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What Will Happen to Health Care Spending If the American Rescue Plan Act Premium Tax Credits Expire?

Estimated Impact on Health Care Provider Revenue

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The American Rescue Plan (ARP) Act of 2021 increased premium tax credits (PTCs) for Marketplace coverage and extended eligibility for PTCs to people with incomes above 400 percent of the federal poverty level (FPL). Consequently, Marketplace enrollment reached a record high during the 2022 open enrollment period (OEP), which ended in January 2022. However, these enhancements will expire after 2022 unless Congress extends them. In a prior study, we estimated that if enhancements are not extended, 3.1 million more people would be uninsured in 2023, and Marketplace enrollees would spend hundreds of dollars more per person on premiums.

In this new analysis, we find that with the increase of uninsured people, health care spending by private and public insurers and households would decline by $11.4 billion in 2023 if enhanced PTCs expire. Uninsured individuals use substantially less health care than insured individuals. We estimate spending decreases of $3.8 billion on hospital services, $1.3 billion on services in physician practices, $3.4 billion on other services, and $2.8 billion on prescription drugs.

Thus, if enhanced PTCs are not renewed, not only would health care provider revenue be lower, but more than 3 million people would become uninsured, receive less health care, and likely experience greater morbidity and financial insecurity.

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.

Introduction

The ARP included two major changes designed to expand access to affordable health insurance coverage for people who enroll in the Marketplace. It enhanced PTCs for people previously eligible for subsidies and expanded eligibility for subsidies to individuals and families previously ineligible because their incomes were greater than 400 percent of FPL. Because of these reductions in household premiums, Marketplace enrollment has increased to record levels. By the end of the 2022 Marketplace OEP in January, 2.5 million more people had made plan selections than after the 2021 OEP.[1]

However, the ARP's enhanced PTCs are set to expire after 2022. Extending them would require congressional action, such as passing some of provisions that were in the Build Back Better Act considered in 2021. In a previous report, we estimated health coverage and costs in 2023 both with and without extension of the ARP's enhanced PTCs (Buettgens, Banthin, and Green 2022). We found the following:

- If enhanced PTCs expire, 3.1 million more people will be uninsured.
- If enhanced PTCs are not extended, individuals and families enrolled in the Marketplaces or other nongroup coverage will pay hundreds of dollars more per person each year in premiums.

In this brief, we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the spending on health care services for the nonelderly by public and private insurers and households, including uncompensated care provided to the uninsured, both with and without enhanced PTCs. HIPSM incorporates parameters to account for the reduced spending on health care services by uninsured individuals, and health care spending for Marketplace coverage is set to be consistent with 2022 premiums in each state rating region (Buettgens and Banthin 2020). We separate spending on hospital services, physician practice services, other services,[2] and prescription drugs. We find the following:

- Total health care spending would decline by $11.4 billion nationally in 2023 as more than 3 million people would become uninsured and receive less health care.
- Hospital spending would decline by $3.8 billion.

- Spending on physician practice services would decline by $1.3 billion.
- Spending on other services would decline by $3.4 billion.
- Spending on prescription drugs would decline by $2.8 billion.

Five states would see particularly large declines in health care spending: Florida, Georgia, North Carolina, South Carolina, and Texas. In our earlier report, we showed that these states would also experience the greatest losses in coverage if enhanced PTCs expire.

Results

In table 1, we estimate health care spending for the nonelderly by insurers and households,[3] which differs from other HIPSM cost estimates (Buettgens, Banthin, and Green 2022) in that it excludes health insurance premium loads or administrative costs because that spending does not go to health care providers.

TABLE 1

Health Care Spending for the Nonelderly by Public and Private Insurers and Households, 2023

In millions of dollars

Service type	Enhanced ARP PTCs are extended	Enhanced ARP PTCs expire	Difference
Hospitals	654,947	651,132	-3,816
Physician practices	294,173	292,851	-1,322
Other services	589,132	585,697	-3,435
Prescription drugs	558,676	555,839	-2,837
Total	2,096,928	2,085,518	-11,410

Source: Urban Institute Health Insurance Policy Simulation Model, 2022.
Notes: ARP = American Rescue Plan; PTCs = premium tax credits.

