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A Targeted Affordability Improvement Proposal:

The Potential Effects of Two Nongroup Insurance Reforms Designed to Increase Affordability and Reduce Costs

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Timely Analysis of Immediate Health Policy Issues **JUNE 2019**

In Brief

While the public discussion over more comprehensive reforms to the health insurance system continues in the context of the 2020 presidential election campaigns, this brief presents an analysis of much more limited reforms to the Affordable Care Act. Taken together, the two policies analyzed here would lower federal health spending while improving insurance and medical care affordability for people faced with the full cost of nongroup insurance coverage. The first policy would either introduce a public insurance option offering ACA-compliant coverage in the nongroup market or cap private nongroup insurers' provider payment rates at levels based on those used in the Medicare program. The second policy would extend the ACA's premium tax credits to eligible people with incomes above 400 percent of the federal poverty level; today, no one with income above this level is eligible for those credits.

Using the Urban Institute's Health Insurance Policy Simulation Model, we estimate that the combined policies would lower federal health spending on Medicaid acute care for the nonelderly and marketplace premium tax credits by 2.9 percent in 2020 and would increase the number of people with comprehensive insurance coverage by about 1.2 million. In addition, higher-income people (400 percent of the federal poverty level and above) buying coverage in the nongroup insurance market would save an average of 29 percent ($200) on their monthly premiums and out-of-pocket medical costs.

The desire for additional health insurance reform is frequently driven by the public's desire for greater affordability, but legislative action is frequently thwarted over concerns with the associated increased federal costs, substantial disruption to existing markets, and/or excessive impacts on health care providers. Though not a solution to all gaps in today's health insurance system, this analysis provides evidence that incremental reforms are available that could be targeted to improve affordability for some consumers without increasing federal costs or triggering overly large changes for markets or providers.

Introduction

Debate over the future of the health insurance system continues. A case before the U.S. Court of Appeals for the Fifth Circuit has the potential to invalidate the entire Affordable Care Act (ACA), and the U.S. Department of Justice and the president support that invalidation. Meanwhile, congressional democrats have introduced an array of legislation, including single-payer (or Medicare for All) bills and multiple bills intended to make an array of improvements to the reforms introduced by the ACA, such as enhancing marketplace premium tax credits and/or introducing a public option in some insurance markets. Aside from the divisiveness of the current political climate, the additional federal costs associated with large increases in subsidies to decrease households' health insurance premiums and out-of-pocket costs are a significant barrier to even incremental improvements to the current system. Therefore, we provide estimates of the implications of two reforms frequently discussed as components of larger policy packages that, taken together, would address ACA marketplace affordability and trim federal spending without excessive market disruption. This limited step would not address all the gaps in the current system, but it would have a significant effect within particular populations and would not require new revenue. The two reforms are

1. capping the provider payment rates both in and out of network for insurance coverage sold in the ACA-compliant nongroup market, or, alternatively, introducing a public option into the nongroup market, assuming both approaches include prescription drug savings relative to commercial rates under current law; and
2. extending the marketplace premium tax credit to people and families with incomes above 400 percent of the federal poverty level (FPL).

Markets with little or no insurer and/or provider competition are frequently associated with high private insurance premiums.[1,2] Without significant competition, insurers have little incentive to negotiate with providers for lower reimbursement rates. In areas with little

or no provider competition, insurers are unlikely to have the leverage to be tough negotiators with "must-have" providers. A public plan option would give consumers a lower-cost, government-structured insurance plan, with lower premiums resulting from lower regulated provider payment rates, most likely based on those used by the traditional Medicare plan. Private insurers could then compete with the public plan in the nongroup market, having increased negotiating leverage with providers to bring down their own rates. Capping provider payment rates for all private insurers participating in the nongroup market at the same level would lower the claims costs, and thus premiums, for many of the market's enrollees.

