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ARPA's Enhanced Premium Subsidies Provide Particularly Large Benefits to Residents of Rural Areas

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Introduction

The American Rescue Plan Act (ARPA) significantly expanded the Affordable Care Act's (ACA) advanced premium tax credits, or premium subsidies. The ACA provides two forms of financial assistance to Marketplace nongroup insurance enrollees: capping household premium contributions as a percentage of income (with more generous assistance for those with lower incomes) and lowering out-of-pocket costs such as deductibles, copayments, coinsurance, and out-of-pocket maximums in the form of cost-sharing reductions. Because of the structure of premium assistance, people living in areas of the country with the highest premiums see the greatest benefit from ARPA subsidies—and residents of rural areas are more likely to see higher insurance premiums.

As shown in table 1, ARPA premium subsidies provide greater assistance at every income level than the original ACA subsidies. Additionally, the premium subsidies extend assistance to people earning above 400 percent of the federal poverty level (FPL) with a cap that limits any qualifying individual's premium contributions to 8.5 percent of their income, while the original ACA subsidies were not available to people with incomes above 400 percent of FPL.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation's and Urban Institute Health Policy Center's websites.

TABLE 1

Premium Tax Credit Percentage of Income Limits for Benchmark Coverage, Before and After ARPA Implementation

Income (Percentage of FPL)	Pre-ARPA Subsidy Schedule	ARPA Subsidy Schedule
<138	2.07	0.0
138–150	3.10–4.14	0.0
150–200	4.14–6.52	0.0–2.0
200–250	6.52–8.33	2.0–4.0
250–300	8.33–9.83	4.0–6.0
300–400	9.83	6.0–8.5
400–500	N/A	8.5–8.5
500–600	N/A	8.5–8.5
>600	N/A	8.5–8.5

Sources: Internal Revenue Service, US Department of Health and Human Services, and the American Rescue Plan Act.
Notes: FPL is federal poverty level. Percentage-of-income caps are applied in 2022; pre-ARPA caps are for 2021 and are indexed each year. Annual adjustments to the caps have been modest and are not announced until close to the end-of-year open enrollment period.

Advanced premium tax credits, or federal government premium subsidy payments, are calculated as the difference between the benchmark premium (the second-lowest-cost silver plan in the enrollee's area of residence) and the specified percentage of income for the household, as shown in table 1.[1] Because the percentage-of-income caps do not vary with premiums, the higher the benchmark premium, the greater the size of the federal government's premium contribution for the household. This also applies to older individuals since the ACA established a 1:3 standardized age rating curve, with younger people paying less in premiums than older individuals.[2] In other words, as the benchmark premium increases with age, so does the value of the subsidy.

In this brief, we show that in several states, benchmark premiums are often significantly higher in rural areas than in urban areas. The enhanced premium subsidies provided by the ARPA are temporary and are scheduled to end before the next plan year, beginning in January 2023. Part of the Biden administration's Build Back Better agenda, which remains under consideration by Congress, includes extending the ARPA subsidies. In general, rural areas and other areas with high insurance premiums will

feel the greatest financial impact if the enhanced subsidies expire, and insurance coverage in these areas would likely fall significantly as a result.

Findings

We present descriptive data on the differences between average premiums for urban and rural areas in 2019 and 2022 for all 50 states and the District of Columbia. Each state's average rural and urban benchmark premiums are calculated as statewide averages weighted using the rating region population. Urban regions are those classified by the Iowa Center for Rural Public Health as having a majority of counties that are urban.[3] The urban/rural classification is determined by whether a rating region has more urban or rural counties.

Benchmark Premium Differences

Table 2 shows the large differences in average benchmark premiums between urban and rural regions within each state in 2022. The US average weighted across states shows that benchmark premiums in urban areas are about 10 percent lower than the benchmarks in rural areas; unweighted, this difference drops to around 5 percent. In 34 states, average benchmark premiums in rural areas exceed those in urban areas. In another 9 states, all ACA rating regions in the state are classified as either entirely urban or entirely rural, or the state has only a single rating region. Therefore, only 8 states have average urban benchmark premiums that exceed average rural premiums.

