Latest Premium Tax Credit Proposal Would Raise Premiums for Millions of People

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February 2026

On January 1, 2026, the premium tax credit (PTC) enhancements expired, raising costs for more than 20 million Americans. Open enrollment closed January 15 in most states, and monthly bills now reflect the reduced PTC amounts. Although the full effects won't be known for months, it is already clear that millions are dropping coverage, switching to plans with higher deductibles, or sacrificing other needs to pay more for health insurance.[1] The Congressional Budget Office (CBO) has projected that expiration will increase the ranks of the uninsured by 2.2 million in 2026 and 3.8 million in later years.[2]

With these long-expected harms now being realized,[3] the past month has brought new efforts to restore the enhancements. On January 8, a bipartisan majority in the House of Representatives passed a standalone three-year extension.[4] In the Senate, bipartisan negotiations led by Senator Bernie Moreno (R-OH) reportedly worked toward a compromise package combining a two-year partial restoration of the enhancements with new PTC reductions and other provisions.[5]

Amid reports of these negotiations stalling,[6] on January 28, Senator Moreno released his own draft legislation, the CARE Act.[7] While the language could change as negotiations continue, it is worth understanding what it would do.

An examination of the CARE Act suggests the negotiating parties may still be far apart. That's because the language combines partial, delayed, and short-term relief with several substantial new PTC reductions that would leave many people worse off than under current law. In particular, the CARE Act:

- Partially restores the enhanced PTC schedule for just one year, 2026. After that, the PTC declines, falling well below enhanced levels in 2027 and below current-law levels for millions of people in 2028, even before the new restrictions proposed by the legislation.
- Imposes substantial new PTC restrictions in 2026, 2027, and 2028, leaving millions of people worse off than under current law.
- Delays relief getting to consumers by months or more by introducing changes for 2026 that would require new IT builds, rather than restoring the 2025 policy that could be implemented immediately.
- Includes other provisions that would have little impact on affordability

In short, the CARE Act would reduce the PTC for millions of people in 2026, 2027, and 2028, while denying consumers the immediate help they need for 2026.

This piece examines the CARE Act with a focus on the provisions that affect affordability and coverage.

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The PTC amount is calculated to limit consumers' premium contribution for a benchmark plan to a certain percentage of income, referred to as the "applicable percentage." The benchmark plan is the second-lowest-cost "silver" tier plan. If the consumer chooses a more or less expensive plan, they bear the cost difference. The applicable percentage increases with income based on a schedule set in statute. The enhancements increased the PTC by introducing a new schedule with lower applicable percentages at each income level, as well as extending eligibility out to higher incomes.

The CARE Act generally restores the enhanced PTC schedule for 2026, subject to new restrictions discussed below. But for 2027 and 2028, it introduces new schedules of applicable percentages that differ from those under both the PTC enhancements and the current, reduced PTC. These new schedules leave the applicable percentages substantially higher (and thus the PTC substantially lower) than under the enhancements at almost every income level. For example, in 2026, an individual with an income of $40,000 (256 percent of federal poverty level [FPL]) would have an expected contribution of $1,689 (or 4.2 percent of income) under the enhancements compared to $3,000 (or 7.5 percent of income) under the CARE Act's 2027 schedule and $3,600 (or 9.0 percent of income) under the CARE Act's 2028 schedule (table 1). (For comparison, the individual would owe $3,444 [or 8.6 percent of income] under current law for 2026.) These examples do not reflect the new PTC restrictions in the CARE Act, discussed below.

TABLE 1

Individuals' Applicable Percentage (expected contribution as a percent of income) to Purchase Benchmark Plan with the PTC

Income as a percent of the federal poverty level	Reduced PTC	PTC enhancements	CARE Act 2026*	CARE Act 2027*	CARE Act 2028*
<133%	2.1%	0.0%	0.0%	2.1%	2.1%
133–150%	3.14–4.19%	0.0%	0.0%	3.14–4.19%	3.14–4.19%
150–200%	4.19–6.6%	0-2%	0-2%	4.0%	6.0%
200–250%	6.6–8.44%	2–4%	2–4%	5.5%	7.0%
250–300%	8.44–9.96%	4–6%	8.5%**	7.5%	9.0%
300–400%	9.96%	6–8.5%	8.5%**	9.0%	9.0%
400–500%	N/A	8.5%	8.5%	9.0%	9.5%
500–600%	N/A	8.5%	8.5%	9.5%	10.5%
600–700%	N/A	8.5%	8.5%	9.5%	11.5%
>700%	N/A	8.5%	N/A	N/A	N/A

