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CityRx: A Blueprint for Public-Powered Pharmacies in New York City

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Introduction

New York City has a growing pharmacy gap, and the culprit is corporate power. Large corporate pharmacy chains have increasingly abandoned the City's most vulnerable neighborhoods—while other dominant healthcare corporations have short-changed the community-based independent pharmacies committed to serving the City.

This paper proposes an innovative policy solution to address this pharmacy gap: a framework and vision we call "CityRx." CityRx adopts a two-pronged approach to deploying public power to strengthen citywide pharmacy access. First, it creates *public options* through an expanded network of City-owned pharmacies. Second, it wields *industrial policy* to support and strengthen the City's independent pharmacies. Together, these approaches would use public power to add public alternatives and lift up independent operators to fill the void that large corporations have left in New York. In the long term, CityRx could provide a foundation for New York to pursue public drug procurement and manufacturing.

In short, CityRx would restore access to pharmacy services, stabilize independent pharmacies, and ultimately lower prescription drug costs by leveraging the City's purchasing power and healthcare infrastructure.

I. New York City's Pharmacy Gap

New York City has a growing healthcare infrastructure gap from the loss of pharmacies. Large chain pharmacies have closed 45 percent of their storefronts in the City since 2019.[1] Rite Aid—now bankrupt and defunct—left the city completely, while CVS and Duane Reade (owned by Walgreens) have significantly reduced their locations.[2] Small independent pharmacies are valuable community institutions, but are not complete substitutes under current market conditions: they often cannot provide the full range of products, services, hours, and prices that large chains do, and (as discussed below)

[1] CTR. FOR AN URBAN FUTURE, STATE OF THE CHAINS 2025 7 (Dec. 2025), https://nycfuture.org/pdf/state-of-the-chains-2025.pdf.
[2] *Id.*

face financial disadvantages.[3] This has left New Yorkers with fewer options, higher prices, and less access to healthcare services.[4]

Much of this emerging gap is the result of concentrated corporate power exploiting the City's small businesses. New York City's small independent pharmacies are victimized by larger corporations in the pharmaceutical ecosystem. Small pharmacies lack the scale to negotiate better prices when purchasing their drugs from wholesalers and better reimbursement when seeking payment from pharmacy benefit managers (PBMs), which administer prescription drug plans for insurance companies. They are also disfavored by insurance plans that "preference" the larger pharmacy chains and their pharmacy benefit managers.[5] Even through group purchasing and pooled negotiations (such as through pharmacy services administrative organizations), small pharmacies have a harder time securing fair prices than big chains due to PBMs' dominant market power and standard contract terms.[6] In a 2024 report, the Federal Trade Commission found that PBMs' market power gives them the ability to disadvantage small independent pharmacies through unfair take-it-or-leave-it contracting practices and lowball reimbursement rates.[7]

This has left small pharmacies paying more to buy medicine and receiving lower reimbursement rates when they dispense it, making it harder for them to survive and serve patients. In a 2024 survey of 176 of the City's independent pharmacies, 92 percent said they had been forced to turn away patients because PBM

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[3] *See* Sharon Otterman, *Mom-and-Pop Drugstores Thrive as Chain Pharmacies Close in New York*, N.Y. TIMES (Dec. 24, 2023), https://www.nytimes.com/2023/12/24/nyregion/pharmacies-closures-shoplifting.html; Philippe Amstislavski et al., *Medication deserts: survey of neighborhood disparities in availability of prescription medications*, 11 INT'L J. HEALTH GEOG. 1, 10 (2012).

[4] *See* Amstislavski et al., *supra* note 3, at 10; *see also* Jing Luo et al., *Variation in Prescription Drug Prices by Retail Pharmacy Type: A National Cross-sectional Study*, 171 ANNALS INTERN. MED. 605 (2019).

[5] Otterman, *supra* note 3.

