHP enrollees will participate, and 25 percent of lawfully present immigrants currently enrolled in the 1332 Waiver EP expansion will participate.

Coverage costs and BHP Trust Fund revenue analyses utilize current and historical data for EP and QHP premiums, trended according to observed historical trend rates for each program.

- 2026 Essential Plan premium rates for each eligibility group (EP1-EP5) are drawn from the 2026 New York State Department of Health Essential Plan Rate Development presentation (Bureau of Managed Care Reimbursement). For future years, CSS applied an average observed 2025-2026 trend rate of 5.15 percent for each premium group.
- 2026 Qualified Health Plan premium rates are estimated based on the New York State Marketplace Average Benchmark Premiums provided by Kaiser Family Foundation. For future years, given the high volatility in observed QHP premium trends, CSS applied the observed 2025-2026 average trend rate of 5.5 percent.
- The Marketplace Average Benchmark Premiums are based on the Second-Lowest Cost Silver Plan (SLCSP), which is the benchmark used to calculate Advanced Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs) under the ACA. These premium rates are used to calculate both QHP costs and BHP Trust Fund revenue.

For the proposals where options are provided that would reduce EP premiums, the specific reductions are identified within the paper as a proportional reduction in the baseline and trended Essential Plan premiums, relative to Medicaid.

Endnotes

- 1 There are 19.8 million residents in New York State. The largest portion of these individuals have access to coverage through their jobs (8.9 million). An additional 3.94 million have Medicare coverage. These groups may experience some coverage disruptions that are not the focus of this report.
- 2 The HR 1 Qualified Immigrants have one of three statuses: (1) Lawful Permanent Residents (“green card holders”) for more than five years; (2) Cuban and Haitian entrants; and (3) immigrants from the Compacts of Free Association (e.g., citizens of Micronesia, Palau, and the Marshall Islands).
- 3 *Aliessa v. Novello*, 730 N.Y.S.2d 1 (2001).
- 4 The 6,000 immigrants in this proposal are current distributed between EP1 and EP2 in Figure 1.
- 5 The 30,000 people in this proposal include the 20,000 lawful immigrants in Qualified Health Plans and 10,000 lawful immigrants in EP 5. See Proposal 4 for more detail.
- 6 E. Benjamin, A. Slagle, “Bridging the Gap: Exploring the Basic Health Insurance Option for New York,” (January 2012). <https://www.cssny.org/publications/entry/bridging-the-gapjune2011revisedjanuary2012>.
- 7 New York State Department of Health, “Submission to the Centers for Medicare and Medicaid Services: 1332 Waiver Amendment Application,” June 28, 2024. https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Amendment_6.28.2024.pdf.
- 8 Under a Section 1332 Waiver, a state may receive the 100 percent of what it would have spent on the impacted population’s Advance Premium Tax Credits and Cost Sharing Reductions. See 42 U.S.C. Section 18052(a)(3); see also, U.S. Congress, “State Innovation Waivers: Frequently Asked Questions, Report No. R44760, January 29, 2021. The Basic Health Program’s financing is slightly less generous at 95 percent.
- 9 Other states used the 1332 waiver to generate surplus passthrough funds to support expanding coverage to undocumented immigrants, including Washington and Colorado.
- 10 New York State Department of Health, Bureau of Managed Care Reimbursement, “Essential Plan Rate Development,” January 2026 - December 2026.
- 11 New York State of Health, “2016 Open Enrollment Report,” August 2016. “Essential Plan and Qualified Health Plan Enrollment by County and Plan as of December 2025.” <https://info.nystateofhealth.ny.gov/enrollmentdata>.
- 12 New York Division of Budget, “FY2026 NYS Enacted Budget Financial Plan: Mid-Year Update,” page 136. <https://www.budget.ny.gov/pubs/archive/fy26/enfy26fp-en-myu.pdf#page=142>.
- 13 The Senate’s Byrd Rule, August 2025. <https://www.congress.gov/crs-product/R48640>.
- 14 New York State Department of Health, “Submission to the Centers for Medicare and Medicaid Services: New York State’s Request to Terminate the Section 1332 State Innovation Waiver and Return to the Basic Health Program,” October 21, 2025. <https://info.nystateofhealth.ny.gov/sites/default/files/1332%20Termination%20Notice%2010-20-25.pdf>.
- 15 KFF, “Marketplace Average Monthly Benchmark Premiums,” 2026. <https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums>.
- 16 New York Section 1332 Innovation Wavier Essential Plan Expansion Waiver Term Alignment Requests, updated, December 11, 2024, at Table E4 & E5 (pp. 44-45). <https://info.nystateofhealth.ny.gov/sites/default/files/NYS%201332%20Waiver%20Term%20Alignment%20Request%2012-11-24%20final%20updated.pdf>
- 17 NY Section 1332 Innovation Waiver Essential Plan Expansion Draft Amendment, May 28, 2024, p. 15. <https://info.nystateofhealth.ny.gov/sites/default/files/NY%201332%20Waiver%20Draft%20Amendment%205.28.2024.pdf>
- 18 Immigrants considered to have “residual PRUCOL” status are: Applicants for immigration benefits who do not have an employment authorization document; Registry Aliens (arrived before 1/1/72); immediate relatives with approved I-130 documentation; Deferred Action for Childhood Arrival (including applicants for DACA); and those who have requested Deferred Action; and other noncitizens residing in the US with the knowledge, permission or acquiescence of USCIS/ICE. See “NYS: Immigrant Health Coverage” chart, available from the Community Service Society of NY.