Source: "Rev. Proc. 2024-35," IRS, 2024; "Rev. Proc. 2025-25," IRS, 2025; and "CARE Act," accessed January 30, 2026.
Notes: PTC = premium tax credit. Enrollees with incomes under 100 percent of the federal poverty level (FPL) and those eligible for Medicaid or CHIP are generally ineligible for PTC. The CARE Act uses a series of steps with cliffs in between for the applicable percentages instead of the smooth progression under current law and the PTC enhancements. *The CARE Act requires all Marketplace enrollees to pay a minimum premium of $5 in all three years. **The bill draft contains conflicting language for the applicable percentage for incomes between 250 and 400 percent of FPL. We assume the language newly added by the CARE Act is intended to govern.

Moreover, the CARE Act's 2028 PTC schedule would increase applicable percentages (and thus reduce PTC) for millions of consumers *relative to current law*. (The applicable percentages for 2028 under current law have not been announced, so for purposes of this paper, we assume that they would be the same as the 2026 values.) For example, everyone with incomes between 150 and 188 percent of FPL would have a lower applicable percentage under

current law than under the CARE Act's 2028.[8] This range includes many PTC recipients—individuals with incomes between 150 and 200 percent of FPL account for nearly one-third (3.5 million out of 11.7 million) of PTC recipients under the current PTC in 2026, according to the Urban Institute's (Urban) 2026 baseline.[9] An individual with income of $24,000 (153 percent FPL) would pay $1,044 for a benchmark silver plan under current law in 2026 but $1,440 under the CARE Act's 2028 schedule—an increase of 38 percent.[10] Again, this example excludes the effects of the CARE Act's other new PTC restrictions, discussed next.

In addition, the CARE Act replaces the smooth progression of the applicable percentages under current law and the enhancements with a series of steps with cliffs in between. Cliffs create perverse incentives and are generally considered bad tax policy (Maag et al. 2012; Roll, Despard, and Miller 2025; Viswanathan 2016).[11] It is unclear if imposing these cliffs is a policy choice or an artifact of the drafting process.

The CARE Act imposes substantial new PTC restrictions in 2026, 2027, and 2028, leaving millions of consumers worse off than under current law.

Beyond the changes to the PTC's schedule of applicable percentages, discussed above, the CARE Act includes several new reductions in PTC eligibility and PTC amounts that would affect virtually every recipient. Several of these go beyond curtailing the enhancements and would reduce the PTC below its current-law level for some people. As a result, the CARE Act would increase many people's net premiums each year *relative to what they would be if no legislation passed*. (In addition, the changes would make it impossible to immediately reduce prices for consumers in 2026, as discussed below.)

Specifically, the CARE Act would:

- **Raise premiums and administrative burden for millions by imposing a $5 minimum monthly premium.** The CARE Act caps the monthly PTC amount at $5 less than the enrollee's monthly premium in 2026, 2027, and 2028. This would effectively require consumers to pay at least $60 per year out of pocket for premiums, in addition to any deductibles and other cost-sharing. This would raise premiums for many people relative to current law and for even more people relative to the enhancements.

  The availability of zero-premium coverage has an impact on coverage disproportionate to its direct cost because of the administrative burdens involved in making even small premium payments (Drake et al. 2021). Both the costs and administrative burdens are especially salient for low-income people, who may not have bank accounts. In light of these concerns, zero-premium coverage is a mainstay of both Medicaid and Medicare Advantage (MedPAC 2025).[12] A Brookings analysis found that a $1 premium floor in the Marketplace would lead to nearly 1 million people dropping coverage (Fiedler 2025). A larger premium floor, like $5, would be expected to reduce coverage more (McIntyre, Shepard, and Layton 2024).