[6] Priyanka A. Abraham et al., *Reforming Markets to Strengthen Independent Pharmacies*, JAMA HEALTH FORUM (Apr. 4, 2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2831934; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-176, PRESCRIPTION DRUGS: THE NUMBER, ROLE, AND OWNERSHIP OF PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS 7 (2013), https://www.gao.gov/assets/gao-13-176.pdf; *see also The Role of Pharmacy Services Administrative Organizations for Independent Retail and Small Chain Pharmacies*, AVALERE HEALTH (Sept. 30, 2021), https://www.hda.org/getmedia/9902c3e9-81ae-422c-b413-d982e995e9d4/The-Role-of-PSAOs-for-Independent-Retail-Small-Chain-Pharmacies.pdf.

[7] FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: THE POWERFUL MIDDLEMEN INFLATING DRUG COSTS AND SQUEEZING MAIN STREET PHARMACIES 48-55 (July 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf.

reimbursements for certain drugs were lower than what the pharmacy paid for them, and nearly all reported that they had stopped carrying certain medicines for this reason.[8] On average, these pharmacies were forced to turn away patients between 4-10 times per day.[9]

The City's lost healthcare infrastructure is having a tangible impact on neighborhoods, communities, and health. A 2022 study found that nearly 40,000 New Yorkers live in full-fledged pharmacy deserts, with limited access to nearby pharmacies—a number that has likely only increased as large chains have further reduced their footprint over the last three years.[10] Limited physical access to retail pharmacies is particularly detrimental to those who already may face access challenges, such as elderly patients, those with limited mobility, patients with mental health conditions, and patients with extended working hours (such as those working multiple jobs).

The exodus of large chain pharmacies has created blighted "zombie" storefronts.[11] The City has over a million square feet of vacant retail space formerly occupied by large pharmacies still locked into long-term leases.[12] These storefronts are expensive to lease, and in many cases the former chain pharmacy tenants continue paying "dark rent" while shuttering their stores under leases that could extend up to twenty years.[13] These vacant spaces attract illegal activity and depress nearby businesses.[14]

Beyond big chain pharmacies and small independents, New York City also has an existing public pharmacy network. New York City Health + Hospitals (H+H), a state-chartered public benefit corporation that operates the City's public hospital system, manages at least sixteen in-hospital pharmacies, employs 1,200 pharmacy staff, and

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[8] *Survey Finds 92% Of NYC Pharmacies Forced To Turn Patients Away In Last 6 Months*, HARLEM WORLD (Aug. 21, 2024), https://www.harlemworldmagazine.com/survey-finds-92-of-nyc-pharmacies-forced-to-turn-patients-away-in-last-6-months/.

[9] *Id.*; *see also* Ed Hersh, *UWS Independent Pharmacies Face Existential Threat From PBMs: Survey*, WEST SIDE RAG (Sept. 25, 2024), https://www.westsiderag.com/2024/09/25/uws-independent-pharmacies-face-existential-threat-from-pbms-study.

[10] Xiaohan Ying & Peter Kahn, *Pharmacy deserts: More than where pharmacies are*, 62 J. AM. PHARM. ASSOC. 1875 (2022), https://www.japha.org/article/S1544-3191(22)00230-8/abstract.

[11] Stefanos Chen, *The Zombie Pharmacies That Are Holding Back New York City Retail,* N.Y. TIMES (Aug. 6, 2024), https://www.nytimes.com/2024/08/06/nyregion/pharmacies-vacant-drugstores-retail.html.

[12] *Id.*

[13] *Id.*

[14] *Id.*

dispenses 2 million outpatient prescriptions each year.[15] H+H pharmacies currently prioritize serving patients on Medicaid and those without insurance coverage. H+H also recently launched a delivery pharmacy service to serve patients at the City's 29 community health centers.[16]

II. CityRx: A Public Power Vision for Pharmacy Access in New York City

To address its growing pharmacy gap, New York City should adopt the "CityRx" vision: combining public option pharmacies with City-backed independent pharmacies to provide superior access to all New Yorkers.

