



# Hospitals, Physicians, and Other Stakeholders Face Billions of Dollars in Uncompensated Care Costs and Lost Revenue if Enhanced ACA Tax Credits Expire

## Results by State and Substate Region

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## Introduction

The Affordable Care Act (ACA) established sliding-scale premium tax credits (PTCs) and cost-sharing reduction subsidies for individuals with lower or moderate incomes to purchase coverage through health insurance Marketplaces. Congress expanded the PTCs as part of the American Rescue Plan Act in March 2021 and extended them through 2025 as part of the 2022 Inflation Reduction Act. These enhanced PTCs helped spur record enrollment in the ACA Marketplaces by lowering the caps on premium contributions for people of all income levels, allowing people with incomes between 100 and 150 percent of the federal poverty level (FPL) to pay \$0 in premiums for “benchmark” silver-level plans; and extending PTC eligibility to individuals with incomes above 400 percent of FPL (Lukens and Zhang 2024).<sup>1</sup>

Several studies have assessed the likely coverage and cost effects of allowing the enhanced PTCs to expire after 2025. For instance, findings from the Urban Institute’s Health Insurance Policy Simulation Model (HIPSIM) show that enhanced PTC expiration could cause 4 million people to lose health insurance as individuals would face significantly higher premium costs, with larger declines occurring in states that have not expanded Medicaid (2.5 million) than in states that have (1.5 million).<sup>2</sup> Several related analyses have also documented who benefited from the enhanced PTCs (Banthin et al. 2024; Banthin, Simpson, and Akel 2024; Banthin, Skopec, and Simpson 2024).

Building on these previous HIPSM analyses, this brief focuses on the implications of projected coverage losses on providers through reductions in health care spending and increases in uncompensated care. The increase in the number of uninsured would significantly impact providers, as it is well-documented that uninsured people use less medical care than they would if they had health insurance.<sup>3</sup> Moreover, uninsured people often seek uncompensated care from providers when they do use medical services.

We estimate how the reductions in health care spending and increases in uncompensated care would be distributed across hospital care, office-based physician care, prescription drugs, and other services. We also provide in-depth estimates on how the decline in overall health care spending and spending on hospital care would vary across states and sub-state areas, as defined by hospital referral regions (HRRs).<sup>4</sup> Our estimates are presented in 2025 dollars under the alternative policy scenario that the enhanced PTCs would have already expired in 2025, and resulting coverage shifts would occur in that same year. With the end of these subsidies on the horizon, federal, state, and local policymakers must consider the expiration’s potential adverse effects on health care access and affordability, as well as revenue losses for providers of all types.

## Results

If the enhanced PTCs were to expire, the number of uninsured nonelderly adults would increase by 4.0 million, from 24.4 million to 28.4 million (table 1). The reduced financial assistance available to lower- and moderate-income adults would lower subsidized Marketplace coverage by 7.2 million and unsubsidized nongroup coverage by 500,000. Around half of those who lose nongroup coverage would enroll in an employer-sponsored health insurance plan, which typically has higher reimbursement rates for providers, while the remaining half would become uninsured.

**TABLE 1**

### Health Insurance Coverage Distribution of the Nonelderly US Population, with and without Enhanced PTCs, 2025

*Millions of people*

	Enhanced PTCs		Standard PTCs		Difference
Insured	256.0	91%	252.0	90%	-4.0
Employer	147.2	52%	151.2	54%	4.0
Basic health programs	1.5	0.0	1.5	0.0	0.0
Nongroup Marketplace with PTC	17.4	6%	10.2	4%	-7.2
Nongroup unsubsidized	8.5	3%	7.9	3%	-0.5
Medicaid/CHIP	72.8	26%	72.6	26%	-0.2
Other public	8.7	3%	8.7	3%	0.0
Uninsured	24.4	9%	28.4	10%	4.0
<b>Total</b>	<b>280.4</b>	<b>100%</b>	<b>280.4</b>	<b>100%</b>	<b>0.0</b>

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM).