  The enhancements greatly expanded the availability of zero-premium coverage by eliminating the premium to purchase a benchmark silver plan for people with incomes up to 150 percent of FPL ($23,475 for an individual seeking coverage in 2026). In 2025, 39 percent of federal Marketplace enrollees owed no premium.[13]

  But zero-premium coverage was common even before the enhancements. The PTC without the enhancements requires the lowest-income families to contribute a certain share of income (2.1 percent in 2026) *for a benchmark silver plan*, but consumers can pay less by "buying down" to a less expensive (often bronze) plan.[14] If the difference between the silver and bronze premiums exceeds a consumer's expected premium contribution for the silver plan, the net premium for the bronze plan is zero. Using this approach, 16 percent of enrollees paid no premium in 2020.[15]

  This figure is almost certainly higher in 2026, since many states have now increased the premium differential between silver and bronze plans by strengthening silver loading rules (explained below).[16] Indeed, by applying

the 2026 premiums to Urban's Health Insurance Policy Simulation Model's latest baseline, we estimate that about two-thirds of 2026 PTC recipients had the option to choose a zero-premium plan this year—without the enhancements in effect.[17]

Thus, a $5 premium floor would raise premiums for millions of people relative to current 2026 law. Implementing this change for 2026 would presumably mean Marketplaces reaching out to enrollees with premiums of less than $5 and notifying them that new legislation has increased their current premiums. This would result in new coverage losses midyear.

Finally, the CARE Act may interfere with states' long-standing flexibility to provide state subsidies that wrap around the PTC, by requiring "the health insurance issuer [to] require such individual to pay the [$5] minimum premium contribution." This would introduce additional disruption in 2026 and beyond.

- **Reduce the PTC across the board by appropriating cost-sharing reduction (CSR) payments in 2027 and 2028**. Proposals to appropriate CSR payments are a common source of confusion. Appropriating CSR payments sounds like it would make coverage *more* affordable and thus expand coverage, but in fact, the opposite is true: due to the complex mechanics of CSR payments and silver loading (box 1), it would reduce PTC amounts across the board and thus reduce coverage.

  These effects go well beyond limiting the restoration of the enhancements and would increase consumer costs relative to current law. For example, under 2026 rules (no enhancements), a 60-year-old with income at $47,000 (about 300 percent of FPL) can, on average, purchase the lowest-cost gold plan for $4,718 per year after the PTC. If eliminating silver loading caused the benchmark silver premium to fall by 11 percent, as CBO projects, the individual would pay $5,890 under the CARE Act's 2027 and 2028 rules, about 25 percent more.[18] Some people would see much larger cost increases. Under 2026 rules, a 60-year-old with income of $47,000 living in Houston, Texas, can purchase the lowest-cost gold plan for $2,376 per year after the PTC. If eliminating silver loading caused the benchmark silver premium to fall by 20 percent, which is likely an underestimate given Texas's aggressive silver loading rules,[19] the individual would pay $4,943 for the same gold plan, more than twice as much, under the CARE Act's 2027 and 2028 rules.[20]

  CBO has estimated that the CSR appropriation in H.R. 6703—the Republican health care bill that passed the House in December—would increase the number of people without health coverage by 300,000 and reduce net federal spending on health care by $37 billion over the next 10 years.[21] A CSR appropriation in the compromise framework could have even larger effects, as explained in box 1.

- **Cap eligibility at 700 percent of FPL (about $110,000 for an individual)**. The reduced PTC in effect for 2026 imposes an eligibility cliff at 400 percent of FPL, or about $63,000 for an individual. The enhanced PTC does not have a cliff, but eligibility is still capped, since the credit phases out as income increases. For example, for a 40-year-old purchasing a benchmark plan with the national-average premium ($7,494 for the year), the tax credit zeros out at an income of about $88,000. Because the income cap depends on the premium, the enhanced PTC is available at higher incomes for people who face higher premiums—generally older adults and those in high-premium areas (Levitis, O'Brien, and Gallamore 2025).