We find that health care spending in 2023 would decrease by $11.4 billion if enhanced PTCs expire. Spending on hospital services would decrease by $3.8 billion, spending on physician practice services would decrease by $1.3 billion, and spending on other services would decrease by $3.4 billion. Spending on prescription drugs would decrease by $2.8 billion.

TABLE 2

Public and Private Insurer and Household Spending on Hospitals (H), Physician Practices (PP), Other Services (OS), and Prescription Drugs (PD) for the Nonelderly, by State, 2023

In millions of dollars

	Enhanced ARP PTCs Are Extended					Enhanced ARP PTCs Expire					Difference					
State	H	PP	OS	PD	Total	H	PP	OS	PD	Total	H	PP	OS	PD	Total	%
AL	8,985	3,947	8,142	7,859	28,932	8,914	3,916	8,066	7,791	28,687	-71	-31	-76	-68	-245	-0.8%
AK	1,717	747	1,516	1,375	5,354	1,708	741	1,506	1,363	5,319	-9	-5	-10	-11	-35	-0.7%
AZ	14,791	6,518	12,869	12,173	46,352	14,764	6,507	12,845	12,145	46,261	-28	-11	-24	-29	-91	-0.2%
AR	6,317	2,685	5,434	5,151	19,587	6,296	2,674	5,408	5,131	19,509	-21	-11	-26	-20	-78	-0.4%
CA	76,190	35,123	69,313	65,470	246,096	76,080	35,100	69,221	65,429	245,830	-110	-23	-91	-40	-266	-0.1%
CO	11,248	5,414	10,443	9,835	36,940	11,242	5,413	10,431	9,832	36,918	-6	-2	-12	-3	-22	-0.1%
CT	7,896	3,645	7,539	7,079	26,160	7,898	3,645	7,538	7,076	26,156	1	-1	-1	-3	-4	0.0%
DE	2,164	951	1,891	1,821	6,827	2,151	948	1,885	1,814	6,798	-13	-3	-6	-7	-29	-0.4%
DC	1,792	720	1,323	1,254	5,088	1,797	722	1,326	1,258	5,102	4	2	3	4	13	0.3%
FL	37,160	16,562	34,097	33,055	120,874	36,497	16,277	33,384	32,432	118,590	-664	-284	-713	-623	-2,284	-1.9%
GA	19,928	9,337	18,379	17,687	65,331	19,524	9,220	18,057	17,427	64,229	-404	-117	-322	-259	-1,102	-1.7%
HI	2,443	1,043	2,241	2,092	7,819	2,439	1,042	2,238	2,088	7,807	-4	-1	-3	-4	-12	-0.2%
ID	3,650	1,527	3,171	3,033	11,380	3,633	1,520	3,157	3,021	11,331	-16	-7	-14	-12	-49	-0.4%
IL	23,289	10,961	22,103	20,979	77,331	23,312	10,965	22,114	20,986	77,377	23	4	11	8	46	0.1%
IN	14,063	6,104	12,469	11,986	44,621	14,060	6,102	12,461	11,982	44,606	-2	-2	-8	-3	-15	0.0%
IA	6,655	2,958	6,149	5,608	21,371	6,654	2,957	6,143	5,604	21,358	-1	-1	-6	-5	-12	-0.1%
KS	5,610	2,576	5,193	4,853	18,232	5,605	2,572	5,181	4,850	18,208	-5	-3	-12	-3	-24	-0.1%
KT	9,740	4,123	8,335	8,006	30,205	9,657	4,089	8,258	7,928	29,932	-83	-34	-77	-78	-273	-0.9%
LA	9,452	3,942	7,880	7,627	28,901	9,342	3,901	7,782	7,534	28,559	-109	-42	-98	-93	-342	-1.2%
ME	2,700	1,154	2,541	2,364	8,758	2,686	1,150	2,530	2,355	8,721	-13	-4	-11	-9	-37	-0.4%
MD	12,261	5,586	11,193	10,462	39,501	12,251	5,583	11,178	10,452	39,465	-10	-3	-14	-10	-37	-0.1%
MA	13,893	6,264	12,054	11,483	43,695	13,952	6,266	12,073	11,482	43,773	59	3	19	-1	79	0.2%
MI	19,640	8,617	17,821	17,045	63,123	19,596	8,601	17,770	17,006	62,972	-43	-16	-52	-39	-150	-0.2%
MN	13,179	5,994	12,026	11,246	42,443	13,142	5,982	12,004	11,224	42,351	-37	-12	-22	-22	-92	-0.2%
MS	6,065	2,537	5,029	4,909	18,540	6,009	2,515	4,958	4,856	18,338	-56	-22	-71	-53	-201	-1.1%
MO	14,331	6,044	12,130	11,656	44,161	14,239	6,013	12,044	11,591	43,888	-92	-31	-86	-65	-273	-0.6%
MT	2,369	1,006	2,030	1,898	7,302	2,364	1,004	2,025	1,893	7,286	-6	-1	-5	-5	-17	-0.2%
NE	3,914	1,716	3,643	3,336	12,609	3,884	1,702	3,611	3,313	12,510	-30	-14	-32	-23	-99	-0.8%
NV	6,027	2,661	5,407	5,169	19,263	6,000	2,652	5,386	5,151	19,189	-26	-9	-21	-18	-74	-0.4%
NH	2,558	1,260	2,539	2,434	8,791	2,552	1,258	2,533	2,428	8,771	-7	-2	-6	-6	-20	-0.2%
NJ	16,494	8,313	16,518	15,506	56,831	16,412	8,290	16,451	15,450	56,603	-82	-23	-67	-56	-228	-0.4%
NM	4,752	1,916	3,820	3,585	14,073	4,752	1,914	3,815	3,583	14,063	-1	-1	-5	-3	-10	-0.1%
NY	42,469	17,509	34,899	33,169	128,046	42,410	17,482	34,830	33,105	127,827	-59	-28	-69	-64	-219	-0.2%
NC	21,971	9,803	19,420	18,519	69,713	21,606	9,699	19,153	18,290	68,748	-365	-104	-266	-229	-964	-1.4%
ND	1,513	675	1,363	1,237	4,787	1,511	673	1,360	1,236	4,781	-1	-1	-3	-1	-6	-0.1%
OH	23,416	10,267	21,340	20,186	75,209	23,377	10,254	21,301	20,151	75,083	-39	-13	-39	-35	-127	-0.2%

