Simulated Impacts on Poverty in New York State of Health Insurance Policy Changes of the One Big Beautiful Bill Act of 2025

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Executive Summary

This report simulates the impact on poverty in New York of major health insurance provisions of the One Big Beautiful Bill Act signed into law by President Trump on July 4, 2025. It uses the Health Inclusive Poverty Measure (Korenman and Remler 2016), recommended by a consensus study of the National Academy of Sciences (NAS 2023), and methods employed by the authors in earlier studies and reports for the US (Remler, Korenman and Hyson, 2017) and New York (Korenman, Remler and Hyson 2018).

The simulations show the impact of these federal policy changes when fully phased in, all else the same, before any state or local government policy response, and before any behavioral responses by affected individuals and households. Therefore, the simulations illustrate the size of policy and behavioral adjustments required to prevent poverty rates from rising in New York. We model only changes to Medicaid and ACA Marketplace subsidies, not other policy changes in the OBBBA, such as cuts to food assistance expected to increase poverty, or changes to tax policy that could lower poverty. We use two simulation approaches that we refer to as "direct" and "indirect." The direct approach models the impact of a subset of health insurance policy provisions in the OBBBA; the indirect approach translates CBO estimates of overall reductions in federal Medicaid funding into a reduction in the number of Medicaid enrollees in NY, and then into simulated increases in poverty using assumptions about the incomes of those losing Medicaid coverage.

Our simulations using the direct approach show poverty increasing in New York State by 2.3 to 3.5 percentage points, or by between 450,000 and 690,000 people. For the child poverty rate, the projected increase is from 4 to 6.2 percentage points, or an additional 166,000 to 256,000 impoverished children. Medicaid recipients, Hispanics, Asians, and non-citizen immigrants are especially hard hit, with non-citizen immigrant poverty rising from 32.8% to between 46% and 50%. Nonetheless, the majority of people and the vast majority of children (88%) projected to enter poverty in New York State as a result of these changes are US citizens.

The indirect approach, which captures effects of federal budget cuts that are difficult to model directly, shows increases in poverty from Medicaid changes of 4 to 5.5 percentage points overall, and 6.5 to 9.1 percentage points for children. These figures, which are likely upper bounds, represent increases of 25 to 35 percent in the overall poverty rate (an additional 800,000 to 1.1 million people), and an increase of 40 to 52 percent (270,000 to 378,000) in the number of poor children in New York State. They illustrate that substantial responses by the state, city and households will be required to blunt the poverty effects of the OBBBA.

Background

This report describes simulations of the impact on poverty in New York of health insurance policy changes in the One Big Beautiful Bill Act (OBBBA) signed into law by President Trump on July 4, 2025. To assess these impacts, we use the Health Inclusive Poverty Measure (Remler, Korenman and Hyson 2017; for an New York application, see Korenman, Remler and Hyson 2018). We take two simulation approaches, described below. Our "direct" simulation approach models the effects of Medicaid work requirements (community engagement), restrictions on eligibility for non-citizen populations (for Medicaid and ACA Marketplace premium subsidies), and the failure of the OBBBA to extend Enhanced ACA Marketplace subsidies of the Inflation Reduction Act of 2022. Our "indirect" approach simulates poverty impact of Medicaid enrollment loss using Congressional Budget Office (CBO) estimates of federal budget reductions to Medicaid. Although it uses estimates of the cuts in federal Medicaid spending to simulate increases in poverty, the indirect approach likely captures increases in poverty from loss of Essential Plan benefits since there is no direct indicator permitting us to distinguish those with Medicaid coverage from those with other means-tested health insurance benefits such as the Essential Plan.

The Health Inclusive Poverty Measure (HIPM)
Assessments of the direct impact of changes in health insurance policy on poverty require a health inclusive poverty measure, meaning a measure that includes a basic health care need in the threshold and health insurance benefits and subsidies in household resources. Although the Census Bureau's Supplemental Poverty Measure (SPM) is often used to assess the impact of policy changes on poverty, it is not health-inclusive and therefore does not support poverty analyses of health insurance policy changes: the SPM cannot be used to describe how reductions in health insurance benefits increase poverty by reducing households' ability to meet the need for basic health insurance and care. See the Appendix for additional details on the HIPM.