- 19 New York State Department of Health, Documentation Guide Immigrant Eligibility for Health Coverage in New York State, February 2004, https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/04ma003att1.pdf
- 20 NYS Division of Budget, “NYS FY 2027 Executive Budget Briefing Book,” page 67. <https://www.budget.ny.gov/pubs/archive/fy27/ex/book/briefingbook.pdf>.

Appendix

Take up estimate sensitivity analysis for Essential Plan buy-in program

Proposal 2B estimates how much it would cost to charge a \$50 premium for the Essential Plan to individuals with incomes between 200 and 250 percent of FPL who are slated to lose coverage on July 1, 2026. A sensitivity analysis was applied, assuming 10 percent, 25 percent, and 40 percent take up rates. The main paper adopted the 25 percent take up rate. Assuming a 40 percent take up rate, this proposal would cost the State more, from \$350-\$620 million for six months, or \$750 million to \$1.3 billion per annum. *See* Alternative Figure 8.

Alternative Figure 8. Proposal 2B: Cost of State-Only Funded \$50 Monthly Premium EP Buy-In Program, with Rate Adjustments (40% take up, in millions)

| | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | Total |
|--|----------|---------|---------|---------|---------|---------|---------|----------------|
| No rate intervention (220% of Medicaid) | \$620 | \$1,320 | \$1,390 | \$1,470 | \$1,550 | \$1,640 | \$1,730 | \$9,720 |
| Small rate intervention (200% of Medicaid) | \$570 | \$1,200 | \$1,270 | \$1,340 | \$1,410 | \$1,490 | \$1,570 | \$8,840 |
| Moderate rate intervention (175% of Medicaid) | \$500 | \$1,050 | \$1,110 | \$1,170 | \$1,230 | \$1,300 | \$1,370 | \$7,730 |
| Significant rate intervention (150% of Medicaid) | \$430 | \$900 | \$950 | \$1,000 | \$1,060 | \$1,120 | \$1,180 | \$6,630 |
| BHP Baseline premium rate (125% of Medicaid) | \$350 | \$750 | \$790 | \$840 | \$880 | \$930 | \$980 | \$5,520 |

Applying rate adjustments to only the hospital portion of the Essential Plan premium rate

When it implemented the 1332 State Innovation Waiver, the New York State Department of Health, Office of Health Insurance Programs issued [Essential Plan Guidance 3.1: Updated Information Regarding EP Rate Setting Assumptions for Calendar Year 2023 and 2024](#) (dated April 22, 2024). This Guidance indicates that the Department “expects” that EP health plans should raise provider reimbursements for hospital inpatient, hospital outpatient, and physician services (or approximately 40 percent of an EP rate cell). Calibrating the analysis in this paper to reflect EP rate adjustments solely on these components of an annual EP premium rate would result in a quicker spend down of the BHP Trust Fund. See Alternative Figure 5. Additionally, the cost to the State would be slightly different for Proposal 2A, Proposal 2B, and Proposal 3. See Alternative Figures 7, 8 and 9.

