COOK COUNTY HEALTH:

FY2026 Budget and Long-Term Risks

CIVIC FEDERATION

Authored by Paula R. Worthington

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EXECUTIVE SUMMARY

Cook County's enacted budget for FY2026 totals $10.0 billion, half of which pertains to Cook County Health (CCH), which provides mandatory health services to County residents and others, including those who cannot afford care elsewhere. Previous Civic Federation work has analyzed the County's overall FY2026 budget, and this complementary report provides more detail and context on Cook County Health's fiscal impacts on the County as a whole. With preliminary FY2025 financial results now available, state budget deliberations underway, and continued federal policy shocks, the time is right to review Cook County Health's FY2026 budget and FY2027-FY2030 long-term forecast and assess risks going forward.

Cook County Health plays dual roles in the local healthcare sector. It operates CountyCare, one of Illinois's Medicaid managed care organizations, and it directly provides health care services through County-owned hospitals, clinics, and programs. These two roles expose CCH to different but overlapping fiscal risks that are increasingly moving in the same direction.

Nearly two-thirds of CCH's $5.1 billion budget pertains to CountyCare. CountyCare enrollment swelled during the COVID-19 pandemic but has dropped from its peak of about 450,000 to less than 400,000. This decline is expected to continue as new state and federal rules take effect. Fewer members in CountyCare reduce both revenues and expenses, but the program's fiscal impact depends in large part on whether per-member revenues exceed per-member clinical expenses. Preliminary results reported for year-end FY2025 point to an operating loss of $149.3 million on a budget of $3.7 billion—a loss driven by unexpectedly high clinical care expenses. CountyCare is budgeted to perform better in FY2026, but the long-term forecast shows continued annual losses as costs grow faster than revenues. This means that even with fewer members, CountyCare will face challenges balancing member revenues against clinical expenses going forward.

The County's Health Care Services, its "fee for services" arm, also faces challenges. After several years of generating surpluses, preliminary FY2025 results show operating losses driven by a rising number of uninsured patients and the uncompensated care they receive (care provided without payment). In 2025, charity care exceeded $300 million, and the share of uninsured patients rose sharply. Health Care Services is expected to essentially break even in FY2026 but to generate increasing deficits over time, reaching $246 million by FY2030.

These trends must be understood in the larger context of significant federal policy changes. New federal laws are expected to reduce Medicaid enrollment, increase the number of uninsured residents, and place limits on the supplemental funding and directed payments that are critical to safety-net providers like Cook County Health. Together, these changes increase uncertainty around both demand for services and the funding used to support them.

Overall, CCH faces significant pressures going forward. Through this analysis, stakeholders can better understand the sources and implications of those pressures and, more importantly, better prepare their own responses to protect residents' access to affordable healthcare.

BACKGROUND AND CONTEXT

Cook County, Illinois, serves its 5.18 million residents via the provision of public health services, the protection of persons and property through its court system, and the administration of the nation's largest property taxation system. The County's enacted FY2026 budget (December 1, 2025, through November 30, 2026) includes $10.0 billion across all funds, with general funds ($1.8 billion) and the health enterprise fund ($5.1 billion) accounting for 78.0% of the total.[1] As analyzed in a companion Cook County FY2026 budget overview, the General Fund includes the Corporate and Public Safety Funds of the County,[2] and principal sources of revenues are property tax revenues; non-property tax revenues (including sales taxes, use taxes, various excise and other home-rule taxes, etc.); and fees revenues (from County Clerk, County Treasurer, County Recorder, Clerk of the Circuit Court, etc.).

The County's health operations are reflected in its Health Enterprise Fund, the County's proprietary fund used to report and manage its health operations. Cook County Health (CCH) plays dual roles in the local healthcare sector:

- **Insurance Provider:** The County runs CountyCare, a managed care organization (MCO) in the state's Medicaid system, in which it enrolls participants, receives capitation payments at a fixed per-member-per-month rate from the state, and either provides health care services directly to CountyCare participants or pays third parties to do so.[3]

- **Health Care Services Provider:** The County also owns and operates health care facilities and programs (e.g., Stroger Hospital) which provide services to CountyCare enrollees, Medicaid participants other than CountyCare enrollees, other insured individuals, private payers, and uninsured individuals. In this capacity, the County collects net patient service revenues (NPSR), which are fees for services provided at County health care facilities or by County health care providers. The County also receives several other distinct supplemental funding streams, including directed

[1] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation* (2025), 11, https://www.cookcountyil.gov/sites/g/files/ywwepo161/files/documents/2025-10/Volume%20I%20-%20Budget%20Overview%20FY2026%20Executive%20Recommendation.pdf.
[2] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 16.
[3] In Cook County, Medicaid enrollees may choose from one of the State's six managed care organizations (MCO's), of which CountyCare is one (Department of Healthcare and Family Services 2021), and CountyCare's most recent estimated "market share" was 26.4%: As of June 30, 2025, over 1.5 million Cook County residents received full Medicaid benefits, and as of July 1, 2025, CountyCare enrollment stood at just below 400,000 Illinois Department of Healthcare and Family Services, *Medical and Managed Care Enrollment by Month* (2025), https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/202507hb2731.pdf; Illinois Department of Healthcare and Family Services, "Number of Persons Enrolled in Cook County," accessed February 2, 2026, https://hfs.illinois.gov/info/factsfigures/program-enrollment/cook.html.. Statewide, about 80% of the state's 3.1 million Medicaid enrollees are in MCOs Illinois Department of Healthcare and Family Services, *Medical and Managed Care Enrollment by Month-November 2025* (2025), https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/mcodetailedenrollment112025.pdf .

payments. The County's general resources also subsidize CCH by providing annual property tax support as well as paying certain CCH costs directly (e.g., health system-related pension costs and debt service).[4]

In the County's FY2026 budget, Health Plan Services (CountyCare) accounts for $3.5 billion in revenues, and Health Care Services (fee for services) accounts for $1.6 billion, bringing total CCH revenues to just over $5.1 billion. In other words, on average, CountyCare accounts for about two-thirds of health enterprise revenues for the County.