As detailed below, CityRx could proceed in three initial phases: (1) new City-owned delivery and mobile pharmacy options; (2) an expansion of the City's existing public pharmacy network; and (3) a new alliance of City-certified and -supported independent pharmacies. Once this initial vision is achieved, CityRx can explore additional steps that would promote affordable medicine and cost savings shared between the City, patients, and small independent pharmacies.

Phase 1: Public Delivery and Mobile Pharmacies

Within its first six months, the City could launch a comprehensive delivery pharmacy service to provide immediate improved access to New Yorkers. "CityRx Delivery" could build on the H+H/Gotham Health delivery pharmacy service that currently serves the City's community health centers.[17] In coordination with the New York City Department of Health and Mental Hygiene, this program could be expanded to serve any New York City resident, regardless of their primary care provider.[18]

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[15] *See Never a Dull Moment: First Hand Stories from Our Pharmacy Staff*, NYC HEALTH + HOSPS., https://www.nychealthandhospitals.org/insider/never-a-dull-moment-first-hand-stories-from-our-pharmacy-staff/ (last visited Month XX, 2026).

[16] Press Release, NYC Health + Hospitals, NYC Health + Hospitals/Gotham Health Launches Pharmacy Home Delivery Program Across New York City (Jan. 8, 2026), https://www.nychealthandhospitals.org/pressrelease/nyc-health-hospitals-gotham-health-launches-pharmacy-home-delivery-program-across-new-york-city/.

[17] *Id.*

[18] *See* N.Y.C. Charter § 556(d)(1) (authorizing the Commissioner of Health to "[m]aintain and operate public health centers and clinics as shall be established in the department").

While drug delivery is convenient for many patients, some may continue to face access gaps. To provide an initial in-person pharmacy option, CityRx could additionally provide mobile pharmacy service—a "pharmacy on wheels," modeled after the City's mobile "Test to Treat" program which used mobile vans to test for COVID-19 and dispense Paxlovid antiviral medication.[19] "CityRx Mobile" could make scheduled stops across the five boroughs, with a particular focus on neighborhoods with the largest existing access gaps. (To that end, the City may commission a preliminary study of which neighborhoods have the least access to high-quality pharmacies, based on metrics such as physical distance, transit availability, and relevant socioeconomic factors.)

While both CityRx Delivery and Mobile should aspire to offer a robust range of medicines for all New Yorkers, they may initially prioritize particular high-need treatments of public health importance, such as medicines to treat HIV, Hepatitis C, and opioid use disorders.

The City can leverage its scale as a massive purchaser of medications to assure fair acquisition prices for medicines distributed through the delivery program. For patients who fill their prescriptions via the new delivery program, the extent to which those savings can be passed on depends to some degree on their insurance coverage. The Beyond Phase 3 section below offers further suggestions of how the City can ensure that lower drug prices benefit both the City as a purchaser and its residents as consumers.

Phase 2: New & Improved Public Option Pharmacies

Within the next year, the City could strengthen its existing public pharmacy footprint to serve more New York City residents. H+H's existing in-hospital pharmacies, which serve Medicaid patients and uninsured patients, provide a foundation for the City to expand upon. With added capacity, these existing H+H pharmacy locations could serve additional patients as well, such as those on Medicare or with private insurance plans. This would allow H+H pharmacies to become general community pharmacies.

[19] Press Release, NYC Office of Mayor, *Mayor Adams Launches Nation's First Mobile Test to Treat Program, To Provide Immediate Access to Anti-viral COVID-19 Medications at Mobile Testing Locations*, (Jun. 30, 2022), https://www.nyc.gov/mayors-office/news/2022/06/mayor-adams-launches-nation-s-first-mobile-test-treat-program-provide-immediate-access-to.