  The CARE Act would cap PTC eligibility at 700 percent of FPL. This could leave those with higher incomes paying unaffordable amounts. For example, the benchmark premium for a 60-year-old in Cheyenne, Wyoming, is $26,180.[22] With the enhancements in place, an individual with income of $110,000 would pay 8.5 percent of income, or $9,350. With a cap at 700 percent of FPL, this person would pay the full premium of $26,180, which is 24 percent of their income. That's enough to deter substantial numbers of people from re-enrolling: CBO estimates that the enhancements increase coverage by 400,000 people among those with incomes above 750 percent of FPL.[23] A cliff at 700 percent would presumably reduce coverage by more than this in 2026.

- **Reduce the PTC for millions of moderate-income people in 2026.** The section of the CARE Act that caps eligibility at 700 percent of FPL also appears to reduce the PTC well below enhancement levels for everyone with incomes between 250 and 400 percent of FPL, though the drafting is ambiguous.[24] With the enhancements in place, this group represents more than 6 million people, according to Urban's baseline. For some, the PTC would be reduced below current-law levels. Specifically, the provision would set the applicable percentage for this group at 8.5 percent, versus as low as 4 percent under the enhancements and 8.44 percent under current law. For example, an individual with an income of $40,000 (256 percent of FPL) would pay $3,400 for a benchmark plan under the CARE Act compared to $1,689 under the enhancements—more than twice as much—and $3,444 under current law. That said, the draft bill also retains conflicting language regarding the applicable percentages for this population, raising questions about its intent. We assume here that the language newly added by the CARE Act is intended to govern.
- **Seemingly deny PTC to additional lawfully present immigrants**. The 2025 reconciliation package, H.R.1, eliminated PTC and CSR eligibility for many lawfully present immigrants, preserving eligibility for just three groups: lawful permanent residents (Green Card holders), Cuban/Haitian Entrants, and citizens of Compact of Free Association states (Micronesia, Palau, and Marshall Islands).[25] The CARE Act includes ambiguous language that seems to deny eligibility to these groups as well. It would eliminate PTC and CSR eligibility for "any individual who is not a citizen or national of the United States." If "national" is interpreted to exclude the remaining eligible groups, this would eliminate their eligibility as well. However, the section in the bill is titled "Ineligibility of Individuals Not Lawfully Present," suggesting that that may not be the intent. Given that there are 12.8 million lawful permanent residents in the US, this is important to iron out (Miller 2024).

The actual effects of these provisions may differ from the estimates cited, especially for those whose meaning is unclear. Regardless, clearly these new restrictions would make coverage less affordable for millions of people while greatly reducing coverage relative to both the enhancements and current law. The coverage loss estimates cited for the first three bullets above total about 1.7 million. Millions of people would see higher premiums.

By introducing changes for 2026 rather than restoring the enhancements in their earlier form, the language would make it impossible for Marketplaces to lower premiums immediately.

The effects of PTC reductions are now being felt acutely and are increasing every day. Millions of Americans are paying higher premiums, going uninsured, or facing unaffordable deductibles after switching to a cheaper plan.[26] Terminations are expected to grow as newly increased premiums go unpaid and grace periods expire.[27] Other consumers, especially those with pre-existing conditions, are paying their premiums by making painful choices such as cashing out retirement funds or forgoing dreams to start a small business, go to school, or buy a house.[28]

In the medium term, numerous options could be considered to increase affordability or reform the health care system more broadly. *But to restore affordability immediately, the only workable option is a "clean" extension of the PTC enhancements for 2026—bringing back the policy that was in place in 2021 through 2025*. That's because Marketplaces have built IT systems for this policy and could switch these systems back "on" in a matter of days.[29] Implementing a different policy, like a minimum premium requirement, would require additional months to build, test, and deploy new IT systems. Such policies could be considered for later years. But any proposal that does not include a clean extension for 2026 will not address the immediate affordability issue.

In addition to making it impossible for Marketplaces to provide immediate relief, the CARE Act does little to ensure that they try to provide relief quickly. Bringing relief to consumers requires updating Marketplace IT systems, increasing PTC payments for current enrollees, undertaking extensive outreach and consumer support, and opening a new enrollment period. The CARE Act includes a provision to extend the open enrollment period through

March 31, but that is too little time for Marketplaces to even implement the new PTC rules. Beyond that, the language includes no requirements for speedy and effective implementation, nor funding to support these measures.