Health Enterprise Fund Revenues
(in millions of $)

	Health Plan Services (CountyCare)	Health Care Services	Total
FY2022 (Actual)	$3,059.6	$1,739.3	$4,798.9
FY2023 (Actual)	$3,445.2	$1,767.4	$5,212.6
FY2024 (Actual)	$3,388.8	$1,606.1	$4,994.9
FY2025 (Estimated)	$3,567.9	$1,639.5	$5,207.3
FY2026 (Budget)	$3,500.0	$1,644.2	$5,144.2
FY2027 (Forecast)	$2,794.4	$1,621.0	$4,415.4
FY2028 (Forecast)	$2,731.7	$1,608.7	$4,340.4
FY2029 (Forecast)	$2,838.2	$1,620.4	$4,458.7
FY2030 (Forecast)	$2,953.2	$1,632.3	$4,585.5

Source: Cook County Executive Recommended Budget, FY2026, pp. 87-88.

Finally, before diving into the details of how CCH works and affects the County's fiscal condition, it is worth quickly sketching the policy landscape. Recent federal policy changes—and Illinois's response to those changes—will have significant impacts over the next few years. H.R. 1—also known as Public Law 119-21—makes many major changes that will affect Medicaid program eligibility and enrollment, program funding, and public support for safety net hospitals and other facilities and programs.

- New work requirements and more frequent eligibility redeterminations for certain Medicaid populations will result in decreased CountyCare enrollments, decreased CCH patient loads with Medicaid coverage, and increased need to provide uncompensated care.
- The December 31, 2025, expiration of enhanced tax subsidies for individuals purchasing insurance on the state's Affordable Care Act exchange, which H.R. 1 did *not* address, is expected to depress insurance coverage and increase the need to provide uncompensated care.

[4] Civic Federation, *Cook County FY2022 Proposed Budget: Analysis and Recommendations* (2021), 34, https://www.civicfed.org/sites/default/files/civicfederationanalysis_cookcountyfy2022budget.pdf.

- New curbs on the use of so-called "provider taxes" and the state-directed payments such taxes support threaten the ability of the state to direct critical supplemental funding to safety net providers statewide. CCH expects to receive $539.4 million in state-directed payments in FY2026, representing 10.3% of all Health Enterprise Fund revenues, underscoring the potential vulnerability of CCH to potential limits.

COUNTYCARE

After swelling to over 450,000 members during the COVID pandemic when states implemented Medicaid "continuous enrollment" provisions and suspended eligibility determinations, CountyCare enrollment is now falling, with continued drops reflected in the County's FY2026 budget and 2027-2030 long-term forecast. Much of the future decrease is expected to come from declining enrollment of individuals made newly Medicaid-eligible under the 2010 Affordable Care Act. Assumed increases in state capitation rates offset these impacts to some extent, but the net effect will be to shrink CountyCare's fiscal footprint in the years ahead. Adjusting to membership declines and balancing capitation revenues against clinical costs of providing services to members are key challenges going forward.

Below, we describe how the program works; summarize enrollment and capitation revenue trends; analyze the program's net budgetary impact; and then assess FY2025 preliminary results and budget and long-term forecasts for future years.

COUNTYCARE BASICS

CountyCare receives a per-member-per-month (PMPM) capitation payment from the state. Total capitation revenues, then, depend on both enrollment ("member months") and the PMPM levels set by the state. These payments depend on the characteristics of the enrollee, so that PMPM payments for children, for example, are far less than PMPM payments for disabled enrollees. CountyCare also incurs expenses to provide healthcare to its members, either via County facilities and personnel or via third-party providers.

A key factor in CountyCare's budgetary impact is the "medical loss ratio" (MLR), essentially the ratio of claims expenses to capitation revenues. A low MLR means that the "spread" between PMPM revenues and claims expenses is large, which has a net positive budgetary impact. On the other hand, a high MLR means that the spread is small, meaning each member contributes less to the County's net income.

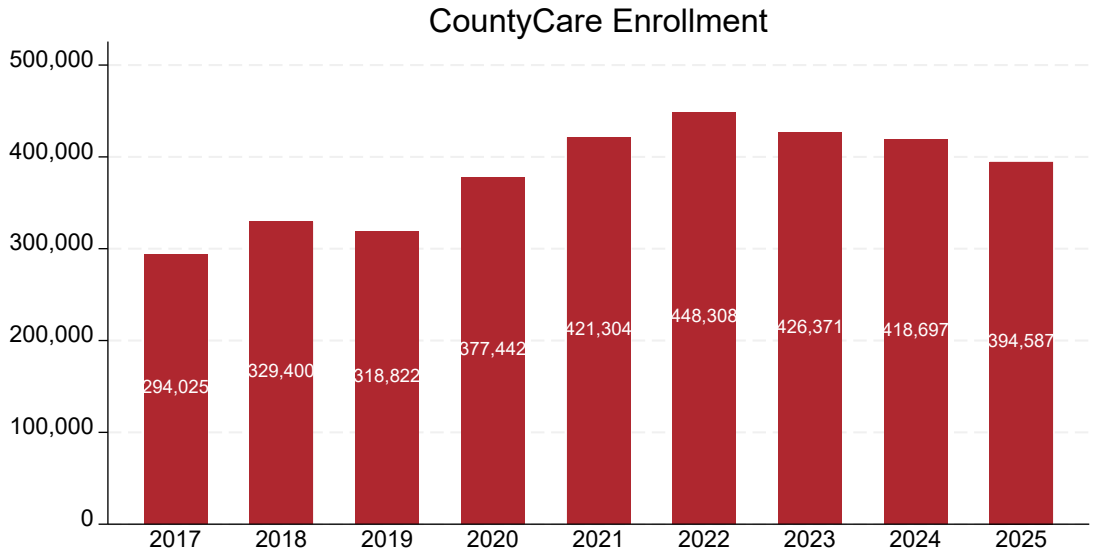
Thus, the key factors that drive the budgetary impact of CountyCare are enrollments, capitation levels, and clinical expenses incurred to provide care for enrollees:

- Higher enrollments mean higher total capitation revenue, but also potentially higher claims expenses;
- Higher PMPM capitation levels, even absent enrollment increases, will increase the County's net income;

- Higher claims expenses, with no offsetting increase in capitation revenues, will worsen the program's impact on the County's net income.