A public plan or capped provider payment rates would therefore lower the full premiums for private nongroup health insurance on average, with the largest premium decreases occurring in geographic areas with the least competitive nongroup insurance and provider markets and little savings occurring in highly competitive markets. The savings would most benefit people paying the full premium for their coverage (those ineligible for premium tax credits and those for whom the credit is effectively zero because the premium they face falls below the percent of income by which their potential tax credit is determined). In addition, the premium decreases would lower the cost of federal premium tax credits provided to enrollees in higher-cost areas, reducing the government cost of providing financial assistance for purchasing coverage. We also assume that, along with the lower provider payment rates, the federal government would require prescription drug manufacturers to provide rebates in this market that would be halfway between those provided to Medicaid and Medicare.

The second policy, extending marketplace premium tax credits to those with incomes above the current cap of 400 percent of FPL, would provide new financial assistance to middle-income people purchasing private insurance coverage not sponsored by an employer. The policy would provide significant assistance for some people, particularly older adults who face higher premiums because of age rating and still have modest incomes and those living in areas where premiums are particularly high due to lack of market competition. Though the policy does not have an explicit maximum income, as incomes increase, the subsidies would decrease, ultimately to zero, as premiums fell below 9.86 percent of income (the highest premium tax credit percent-of-income cap under current law).

We simulate the coverage and cost implications of each of these policies separately and combined using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). We chose these two policies to provide an incremental reform option that would improve affordability for a segment of the population, but when combined, would not require increased government revenue to fund it.

HIPSM has been used extensively to estimate the effects of the ACA, modifications to it, and its potential repeal. All simulations and results presented here reflect policy effects in 2020. Our main findings include the following.

- Capping provider payment rates for ACA-compliant nongroup insurers or introducing a public plan marketplace option alone would
  - » decrease federal spending by $19.4 billion in 2020, an almost 5 percent decrease in current-law spending on Medicaid/the Children's Health Insurance Program (CHIP) acute care for the nonelderly and marketplace subsidies, with the largest percentage decreases in states that have not expanded Medicaid, have high marketplace premiums, and lack significant insurer participation in their ACA marketplaces;
  - » decrease aggregate household spending on premiums and out-of-pocket costs by $10.9 billion (nearly 2 percent);
  - » lower the average per enrollee spending on premiums and out-of-pocket costs by those enrolled in ACA-compliant nongroup coverage without federal tax credits by 22.0 percent, or about $150 per month, with the largest average premium decreases occurring in states with high premiums because of limited or no insurance market competition; and
  - » increase the number of people with comprehensive insurance coverage by 325,000.
- Extending the highest premium tax credit percent-of-income cap to those with incomes above 400 percent of FPL alone would
  - » increase federal government spending by $8.2 billion in 2020 (an additional 2 percent compared with current-law spending on Medicaid/CHIP acute care for the nonelderly and marketplace subsidies), with the largest percentage increases occurring in states that have not expanded Medicaid, have high marketplace premiums, have higher shares of nongroup market enrollment among its population with incomes above 400 percent of FPL, and have significant numbers of higher-income uninsured people;
  - » lower household spending by $1.7 billion in aggregate (less than 1 percent);
  - » lower average premium spending by $130 per month, or 18.7 percent per enrollee, for those with incomes over 400 percent of FPL buying nongroup coverage; states with the highest average premium savings within this income group are those where marketplace premiums are higher and larger shares of this income group have incomes closer to 400 percent of FPL; and
  - » increase the number of people

with comprehensive insurance coverage by 912,000.

- Combining both of these policies would
  - » reduce federal government spending by $12.0 billion in 2020;
  - » decrease household spending by $9.2 billion in aggregate;
  - » lower average premium spending by $200 per month, or 29.0 percent, for those with incomes over 400 percent of FPL buying nongroup coverage; and
  - » increase the number of people with comprehensive insurance coverage by 1.2 million.

The public's desire for greater health insurance affordability tends to meet political barriers because of the additional federal costs associated with such improvements, in addition to concerns over excessive disruption of existing markets and/or large effects on health care providers. This targeted approach takes into consideration the countervailing pressures that have historically blocked progress in addressing market dysfunction, improving affordability for a segment of the population currently ineligible for marketplace financial assistance, limiting provider effects to the nongroup insurance market, and reducing government spending.