	Enhanced ARP PTCs Are Extended					Enhanced ARP PTCs Expire					Difference					
State	**H**	**PP**	**OS**	**PD**	**Total**	**H**	**PP**	**OS**	**PD**	**Total**	**H**	**PP**	**OS**	**PD**	**Total**	**%**
OK	8,259	3,472	7,075	6,697	25,503	8,160	3,434	6,997	6,630	25,221	-99	-38	-78	-67	-282	-1.1%
OR	8,740	3,944	7,840	7,510	28,034	8,736	3,942	7,833	7,503	28,013	-4	-2	-7	-7	-20	-0.1%
PA	27,619	12,489	25,231	23,658	88,998	27,582	12,474	25,178	23,622	88,855	-37	-15	-54	-37	-143	-0.2%
RI	2,024	917	1,857	1,739	6,537	2,025	917	1,860	1,741	6,544	1	1	3	2	7	0.1%
SC	9,168	4,050	8,114	7,933	29,265	9,021	4,009	7,998	7,847	28,875	-147	-41	-116	-86	-390	-1.3%
SD	1,794	771	1,609	1,462	5,636	1,794	768	1,600	1,458	5,620	0	-2	-9	-5	-16	-0.3%
TN	13,402	5,997	12,108	11,559	43,067	13,328	5,966	12,022	11,491	42,807	-74	-31	-86	-68	-260	-0.6%
TX	57,329	26,504	51,109	48,060	183,001	56,289	26,202	50,340	47,442	180,272	-1,039	-302	-770	-618	-2,729	-1.5%
UT	6,957	3,104	6,424	5,738	22,224	6,921	3,085	6,387	5,706	22,099	-36	-19	-38	-32	-125	-0.6%
VT	1,646	679	1,365	1,305	4,995	1,645	679	1,364	1,305	4,994	-1	0	-1	1	-1	0.0%
VA	16,088	7,565	14,958	14,337	52,949	16,055	7,555	14,923	14,315	52,847	-33	-11	-35	-22	-102	-0.2%
WA	14,750	7,085	13,755	12,989	48,580	14,756	7,088	13,761	12,995	48,599	6	2	6	6	19	0.0%
WV	3,605	1,486	3,078	2,989	11,158	3,583	1,477	3,062	2,970	11,092	-22	-9	-16	-19	-66	-0.6%
WI	11,667	5,357	11,223	10,504	38,751	11,667	5,358	11,229	10,512	38,766	0	1	6	9	16	0.0%
WY	1,257	549	1,125	1,052	3,984	1,255	547	1,119	1,047	3,969	-2	-2	-6	-5	-15	-0.4%
Total	654,947	294,173	589,132	558,676	2,096,928	651,132	292,851	585,697	555,839	2,085,518	-3,816	-1,322	-3,435	-2,837	-11,410	-0.5%