Methods for Simulating Poverty Impacts of the OBBBA
It is not possible to estimate the actual effects of policy changes that have not gone into effect. We instead simulate the immediate, static impact of the policy changes as if they went into effect instantaneously, in pooled Current Population Survey Annual Social and Economic Supplement (CPS-ASEC) data, selecting households in New York, for 2022 and 2023, the most recent years available. We pool two survey years to increase the analysis sample size for New York (a pooled sample size of 10,744). By static we mean the impact on poverty before state and local governments take actions to offset the effects of the policy changes and

before individuals change their behaviors in response to the change (for example, by increasing their work hours to comply with work requirements). These simulations illustrate the size of the adjustment by states, cities and households required to offset the poverty impacts of the federal policy changes.

Direct Approach. We model three major changes that the OBBBA made to federal insurance programs: eliminating eligibility for benefits or subsidies for certain non-citizen populations; requiring work or community engagement to maintain eligibility for certain program participants; and reductions in ACA premium subsidies that result from failure to extend the Enhanced Premium Tax Credits in the Inflation Reduction Act in 2022. We simulate static impacts of benefit reductions (when fully phased in) following long-standing practices by the Census Bureau (e.g., Shrider 2024) and poverty scholars: we subtract the value of lost benefits and subsidies from the resources of affected households.

Immigrant provisions. The OBBBA makes classes of non-citizen immigrants ineligible for benefits. Generally, naturalized citizens and legal permanent residents (green card holders) remain eligible, while undocumented persons and legally present refugees and asylum seekers do not. Given difficulty of identifying different categories of non-citizen immigrants in the CPS-ASEC data, we use two different definitions of non-citizens losing eligibility for benefits as a result of the OBBBA that we believe will bound the poverty impacts.

The CPS data allow identification of immigration (i.e., place of birth and year when first came to US to stay), and citizenship. Our first definition of those losing eligibility due to OBBBA immigrant provisions is any non-citizen. The second is non-citizen immigrants who either resided in the US under 5 years or who have been in the US for 5 years or more and for whom we do not impute permanent residency (see Remler, Korenman and Hyson 2017 for imputation of permanent residency vs. undocumented status using the method developed by Borjas (2017)). Noncitizen children living in a household with adult citizens or adults who have been in the US 5+ years with imputed permanent residency are assumed to remain eligible for Medicaid and ACA subsidies.

The first definition provides an upper bound on the loss of eligibility and increase in poverty. The second is a better proxy for ineligible non-citizen immigrants and is likely a lower bound. We do not attempt to model the chilling effect on benefit receipt of more stringent and harsh immigration enforcement interacting with more frequent certification of eligibility mandated by the OBBBA. In this case, our lower bound definition for eligibility losers may greatly understate the loss of benefits if take-up of benefits falls among eligible non-citizen (and citizen) immigrants as a result.

In our direct simulation approach, if anyone loses eligibility for Medicaid or ACA premium subsidies due to immigrant eligibility restrictions, others in the household covered by that insurance also lose benefits and resources decrease for the entire household.

Work/community engagement requirements. The OBBBA requires non-exempt adults aged 19-64 to work or participate in certain community engagement activities for 80 hours per month or more to maintain eligibility for Medicaid. Exempt persons include students (half-time or more) and disabled individuals (which we proxy using receipt of disability benefits).

However, non-exempt adults can fulfill the work requirements if they earn the equivalent of 80 hours per month at the federal minimum wage, or $580 per month. Since we are modelling eligibility on an annual basis, we make ineligible those who, over one year, earn less than 12 X $580 or $6,960. Since the NY minimum wage in 2022 and 2023 was more than twice the federal minimum, someone in NY could earn a sufficient income for Medicaid eligibility in less than 40 hours per month, or 10 hours per week.

Work requirements vary by family structure. For households with two parents and one or more children under age 14, at least one parent must meet the work requirement. For single-parent households with a child under age 14, the parent is exempt from the work requirement. In our direct simulation approach, when an adult loses Medicaid due to work requirements, children retain coverage. In households with a person with a disability, a caretaker can be exempted from work requirements.