Methodology

HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the American Community Survey, which provides national- and state-representative samples. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program. HIPSM is designed to incorporate timely, real-world data when they are available. We regularly update the model to reflect published Medicaid and marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives. The current version of HIPSM is calibrated to state-specific targets for marketplace enrollment following the 2019 open enrollment period, 2019 marketplace premiums, and late 2018 Medicaid enrollment from the Centers for Medicare & Medicaid Services monthly enrollment snapshots. As of this publication, no 2019 data were available on off-marketplace or non-ACA-compliant nongroup coverage. Here we describe approaches to simulating current law and the two policy options described above.

Simulation of insurance coverage and health care spending under current law, 2020. We begin by estimating health insurance coverage and health care spending by governments, employers, and households under current law. Our current-law ACA simulations are based on enrollment in the marketplaces in each state following the 2019 open enrollment period. We capture the collective effect of policy changes implemented by the Trump administration by benchmarking the current-law simulation to 2019 marketplace enrollment, the most recent Medicaid enrollment data, and nongroup market premium changes between 2018 and 2019. We then age these benchmarks to our analysis year, 2020, accounting for estimated premium growth, changing demographics, and anticipated shifts in the income distribution. Because the individual mandate penalties are set to $0 under current law in 2019, our 2020 current-law estimates must simulate elimination of these penalties, except in Massachusetts, New Jersey, and the District of Columbia, which have passed legislation enacting their own penalties. In addition, effects of the Trump administration's finalized regulations allowing the expansion of sales of short-term, limited-duration (STLD) policies will not be fully realized until at least 2020. States regulate these policies differently, so we must explicitly estimate the effects of eliminating the individual mandate penalties and expanded sales of STLD policies by state and incorporate these estimates into our simulation of current law in 2020. Our 2020 current-law simulation also assumes that all states would instruct their insurers to add the costs associated with cost-sharing subsidies into their silver-level premiums, consistent with 2019 rules.

Simulation of policy options. The first policy option would cap payment rates or, equivalently, add a public option with the same rates, as well as cut payments for prescription drugs. We estimated what payment rates would be in each rating region if provision of health care in the region were highly competitive, defined here as having five or more active insurers in the nongroup market and low market concentration for hospitals. We use this proxy for the most efficient provider payment rates achievable under reform because there is insufficient claims data from nongroup insurers nationwide to compute average claims relative to Medicare rates, for example. Our previous research has shown that marketplace nongroup premiums decrease dramatically as the number of competing insurers increases.[2] We estimate the potential savings achievable under a public option or capped payment rates using the premium gradient produced through that work, controlling for other market characteristics. The policy change would not decrease premiums in highly competitive areas but would drop by more than one-third in the least competitive markets. In addition to those reductions, all regions would see costs cut by an additional 6.9 percent to reflect the reform's controls on the prices paid for prescription drugs in the ACA-compliant nongroup markets. This 6.9 percent premium savings estimate (1) assumes that ACA-compliant nongroup purchasers would receive additional discounts on prescription drug prices that are roughly halfway between the Medicaid and Medicare discounts provided under current law[3] and (2)

accounts for the share of private health insurance spending on the nonelderly devoted to prescription drugs, according to the 2016 Medical Expenditure Panel Survey.[4]

The second policy option would extend premium tax credits above the current cap of 400 percent of FPL. People with household incomes above this level who would otherwise be eligible for premium tax credits, if not for their income, would be made eligible under the reform. Tax credits would still not be available to those ineligible for other reasons, such as not being legally present in the country, being eligible for other public coverage like Medicare or Medicaid, and having an affordable offer of insurance through an employer. Currently, people with incomes between 300 and 400 percent of FPL have their contribution for the second-lowest silver premium available to them capped at 9.86 percent of their income (lower-income families are offered lower percent-of-income caps). The premium tax credit offered to those above 300 percent of FPL is computed as the difference between the full premium for the second-lowest premium silver plan and 9.86 percent of their income. That highest 9.86 percent of income cap would, under this policy, apply not only to people with incomes between 300 and 400 percent of FPL, but to those with incomes at or about 300 percent of FPL. However, as income increases, it becomes more likely that a full premium would cost less than 9.86 percent of the person's or family's income, and thus, even eligible people will eventually not qualify for a nonzero tax credit.