Within the next 1-2 years, H+H could begin adding new satellite pharmacies not connected to its hospital locations.[20] These new retail pharmacies would focus on high-need neighborhoods. Following the model of the Mamdani Administration's public grocery store plan, CityRx could begin by piloting one location per borough, while ultimately scaling to ensure that every New Yorker has high-quality pharmacy access (for example, within a fifteen-minute walk). To acquire space, H+H could prioritize (1) vacant retail pharmacy spaces; (2) existing city real estate holdings; and (3) co-location with public grocery stores or other existing public-facing community assets. City and state policy support could assist with property acquisition, such as by deploying eminent domain authority or imposing a vacancy tax on empty "zombie" retail space.[21]

Phase 3: Industrial Policy for Independent Pharmacies

Unlike many of the most dire pharmacy deserts in the United States, New York City does have a robust presence of small independent pharmacies that, with government support, can help bridge the city's access gap. To boost independent pharmacies, New York City can create a government-coordinated alliance—the "CityRx Alliance"—of qualifying independent pharmacies (i.e., those that meet some minimal established criteria pertaining to scale, service, and quality). The City could then provide these qualifying independent pharmacies with a series of supports to promote their economic wellbeing, future growth, and ability to serve New Yorkers. (This could in part be modeled on the City's Minority and Women-owned Business Enterprise (M/WBE) Certification Program, which aims to help the City's small businesses access government procurement opportunities.[22])

First, CityRx Alliance members could gain better terms from their suppliers and payers. City government could leverage its contractual relationships to demand stronger reimbursement from PBMs, and preferential (or at least neutral) treatment from insurers on behalf of Alliance member pharmacies. For instance, New York City

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[20] *See* N.Y. Unconsol. Law §§ 7385(5)-(8) (authorizing H+H to make contracts, acquire property, operate health facilities, and provide health services).

[21] For a discussion of vacancy taxes in the context of housing, see Ganesh Sitaraman & Christopher Serkin, *Post-Neoliberal Housing Policy*, VAND. POL'Y ACCELERATOR (2025), at 49, https://cdn.vanderbilt.edu/vu-URL/wp-content/uploads/sites/412/2025/04/22200114/Post-Neoliberal-Housing-Policy.pdf (forthcoming U. PA. L. REV.).

[22] *Minority and Women-owned Business Enterprise (M/WBE) Certification Program*, CITY OF NEW YORK, https://nyc-business.nyc.gov/nycbusiness/description/minority-and-womenowned-business-enterprise-certification-program-mwbe (last visited Month XX, 2026).

currently has a $60 billion contract with UnitedHealthcare to provide health insurance coverage for city employees.[23] The City could insist that UnitedHealthcare (a) include any CityRx Alliance pharmacy among its preferred pharmacies, and (b) include CityRx Delivery as one of its preferred delivery pharmacies (once it has achieved sufficient scale). The City also has contractual relationships with PBMs: UnitedHealthcare owns the PBM Optum Health, while H+H owns an insurance plan that contracts with CVS Caremark as its PBM.[24] New York City could use its purchasing power as an employer and insurer to demand that its contract partners' PBMs provide CityRx Alliance members with fair and adequate reimbursement terms, such as terms at least as good as what H+H pharmacies receive.[25] Moreover, the Alliance itself could function as a pharmacy services administrative organization to negotiate additional terms from suppliers and payers, including those otherwise unaffiliated with the City. (City- and State-level regulatory and legislative enforcement could also help incentivize PBMs to offer fair terms to CityRx and independent pharmacies.)

Second, Alliance members could be given business access to CityRx Delivery, along with a share of the program's revenues. In addition to directly serving patients, CityRx Delivery could serve as a public option for medicine delivery for independent pharmacies: it could offer delivery services to independents at rates competitive with private options like Amazon Pharmacy and Express Scripts. Recognizing that direct-to-patient pharmacy delivery services put competitive pressure on independent retail pharmacies, CityRx Delivery could create a fund that shares some of its proceeds back with Alliance members as a form of industrial policy support for independent community pharmacies.

Third, the City could establish specialized support programs for Alliance members through Small Business Services, the New York City Economic Development Corporation, and the Department of Health and Mental Hygiene. These programs

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[23] *See* Barbara Caress, *City Workers Have a New Health Plan. Mayor Mamdani: Good Luck With That*., NEW SCHOOL (Jan. 7, 2026), https://www.centernyc.org/urban-matters-2/city-workers-have-a-new-health-plan-mayor-mamdani-good-luck-with-that.