**Notes:** PTC = premium tax credit; CHIP = Children’s Health Insurance Program.

Total spending on health care services would decrease by \$20.9 billion in 2025—approximately 1 percent of current total spending—because of these coverage changes (table 2). Around \$8.2 billion less would be spent on services provided by hospitals (nearly 40 percent of the total decline in spending), \$3.1 billion less on services provided by office-based physicians, \$5.6 billion less on other health care services<sup>5</sup>, and \$4.0 billion less on prescription drugs. These declines in insurer (public and private) and household spending on health care are mainly driven by decreases in payments by private insurers for health care claims incurred by Marketplace enrollees and households’ direct out-of-pocket spending on services.

**TABLE 2**  
**Health Care Spending for the Nonelderly by Insurers (Public and Private) and Households, with and without Enhanced PTCs, 2025**

*Billions of dollars*

	<b>Total health care spending</b>	<b>Hospitals</b>	<b>Physician practices</b>	<b>Other services</b>	<b>Prescription drugs</b>
Enhanced PTCs	2,225.1	786.2	356.1	585.7	497.1
Standard PTCs	2,204.2	778.0	353.0	580.2	493.1
Difference	-20.9	-8.2	-3.1	-5.6	-4.0

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM).

Notes: PTC = premium tax credit.

Coverage losses from the expiration of the enhanced PTCs would also increase the amount of uncompensated care sought by the uninsured (table 3).<sup>6</sup> We estimate that total uncompensated care costs would increase by \$6.3 billion (9.1 percent relative to the \$68.9 billion baseline) if PTCs reverted to standard levels. The burden of the additional \$6.3 billion in uncompensated care costs would fall on all provider types: about \$1.7 billion on hospitals, \$0.8 billion on physician offices, \$2.6 billion on other services, and \$1.2 billion on prescription drugs.

**TABLE 3**  
**Uncompensated Care Demand for the Nonelderly by Insurers (Public and Private) and Households with and without Enhanced PTCs, 2025**

*Billions of dollars*

	<b>Total uncompensated</b>	<b>Hospitals</b>	<b>Physician practices</b>	<b>Other services</b>	<b>Prescription drugs</b>
Enhanced PTCs	68.9	19.6	8.9	26.4	14.0
Standard PTCs	75.2	21.3	9.7	28.9	15.2
Difference	6.3	1.7	0.8	2.6	1.2

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM).

Notes: PTC = premium tax credit.

Uncompensated care is financed in different ways: some is paid for directly by the uninsured, some is financed by the federal government (e.g., Medicare and Medicaid disproportionate share hospital