Essential Plan. New York has an extensive "Basic Plan" for lower income households, called the Essential Plan, with income eligibility limits reaching 250% of the Federal Poverty Level. It is unclear how the respondents to the CPS who are covered by the Essential Plan would report their health insurance type to the CPS (or be allocated an insurance type by the CPS if they did not report one).

Although funding for the Essential Plan is endangered by the OBBBA, in our direct approach we simulated the Essential Plan and its potential loss only for those classified in our data as covered by Medicaid (or another means-tested health insurance program) or Direct Purchase insurance. If so classified, they will be affected by Medicaid work requirements and Medicaid or ACA restrictions on non-citizen eligibility. In these cases, the Essential Plan was modeled as filling the basic need for health insurance, less a deduction for outof-pocket premiums for adults limited to $240 per year for full-year coverage ($120 for part-year coverage) for with incomes in the relevant range. Those subject to work or non-citizen immigrant restrictions lose coverage in our simulations using the direct approach.

Indirect Approach. Although the direct approach models the impacts of a limited number of provisions of the OBBBA, it does not capture many of the ways that OBBBA cuts federal health spending (e.g., restricting use of provider taxes and state directed payments).

To capture the broader impacts of all Medicaid cuts on poverty, our indirect approach uses estimates of overall federal cuts to New York's Medicaid spending to project poverty impacts. In order to do so, we make assumptions about the number of people who lose coverage due to federal budget cuts, as well as where they fall in the distribution of income.

We begin with an estimate intended to provide a rough magnitude of the cut to federal Medicaid funding in New York State and Medicaid disenrollment. The KFF (Euhus et al. 2025a) has "allocated" to states CBO's national estimates of Medicaid budget reductions. KFF estimates that, on a 10-year basis, New York faces a reduction of 16% of its projected federal Medicaid dollars (compared to 14% for the US). However, cuts to federal funding are backloaded, with three-quarters of federal cuts nationally occurring in the second half of the period. The cut to the 2034 budget in percentage terms will exceed the 16% average for the 10-year period because many of OBBBA's provisions begin in 2027 or later. Thus, the reduction of federal Medicaid dollars to New York in 2034 (i.e., when fully phased in) will far exceed 16%. For this explanation, we conservatively assume a 20% cut in the federal allocation to NY in that year relative to baseline.

If Medicaid benefits were funded only with federal resources, and cuts to funding were achieved only by reducing the number of people covered (all else the same), then a 20% cut in federal funding would result in a 20% decline in enrollment. However, the federal share of funding for New York is between 50% (traditional Medicaid) and 90% (ACA expansion); the overall federal share in State Fiscal Year 2025 was about 60%.[1] If we take 60% as an average federal share for people disenrolled from Medicaid, and we assume total state and local spending on Medicaid does not change, then the reduction in spending would be 60% of 20%, or about 12%.

An initial KFF estimate of New York's Medicaid enrollment reduction based on allocating Medicaid enrollment loss from the original US House version of the OBBBA was close to this number, 14%, when fully phased in (Euhus et al. 2025b). That estimate was based on a CBO preliminary budget projection. The final version of the reconciliation bill included larger Medicaid cuts (about 45% larger), but as of this writing KFF has not updated their estimates of Medicaid disenrollment for New York State. If we assume that the enrollment decline from the final bill will also exceed enrollment decline from the original house bill by 45%, we get approximately a 20% decline in enrollment. While there is large uncertainty in these figures, we regard 14% to 20% to be reasonable range for the projected Medicaid disenrollment in New York State, although given CBO's methods, even the 20% decline could be an underestimate.[2]

We must next assign the 14% to 20% reduction in enrollment in our data. We removed Medicaid benefits for Medicaid recipient households with resources just above the HIPM poverty threshold, moving up the resource distribution until 14% (or 20%) of the Medicaid population had their insurance benefits removed. One the one hand, targeting those just above the poverty threshold produces upper-bound estimates of the poverty impact since they are most likely to fall into poverty; removing benefits from those with resources below the HIPM poverty threshold does not increase the poverty rate, although it would greatly deepen poverty among poor households. On the other hand, Essential Plan beneficiaries have somewhat higher income than other Medicaid beneficiaries. To the extent that the health insurance type of Essential Plan beneficiaries is classified as Medicaid (or other means-tested public health insurance), this approach will capture some poverty due to lost Essential Plan benefits, not to Medicaid losses alone.