Source: Urban Institute Health Insurance Policy Simulation Model, 2022.

Notes: ARP = American Rescue Plan; PTCs = premium tax credits; H = hospitals; PP = physician practices; OS = other services; PD = prescription drugs.

In table 2, we show how these decreases in health care spending would be distributed across states. Five states would see decreases in total health care spending of 1.3 to 1.9 percent: Florida, Georgia, North Carolina, South Carolina, and Texas. In our previous report, we showed that these states had the highest enrollment increases in the 2021 OEP. If enhanced PTCs expire, these states would see the largest losses in health coverage and the largest declines in health care spending. In Texas, hospital spending would decline by $1.0 billion and total health care spending would decline by $2.7 billion.

On the other hand, California, Massachusetts, New York, and Vermont, which had state programs providing enhanced PTCs or cost sharing reductions before the ARP, would see virtually no change in health care spending because those programs would remain in place even if federal enhanced PTCs were allowed to expire.[4]

Discussion

If enhanced PTCs are not renewed, we estimate that health care spending on the nonelderly would fall by $11.4 billion in 2023. Hospitals would see the largest reduction, $3.8 billion. Spending on services provided by physician offices would decline by $1.3 billion. Prescription drug spending would decline by $3.4 billion. Spending in the broad category of other services, which includes services provided outside hospitals and physician offices, dental care, home health care, and medical devices, would decline by $2.8 billion.

The results of our model are consistent with many studies that show uninsured people use less medical care than they would if they had insurance (Card, Dobkin, and Maestas 2004; Lau et al. 2014; Spillman 1992). Uninsured parents and children are much more likely than those with health coverage to have delayed health care because of costs and problems paying medical bills and greater unmet health care needs (Gates et al. 2016; Karpman et al. 2016). Those uninsured are also much less likely to have seen a doctor or dentist over the past 12 months. Forgoing health care has serious consequences, as health coverage decreases mortality (Goldin, Lurie, and McCubbin 2019; Miller, Johnson, and Wherry 2021).

Thus, if enhanced PTCs are not renewed, not only would the revenue of health care providers be reduced but also 3 million people would become uninsured, receive less health care, and likely experience greater morbidity and financial insecurity.

Methods

The results in this brief are based on our earlier report estimating the coverage and cost implications if the ARP enhanced PTCs expire in 2023 (Buettgens, Banthin, and Green 2022). In this brief, we separate health care spending by public and private insurers and households on the nonelderly into four categories: hospital expenditures (including inpatient, outpatient, and emergency room care), physician expenditures, expenditures on prescription drugs, and all other spending for insurance covered services (including health care services delivered by providers other than hospitals and office-based physicians

and additional services, such as dental care, home health care, and other medical equipment). These costs include uncompensated care for the uninsured that are funded by federal, state, and local governments. Specifically, we count the following for different types of coverage:

- **Employer coverage.** We count both employer premium contributions and premiums paid by households, minus the administrative load, as well as household out-of-pocket (OOP) health care costs not covered.
- **Nongroup coverage.** We count premiums paid by households, federal PTCs, federal and state reinsurance costs, and additional state PTCs, minus the administrative load. We also count household OOP spending and additional state cost sharing reductions in the handful of states that have their own programs.
- **Medicaid.** We count federal and state Medicaid costs, minus the administrative load.
- **The uninsured.** We count OOP health care spending and uncompensated care funded by federal, state, or local governments.
- **Non-ACA-compliant coverage.** We count premiums minus the administrative load and OOP spending not covered by the plan.