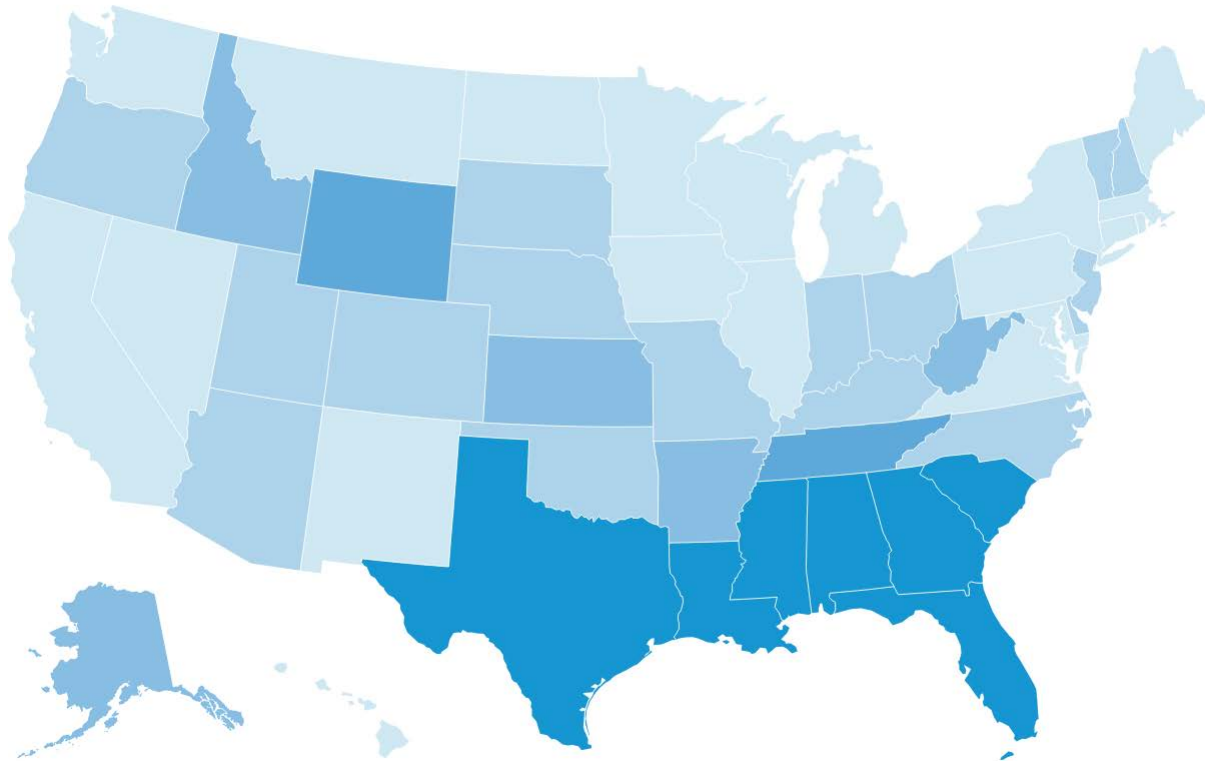
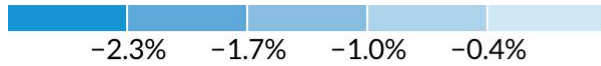
programs), some is financed by state and local governments (e.g., uncompensated care pools, Medicaid disproportionate share hospital programs, funding for public hospitals), and some is delivered as free or reduced-price care by providers (e.g., hospitals, physicians, pharmaceutical companies). In general, uncompensated care funding (e.g., from federal, state, and local governments or health care providers) does not increase automatically with the number of uninsured.<sup>7</sup> It is unclear whether funding from federal, state, and local governments would increase to meet the larger amount of uncompensated care expected to be sought by the newly uninsured. As a result, we estimate the amount of care the newly uninsured would seek, not the value of the uncompensated care they would receive. Our estimates indicate that just over half of the increase in uncompensated care would be financed by providers, 30 percent by the federal government, and 19 percent by state and local governments (data not shown). If government uncompensated care funding is less than we estimate, providers would be responsible for more uncompensated care, and the uninsured would forego additional health care.

Driven in part by the relative share of the population currently enrolled in Marketplace coverage, we see substantial variation in the percent change in total spending on health care services by state (figure 1 and appendix table A.1). Nearly a third of states would have declines of 1 percent or more of total spending, while other states would have percent declines as small as 0.1 percent or even small increases. For example, Mississippi and Georgia would experience the largest declines of 3.0 percent and 2.8 percent, while Hawaii and Michigan would each experience a 0.1 percent decline.

FIGURE 1

Percent Decline in Total Health Care Spending Associated with Expiration of Enhanced PTCs, by State

Percent change



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Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: PTC = premium tax credit.

A previous analysis found that without enhanced PTCs, the 10 states that have not expanded Medicaid would account for 63 percent of the enrollment decline in subsidized Marketplace plans (4.5 million people), even though they account for just 28 percent of the nation's under-65 population.<sup>8</sup> This is largely because individuals between 100 and 138 percent of FPL are eligible for Marketplace PTCs in nonexpansion states, whereas those in this same income band in expansion states are generally eligible for Medicaid.