[24] *See Quality Management Program*, METROPLUSHEALTH, https://metroplus.org/members/blog/quality/ (last visited Month XX, 2026).

[25] While federal preemption under the Employee Retirement Income Security Act (ERISA) limits the authority of states and cities to regulate certain aspects of health insurance plans, the city could nonetheless bargain for concessions from insurance plans and their PBMs in its contracting capacity as a market participant. *See Rutledge v. Pharmaceutical Care Management Ass'n*, 592 U.S. ___ (2020); *Reeves, Inc. v. Stake*, 447 U.S. 429 (1980).

could help Alliance members grow their businesses, such as through dedicated preferential access to loans and capital, and operational and logistics support, such as adding important ancillary services like immunizations, vaccinations, and basic diagnostics and testing.

Beyond Phase 3: Public Drug Wholesale & Manufacturing

After achieving the initial CityRx vision, this City-supported pharmacy ecosystem could become a foundation for even bolder policy actions to use public power to improve the health of New Yorkers.

First, CityRx could engage in direct public drug procurement. In the long term, all CityRx pharmacies—whether Alliance members, H+H pharmacies, or CityRx mobile and delivery pharmacies—could bypass wholesalers by purchasing directly from the manufacturers.[26] This would emulate one of the key pieces of the model adopted by the company Cost Plus Drugs, which offers low prices for generic drugs by selling them near the price charged by the manufacturer. Wholesalers currently take a significant cut of generic pharmaceutical sales, indicating that there is ample savings to be had if the City circumvents them.[27] If CityRx became its own wholesaler, it could automatically offer patients a "cost plus" price in the event that price is lower than their insurance plan's out-of-pocket costs for a given prescription, promoting drug affordability for more patients. For the time being, those "cost-plus" prices would apply to consumers paying cash for their medications. However, if New York State adopted legislation similar to that recently passed in Tennessee[28] and Texas,[29] those cash payments would automatically count towards the patient's insurance deductible.

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[26] Additionally, some scholars suggest that 340b-qualified entities (like H+H pharmacies) could acquire larger volumes of medication at steeply discounted 340b prices and pass along those savings to consumers, irrespective of their health coverage. For further details, see Emma Freer, *The Penny Price Pharmacy Toolkit: How Local Government Can Leverage the Federal 340B Program to Lower Out-of-Pocket Prescription Drug Costs*, AM. ECON. LIBERTIES PROJECT (Aug. 2025), https://www.economicliberties.us/wp-content/uploads/2025/08/20250807-AELP-pennyprice-toolkit-final-2.pdf.

[27] See Neeraj Sood et al., *Flow of Money Through the Pharmaceutical Distribution System*, SCHAEFFER CENT. WHITE PAPER SERIES (JUNE 2017), https://schaeffer.usc.edu/wp-content/uploads/2024/10/The-Flow-of-Money-Through-the-Pharmaceutical-Distribution-System_Final_Spreadsheet.pdf.

[28] Tennessee HB 1213, An act to amend Tennessee Code Annotated, Title 8; Title 56 and Title 71, relative to insurance, https://www.capitol.tn.gov/Bills/113/Bill/HB1213.pdf

[29] Texas HB 2002, An act relating to preferred provider benefit plan out-of-pocket expense credits for payments made by an insured directly to a physician or health care provider, https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB2002

CityRx could even provide a foundation to expand directly into drug manufacturing. Public jurisdictions can directly bring pharmaceutical prices down and assure a safe and consistent supply of medicines by manufacturing generic medications and/or medical devices in the public sector. Public manufacturing can return revenue to public balance sheets, reduce inefficiencies, and create surge capacity for emergencies, helping create more resilient supply chains. Additionally, it helps break Big Pharma's monopoly on our medicines supply, not only by directly providing competition, but also by creating capacity that can be used by small biotech companies and university researchers who want to scale up operations, giving them an alternative to going with Big Pharma companies.