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[1] https://www.osc.ny.gov/reports/budget/fed-funding-ny/medicaid; ($69.2 out of $115.6 Billion for SFY25)

[2] CBO's method and hence KFF's estimates assume that states will use their own resources to replace half of some types of federal spending cuts (those that do not directly reduce eligibility, such as ending the use of provider taxes). This assumption represents a conceptual departure from our simulation assumption of "everything else the same" and will understate the size of federal cuts and enrollment that would take place under this assumption.

Results

Direct Approach. Table 1 shows estimated HIPM poverty rates and simulated HIPM poverty rates under various provisions of the OBBBA for New York State. Column (1) is the baseline HIPM rate, which is the combined rate for 2022 and 2023 for the state. Columns 2, 3A, 3B, 4A and 4B simulate the HIPM rate if one (or more) health insurance provisions of the OBBBA were imposed, all else the same, before any policy actions taken by NY state or any city in NY, and before any behavioral adjustments by individuals or families. Column 2 shows effects of the Medicaid work requirements, Columns 3A and 3B show HIPM rates if non-citizens lose eligibility for Medicaid and ACA premium subsidies under two different definitions of "non-citizen." For 3A we assume all non-citizens lose eligibility whereas for 3B we assume those with imputed permanent residence status retain eligibility. Column (4A) and (4B) show the combined impact of changes from (2) and (3A) or (3B) plus the (very small) poverty effects ending of enhanced ACA Premium Tax Credits. Shading indicates an increase in HIPM poverty of 2.0 percentage points or more.

The poverty rate for NY State at baseline (2022/2023) was 15.5%. Making those not meeting work requirements ineligible for Medicaid would, all else the same, increase the rate to 17.1%. Immigrant eligibility restrictions alone would increase the poverty rate to between 16.4% and 17.9% The combined effects of the health insurance changes modeled here would be to raise the HIPM rate to between 17.8% and 19.0%, or by 2.3 and 3.5 percentage points, representing a 15 to 23 percent increase in the rate of poverty and number of poor people in New York State.

While an increase in poverty of 2.3 to 3.5 percentage points may seem small, it is large both compared to the impact of Medicaid overall and compared to the impact of other transfers programs. We simulated the static increase in the New York poverty rate of ending the Medicaid program entirely: 8.2 percentage points. In other words, the 2.3 to 3.5 percentage point increase in poverty from the OBBBA provisions modeled here represents 28 to 43 percent of the poverty-reduction from the entirety of Medicaid in New York. Our prior work on the US and New York shows that Medicaid has among the largest poverty impacts of government programs (Remler, Korenman and Hyson 2017; Korenman, Remler and Hyson 2018).

Groups more reliant on Medicaid or ACA premium subsidies see larger increases in poverty from work requirements and restricted immigrant eligibility. Child poverty rates would increase from 17.6% to between 21.6% and 23.8%. Although this large increase is shocking, it is not surprising since children are highly reliant on Medicaid for health insurance. Projected increases in poverty among adults under the age of 65, though smaller, are also large: 2.3 to 3.5 percentage points. Those over age 65 are less affected by these changes.

Those currently receiving Medicaid benefits would be greatly affected. Work requirements alone would increase their poverty rate from 30.8% to 36.3%. Immigrant provisions would increase it to 33.3% to 38.3%. The combined effect of these changes would be to increase poverty to between 38.3% and 42.2%, or by 7.5 to 11.4 percentage points.

Those who purchase insurance policies individually (on the ACA Marketplace or from an insurance company) would see an increase in their poverty rate from 18.9% to 21.4% to 23.3% due to immigrant eligibility provisions.

Hispanics and (non-Hispanic) Asians would be particularly hard hit by the restrictions on immigrant eligibility, and to a smaller extent (though still substantially), by work requirements. Hispanic poverty would increase by 2.3 percentage points as a result of work requirements, and by 2.6 to 6.2 percentage points from immigrant restrictions. Work requirements would raise the poverty rate among Asians by 3.7 percentage points, and immigrant restrictions would raise it by 2.3 to 6.2 percentage points. The combined effects of all these changes, all else the same, would be to increase Hispanic poverty by 4.6 to 7.8 percentage points and Asian poverty by 5.4 and 8.2 percentage points.