Of the 34 states with higher rural premiums, more than half (18 states) have average rural premiums that are more than 10 percent higher than the average urban premiums; in 12 of these states, the rural premiums are more than 20 percent higher than the urban ones. For example, in California, the average rural benchmark premium is $519 per month for a 40-year-old nonsmoker, while the average urban benchmark premium is $413—a difference of 26 percent. In Arizona, the average rural benchmark premium is $500 per month, compared with the average urban benchmark premium of $379—a difference of 32 percent. In Illinois, the average rural benchmark monthly premium is $590, and the average urban premium is $373—a difference of 58 percent. In Florida, the average rural benchmark premium is $582, and the average urban benchmark premium is $453—a difference of 28 percent. The urban/rural premium differences in Missouri, North Carolina, South Dakota, and Utah are 25 percent, 22 percent, 38 percent, and 27 percent, respectively.

TABLE 2

Average Benchmark Monthly Premiums in Rural and Urban Areas by State, Weighted by Population

	2022 Benchmark Premium			
State	Urban area (dollars)	Rural area (dollars)	Difference in level, urban/rural (dollars)	Percent difference, urban/rural
US average (weighted)	**$430**	**$471**	**-$41**	**-10%**
US average (unweighted)	**$461**	**$484**	**-$22**	**-5%**
Alabama	$589	$594	-$5	-1%
Alaska	N/A	$717	N/A	N/A
Arizona	$379	$500	-$121	-32%
Arkansas	N/A	$387	N/A	N/A
California	$413	$519	-$106	-26%
Colorado	$337	$452	-$115	-34%
Connecticut	$578	$553	$25	4%
DC	$387	N/A	N/A	N/A
Delaware	$548	N/A	N/A	N/A
Florida	$453	$582	-$128	-28%
Georgia	$398	$359	$40	10%
Hawaii	$487	N/A	N/A	N/A
Idaho	$451	$457	-$7	-2%
Illinois	$373	$590	-$217	-58%
Indiana	$403	$393	$10	3%
Iowa	$435	$478	-$43	-10%
Kansas	$449	$456	-$6	-1%
Kentucky	$401	$409	-$8	-2%
Louisiana	$508	$519	-$10	-2%
Maine	$394	$448	-$53	-14%
Maryland	$326	N/A	N/A	N/A
Massachusetts	$399	$418	-$19	-5%
Michigan	$319	$375	-$56	-17%
Minnesota	$299	$370	-$71	-24%
Mississippi	$447	$452	-$5	-1%
Missouri	$405	$508	-$103	-25%
Montana	N/A	$479	N/A	N/A
Nebraska	$541	$605	-$63	-12%
Nevada	$366	$563	-$197	-54%
New Hampshire	N/A	$309	N/A	N/A
New Jersey	$422	N/A	N/A	N/A
New Mexico	$366	$447	-$81	-22%
New York	$622	$480	$142	23%
North Carolina	$468	$569	-$102	-22%
North Dakota	$445	$428	$17	4%
Ohio	$370	$382	-$12	-3%
Oklahoma	$462	$433	$29	6%
Oregon	$435	$461	-$26	-6%
Pennsylvania	$432	$492	-$60	-14%
Rhode Island	$360	N/A	N/A	N/A
South Carolina	$449	$425	$25	5%
South Dakota	$460	$633	-$173	-38%
Tennessee	$438	$458	-$21	-5%
Texas	$413	$457	-$44	-11%
Utah	$444	$562	-$118	-27%
Vermont	N/A	$749	N/A	N/A

State	2022 Benchmark Premium			
	Urban area (dollars)	Rural area (dollars)	Difference in level, urban/rural (dollars)	Percent difference, urban/rural
Virginia	$450	$453	-$2	-1%
Washington	$388	$393	-$5	-1%
West Virginia	$774	$761	$13	2%
Wisconsin	$407	$441	-$34	-8%
Wyoming	$734	$771	-$38	-5%

Source: Urban Institute analysis of Marketplace premium data from healthcare.gov public use files and relevant state-based Marketplace websites.
Note: The premiums displayed are monthly benchmarks for a 40-year-old nonsmoker.