Without such provisions, there is reason to doubt that the federal Marketplace, which covers 69 percent of all Marketplace enrollees in 2026,[30] will prioritize these measures. The Centers for Medicare & Medicaid Services (CMS), which runs the federal Marketplace, reduced navigator funding by 90 percent earlier this year[31] and has repeatedly asserted, without evidence, that the enhancements resulted in widespread fraud.[32]

CBO's score of the House-passed three-year-extension bill projects that coverage in 2026 would increase by just 100,000 people,[33] which is a small fraction—about 5 percent—of CBO's projection for 2026 coverage losses because of the enhancements expiring.[34] CBO does not explain this pessimism, but a likely factor is the bill's lack of provisions to ensure speedy and effective implementation.[35] If the framework also lacks such requirements, many consumers could see no benefit in 2026.

The CARE Act does include a measure providing that health insurers "may" adjust their 2026 gross premiums if "the State insurance commissioner determines an adjustment to premiums for such plans for plan year 2026 is necessary to ensure that premium rates for such plans remain actuarially justified." This provision would likely have little or no effect, given that changing premiums so late in the game would present immense logistical challenges, that insurers are unlikely to choose to do so, and that actuaries are unlikely to project that lower-cost consumers will return this year, consistent with CBO's estimate of the House-passed three-year extension.[36]

The proposal includes other provisions that would have little impact on affordability.

The proposal also includes provisions that are generally outside the scope of this piece. For example, it permits bronze enrollees to divert some of their advance PTC dollars to new "Exchange Plan HSAs"—a potential 25th variety of tax-preferred health spending arrangements.[37] This would provide little benefit, since bronze enrollees are already HSA-eligible, the provision provides no new funding, and diverting PTC to an HSA would generally just mean paying more in premiums out-of-pocket. Perhaps the most likely effect would be to encourage some consumers who would be better off in silver plans to shift to bronze plans, which come with deductibles averaging nearly $7,500 for an individual and around twice that for a family.[38] Because of CSRs, deductibles are currently less than $1,000 for most silver enrollees.[39] This difference in deductibles greatly exceeds the difference in premiums for most people.[40] If the proposal nudges consumers eligible for valuable CSRs into bronze plans, more people risk being left with unaffordable out-of-pocket costs.

The language also provides authority to impose penalties on brokers who are shown to "knowingly and willfully" engage in fraudulent conduct.

Finally, the language attempts to steer a middle ground on the contentious issue of abortion. The Affordable Care Act has long prohibited federal funding, including the PTC, from paying for abortions, consistent with long-standing Hyde Amendment rules (Keith 2025). States decide whether insurance covers abortion. But some abortion opponents want to prohibit Marketplace plans from covering abortion, even with other funds, and to prohibit HSAs from paying for abortions as they can for other medical care.[41] Democrats have firmly rejected such changes.[42] The CARE Act prohibits Marketplace HSAs from paying for abortions and requires audits of Marketplace plans to ensure they are not using federal funds for abortion coverage. But it omits the requirement to prohibit Marketplace plans from covering abortion. It is not clear if this middle ground would prove acceptable to either side.

Looking Forward

The PTC enhancements play a crucial role in making coverage affordable for millions of Americans. Extending the enhancements may require difficult compromises, but the details matter. Our research suggests that the CARE Act

would lead to one step forward, three steps back on affordability, with partial, delayed, and short-term relief eclipsed by substantial new PTC reductions that would leave many people worse off than under current law.

BOX 1

UNDERSTANDING COST-SHARING REDUCTIONS AND SILVER LOADING

Among the provisions of the CARE Act, perhaps the hardest to understand is the appropriation for cost-sharing reduction (CSR) payments. Appropriating CSR payments sounds like it would make coverage *more* affordable. And its proponents often claim that it would,[43] pointing to the Congressional Budget Office's (CBO) projection that it would reduce benchmark silver premiums.[44] But in fact, it would undoubtably make coverage less affordable overall and leave more people uninsured. The reason, in short, is that consumers don't generally pay the benchmark premium out of pocket. But the premium tax credit (PTC) is tied to it, so reducing it reduces PTC amounts and increases many consumers' net premiums. That's why CBO estimates that the H.R. 6703 provision would reduce coverage by 300,000 while reducing federal spending on health coverage. This text box explains this complex mechanism and why the CBO score of H.R. 6703 likely understates the effects of a CSR appropriation.