The NYC metro area would see the largest increases in poverty rates, with notable increases both in the five boroughs of NYC and in the metro area outside NYC. The increase in the city would be 2.8 to 4.7 percentage points; in the balance of the Metro area, 1.9 to 3.1 percentage points.

Poverty rates for US citizens would rise less than those for non-citizen immigrants. Nonetheless, even citizens would see a non-trivial increase in poverty in proportional terms, in part because citizens and non-citizens co-reside. Work requirements would increase citizen poverty from 12.8 to 14.1, or by 1.3 percentage points, whereas immigrant restrictions alone would increase it by 0.2 to 1.5 percentage points. The combined effect of all changes (including the ending of enhanced premium tax credits, not shown separately) would increase poverty among citizens by 1.5 to 3.0 percentage points.

Since we use two definitions of non-citizen immigrants ("A" and "B"), the last panel of the table shows rates for both definitions. Note that changing the definition of "noncitizen" also changes the definition of "citizen" since the two groups exhaust the population. (Note that to show the effect of work requirements, we use definition A.) Since changes in health insurance to non-citizen adults affect others on the same insurance policy, our analysis defines citizen and noncitizen "Health Insurance Units (HIUs)": persons covered by the same insurance plan. Households may have multiple HIUs, possibly with different types of coverage.

The baseline poverty rate for all non-citizen immigrants in New York according to definition A is 32.8%, compared to 34.7% according to definition B. The poverty rate for citizens is somewhat higher under definition B than A as well.

Among non-citizen immigrants, work requirements raise poverty from 32.8% to 36.5% (Column 1 vs. Column 2). Immigrant restrictions, work requirements and changes to ACA premium subsidies together would raise poverty in New York State for this population from 32.8% to 49.1% or, or from 34.7% to 46.3%, or by roughly one third to one half.

Poverty population increases. Table 2 translates the simulated increases in poverty from Table 1 into increase in the number of poor persons, using population estimates for 2023 from the American Community Survey (ACS) for selected sub-populations.[3] We used the change in poverty estimates (Column 4A of Table 1 minus Column 1 of Table 1) to calculate the poverty population increases in Table 2 (rather than Column 4B minus Column 1), since estimates of populations of non-citizens for the subpopulations shown in Table 2 are available from the ACS but populations estimates corresponding to the definition used for Column 4B are not.

While our use of Column 4A (rather than 4B) poverty estimates provides an upper bound for the direct effects we model, it also raises the impact of immigrant provisions relative to those of work requirements and ACA Marketplace changes. Despite this, Table 2 shows that the majority of people entering poverty, and the overwhelming majority of children entering poverty, in New York State as a result of the OBBBA health insurance changes are US citizens. This results both from the larger citizen than non-citizen population sizes, and from the entry of citizens who reside with non-citizens who lose health insurance benefits.

Our simulations show that 415,000 of the 618,000 people entering poverty in New York State as a result of the policy changes are US citizens, including 225,000 of the 256,000 children entering poverty. In New York City, the number of persons entering poverty is evenly split between citizens and non-citizens (193,000 and 195,000, respectively) but among the 136,000 NYC children projected to enter poverty, 111,000 are US citizens. In New York State outside of NYC, three quarters of people entering poverty are US citizens (223,000 out of 298,000).

Indirect Approach. To simulate the loss of Medicaid benefits from the OBBBA, we remove from resources the benefits of 14% and 20% of those classified as covered by Medicaid or other means-tested public health insurance. Again, by targeting for benefit loss those with resources just above the HIPM poverty threshold, our approach provides an upper bound for the increase in poverty that results from reductions in Medicaid funding.

Table 3 shows these results. Poverty for NY State increases from 15.5% to 19.5% or 21.0%, or by 4.0 to 5.5 percentage points. These poverty rate increases represent an increase of roughly 25 to 35 percent in the number of poor New Yorkers. Medicaid recipients are most affected, with the poverty rate increasing from 31.0% to between 45.0% and 50.3%.

While these poverty increases are overstated due to our assumptions about the incomes of Medicaid losers, to the extent that the health insurance type of persons covered by the Essential Plan is classified as Medicaid or another means-tested public insurance program in the CPS-ASEC, they may partly capture poverty due to loss of Essential Plan coverage.