OVERALL ENROLLMENT

CountyCare enrollment stood at 394,587 in November 2025, well below its COVID-era peak of 448,306, according to state data.[5] [6] Program enrollments swelled during the pandemic, as medical assistance needs increased and states implemented "continuous enrollment" provisions, which suspended eligibility redeterminations. Once the public health emergency was declared over, states resumed regular redeterminations, and Illinois began its redetermination process in the spring of 2023. State-wide Medicaid enrollments started to fall in July 2023 and have continued to drop, and CountyCare largely follows that pattern [7]. The enrollment decrease since 2023 also reflects the elimination of the Health Benefits for Immigrant Adults (HBIA) program, effective July 2025.[8]



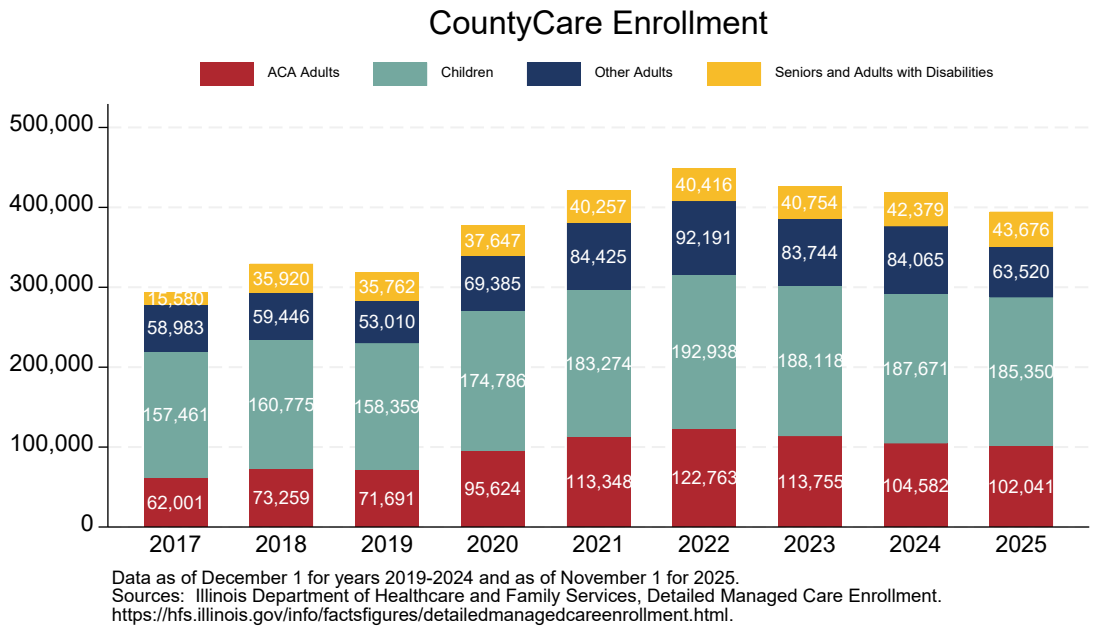
Data as of December 1 for years 2019-2024 and as of November 1 for 2025.
Sources: Illinois Department of Healthcare and Family Services, Detailed Managed Care Enrollment. https://hfs.illinois.gov/info/factsfigures/detailedmanagedcareenrollment.html.

ENROLLMENT BY CATEGORY

Historically, Medicaid programs covered medically needy individuals whose incomes fell below the federal poverty line (FPL) or other related measures. These participants typically included

[5] Illinois Department of Healthcare and Family Services, *Medical and Managed Care Enrollment by Month-November 2025* (2025).
[6] These figures from the state differ slightly from those typically provided by the County; specific data sources are indicated below as needed.
[7] KFF, "Medicaid Enrollment and Unwinding Tracker," *KFF*, January 5, 2026, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/.
[8] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 62.

low-income children, their parents and caretakers, seniors, and adults with disabilities. With the passage of the Affordable Care Act (ACA) in 2010, many states, including Illinois, expanded eligibility to all adults under age 65 with incomes below 133 percent of the federal poverty line [9]. Further, states throughout the country developed numerous special programs intended to improve the efficiency, quality, and coordination of care for selected types of enrollees—for example, so-called "dual eligibles", who receive full benefits under both Medicaid and Medicare.



Data as of December 1 for years 2019-2024 and as of November 1 for 2025.
Sources: Illinois Department of Healthcare and Family Services, Detailed Managed Care Enrollment.
https://hfs.illinois.gov/info/factsfigures/detailedmanagedcareenrollment.html.

- Children comprise the largest share of enrollees throughout—nearly 47.0% in 2025, and enrollment has fallen 3.9% since its peak in 2022. This category consists primarily of children enrolled via the state's Family Health Program.
- Adults who became eligible under the ACA comprise the second largest group of enrollees; their enrollment spiked 71.2% during the pandemic and has fallen to just over 100,000 members in 2025.
- Enrollment of seniors and adults with disabilities—including participants in the state's Managed Long-Term Services and Support (MLTSS) program—grew during the pandemic and has continued to increase, totaling over 43,000 enrollees and accounting for about 11% of total enrollment.[10]

[9] MACPAC, "Medicaid Expansion to the New Adult Group," *Medicaid and CHIP Payment and Access Commission*, March 30, 2023, https://www.macpac.gov/subtopic/medicaid-expansion/.

[10] MLTSS enrollees receive full Medicaid and Medicare benefits and have opted out of the State's Medicare-Medicaid Alignment Initiative (MMAI). According to IDHFS: "MLTSS individuals enrolled in HealthChoice Illinois include: Individuals receiving full Medicaid and full Medicare benefits who have opted out of MMAI and receive Long Term Services and Supports (LTSS) where MMAI operates; and Individuals receiving full Medicaid with full Medicare benefits who reside in a nursing facility or are receiving home and community based services under certain waivers" Illinois Department of Healthcare and Family Services, *Medical and Managed Care Enrollment by Month-November 2025* (2025), https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/mcodetailedenrollment112025.pdf

- The remaining category, other adults, includes parents and caregivers of participating children as well as pregnant women and participants in the health benefits for immigrant seniors (HBIS) and health benefits for immigrant adults (HBIA) programs.[11]

FUTURE ENROLLMENT

The County projects declining average monthly membership over the period from 2026-2030, with budgeted FY2026 enrollment at 362,287,[12] another significant step-down in FY2027, and then stable membership of about 300,000 from FY2028 onwards. Three key factors drive continued membership declines under the long-term forecast's baseline scenario:

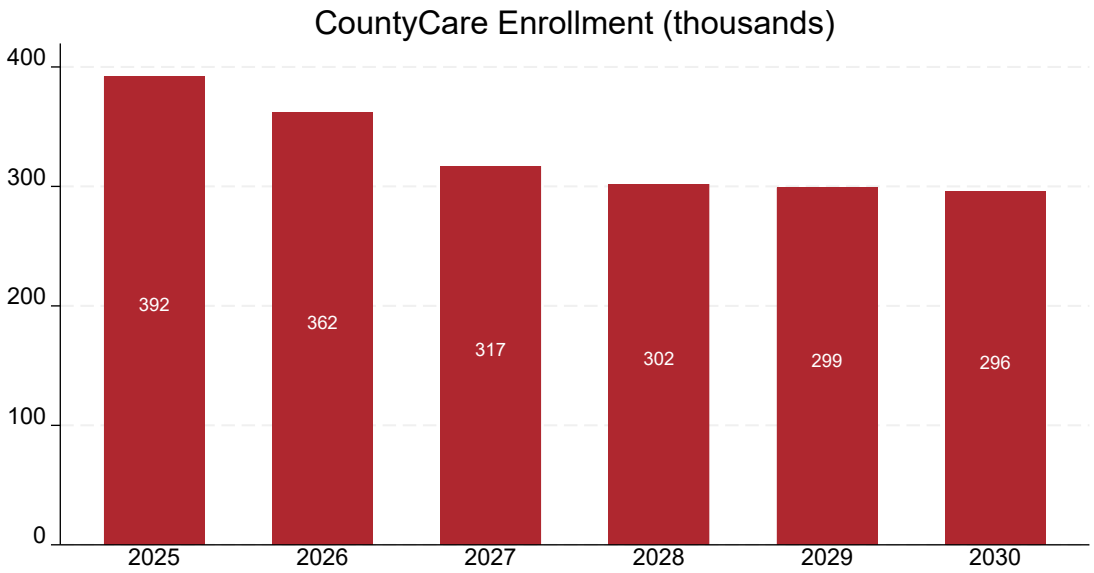
- First, participants in the state's Managed Long-Term Services and Support (MLTSS) program will no longer enroll in CountyCare starting in FY2027.[13] As of November 1, 2025, CountyCare included 11,498 of these enrollees.
- Second, regular and, for some enrollees, more frequent redeterminations of eligibility will continue to push membership down across the board.
- Third, provisions in H.R. 1 imposing new work requirements on ACA expansion adults and requiring twice-yearly eligibility redeterminations are expected to decrease future enrollments as changes are rolled out starting on January 1, 2027.

Note also that the baseline scenario assumes that the state ends its Health Benefits for Immigrant Seniors (HBIS) program in January 2028.

[11] HBIS and HBIA enrollments are not reported separately or consistently over this time period. The HBIS and HBIA programs are fully State-funded with no federal support, established in 2020 and 2022, respectively, to serve immigrants regardless of immigration status. Ballooning costs led the State to impose cost-sharing requirements and limit new enrollments starting in 2023. The HBIA program was fully discontinued as of July 2025. CountyCare had 3,820 HBIS members as of November 1, 2025. Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 62.

[12] Erik Mikaitis and Pamela Cassara, "FY26-Budget-Presentation_CCH-Finance-08-05-25," July 2025, 23, https://cookcountyhealth.org/wp-content/uploads/FY26-Budget-Presentation_CCH-Finance-08-05-25.pdf.

[13] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 79.



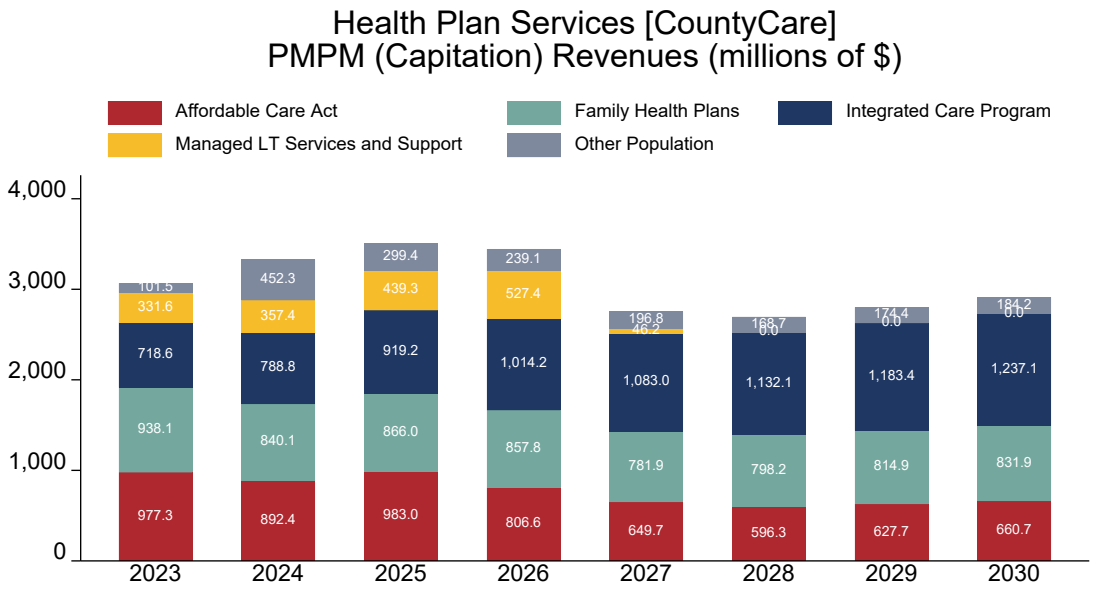
FY2025 is estimated; FY2026-2030 are from baseline long-term forecast.
Source: Executive Budget Recommendation Fiscal Year 2026, Cook County.

CAPITATION REVENUES

Total capitation revenue is essentially the number of plan members multiplied by the relevant PMPM rates, which are set by the State. The County expects overall average PMPM rates to decrease in FY2027, as the "high-cost" (and high PMPM capitation revenue) MLTSS population leaves the CountyCare rolls. From FY2028 through FY 2030, the baseline scenario assumes modest subsequent growth in PMPM rates.[14]

Putting expected enrollments and PMPM rates together, the County has budgeted capitation revenues of $3.445 billion for FY2026. Total capitation revenues are expected to step down sharply in FY2027, reflecting a one-time adjustment due to the loss of MLTSS enrollees, the initial wave of enrollment decreases as H.R. 1's provisions take effect, and a limited offset from expected increases in PMPM rates. From FY2027 onward, the County anticipates that total capitation revenues will grow slowly as increases in PMPM capitation rates offset declining to stable enrollments.

[14] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 79.