Silver Loading Explained

In 2017, CMS terminated the payments that reimburse insurers for CSRs. This was widely expected to harm consumers and undermine the Affordable Care Act, but in fact, it has had the opposite effect. That's because insurers were still required by law to provide the lower-cost-sharing silver plans to low-income enrollees for the same price as a standard silver plan. To cover their costs, insurers responded by increasing Marketplace silver premiums—a practice known as "silver loading." Because the PTC adjusts dollar-for-dollar with Marketplace silver premiums, this increases PTC amounts across the board. PTC recipients purchasing silver plans were generally unaffected, but the greater purchasing power reduced net premiums for bronze and gold plans. (People ineligible for PTC could also avoid the premium increases by purchasing a bronze or gold plan or an unloaded silver plan off-Marketplace.) The net result was—unintuitively—to make coverage more affordable and expand coverage. Appropriating CSR payments would eliminate silver loading and thus reverse these effects, reducing affordability and coverage. That's why CBO has consistently projected that appropriating CSR payments would leave more people uninsured.

Why CBO's H.R. 6703 Score Likely Understates the Effects of the CSR Appropriation in the CARE Act

CBO estimated that the CSR appropriation in H.R. 6703 would reduce coverage by 300,000. The CSR appropriation in the CARE Act would likely have larger effects, for two reasons.[45] First, at the insistence of abortion opponents, H.R. 6703 included a provision that denies CSR payments to insurers that provide abortion coverage. CBO's score assumed that this would avert PTC reductions in states that require abortion coverage. These states account for about one-quarter of the US population, reducing CBO's coverage loss estimate. The CSR appropriation in the CARE Act does not include this abortion carve-out, so it would have correspondingly larger effects.[46]

Second, CBO's modeling may not have been fully updated to reflect that several states updated their silver loading rules in 2026 to ensure that silver premiums reflect the full effects of CSRs.[47] This stronger silver loading increases the affordability losses from appropriating CSR payments.

Notes

[1] "Early Analyses of Marketplace Open Enrollment Data Reveal Warning Signs," State Marketplace Network, January 2026; Jared Ortaliza, "ACA Signups Are Down, But Still an Incomplete Picture," *KFF*, January 12, 2026, https://www.kff.org/quick-take/aca-signups-are-down-but-still-an-incomplete-picture/; Benjamin Guggenheim, "Senators Punt Release of Health Package to End of January," *Politico*, January 13, 2026, https://www.politico.com/live-updates/2026/01/13/congress/senators-punt-release-of-health-package-to-end-of-january-00725086; and Covered California, "Open Enrollment and Renewal Dashboard," accessed January 15, 2026, https://hbex.coveredca.com/data-research/dashboards/open-enrollment-and-renewal-dashboard/.

[2] Phillip L. Swagel, "Re: The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums," Congressional Budget Office, December 5, 2024, https://www.cbo.gov/publication/59230.

[3] Jameson Carter, Jessica Banthin, Michael Simpson, Matthew Buettgens, "Four Million People Will Lose Health Insurance If Premium Tax Credit Enhancements Expire in 2025," *Urban Wire* (blog), Urban Institute, November 14, 2024, https://www.urban.org/urban-wire/four-million-people-will-lose-health-insurance-if-premium-tax-credit-enhancements-expire.

[4] H.R.1834, 119th Cong. (2025–2026).

[5] Alex Miller, "Key Republican Negotiator Details Bipartisan Obamacare Fix as Abortion Dispute Remains Sticking Point," *Fox News*, January 9, 2026, https://www.foxnews.com/politics/key-republican-negotiator-details-bipartisan-obamacare-fix-abortion-dispute-remains-sticking-point; and Jordain Carney, "This GOP Senator Says Reviving Obamacare Subsidies Would Be 'Putting America First,'" *Politico*, January 12, 2026, https://www.politico.com/news/2026/01/12/bernie-moreno-obamacare-talks-00719585.