Under the assumption that income and health insurance type is correctly reported and classified, our estimates would overstate poverty from Medicaid losses but understate poverty from the combined loss of Medicaid and Essential Plan coverage.

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[3] *U.S. Census Bureau, U.S. Department of Commerce. "Sex by Age by Nativity and Citizenship Status." American Community Survey, ACS 1-Year Estimates Detailed Tables, Table B05003, https://data.census.gov/table/ACSDT1Y2023.B05003?q=citizenship+and+age+new+york+city+5+year&d=ACS+1Year+Estimates+Detailed+Tables andhttps://data.census.gov/table/ACSDT1Y2023.B05003?q=citizenship+new+york+state+5+year&d=ACS+1-Year+Estimates+Detailed+Tables. Accessed on 17 Aug 2025. We adjusted ACS population estimates for ages under 18 to ages under 19 to match our poverty simulations.*

Limitations

We discuss the nature and likely implications to three important limitations of the CPS-ASEC data for our purposes: the inability to identify households that benefit from rent-regulated and other below-market rate residences (other than public housing); underreporting of Medicaid receipt; and lack of information on coverage by the Essential Plan. Although the effects of these limitations are uncertain, we believe they lead our "direct approach" simulations to understate the static increases in poverty resulting from the OBBBA.

Rent-regulation. Roughly half of rental units in NYC are below-market rent. Although these units cannot be identified in the CPS-ASEC data, they provide meaningful implicit subsidies that help households meet their basic need for shelter. The New York City Government poverty measure (NYC Mayor's Office for Economic Opportunity 2024, especially Appendix C: Adjustment for Housing Status) uses the NYC Housing and Vacancy Survey data to impute a resource value to below-market rental units for their analyses of American Community Survey data. It finds that these implicit subsidies reduce poverty by 3 to 5 percentage points in the City.

While our estimates of poverty in NYC are likely too high for this reason, the implications for our simulated impact of the OBBBA are less clear. Our simulations could very well understate the poverty increase from the OBBBA. Those lifted above the HIPM poverty threshold by the implicit subsidy of rent regulation would not be lifted far above the threshold. The resulting increase in the number of households just above the poverty threshold may increase the proportion of the population at risk for falling into poverty from a loss of health insurance benefits driven by the OBBBA.

Medicaid under-reporting. The CPS-ASEC has been affected by substantial under-reporting of Medicaid receipt. Census Bureau efforts have improved insurance reporting, but substantial errors remain. Hartman (2022) compared CPS estimates of the number of Medicaid beneficiaries to administrative data. Using a hierarchical classification of insurance type similar to the one we use in constructing the HIPM, Hartman found a net undercount of 32% in CPS-ASEC data for New York for 2020 (Hartman 2022, Table 3). The impact of this substantial undercount for our poverty estimates is unclear and depends on the insurance type (or uninsured status) of the "missing" Medicaid recipients. Nonetheless, it seems likely that substantially understating the number of Medicaid recipients will lead our direct approach simulations to understate the number of people losing Medicaid benefits as a result of the OBBBA and, therefore, lead us to understate the increase in poverty from the OBBBA.

Essential Plan. Perhaps the most serious limitation of the CPS-ASEC is the inability to definitively identify people covered by New York's Essential Plan. The implications of this limitation depend on how they report (and the CPS-ASEC classifies) their health insurance status and type. While we attempt in our simulations to model some effects of the OBBBA on people covered by the Essential Plan who report Direct Purchase coverage (insurance purchased directly from an insurance company or on the ACA Marketplace), or who report coverage by Medicaid or another means-tested public health insurance plan, we are limited in our ability to do so. As a result, while our direct approach simulates effects of the OBBBA work requirements and restrictions on non-citizen eligibility, it does not simulate coverage losses due to other reductions in Federal Medicaid funding or the elimination of the Essential Plan. Thus, they will likely understate the static impact of the OBBBA on poverty. Given the extent of Essential Plan coverage in New York (GNYHA 2025), a high priority for future research would be to develop a proxy measure of Essential Plan coverage in the CPS-ASEC.