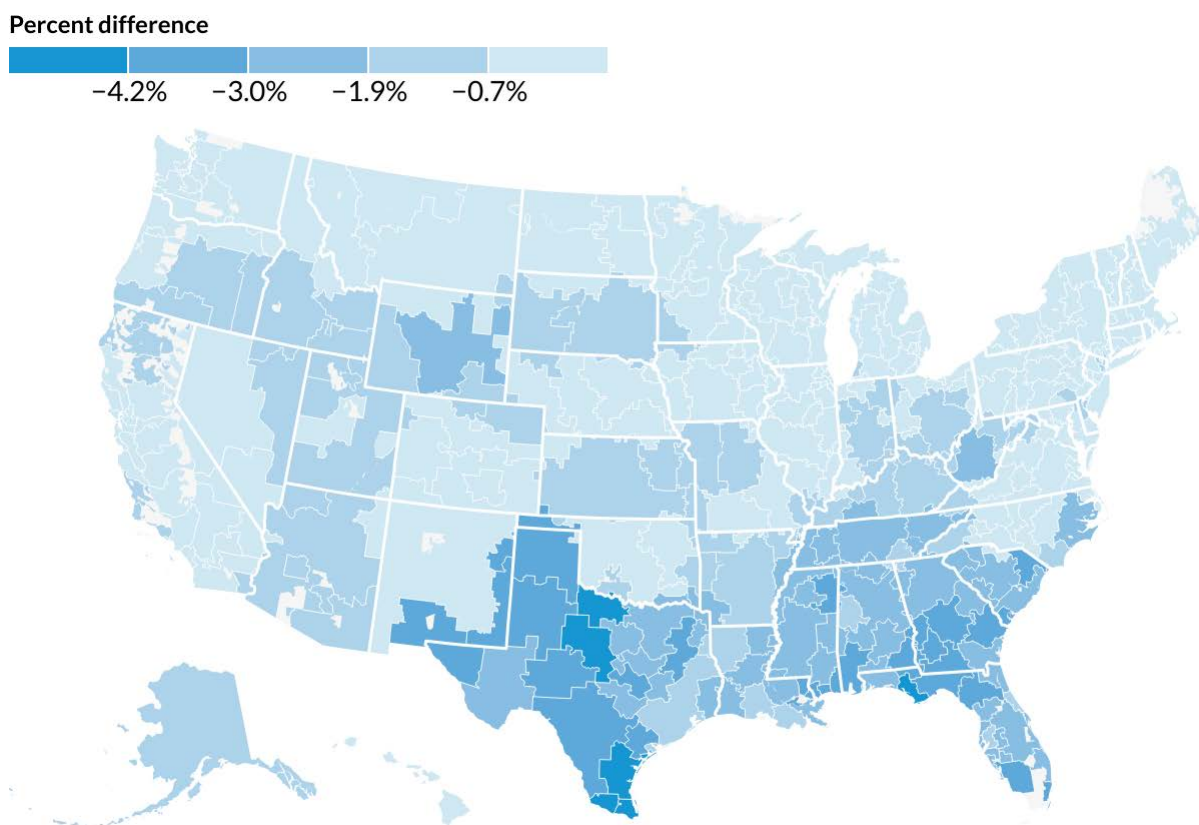
Consistent with this finding, eight of the nine states that would experience the largest percent declines in total health care spending (i.e., declines of more than 2 percent) if the enhanced PTCs were to expire are all nonexpansion states. Including Wyoming and Idaho, all the other states in the top quintile of total health spending declines (based on percent change) are in the South (figure 1 and appendix table A.1) and have a larger share of the population that lives in rural areas.

## Results by HRR

We present results by HRRs to unpack variation in spending within states and provide additional context on the markets most likely to be affected by the expiration of enhanced PTCs. We find that percent changes in total spending range from -5.3 percent in the Harlingen, Texas HRR to 0.45 percent in the Minot, North Dakota HRR (figure 2 and full data in appendix table A.2).<sup>9</sup> Although the overall patterns of spending changes are consistent in the state and HRR maps, figure 2 highlights some notable variation across HRRs within states. For example, in Florida, the percent decline in spending ranges from -4.4 in the Panama City HRR to -1.6 percent in the Tampa HRR.

The patterns of spending declines for hospital services across states and HRRs are generally consistent with those observed for total health spending (appendix table A.1 and appendix table A.2).

**FIGURE 2**  
**Percent Decline in Total Health Care Spending Associated with Expiration of Enhanced PTCs, by HRR**



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Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: PTC = premium tax credit; HRR = hospital referral region.

## Conclusion

If Congress doesn't extend enhanced PTCs after 2025, millions of people would become uninsured, resulting in health care spending declines of \$8.2 billion on hospital services, \$3.1 on office-based physician services, \$5.6 on other health care services, and \$4.0 billion on prescription drugs. Declines in health care spending would be more pronounced in states that have not expanded Medicaid, communities in the south, and rural communities. The expiration of the enhanced PTCs would also result in a \$6.3 billion increase in uncompensated care sought by the uninsured. The overall use of care would decline when people become uninsured, and unmet health care needs could also increase (Gates et al. 2016; Karpman et al. 2016).