Note: Actual (2023-2024); Estimated (2025); Budget (2026); and Forecast (2027-2030) data are included.
Source: Cook County Executive Recommended Budget, FY2026, pp. 87-88.

NET BUDGETARY IMPACT

CountyCare's net budgetary impact on the County depends not only on the number of members and capitation rates, but on the expenses incurred to provide care to those members. For CountyCare to be a net fiscal positive for the County, revenue PMPM must exceed the corresponding "clinical cost" per member per month, with a "spread" big enough to cover other non-clinical CountyCare expenses.

FY2025 Preliminary Results

Preliminary financial results for FY2025 show that CountyCare experienced a net income loss of $149.3 million, compared with a budgeted gain of $3.4 million. CountyCare experienced above-budgeted membership levels and capitation revenues, increasing revenues, but also saw big increases in claims expenses incurred to provide services for those members. In fact, the reported "medical loss ratio" (MLR), budgeted at 95.2%, came in at 98.7%; this means that, on average, it was more expensive to provide care for each member than budgeted.[15]

Putting this in more familiar dollar terms: the budgeted "spread" between PMPM capitation revenues and PMPM clinical costs was $707.67 - $673.47 = $34.20; but the actual spread was $755.65 - $746.09 = $9.56. Thus, an average member of CountyCare was budgeted to generate $34.20 in net income but actually only generated $9.56. Even if CountyCare membership had come in as budgeted, the County would have seen a net income variance of $116 million

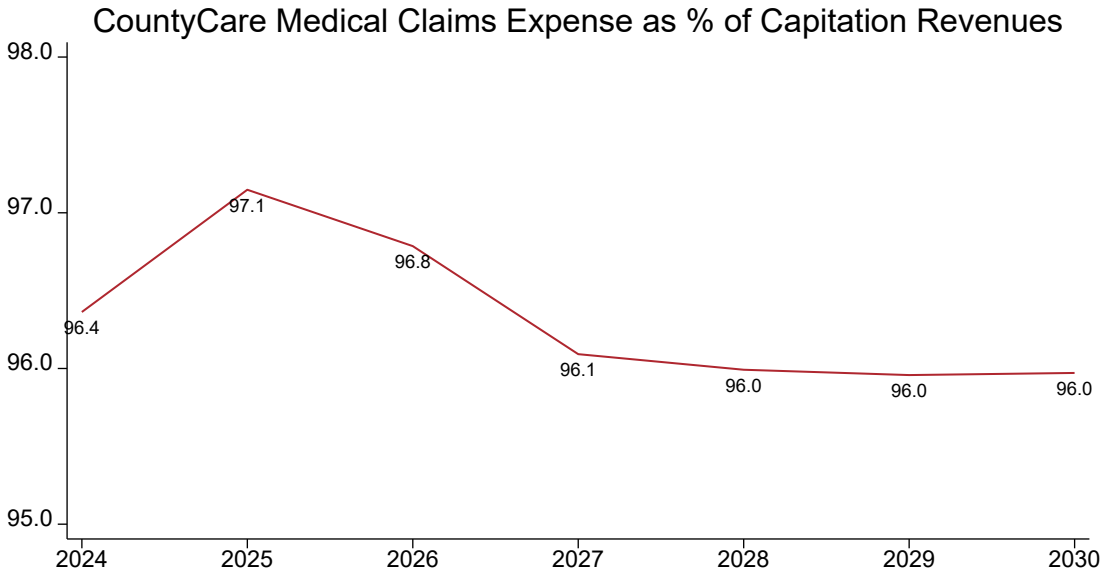
[15]The County reports that the elevated MLR was due to underfunding for high-cost drugs and NICU cases. Scott Spencer and Curtis Haley, "CCH YTD Financial Update – November 30, 2025," January 2026, 13, https://cookcountyhealth.org/wp-content/uploads/Item-VA-Financials-01-08-26.pdf.

coming from the unexpectedly "tight" spread between revenues and clinical costs.[16] This factor explains much of the $152.7 million negative variance overall in CountyCare net income for FY2025.

FY2026 Budget and FY2027-FY2030 Forecast

CountyCare is budgeted to generate a modest $1.6 million net income loss in FY2026, an improvement over FY2025's net loss of $149.3 million on a budget of $3.7 billion.[17] Future net income losses settle between $28 million and $32 million annually over the next five years, as costs grow faster than revenues.[18]

FY2026's budgeted improvement over FY2025 is due to an expected widening of the dollar "spread" between capitation revenues and clinical costs; when this dollar spread widens, the County's net income rises. Movements in this dollar spread are also reflected in movements in the ratio of CountyCare claims expenses to capitation revenues—itself a close approximation to the MLR reported by CCH in its monthly reports.[19] When this ratio of expenses to revenues declines, the County's net income rises. The County forecasts improvement in this ratio (decreases in the ratio) in the FY2026 budget and the longer-term forecast, but the ratio still exceeds what is needed for CountyCare to avoid net income losses in the future.



Author's calculations based on actual (2023-2024), estimated (2025), budget (2026), and forecast (2027-2030) data.
Source: Cook County Executive Recommended Budget, FY2026, pp. 87-88.

[16] The PMPM spread was $24.64 lower than budgeted. At budgeted annual member months of 4,707,616, this implies net revenues $116 million below budget. Spencer and Haley, "CCH YTD Financial Update – November 30, 2025," 13.
[17] Spencer and Haley, "CCH YTD Financial Update – November 30, 2025," 4.
[18] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 87.
[19] Pamela Cassara, "CCH YTD Financial Update – October 31, 2025," December 2025, https://cookcountyhealth.org/wp-content/uploads/Item-VC-Financials-12-11-25.pdf.

HEALTH CARE SERVICES

In addition to CountyCare, the County directly provides health care services to patients via its facilities and staff, generating revenues and incurring expenses. After several COVID-era years of generating significant positive net income for the County, Health Care Services is expected to essentially break even in FY2026 but to generate increasingly large deficits over time, reaching $246 million by FY2030. Expected decreases in insured patients and increased demand for uncompensated care are key factors in the budget and forecast.

Below, we explain the key revenues of the program; review the role of public funding; and then assess FY2025 preliminary results as well as the budget and long-term forecast.