New York City can learn from the state's successful history of public drug production for public health needs. For example, the New York State Public Health Department developed and manufactured diphtheria antitoxin in the early 1900s as a response to a growing outbreak.[30]

In fact, the U.S. has a long and successful track record of state-owned pharmaceutical manufacturing.[31] For example, for over 125 years, the Massachusetts state-owned MassBiologics has developed and distributed vaccines and other biologic drugs like monoclonal antibodies.[32] The Michigan Biologic Products Institute successfully manufactured anthrax and rabies vaccines and distributed some of its products for free to state residents until its privatization in 1998 (at which time it was the only domestic producer of anthrax vaccines).[33] In the 1980s and '90s, the California Department of Public Health created treatment for infant botulism and distributed it at cost.[34] At the federal level, the Walter Reed Pilot Bioproduction Facility produces

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[30] *About Us*, NYS DEPARTMENT OF HEALTH, WADSWORTH CENTER, https://www.wadsworth.org/about/history?mc_cid=606f50eeaf&mc_eid=06ef7027a6.

[31] Dana Brown & Tom Latkowkski, *Public Pharmaceuticals State Policy Kit*, DEMOCRACY COLLABORATIVE (Dec. 2022), https://www.democracycollaborative.org/whatwethink/state-public-pharma-policy-toolkit.

[32] *History,* UMASS CHAN MED. SCH., https://www.umassmed.edu/massbiologics/about/history/ (last visited Month XX, 2026); *Facilities*, UMASS CHAN MED. SCH., https://www.umassmed.edu/massbiologics/about/facilities/ (last visited Month XX, 2026).

[33] Judith Miller, *Company Led by Top Admiral Buys Michigan Vaccine Lab*, N.Y. TIMES (Jul. 8, 1998), https://www.nytimes.com/1998/07/08/us/company-led-by-top-admiral-buys-michigan-vaccine-lab.html.

[34] *Antitoxin, Baby BIG (Botulism Immune Globulin)*, AMERICAN HISTORY MUSEUM, https://www.si.edu/object/antitoxin-baby-big-botulism-immune-globulin%3Anmah_1446817 (last visited Month XX, 2026).

vaccines and other biologics as part of the Defense Department's research and development efforts.[35]

More recently, California established CalRx, a state-run program that contracts with a nonprofit drug manufacturer to bring affordable insulin to market.[36] Advocates, however, have pushed California to consider full public ownership and operation of drug manufacturing facilities in the future—not only as a source of good local jobs and an upstream investment in community health, but also as a way to ensure the CalRx program remains centered on the public interest.. Indeed, studies show serious vulnerabilities to contractor owned and operated facilities such as technological lock-in, possible market exit or failure of contractor to fulfill the public mission, and more.[37]

The City could work through its Economic Development Corporation or H+H's Supply Chain Services division to directly manufacture or contract with an existing FDA-approved manufacturer to make low-cost asthma inhalers, EpiPens, and other lifesaving drugs available to New Yorkers as a public service. In addition, the City could enter into contracts with other public jurisdictions to produce other generics, beginning to form a public-interest supply chain for essential medicines. For example, MassBiologics, the public biopharmaceutical manufacturer operated by the University of Massachusetts, markets some of its products nationwide and funnels the proceeds back into its public-interest mission.[38] Lastly, the City should voice its support for current efforts at the state level to pass legislation to empower public production of essential medications.[39] If New York State becomes a producer of low-cost, high quality

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[35] *Pilot Bioproduction Facility (PBF)*, WALTER REED ARMY INST. OF RSCH., https://wrair.health.mil/Collaborate/Pilot-Bioproduction-Facility/ (last visited Month XX, 2026).