Because lower spending on health care services means lower revenue for health care providers and fewer services rendered, the resulting decline in revenue for providers in these communities could have adverse consequences for providers, particularly hospitals that are already financially at-risk.

## Data and Methods

We used the Urban Institute's HIPSM to estimate the effects of the enhanced PTCs on coverage in 2025 and out-of-pocket premium spending in 2024. HIPSM is a microsimulation model of the US health care system focused on the nonelderly population and is designed to estimate the cost and coverage effects of proposed policy changes. The model's baseline is regularly updated to reflect changes in law and state policies, premium increases, population growth, and the most recently published Medicaid and Marketplace enrollment and costs in each state. To estimate Marketplace enrollment and enhanced PTCs by age, income, and state, we rely on the representative population sample in our model, based on two years of American Community Survey data consisting of more than 6 million observations of individual people. The American Community Survey is representative at the state and substate level and is reweighted to match current national and state population estimates.

We projected the model's baseline to 2025, the final year of enhanced PTCs under current law, and the year we expect to find their largest impact. For this analysis, we simulate 2025 coverage and spending with and without enhanced PTCs in effect. More information on HIPSM and our methodology for these estimates is available in our prior report on the effects of enhanced PTCs on Marketplace enrollment (Banthin et al. 2024) and in our methodological report on the model (Buettgens and Banthin (2022).

We assume that newly uninsured people would contribute to their care costs consistent with the spending patterns of uninsured people with similar characteristics and health needs in recent years.

# Appendix

## APPENDIX TABLE A.1

### Health Care Spending for the Nonelderly by Insurers (Public and Private) and Households with and without Enhanced PTCs, by State, 2025

Millions of dollars

State	All Health Spending for the Nonelderly				Hospital Spending for the Nonelderly			
	Enhanced PTCs	Standard PTCs	Difference	Percent difference	Enhanced PTCs	Standard	Difference	Percent difference
All States	2,225,140	2,204,214	-20,925	-0.9%	786,172	777,959	-8,213	-1.0%
AL	30,451	29,710	-741	-2.4%	10,927	10,591	-336	-3.1%
AK	5,740	5,679	-61	-1.1%	2,032	2,009	-23	-1.1%
AZ	49,759	49,368	-391	-0.8%	17,653	17,490	-162	-0.9%
AR	20,850	20,613	-237	-1.1%	7,490	7,395	-95	-1.3%
CA	269,021	268,446	-575	-0.2%	93,991	93,652	-339	-0.4%
CO	38,819	38,624	-195	-0.5%	13,367	13,327	-41	-0.3%
CT	27,810	27,759	-51	-0.2%	9,581	9,559	-22	-0.2%
DE	7,287	7,226	-60	-0.8%	2,590	2,568	-22	-0.9%
DC	5,550	5,545	-5	-0.1%	2,034	2,031	-3	-0.2%
FL	127,057	123,723	-3,333	-2.6%	44,926	43,551	-1,375	-3.1%
GA	70,454	68,457	-1,997	-2.8%	25,005	24,156	-849	-3.4%
HI	8,216	8,204	-12	-0.1%	2,937	2,932	-4	-0.2%
ID	12,107	11,925	-182	-1.5%	4,329	4,267	-62	-1.4%
IL	80,054	79,909	-145	-0.2%	27,739	27,682	-57	-0.2%
IN	46,957	46,598	-359	-0.8%	16,746	16,597	-149	-0.9%
IA	22,426	22,388	-39	-0.2%	7,837	7,817	-19	-0.2%
KS	19,101	18,824	-276	-1.4%	6,692	6,560	-132	-2.0%
KY	31,932	31,618	-314	-1.0%	11,506	11,380	-126	-1.1%
LA	30,876	30,098	-778	-2.5%	11,195	10,924	-271	-2.4%
ME	9,146	9,125	-21	-0.2%	3,209	3,208	-1	0.0%
MD	41,823	41,721	-103	-0.2%	14,587	14,571	-16	-0.1%
MA	45,552	45,685	133	0.3%	16,064	16,103	39	0.2%
MI	64,211	64,140	-71	-0.1%	22,781	22,751	-30	-0.1%
MN	44,373	44,234	-138	-0.3%	15,496	15,450	-46	-0.3%
MS	19,524	18,939	-585	-3.0%	7,207	6,947	-260	-3.6%
MO	46,161	45,886	-276	-0.6%	16,687	16,603	-84	-0.5%
MT	7,644	7,631	-12	-0.2%	2,743	2,747	5	0.2%