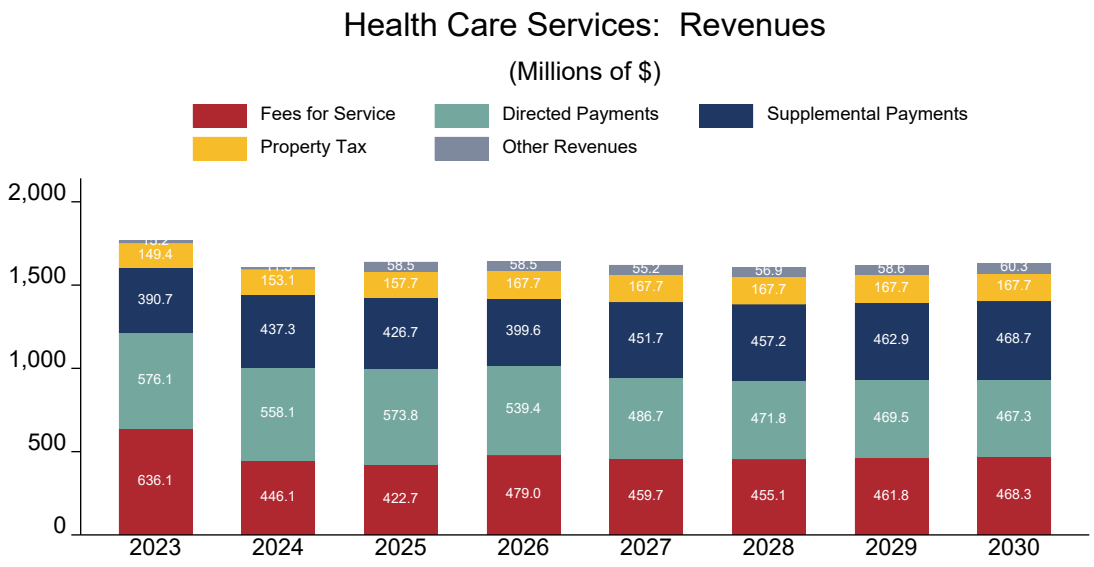
HEALTH CARE SERVICES: THE COUNTY'S "FEE FOR SERVICE" PROGRAM

With its "fee for service" program, Health Care Services, the County provides healthcare services to non-CountyCare Medicaid enrollees, individuals with Medicare or commercial insurance coverage, and private payers. Uninsured individuals can and do receive care as well. On the revenue side, payments come from Medicaid, Medicare, other insurers, and private payers. Additional sources of funds come from public sources (GME, DSH, and BIPA) as well as "directed payments", which are essentially state-directed payments from non-CountyCare MCOs to make County services available to their members.[20] The expenses side includes salaries, facilities costs, contractual services, and other expenses incurred to provide inpatient and outpatient care at County facilities.

REVENUES

Budgeted FY2026 revenues are $1.64 billion, with fees for services ("Net Patient Service Revenue"), including payments from Medicaid, Medicare, other insurers, and private payers, comprising a key share. The County's ability to attract patients, provide services, and bill third parties appropriately affects NPSR directly. Other revenue streams are, to a significant degree, not under the County's direct control, nor do the payments vary with services provided, CountyCare enrollment, or other County-controlled factors.

[20] Cook County, "Annual Comprehensive Financial Report 2024," 2025, 52, https://www.cookcountyil.gov/sites/g/files/ywwepo161/files/documents/2025-07/Annual%20Comprehensive%20Financial%20Report%202024.pdf.



Note: Actual (2023-2024); Estimated (2025); Budget (2026); and Forecast (2027-2030) data are included.
Fees for services includes payments from Medicare, Medicaid, and private payers and are net of payments from CountyCare.
Supplemental payments include GME, BIPA, and DSH funding streams.
Source: Cook County Executive Recommended Budget, FY2026, pp. 87-88.

Net Patient Services Revenue

The County has budgeted $479.0 million in NPSR for FY2026, down $226.8 million from the FY2025 budget but up $56.3 million over estimated FY2025 actual results. This category includes payments from Medicare, Medicaid, and private payers (commercial insurance carriers as well as individuals). The FY2026 budget reflects the ending of the HBIA program, effective July 1, 2025.[21]

Directed Payments

Like many other states, Illinois uses so-called "directed payments" to provide additional support for certain safety-net healthcare providers. In Illinois, these payments are used to channel supplemental payments from other Medicaid MCOs to safety net and other critical care providers, above and beyond revenues tied to specific services, to these providers to make services available at their facilities—in Cook County's case, at CCH facilities including Stroger Hospital, Provident Hospital, and community-based health centers. [22] The current directed payments structure was put in place in 2020.[23] Cook County relies heavily on these revenues, budgeting $539.4 million for FY2026.

[21] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 30.
[22] Cook County, "Annual Comprehensive Financial Report 2024," 52.
[23] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 29.

Supplemental Payments

"Supplemental payments include those from the Benefits Improvement and Protection Act (BIPA), Disproportionate Share Hospital (DSH), and Graduate Medical Education (GME)."[24] The County has little control over these payments, budgeted in total at just under $400 million for FY2026. The BIPA and DSH payments arise from a long-standing intergovernmental transfer agreement between Cook County and DHFS in which the state provides "enhanced Medicaid reimbursement" and assists the County in offsetting the cost of uncompensated care provided.[25] Budgeted FY2026 BIPA and DSH revenues are $131 million and $200 million, respectively, reflecting additional state and matching federal support provided to the County.

NET BUDGETARY IMPACT

The net budgetary impact of health care services depends, of course, on the difference between its revenues and its expenses. On the expense side, personnel expenses are the biggest share, with significant supplies and materials and operations and maintenance expenses as well. Many of these expenses are driven by long-term contractual agreements, offering the County little scope to manage in the short-run. On the revenue side, the County has little direct control over directed payments or the supplemental payments (DSH, BIPA, GME), exposing the County to policy and funding risks it cannot control.[26] The County can and does, however, have some ability to influence NPSR:

- Higher patient volumes will increase services provided and amount billed.
- Increases in the number of uninsured patients will decrease NPSR and increase uncompensated care expenses.
- Improvements in the revenue cycle—submitting claims, limiting claim denials, balance billing and collecting amounts owed in a timely manner—can increase net revenues and improve the budgetary impact.[27]

Preliminary FY2025 Results

Health Care Services ended the year with an operating loss of $120.8 million, which was more than offset by non-operating revenue (principally the County's property tax allocation to CCH), resulting in a net income gain of $32.8 million, according to preliminary results.[28] Contributing factors to the operating loss include:

- Volumes of services provided—inpatient days, ER visits, etc.—fell short of budgeted levels at CCH facilities.[29]