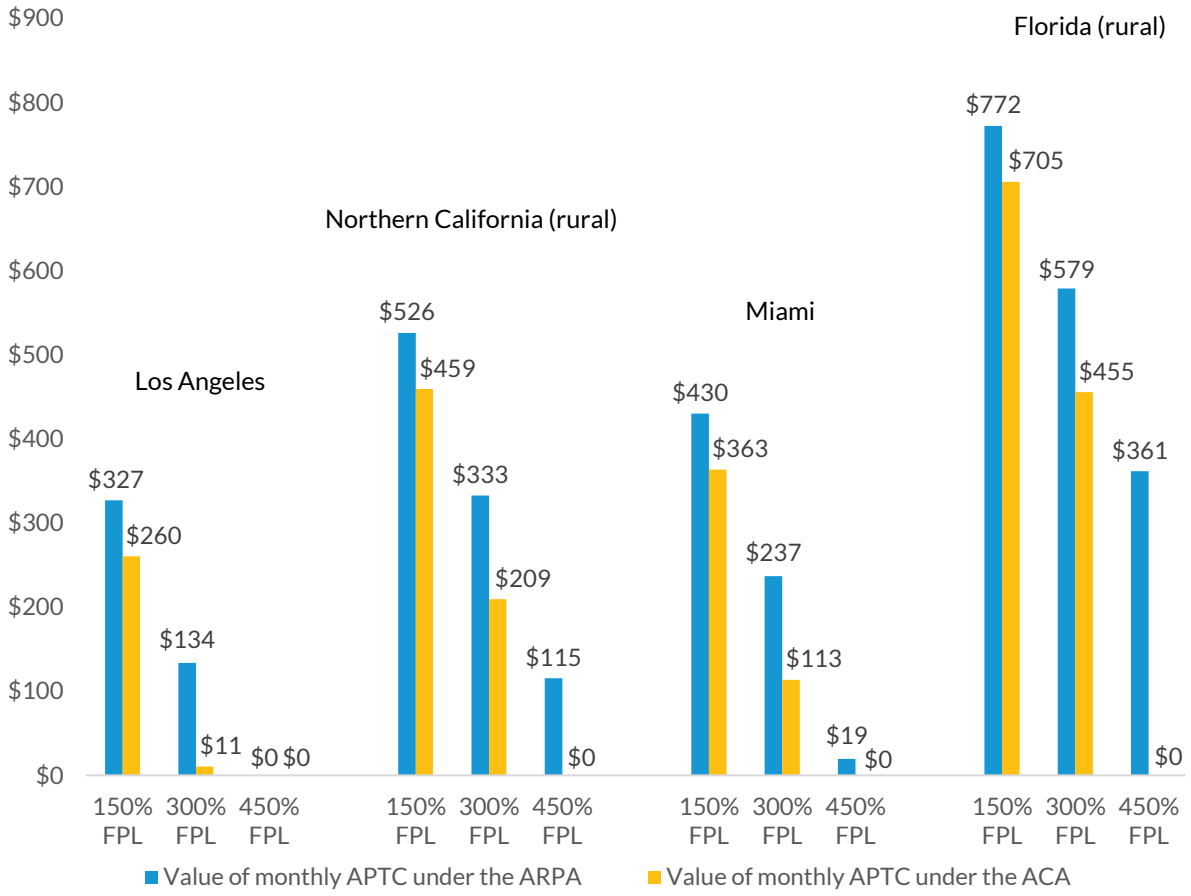
Subsidy Differences

Figure 1 below also demonstrates the impact of high premiums on subsidies in rural areas. As noted above, subsidies are the difference between the benchmark premium and the maximum percentage of income that an individual at a specific income level would be expected to pay. Figure 1 shows the differences in subsidies in urban and rural areas in California and Florida.[4] As shown in table 1, pre-ARPA subsidies are less generous at every income level than subsidies provided under the ARPA. The tax credits are also more generous for people with lower incomes than for those with relatively higher incomes. Figure 1 also shows that there are no premium subsidies in the pre-ARPA schedule for people at 450 percent of FPL, as designed by law. Subsidies are present at 450 percent of FPL under the ARPA because of the 8.5 percent-of-income cap toward premiums, regardless of income. There are no premium subsidies at 450 percent of FPL in Los Angeles because the full premiums are lower than the 8.5 percent cap that an individual would have to pay at that income level.