State	All Health Spending for the Nonelderly				Hospital Spending for the Nonelderly			
	Enhanced PTCs	Standard PTCs	Difference	Percent difference	Enhanced PTCs	Standard	Difference	Percent difference
NE	13,069	13,019	-50	-0.4%	4,557	4,539	-18	-0.4%
NV	20,693	20,641	-52	-0.3%	7,345	7,323	-23	-0.3%
NH	9,148	9,114	-34	-0.4%	3,110	3,092	-17	-0.6%
NJ	59,372	59,028	-344	-0.6%	20,170	20,068	-102	-0.5%
NM	13,490	13,530	40	0.3%	4,882	4,892	10	0.2%
NY	136,441	136,057	-385	-0.3%	49,855	49,702	-154	-0.3%
NC	77,183	76,798	-385	-0.5%	27,378	27,307	-71	-0.3%
ND	4,785	4,791	5	0.1%	1,659	1,670	11	0.6%
OH	79,039	78,471	-569	-0.7%	27,997	27,780	-217	-0.8%
OK	26,705	26,432	-273	-1.0%	9,588	9,504	-84	-0.9%
OR	29,435	29,274	-161	-0.5%	10,314	10,277	-37	-0.4%
PA	93,516	93,349	-167	-0.2%	32,884	32,817	-67	-0.2%
RI	6,793	6,806	13	0.2%	2,373	2,379	7	0.3%
SC	31,099	30,299	-800	-2.6%	11,090	10,787	-302	-2.7%
SD	6,018	5,965	-52	-0.9%	2,131	2,111	-20	-0.9%
TN	46,270	45,211	-1,059	-2.3%	16,518	16,064	-454	-2.8%
TX	197,007	191,942	-5,065	-2.6%	69,974	68,036	-1,939	-2.8%
UT	23,827	23,621	-207	-0.9%	8,312	8,251	-61	-0.7%
VT	5,334	5,306	-28	-0.5%	1,921	1,910	-11	-0.6%
VA	55,495	55,333	-162	-0.3%	19,311	19,240	-72	-0.4%
WA	50,913	50,835	-78	-0.2%	17,624	17,591	-32	-0.2%
WV	12,443	12,250	-193	-1.5%	4,515	4,442	-72	-1.6%
WI	39,925	39,913	-12	0.0%	13,825	13,857	31	0.2%
WY	4,238	4,154	-84	-2.0%	1,490	1,452	-38	-2.6%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2024.

Notes: PTC = premium tax credit

## Notes

- <sup>1</sup> “Marketplace Plan Selections by Enrollment Type,” KFF, accessed December 10, 2024, <https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selections-by-enrollment-type-2/>.
- <sup>2</sup> Jameson Carter, Jessica Banthin, Michael Simpson, and Matthew Buettgens. “Four Million People Will Lose Health Insurance If Premium Tax Credit Enhancements Expire in 2025,” *Urban Wire* (blog), November 14, 2024, <https://www.urban.org/urban-wire/four-million-people-will-lose-health-insurance-if-premium-tax-credit-enhancements-expire>.
- <sup>3</sup> Several decades of literature support this. See Spillman (1992), Card, Dobkin, and Maestas (2008), and Lau et al. (2014).
- <sup>4</sup> HRRs define geographic hospital markets, which are large tertiary referral areas comprised of geographically contiguous hospital service areas with a minimum population of 120,000. There are 306 HRRs in the US, and their boundaries frequently cross state lines.
- <sup>5</sup> Other health care services include 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.
- <sup>6</sup> In this analysis, health care delivered to the uninsured that the uninsured people themselves do not pay for is referred to as uncompensated care.
- <sup>7</sup> The exception is Medicare Disproportionate Share Hospital payments, which would increase modestly.
- <sup>8</sup> Jameson Carter, Jessica Banthin, Michael Simpson, and Matthew Buettgens, “Four Million People Will Lose Health Insurance If Premium Tax Credit Enhancements Expire in 2025,” *Urban Wire* (blog), November 14, 2024, <https://www.urban.org/urban-wire/four-million-people-will-lose-health-insurance-if-premium-tax-credit-enhancements-expire>.
- <sup>9</sup> Appendix table A.2 is available online at <https://www.urban.org/research/publication/hospitals-physicians-and-other-stakeholders-face-billions-dollars>.