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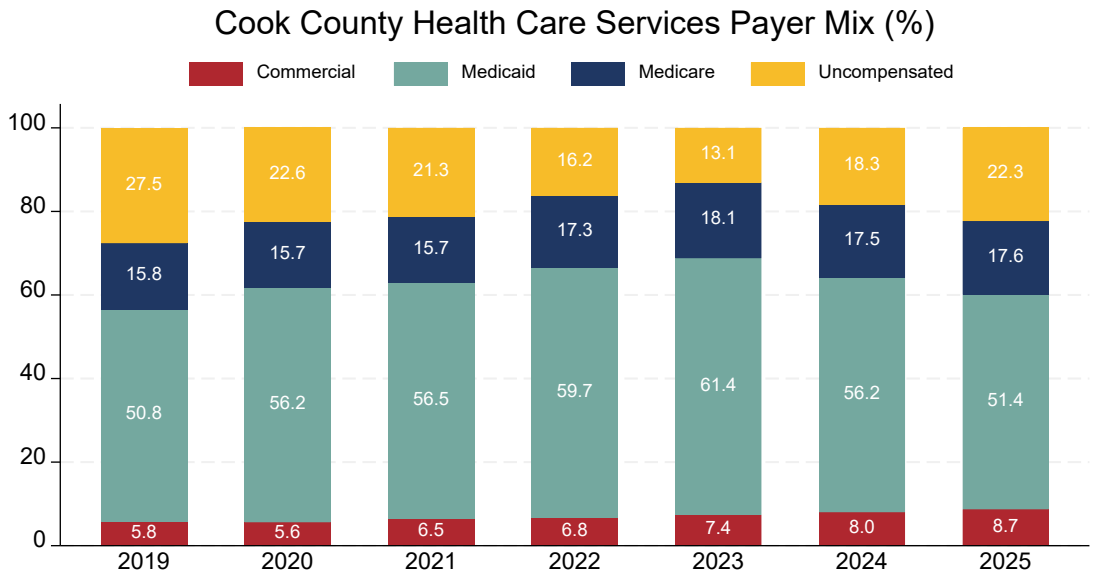
[24] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 29.
[25] Cook County, "Annual Comprehensive Financial Report 2024," 50.
[26] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 81.
[27] Civic Federation, *Cook County FY2022 Proposed Budget: Analysis and Recommendations*, 11.
[28] Spencer and Haley, "CCH YTD Financial Update – November 30, 2025," 4.
[29] Spencer and Haley, "CCH YTD Financial Update – November 30, 2025," 6.

- Traditional charity care, the principal component of uncompensated care, rose from $202.0 million in 2024 to an estimated $309.5 million in FY2025;[30] total uncompensated care for FY2025 was estimated at $410.3 million as of mid-fall 2025.[31]
- The payer "mix" degraded, as more uninsured individuals received care. The graph below shows that the share of uncompensated (uninsured) patients rose from its pandemic-era minimum of 13.1% in 2023 to 22.3% in 2025.



Source: CCH YTD Financial Update-November 30, 2025, slide 8.
https://cookcountyhealth.org/wp-content/uploads/Item-VA-Financials-01-08-26.pdf.

FY2026 Budget and FY2027-FY2030 Forecast

Health Care Services is expected to essentially break even in FY2026 but to generate increasingly large deficits over time, reaching $246 million by FY2030. This trajectory reflects revenues that are essentially flat in the face of rising expenses—even as the County beefs up its own staffing and decreases reliance on more expensive contractual services.[32] Expected decreases in insured patients and increased demand for uncompensated care are key factors in the budget and forecast.

THE PATH FORWARD: POLICY & RISKS

Cook County Health faces considerable fiscal risks going forward, as significant changes in economic conditions, federal policies, and laws promise to affect the County's health operations. H.R. 1 makes many major changes that will affect Medicaid program eligibility and

[30] Spencer and Haley, "CCH YTD Financial Update – November 30, 2025," 11.
[31] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 82.
[32] The County also notes that the net personnel increase in full-time-equivalents (FTE's) also reflects moving positions previously funded by COVID-era programs to the Health Enterprise Fund. Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 63.

enrollment, program funding, and public support for safety net hospitals and other facilities and programs.

- **New work requirements and more frequent eligibility redeterminations** for Medicaid's ACA adult population (non-elderly, non-disabled adults without dependents under age 14) are imposed as of December 31, 2026. Early estimates suggested state Medicaid enrollment declines on the order of 9 to 16%.[33] The County's own projections of CountyCare enrollment show an even larger impact, with average monthly membership of 392,000 in FY2025 falling to 317,000 by FY2027 and even further by FY2030.[34] Further, the County estimates the corresponding annual fiscal impacts at $138 million annually.[35]

- **Expired enhanced tax subsidies** for individuals purchasing insurance on the state-run health insurance exchanges are expected to depress insurance coverage and increase the need to provide uncompensated care. As of January 4, 2026, 445,335 Illinois residents had signed up for an Obamacare health insurance plan, down about 4% from 2025. The state extended the 2026 enrollment deadline to January 31 of this year, with coverage to begin February 1.[36] Individuals who no longer purchase coverage on the exchange may obtain coverage elsewhere, but some number will likely become uninsured, placing more pressure on uncompensated care costs.

- **New curbs on the use of "provider taxes**", essentially assessments paid by hospitals and MCOs throughout the state to support directed payments to safety net providers, promise to limit the state's ability to cover its non-federal share of Medicaid spending: no new taxes may be imposed, although previously-imposed taxes are grandfathered in.[37] In addition, beginning on October 1, 2027, the maximum tax rate states may impose starts to decrease in annual increments of 0.5 percentage points from its current cap of 6.0% until reaching 3.5%. Illinois will be subject to these reductions, with estimated revenue impacts starting in state FY2028. GOMB projects over $300 million in lost state revenues in FY2028, with additional losses as these caps ratchet down, and these projections represent state

[33] Illinois Department of Healthcare and Family Services, "Federal Medicaid Landscape," July 2025, 21, https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/impactoffedchtoilmed.pdf#page=19.

[34] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 80.

[35] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 82.

[36] Elvia Malagón, "Illinois Extends ACA Enrollment after Fewer People Sign up for Health Insurance Plans," Health & Medicine, *WBEZ*, January 9, 2026, https://www.wbez.org/health-medicine/2026/01/09/aca-obamacare-tax-credit-congress-illinois-decrease-enrollment.