Table 1. Simulated Health-Inclusive Poverty Rates Under Selected Health Provisions of the OBBBA, New York State[4]

	Baseline HIPM Poverty Rate (1)	Medicaid Work Requirements (2)	Non-citizens[1] Lose Medicaid & ACA subsidies (3A)	Non-citizens[2] Lose Medicaid & ACA subsidies (3B)	All Changes[3] Combined[1] (4A)	All Changes[3] Combined[2] (4B)
All	15.5%	17.1%	17.9%	16.4%	19.0%	17.8%
Age group						
<18	17.6%	20.4%	21.7%	18.9%	23.8%	21.6%
18-64	14.8%	16.4%	17.2%	15.7%	18.3%	17.1%
65+	15.3%	15.5%	15.6%	15.5%	15.7%	15.6%
Health insurance (base)[5]						
Employer	3.8%	3.9%	3.9%	3.8%	4.0%	3.9%
Direct Purchase	18.9%	18.9%	23.3%	21.4%	23.3%	21.4%
Medicaid	30.8%	36.3%	38.3%	33.3%	42.2%	38.3%
Medicare	12.9%	13.1%	13.1%	13.0%	13.2%	13.1%
Uninsured	48.1%	48.1%	49.2%	48.6%	49.2%	48.6%
Race/ethnicity						
Hispanic	27.4%	29.7%	33.6%	30.0%	35.2%	32.0%
Non-Hispanic White	9.2%	10.1%	9.6%	9.3%	10.4%	10.1%
Non-Hispanic Black	21.0%	22.2%	22.8%	21.4%	23.7%	22.6%
Non-Hispanic Asian	19.3%	23.0%	25.5%	21.6%	27.5%	24.7%
Non-Hispanic Other	13.3%	19.1%	14.3%	13.3%	19.1%	19.1%
New York Geographies						
NYC	22.0%	23.7%	25.8%	23.4%	26.7%	24.8%
NYC Metro	17.8%	19.2%	21.1%	19.0%	21.9%	20.3%
NYC Metro, outside NYC	10.8%	11.9%	13.4%	11.7%	13.9%	12.7%
NYS, outside NYC metro	10.8%	12.6%	11.2%	10.8%	13.9%	12.7%
Family structure						
One person SPM unit	22.9%	23.1%	23.7%	23.2%	23.9%	23.4%
Two adults, 1+ kids	12.3%	15.0%	16.4%	13.7%	17.8%	16.2%
One adult, 1+ kids	28.6%	30.4%	30.5%	29.2%	32.2%	31.0%
3+ adults, 1+ kids	20.7%	23.7%	24.4%	21.6%	27.1%	24.6%
Two adults, no kids	11.4%	12.1%	12.2%	12.0%	12.7%	12.5%
3+ adults, no kids	10.7%	11.8%	13.1%	11.5%	13.9%	12.4%
Citizen/NonCitizen HIU[6]						
Citizen HIU- A	12.8%	14.1%	13.0%	NA	14.3%	
Citizen HIU-B	14.2%	NA	NA	14.3%	NA	15.8%
Noncitizen HIU-A	32.8%	36.5%	49.1%	NA	49.5%	
Noncitizen HIU-B	34.7%	36.5%	NA	46.3%	NA	46.3%

Notes to Table 1:

1. Non-citizen definition in column (3A) and (4A) is all non-citizens.

2. Non-citizen definition in column (3B) and (4B) are those who have resided in the US less than 5 years, or resided 5+ years in the US and not imputed permanent resident

3. Columns (4A) and (4B) show the effects of changes shown in (2) and (3A) or (3B), plus effects (not show separately) of ending the enhanced ACA premium tax credits that began in 2021 as part of ARPA but were not extended by the OBBBA. The effects of ending enhanced ACA premium tax credits alone are small, as shown in Appendix 1, except for people with Direct Purchase insurance for whom the poverty rates rises from 18.4% to 19.7%.

4. Shaded cells indicate an increase in poverty of 2.0 percentage points or more compared to the baseline HIPM rate for the group.

5. Rates for a small number of people covered by Vet/Military care or by a person outside the household are not shown separately.

6. A health insurance unit (HIU) is a group of people covered by the same health insurance policy. A non-citizen HIU is one with any non-citizen. Citizen/non-citizen HIU-A and HIU-B citizen definitions are as in (3A), (3B).