[36] In 2020, California Gov. Gavin Newsom signed into law the California Affordable Drug Manufacturing Act, which built on his first executive order and budget proposal to require the state's Health and Human Services to partner with generic manufacturers to produce low-cost drugs, including insulin. Starting in 2026, Californians will be able to buy a five-pack of state-branded insulin pens manufactured by the nonprofit drug manufacturer Civica Rx for $55. *California Enacts Law to Produce Generic Prescription Drugs*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Oct. 5, 2020), https://nashp.org/california-enacts-law-to-produce-generic-prescription-drugs/; Kristen Hwang & Ana Ibarra, *Newsom unveils $11 state insulin for Californians: 'We took matters into our own hands,'* CALMATTERS (Oct. 16, 2025), https://calmatters.org/health/2025/10/insulin-california-announcement/.

[37] *Deploying the Government Owned, Contractor Operated Model,* PUB. CITIZEN (Mar. 8, 2022), https://www.citizen.org/article/deploying-the-government-owned-contractor-operated-model/.

[38] Annual Reports to the Legislature: MassBiologics of the University of Massachusetts Medical School https://archives.lib.state.ma.us/handle/2452/41074.

[39] New York Affordable Drug Manufacturing Act, https://www.nysenate.gov/legislation/bills/2025/A3236

generic drugs, it could be the source of a very productive public-public partnership with CityRx to source and distribute those medications, assuring that New Yorkers have access to these affordable medications, and leveraging the public sector to assure resilient and robust supply chains as well as good local jobs.

Conclusion

The CityRx vision can reduce New York City's healthcare gaps. By leveraging, expanding, and strengthening the City's existing public and private pharmaceutical infrastructure, CityRx can maximize the potential of both H+H pharmacies and high-quality independent pharmacies, ultimately improving medicine access and health outcomes for New Yorkers.

New York City can afford CityRx. As one reference point, three recent H+H projects to renovate hospitals to add new pharmacies were collectively projected to cost more than $25 million, paid for by the hospital's general funds.[40] The City has also announced plans to spend $30 million building its first public grocery store in East Harlem.[41] Even the largest cost drivers of a pilot version of CityRx would be a comparative bargain. CityRx retail pharmacies could rent existing commercial space, or use preexisting City-owned space, at a fraction of the cost of building or renovating new space. The initial main capital expenses would likely cost around $650,000 per CityRx retail pharmacy,[42] and $300,000 per CityRx mobile pharmacy unit.[43] An initial CityRx delivery pharmacy option could take the form of an incremental expansion of the City's existing H+H/Gotham Health delivery program. Further, support for CityRx Alliance members would have only negligible administrative costs. CityRx may

[40] These projections are drawn from certificate-of-need applications filed in 2024 by H+H hospitals with the New York State Department of Health to add pharmacies at Jacobi Medical Center (project number 242227), Harlem Hospital Center (project number 242211), and Queens Hospital Center (project number 242181), which are accessible at https://apps.health.ny.gov/facilities/cons/nysecon/AdvancedSearch.

[41] *See* Emma G. Fitzsimmons, *Mamdani Plans to Open City-Owned Grocery Store in East Harlem*, N.Y. TIMES (Apr. 12, 2026), https://www.nytimes.com/2026/04/12/nyregion/mamdani-city-owned-grocery-store-la-marqueta.html.

[42] *How to Start an Independent Pharmacy*, RXMILE (Jul. 25, 2023), https://www.rxmile.com/insights/how-to-start-an-independent-pharmacy/.

[43] *See* Margaret Spratt, *How Much Does a Mobile Medical Unit Cost in the U.S. in 2026?*, AVAN MOBILITY (Mar. 17, 2023), https://www.avanmobility.com/learning-center/mobile-medical-unit-cost-in-us/.

ultimately lead to city-wide cost savings from better health outcomes, reduced emergency-room visits and hospitalizations, and improved medication adherence.

Perhaps more importantly, CityRx will chart a path toward a healthcare ecosystem where no New Yorker faces barriers to medicine because large corporations abandoned their neighborhood or squeezed their local healthcare establishment. By countering corporate power with public power, CityRx will build a stronger healthcare system for all New Yorkers.