[37] Most states impose special assessment fees and taxes on healthcare providers (e.g., hospitals), generating revenues which are then used to support state Medicaid expenditures by increasing the non-federal funds against which matching federal funds are then attracted. See Alea Wilbur-Mujtaba et al., *Current Condition and Future Concerns for Growth in Illinois' State Revenue* (2026), 7, https://igpa.uillinois.edu/wp-content/uploads/2026/01/IGPA-State-Revenue-Spotlight.pdf. for further discussion.

funding only, not the additional federal matching funds that would be lost [38]. Other available estimates look broadly similar.[39]

- **New limits on state directed payments** put pressure on the state's ability to direct significant supplemental funding streams to safety net providers. Any new payment structures must cap such payments at 100% of Medicare payment levels, and existing payment structures (in ACA expansion states) must decrease payments to reach that same level by January 1, 2028. Early estimates pointed to a $3.4 billion reduction in directed payments statewide.[40] While CCH's directed payments appear to comply with the new structure, payments to other providers may not, with potential "ripple effects" throughout the state's safety net provider networks. Given CCH's reliance on these directed payments—$539.4 million in the FY2026 budget, the County faces fiscal risks as these structures change.[41]

Taken as a whole, these policy changes present significant concerns for the CCH in the years ahead. Declining CountyCare enrollment, increasing shares of uninsured patients, rising uncompensated care costs—all in a world in which the state itself faces increased uncertainty about its own fiscal situation. The County's reliance on supplemental payments (DSH, BIPA, and GME) and on directed payments is not unusual but also presents revenue risks. Federal DSH funding is at risk unless Congress acts to reverse already-scheduled reductions.[42] Further, the source of directed payments—from non-CountyCare MCOs to CCH—is essentially provider assessments levied by the state, and H.R. 1 makes significant changes to those provider assessments, potentially limiting the funds available to make those directed payments in the future.

[38] Governor's Office of Management and Budget, *Illinois Economic and Fiscal Policy Report* (2025), 18, https://budget.illinois.gov/content/dam/soi/en/web/budget/documents/economic-and-fiscal-policy-reports/Economic_and_Fiscal_Policy_Report_FY26_10.9.25.pdf.
[39] Wilbur-Mujtaba et al., *Current Condition and Future Concerns for Growth in Illinois' State Revenue*, 6–9.
[40] Illinois Department of Healthcare and Family Services, "Federal Medicaid Landscape," 20.
[41] It is worth noting that CCH's "dual roles" in the local health care ecosystem implies that directed payments also flow from Cook County to other safety net institutions. As an MCO, CountyCare is obligated to make "directed payments" to hospitals and other providers throughout the state. These managed care access payments (MCAP) from the state's MCOs are intended to support safety net, critical care, and other facilities statewide. For example, IDHFS reports that in January through March of 2026, La Rabida Children's Hospital will receive monthly MCAP payments of $2.6 million from the state's six MCOs, with CountyCare providing $1.2 million of that total (Illinois Department of Healthcare and Family Services 2026, 1). CountyCare's total monthly payment to all providers is $97.9 million. These payments are essentially "passed through" the County's budget, as CountyCare receives revenues from the state to make these provider payments.
[42] Cook County, *Volume I - Budget Overview FY2026 Executive Recommendation*, 81.

APPENDIX: GLOSSARY

ACA Expansion
The expansion of Medicaid eligibility authorized under the Affordable Care Act (ACA), allowing coverage for non-elderly adults with incomes below 133% of the Federal Poverty Level.

Benefits Improvement and Protection Act (BIPA) Payments
Supplemental Medicaid payments from the federal government to states and providers designed to improve coverage and offset uncompensated care costs.

Capitation Revenues
Payments received by a healthcare provider or managed care organization (MCO) on a per-member-per-month (PMPM) basis, regardless of the number of services provided. The amount is generally set by the state and varies by enrollee characteristics.

Charity Care
Free or reduced-price medical care provided by hospitals and health care providers to patients unable to pay.

CountyCare
Cook County's Medicaid managed care organization (MCO), which enrolls eligible members, receives capitation payments, and pays for healthcare services.

Directed Payments
Supplemental Medicaid payments directed by the state to safety-net providers, above and beyond standard payments, to support essential healthcare services for low-income populations.

Disproportionate Share Hospital (DSH) Payments
Federal and state payments to hospitals that serve a large number of low-income and uninsured patients, intended to help offset the cost of uncompensated care.

Fee for Service
A payment model in which healthcare providers are reimbursed individually for each service or treatment provided to patients, instead of receiving a fixed amount per enrollee.

Graduate Medical Education (GME) Payments
Funds provided for hospitals to support costs associated with training medical residents.

Health Enterprise Fund
A proprietary fund used by Cook County to account for and report its public health operations, including insurance programs and direct health service delivery. In government accounting, proprietary funds are used to report business-type activities that are supported primarily through user fees and charges for services, rather than taxes.

Managed Care Organization (MCO)
A healthcare entity that provides or arranges for health services to enrolled members and is paid a fixed per-member-per-month amount by Medicaid or other insurers.

Managed Long-Term Services and Support (MLTSS)
A Medicaid program providing long-term care and support (such as home and community-based services) using a managed care delivery system.

Medical Loss Ratio (MLR)
The ratio of clinical claims expenses paid out to capitation revenues received. A higher MLR means more is spent on patient care relative to revenue.

Net Patient Services Revenue (NPSR)
Revenues received from patient care services billed to Medicaid, Medicare, private insurers, and individual payers for treatments at healthcare facilities.

Payer Mix
The proportion of patients by insurance status (e.g., Medicaid, Medicare, private insurance, uninsured) treated by a healthcare provider, which affects revenues and uncompensated care costs.

Provider Taxes
Assessments or fees imposed by states on hospitals and managed care organizations (MCOs). These funds are often used to support Medicaid financing, including supplemental payments such as directed payments.

Redetermination
The periodic review process by states to determine if Medicaid participants still meet eligibility criteria.

Safety Net Provider
A healthcare provider—usually a hospital or clinic—that delivers care to patients regardless of their ability to pay, including a disproportionate share of uninsured and low-income individuals.

Supplemental Payments
Payments made to health care providers on top of standard reimbursements; often intended to offset costs related to uncompensated care, training, or special services.

Uncompensated Care
Healthcare services provided to patients who are uninsured and unable to pay, or where payments received are less than the cost of care. This includes charity care and bad debt.