The estimation of health care costs for individuals with various types of insurance and the estimation of uncompensated care are basic features of HIPSM. Health care spending data used in HIPSM come from the Medical Expenditure Panel Survey-Household Component (MEPS-HC), as well as other sources. Details are available in the HIPSM methodology documentation (Buettgens and Banthin 2020). We estimate total health care spending for each person represented in HIPSM for each possible health insurance status; these estimates of spending control for health status and a broad array of sociodemographic variables and reflect the reduced demand for services among people who are uninsured relative to similar people who are insured. Using the MEPS-HC, we then compute the share of individual health expenditures attributable to each type of care (hospital, office-based physician, prescription drugs, other) by individual characteristics: health insurance coverage, age, gender, income, and health status. Other services include health care services delivered by providers other than hospitals and office-based physicians, along with additional services, such as dental care, home health care, and other medical equipment. The percentage splits of spending across provider types are then imputed onto the individuals represented in HIPSM.

Those who would be uninsured without the ARP PTCs would have Marketplace coverage if enhanced PTCs were renewed. In HIPSM, we calibrate the health care spending of Marketplace enrollees based on 2022 premiums in each premium rating region. Thus, the additional health care spending on Marketplace enrollees who would be otherwise uninsured varies by state and rating region. (For more details of how Marketplace premiums were set for these 2023 estimates, see Buettgens and Banthin [2022]; for more about recent Marketplace premium trends, see Holahan, Wengle, and O'Brien [2022]).

For these estimates, we did not include premium loads and Medicaid administrative costs because that spending does not go to health care providers. Employer premium loads vary by firm size and whether the firm self-insures (Buettgens and Banthin 2020). We assume that Marketplace administrative loads average around 15 percent. ACA-noncompliant plans are unregulated, so we assume that their loads are higher and closer to pre-ACA loads, around 35 percent on average. We deduct an administrative load of 2 percent from Medicaid spending. This percentage is based on fee-for-service Medicaid. Loads for Medicaid managed care are generally higher and show substantial variation. We did compute an overall average across managed care plans in each state. However, the policy that we are simulating has virtually no impact on Medicaid coverage (Buettgens, Banthin, and Green 2022), so the differences in health care spending are unaffected by this limitation.

The MEPS-HC separates the amount spent on care by the uninsured themselves, so we can estimate how much of health care spending for each type of service on behalf of the uninsured is self-paid and how much is attributable to uncompensated care. Uncompensated care is care delivered to uninsured people that is financed by government programs or is contributed by the health care providers themselves as free care. According to Coughlin and colleagues (2014) people uninsured for a full year in 2013 paid for an average of 30 percent of the care they received, while the remaining 70 percent of health care spending on their behalf was attributable to uncompensated care.

The record high Marketplace enrollment in the 2021 OEP almost certainly reduced the number of uninsured people. This also reduced the demand for uncompensated care. However, funding of uncompensated care is complex; many sources will not automatically decline with reduced demand. One major source of federal funding that would do so is Medicare Disproportionate Share Hospital. We estimate that the federal government would save half of the federal share of the change in demand for uncompensated care because of this program. The remainder would still be spent but not directly on the health care costs of the uninsured. The impact of a change in demand for uncompensated care is even more uncertain for state and local governments. For simplicity, we assume that they too would realize half of the reduction in demand as savings. If enhanced PTCs expire in 2023, uncompensated care spending would return to near its pre-ARP level.

Notes

1 Centers for Medicare & Medicaid Services, "Marketplace 2022 Open Enrollment Period Report: Final National Snapshot," news release, January 27, 2022, https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot.

2 Other services include health care services delivered by providers other than hospitals and office-based physicians, along with additional services such as dental care, home health care, and other medical equipment.

3 We do not include health care spending for those age 65 and older or Medicare spending for those under age 65.

4 Because of differences in provider reimbursement between nongroup and employer-sponsored insurance, health care spending could rise by trivial amounts in some states in which the number of people uninsured remains essentially unchanged.

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Matthew Buettgens is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes numerous research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

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