Alternative Figure 5. Net BHP Trust Fund Value with EP Rate Adjustments (hospital cost only adjustments, in millions)

| | | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 |
|--|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Small rate intervention (200% of Medicaid) | BHP Trust Fund Spending | \$4,050 | \$9,950 | \$10,460 | \$11,000 | \$11,570 | \$12,170 | \$12,790 |
| | Net BHP Trust Fund value | \$9,850 | \$8,500 | \$7,210 | \$5,830 | \$4,410 | \$2,960 | \$1,470 |
| Moderate rate intervention (175% of Medicaid) | BHP Trust Fund Spending | \$3,850 | \$9,480 | \$9,970 | \$10,480 | \$11,020 | \$11,590 | \$12,190 |
| | Net BHP Trust Fund value | \$10,040 | \$9,210 | \$8,360 | \$7,500 | \$6,630 | \$5,750 | \$4,870 |
| Significant rate intervention (150% of Medicaid) | BHP Trust Fund Spending | \$3,660 | \$9,010 | \$9,480 | \$9,960 | \$10,480 | \$11,020 | \$11,590 |
| | Net BHP Trust Fund value | \$10,230 | \$9,870 | \$9,510 | \$9,170 | \$8,850 | \$8,850 | \$8,260 |
| Return to BHP Baseline rate (125% of Medicaid) | BHP Trust Fund Spending | \$3,470 | \$8,540 | \$8,980 | \$9,450 | \$9,930 | \$10,440 | \$10,980 |
| | Net BHP Trust Fund value | \$10,420 | \$10,530 | \$10,670 | \$10,850 | \$11,070 | \$11,340 | \$11,660 |

Alternative Figure 7. Proposal 2A: Cost of Continuing a State-Only Funded Free EP 5 Program, with Rate Adjustments (hospital cost only adjustments, in millions)

| | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | Total |
|--|----------|---------|---------|---------|---------|---------|---------|-----------------|
| No rate intervention (220% of Medicaid) | \$1,690 | \$3,560 | \$3,750 | \$3,940 | \$4,140 | \$4,360 | \$4,580 | \$26,030 |
| Small rate intervention (200% of Medicaid) | \$1,630 | \$3,430 | \$3,610 | \$3,800 | \$3,990 | \$4,200 | \$4,420 | \$25,080 |
| Moderate rate intervention (175% of Medicaid) | \$1,560 | \$3,270 | \$3,440 | \$3,620 | \$3,800 | \$4,000 | \$4,210 | \$23,900 |
| Significant rate intervention (150% of Medicaid) | \$1,480 | \$3,110 | \$3,270 | \$3,440 | \$3,620 | \$3,800 | \$4,000 | \$22,720 |
| BHP Baseline premium rate (125% of Medicaid) | \$1,400 | \$2,950 | \$3,100 | \$3,260 | \$3,430 | \$3,600 | \$3,790 | \$21,530 |

Alternative Figure 8. Proposal 2B: Cost of State-Only Funded \$50 Monthly Premium EP Buy-In Program, with Rate Adjustments (hospital cost only adjustments, 25% take up, in millions)

| | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | Total |
|--|-----------------|-------------|-------------|-------------|-------------|-------------|-------------|----------------|
| No rate intervention (220% of Medicaid) | \$390 | \$820 | \$870 | \$920 | \$970 | \$1,020 | \$1,080 | \$6,070 |
| Small rate intervention (200% of Medicaid) | \$380 | \$790 | \$840 | \$890 | \$930 | \$990 | \$1,040 | \$5,850 |
| Moderate rate intervention (175% of Medicaid) | \$360 | \$760 | \$800 | \$840 | \$890 | \$940 | \$990 | \$5,580 |
| Significant rate intervention (150% of Medicaid) | \$340 | \$720 | \$760 | \$800 | \$850 | \$890 | \$940 | \$5,300 |
| BHP Baseline premium rate (125% of Medicaid) | \$320 | \$680 | \$720 | \$760 | \$800 | \$850 | \$890 | \$5,030 |

Alternative Figure 9. Cost of State-Only Funded EP Coverage for DACA and Residual PRUCOL Immigrants (hospital cost only adjustments, in millions)

| | Mid-2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | Total |
|---|-----------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------|
| No rate intervention (220% of Medicaid) | \$24 | \$50 | \$53 | \$55 | \$57 | \$60 | \$63 | \$362 |
| Small rate intervention (200% of Medicaid) | \$23 | \$49 | \$51 | \$53 | \$55 | \$58 | \$60 | \$349 |
| Moderate rate intervention (175% of Medicaid) | \$22 | \$46 | \$48 | \$50 | \$53 | \$55 | \$58 | \$333 |
| Significant rate intervention (150% of Medicaid) | \$21 | \$44 | \$46 | \$48 | \$50 | \$52 | \$55 | \$316 |
| Return to BHP baseline rates (125% of Medicaid) | \$20 | \$42 | \$44 | \$45 | \$48 | \$50 | \$52 | \$300 |

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