The main purpose of figure 1 is to show that the value of the subsidies is higher in rural areas than in urban areas in both California and Florida, as well as in several other areas shown in table 2, particularly under the ARPA. For example, at 150 percent of FPL, ARPA subsidies in the northern California rural region are $526 per month for a 40-year-old compared with $327 dollars in Los Angeles for the same recipient. At 300 percent of FPL, subsidies are worth $333 per month for a 40-year-old in the rural region and $134 in Los Angeles. The same results hold for Florida. At 150 percent of FPL, a 40-year-old receives $772 per month in subsidies in the state's rural region and $445 per month in Miami; for a 40-year-old with an income at 300 percent of FPL, subsidies are worth $579 per month in Florida's rural regions and $252 per month in Miami; and at 450 percent of FPL, subsidies are worth $361 per month in the rural region and $34 per month in Miami. These data demonstrate that the differences in benchmark premiums in rural versus urban areas—or in high- versus low-premium states—can result in much greater subsidies at the individual level.

FIGURE 1

Value of the Monthly Advanced Premium Tax Credit under the ARPA and ACA for a 40-Year-Old Nonsmoker, by Income Level



Notes: APTC is advance premium tax credit. FPL is federal poverty level. Values of $0 for a particular income level indicate that the monthly benchmark premium is below the maximum threshold where someone would have to pay a premium at 450 percent of FPL, or that there are no subsidies at this income level.

Conclusion

In most states, for numerous reasons, people living in rural areas face higher benchmark Marketplace premiums compared with their counterparts living in urban areas. The ACA designed premium subsidies to better protect people living in high-premium areas by having the federal government pay the difference between benchmark premiums and percentage-of-income caps. In other words, more federal dollars flow to areas with higher benchmark premiums in order to make comprehensive coverage affordable for more people. Still, even with the original ACA premium subsidies in place, coverage remained out of many people's financial reach. This was particularly true for older adults with incomes greater than the subsidy cutoff (400 percent of FPL), as well as for others struggling to pay their

required premium contributions. People living in areas with high health insurance premiums faced additional risk of not being able to afford coverage.

The enhanced ARPA subsidies go further than the ACA by providing more generous protection for people earning below 400 percent of FPL. They also extend protection to people in the nongroup market with incomes above 400 percent of FPL for the first time by capping their premium contributions for benchmark coverage at 8.5 percent of income. These enhancements have been valuable nationwide, but particularly in high-cost areas such as rural regions of the country, where ARPA subsidies have made comprehensive insurance coverage accessible to many for the first time. Thus, legislation that would extend ARPA subsidies is critical, particularly for rural Americans and those in high-premium states.

Notes

[1] Silver plans are plans with 70 percent actuarial value, meaning that for an average enrollee in an average year, the insurer will pay 70 percent of incurred health care costs.

[2] "2018 State Specific Age Curve Variations" Centers for Medicare and Medicaid Services, Accessed April 20 2022. https://www.cms.gov/sites/default/files/repo-new/44/StateSpecAgeCrv053117.pdf.

[3] "Health Insurance Marketplace Rating Areas," University of Iowa, RUPRI Center for Rural Health Policy Analysis, accessed April 20, 2022, https://rupri.public-health.uiowa.edu/publications/policybriefs/2014/premiums/.

[4] The urban region in California is Los Angeles (rating region 15), and the rural region (referred to as northern counties by Covered California) comprises the rural counties north of San Francisco. In Florida, the urban region is Miami and the rural region is Monroe County, located near Everglades City.

About the Authors

John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act, including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. His recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

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