The third option combines the capped provider payment/public option policy with the extension of premium tax credits to people with incomes above 400 percent of FPL.

Results

Effects on Insurance Coverage

Table 1 shows the estimated effects on insurance coverage of the capped provider payment rates/public option, the extended premium tax credits, and the combination of both policies, as well as the differences in number and percent from current law for each option.

Capped provider payment rates/public option. Capping provider payment rates or, alternatively, offering a public plan option that uses provider payment rates set at the same level, would have a very modest effect on overall insurance coverage. The number of uninsured people would fall by 248,000 nationally, or 0.8 percent. This increase in coverage would result from the lower average cost of ACA-compliant nongroup coverage for people ineligible for premium tax credits. The effect is modest and would vary geographically, because the premium savings would be largest in areas with little or no insurer competition today and smaller in more competitive areas.

The number of people with STLD policies would fall by an additional 78,000, or 3.2 percent, as the cost of more comprehensive coverage decreases.

Table 1. Health Insurance Coverage Distribution of the Nonelderly (Thousands of People), Current Law Versus Reform, 2020

	Current Law ACA		Capped Provider Payment Rates or Public Option				Extend Premium Tax Credits above 400% FPL				Both Reforms Combined			
	Number	Percent	Number	Percent	Difference from Current Law	Percent Difference from Current Law	Number	Percent	Difference from Current Law	Percent Difference from Current Law	Number	Percent	Difference from Current Law	Percent Difference from Current Law
Insured (Minimum Essential Coverage)	**240,271**	**87.3%**	**240,596**	**87.4%**	**325**	**0.1%**	**241,183**	**87.7%**	**912**	**0.4%**	**241,468**	**87.8%**	**1,196**	**0.5%**
Employer	147,574	53.6%	147,574	53.6%	0	0.0%	147,417	53.6%	-157	-0.1%	147,441	53.6%	-134	-0.1%
Private nongroup	15,275	5.6%	15,382	5.6%	106	0.7%	16,326	5.9%	1,051	6.9%	16,370	5.9%	1,094	7.2%
Marketplace with PTC and BHP	*9,075*	*3.3%*	*8,696*	*3.2%*	*-379*	*-4.2%*	*11,138*	*4.0%*	*2,063*	*22.7%*	*10,277*	*3.7%*	*1,202*	*13.2%*
Full-pay nongroup	*6,201*	*2.3%*	*6,685*	*2.4%*	*485*	*7.8%*	*5,188*	*1.9%*	*-1,012*	*-16.3%*	*6,093*	*2.2%*	*-108*	*-1.7%*
Medicaid/CHIP	68,790	25.0%	69,010	25.1%	219	0.3%	68,809	25.0%	19	0.0%	69,026	25.1%	236	0.3%
Other public	8,632	3.1%	8,632	3.1%	0	0.0%	8,632	3.1%	0	0.0%	8,632	3.1%	0	0.0%
No Minimum Essential Coverage	**34,862**	**12.7%**	**34,537**	**12.6%**	**-325**	**-0.9%**	**33,950**	**12.3%**	**-912**	**-2.6%**	**33,666**	**12.2%**	**-1,196**	**-3.4%**
Uninsured	32,420	11.8%	32,172	11.7%	-248	-0.8%	31,856	11.6%	-564	-1.7%	31,624	11.5%	-796	-2.5%
Noncompliant nongroup	2,442	0.9%	2,365	0.9%	-78	-3.2%	2,094	0.8%	-348	-14.3%	2,042	0.7%	-401	-16.4%
Total	**275,134**	**100.0%**	**275,134**	**100.0%**	**0**	**0.0%**	**275,134**	**100.0%**	**0**	**0.0%**	**275,134**	**100.0%**	**0**	**0.0%**

Source: Urban Institute Health Insurance Policy Simulation Model, 2019.

Notes: ACA = Affordable Care Act. PTC = premium tax credit. BHP = basic health program.

Other forms of coverage would stay very stable. In total, the number of people with minimum essential coverage (those moving from STLD policies or uninsurance to enrolling in ACA-compliant coverage) would increase by 325,000.