Table 2: Simulated Number of Persons Falling into Poverty from OBBBA Health Insurance Changes, Direct Approach, 2023

Population Group	Population (000s)	Increase in HIPM Poverty Rate[1] (percentage points)	Increase in Number of Poor People[2] (000s)
All Ages			
NYS	19,571	3.5	688
Citizens	17,741	2.3	415
Noncitizens	1,830	14.3	262
NYC	8,258	4.7	389
Citizens	6,975	2.8	193
Noncitizens	1,283	15.2	195
NYS Outside NYC	11,313	2.6	298
Citizens	10,766	2.1	223
Noncitizens	547	12.4	68
Children under 19			
NYS	4,150	6.2	256
Citizens	3,987	5.6	225
Noncitizens	163	17.3	28
NYC	1,695	8.0	136
Citizens	1,582	7.0	111
Noncitizens	113	23.0	26
NYS Outside NYC	2,454	4.9	120
Citizens	2,405	4.7	113
Noncitizens	49	9.7	5

Notes:

1. Simulated increase in the HIPM poverty rate is the difference: Table 1, column 4A minus Table 1, column 1.

2. Simulated increase in poverty population is the simulated increase in the poverty rate times the corresponding 2023 population estimate from the American Community Survey. Source: U.S. Census Bureau, U.S. Department of Commerce. "Sex by Age by Nativity and Citizenship Status." American Community Survey, ACS 1-Year Estimates Detailed Tables, Table B05003, https://data.census.gov/table/ACSDT1Y2023.B05003?q=citizenship+and+age+new+york+city+5+year&d=ACS+1Year+Estimates+Detailed+Tables, and https://data.census.gov/table/ACSDT1Y2023.B05003?q=citizenship+new+york+state+5+year&d=ACS+1-Year+Estimates+Detailed+Tables. Accessed on 17 Aug 2025. We adjusted ACS estimates for population ages under 18 to ages under 19 to match the ages used for our poverty rate simulations.

Table 3: Simulated Impacts of Medicaid[1] Loss on HIPM Poverty Rate: Indirect Approach, New York State, 2022/2023

	All	Children	Medicaid Recipients
Baseline HIPM	15.5%	17.6%	31.0%
14% of Beneficiaries Lose Medicaid[2]	19.5%	24.1%	45.5%
20% of Beneficiaries Lose Medicaid[2]	21.0%	26.7%	50.3%

N=10,744. Baseline Medicaid: N=2,578

Notes:

1. Medicaid includes other means-tested public insurance.

2. Loss of Medicaid assumed to target 14% (20%) of recipients with household resources just above the HIPM poverty threshold, providing an upper bound to the increase in poverty from this source.

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Appendix: Health Inclusive Poverty Measure, Additional Details

The HIPM enhances the SPM by adding a need for health insurance to the SPM threshold. The threshold health insurance need is the dollar amount required to buy a basic health insurance plan. Affordable Care Act regulations—community rating and guaranteed issue—make identification of the threshold need possible (Remler, Korenman and Hyson 2017). Community rating means that the premium for a standard health insurance plan to be added to the threshold can be determined from a few characteristics such as age and residential location. Due to guaranteed issue, anyone with sufficient resources (income or subsidies) can buy such a plan. For most people, the ACA benchmark silver plan is an obvious choice for the threshold health insurance need since the ACA intended to make it affordable. Furthermore, ACA premium subsidies are based on the benchmark plan premium, and cost-sharing-reduction subsidies are available only to those who actually select the benchmark plan. (The basic need for Medicare beneficiaries is the least expensive Medicare Advantage plan in their area that includes a prescription drug plan.)

In terms of resources, health insurance benefits from an employer or the government are valued at the threshold basic plan value minus required out-of-pocket premium payments that depend on insurance type and income. For those who purchase insurance individually (including on an ACA Marketplace), resources include the premium subsidy for which they qualify, which depends on household income and, with the OBBBA, immigration status. For Medicare beneficiaries, the resource value is the actuarial value of a basic Medicare Advantage plan, which includes the government contributions to that coverage: that is, actuarial value minus required premium payments.

Like the SPM, the HIPM deducts from resources out-of-pocket expenses for cost-sharing (copays and deductibles) but caps those deductions at out-of-pocket limits available to households.