## References

- Card, David, Carlos Dobkin, and Nicole Maestas. 2008. “The Impact of Nearly Universal Insurance Coverage on Health Care Utilization: Evidence from Medicare.” *American Economic Review* 98 (5): 2242–58. <https://doi.org/10.1257/aer.98.5.2242>.
- Banthin, Jessica, Matthew Buettgens, Michael Simpson, and Jason Levitis. 2024. “Who Benefits from Enhanced Premium Tax Credits in the Marketplace?” Washington, DC: Urban Institute.
- Banthin, Jessica, Michael Simpson, and Mohammed Akel. 2024. “The Impact of Enhanced Premium Tax Credits on Coverage by Race and Ethnicity.” Washington, DC: Urban Institute.
- Banthin, Jessica, Laura Skopec, and Michael Simpson. 2024. “Enhanced PTCs Help Older Adults and Those in High-Premium States Afford Coverage: How PTCs Impact Those with Incomes over 400 Percent of FPL.” Washington, DC: Urban Institute.
- Buettgens, Matthew and Jessica Banthin. 2022. “Estimating Health Coverage in 2023: An Update to the Health Insurance Policy Simulation Model Methodology.” Washington, DC: Urban Institute.
- Gates, Jason A., Michael Karpman, Genevieve M. Kenney, and Stacey McMorrow. 2016. “Uninsurance among Children, 1997–2015 Long-Term Trends and Recent Patterns.” Washington, DC: Urban Institute.
- Karpman, Michael, Jason Gates, Stacey McMorrow, and Genevieve M. Kenney. 2016. “Uninsurance among Parents, 1997–2014: Long-Term Trends and Recent Patterns.” Washington: Urban Institute; 2016.
- Lukens, Gideon, and Elizabeth Zhang. 2024. “Premium Tax Credit Improvements Must Be Extended to Prevent Steep Rise in Health Care Costs.” Washington, DC: Center on Budget and Policy Priorities.

Lau, Josephine S., Sally H. Adams, W. John Boscardin, and Charles E. Irwin, Jr. 2014. "Young Adults' Health Care Utilization and Expenditures Prior to the Affordable Care Act." *Journal of Adolescent Health* 54 (6): 663–71. <https://doi.org/10.1016/j.jadohealth.2014.03.001>.

Spillman, B.C. 1992. "The Impact of Being Uninsured on Utilization of Basic Services." *Inquiry* 29 (4): 457–66.

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Before joining Urban, Blavin worked as an economist at the Office of the National Coordinator for Health Information Technology within the US Department of Health and Human Services. Blavin has published widely in peer-reviewed journals on various topics, including the impact of express lane eligibility programs on Medicaid/CHIP enrollment, trends in health care financial burdens and prescription drug spending, measuring and forecasting electronic health record adoption, value-based insurance design, the role of private health insurance in developing countries, and the cost and coverage implications of various state and national health reform policies. Blavin received his PhD in managerial science and applied economics from the University of Pennsylvania in 2011.

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**Jessica S. Banthin** is a senior fellow in the Health Policy Center, where she studies the effects of health insurance reform policies on coverage, costs, and households' financial burdens. Before joining the Urban Institute, she served more than 25 years in the federal government, most recently as deputy director for health at the Congressional Budget Office. During her eight-year term at the Congressional Budget Office, Banthin directed the production of numerous major cost estimates of legislative proposals to modify the Affordable Care Act.

Banthin has also conducted significant research on a wide range of topics, such as the burdens of health care premiums and out-of-pocket costs on families, prescription drug spending, and employer and nongroup market premiums. She has special expertise in the design of microsimulation models for

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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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