[6] Sahil Kapur and Katie Taylor, "Senate ACA Funding Talks Fizzle as Higher Premiums for Millions Take Effect for 2026," *NBC News*, January 15, 2026, https://www.nbcnews.com/politics/congress/senate-aca-funding-talks-fizzle-higher-premiums-take-effect-millions-rcna254227.

[7] "CARE Act," accessed January 30, 2026; Burgess Everett, "Moreno Makes Final Health Care Offer to Democrats," *Semafor*, January 29, 2026, https://www.semafor.com/article/01/28/2026/moreno-makes-final-health-care-offer-to-democrats; and Sigi Ris, "Moreno Offers Potential 'Olive Branch' To Dems In Proposed 1-Year APTC Extension Deal," *Inside Health Policy*, January 28, 2026, https://insidehealthpolicy.com/daily-news/moreno-offers-potential-olive-branch-dems-proposed-1-year-aptc-extension-deal.

[8] Specifically, this group would have applicable percentages of 7 percent under the CARE Act's 2028 schedule and applicable percentages as low as 4.19 percent under current law in 2026.

[9] The baseline used here is the current-law (not enhanced) PTC scenario in Buettgens et al. (2025).

[10] "Calculator: ACA Enhanced Premium Tax Credit," KFF, accessed January 22, 2026, https://www.kff.org/interactive/calculator-aca-enhanced-premium-tax-credit/.

[11] "Effective Marginal Tax Rates/Benefit Cliffs," ASPE, accessed October 15, 2025, http://aspe.hhs.gov/topics/poverty-economic-mobility/marginal-tax-rate-series.

[12] Madeline Guth, Meghana Ammula, and Elizabeth Hinton, "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers," KFF, September 9, 2021, https://www.kff.org/medicaid/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

[13] "Health Insurance Exchanges 2025 Open Enrollment Report," CMS, accessed January 27, 2026.

[14] "Rev. Proc. 2025-25," IRS, accessed January 27, 2026.

[15] "Health Insurance Exchanges 2025 Open Enrollment Report," CMS.

[16] "Premium Alignment, or How a Dozen States Are Quietly Providing ACA Enrollees W/Better Options Even in the Face of Expiring Tax Credits," ACASignups.net, November 6, 2025, https://acasignups.net/25/11/06/premium-alignment-or-how-dozen-states-are-quietly-providing-aca-enrollees-wbetter-options.

[17] More information on HIPSM is available at "Quantitative Data Analysis," Urban Institute, accessed January 30, 2026, https://www.urban.org/research/data-methods/data-analysis/quantitative-data-analysis/microsimulation/health-insurance-

policy-simulation-model-hipsm. The baseline used in the calculation of those eligible for a zero-premium plan is the current-law (not enhanced) PTC scenario in Buettgens et al. (2025).

[18] This example uses 2026 premiums and poverty levels. National average is weighted by rating region population size. Authors' analysis of state-based Marketplace websites and "Health Plan Datasets: Individuals & Families," Healthcare.gov, accessed January 12, 2026, https://www.healthcare.gov/health-plan-information/.

[19] "Premium Alignment, or How a Dozen States Are Quietly Providing Aca Enrollees W/Better Options Even in the Face of Expiring Tax Credits," ACASignups.net.

[20] This example uses 2026 premiums and poverty levels. Authors' analysis "Health Plan Datasets: Individuals & Families," Healthcare.gov, accessed January 12, 2026, https://www.healthcare.gov/health-plan-information/.

[21] Phillip L. Swagel, "Cost Estimate," Congressional Budget Office, December 16, 2025.

[22] "Calculator: ACA Enhanced Premium Tax Credit," KFF.

[23] Phillip L. Swagel, "The Effects of Permanently Extending the Expansion of the Premium Tax Credit and the Costs of that Credit for Deferred Action for Childhood Arrivals Recipients," Congressional Budget Office, June 24, 2024, https://www.cbo.gov/publication/60437.

[24] "CARE Act," section 4.

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Acknowledgments

This brief was funded by the Robert Wood Johnson Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.