Extension of premium tax credits to people with incomes above 400 percent of FPL. Extending premium tax credits to people with incomes above 400 percent of FPL would increase the number of people with ACA-compliant coverage by 912,000. The number of uninsured people would drop by 564,000 and the number of people with STLDs would fall by 348,000, both in response to comprehensive coverage being made more affordable for the population with incomes over 400 percent of FPL.

The number of people enrolled in nongroup coverage with premium tax credits would increase by 2.1 million, the result of shifts from uninsurance and STLDs and people gaining financial assistance for purchasing the ACA-compliant nongroup coverage for which they were paying the entire premium.

Both policies combined. With both policies in place, the number of uninsured people would decrease by 796,000, or 2.5 percent, and the number of people with STLDs would fall by 401,000, or 16.4 percent. The number of people without ACA-compliant coverage would therefore decrease by 1.2 million, or 3.4 percent. Though the number of people with ACA-compliant nongroup coverage in this scenario would be about the same as in the preceding scenario with the extended tax credits alone, more of those people would pay the full premium in this combined policy scenario. That is because the capped provider payment rates/public option lowers the benchmark premium to the point that it falls below the applicable percentage of income for more people.

Breakdown of People Most Affected by Extended Premium Tax Credits

Some might wonder why the estimated effects of extending premium tax credits to higher-income people does not have a larger effect in reducing uninsurance. In fact, estimates by other researchers are higher than ours.[5] The answer is twofold: First, some uninsured people have incomes above 400 percent of FPL, but they are ineligible for premium tax credits under this extension because they or a family member have offers of health insurance coverage from an employer that the law deems affordable. Some of these people fall into the so-called "family glitch" that already affects some lower-income families under current law.[6] Second, relatively few people who would be eligible for nonzero tax credits are otherwise uninsured. Most higher-income people are insured. The extended tax credits improve affordability significantly for a segment of eligible consumers, many of whom currently purchase nongroup insurance but shoulder higher financial burdens to obtain coverage. Others are ineligible because they are undocumented immigrants.

Second, the tax credit in the policy as defined is not large enough to change purchase decisions for a significant share of this higher-income segment of the uninsured population eligible for the credit. The highest applicable percent of income for premium tax credits under current law is 9.86. For many younger, single adults, the full benchmark premium for nongroup coverage would cost less than 9.86 percent, and as such, their extended tax credits would be effectively zero. For others, the amount of the credit would be too small to incentivize them to purchase coverage.

Table 2 shows that the number of people enrolled in ACA-compliant nongroup coverage plus the number of people enrolled in STLDs under current law, both of whom have incomes above

Table 2. Eligibility for Advanced Premium Tax Credits under Extension among People in Families with Incomes above 400 Percent of the Federal Poverty Level, by Current-Law Coverage Status, 2020 (Thousands of People)

	Number (Thousands)	% of Total with That Current Law Coverage Type
Number of People with Incomes above 400 Percent of FPL Enrolled in ACA-Compliant Nongroup Market under Current Law	**3,900**	**100%**
Newly eligible for nonzero APTC under the extended tax credit	1,288	33%
Number of Uninsured People with Incomes above 400 Percent of FPL	**3,179**	**100%**
Newly eligible for nonzero APTC under the extended tax credit	868	27%
Number of People with Incomes above 400 Percent of FPL Currently Enrolled in Noncompliant Coverage	**1,038**	**100%**
Newly eligible for nonzero APTC under the extended tax credit	318	31%

Source: Urban Institute Health Insurance Policy Simulation Model, 2019.

Notes: APTC = advanced premium tax credit. FPL = federal poverty level.

400 percent FPL and would be newly eligible for a nonzero tax credit under the extension policy (1.3 million and 318,000, respectively, for a total 1.6 million people), exceeds the number of uninsured people in that income and eligibility group (868,000). Of the 868,000 uninsured people that would be eligible for a new nonzero tax credit, we estimate that just under half would enroll, with the likelihood of their taking up the newly subsidized coverage increasing with the size of the tax credit for which they are eligible relative to the cost of the premium (see detail in appendix). As income increases and the tax credit decreases in size, the tax credit is less likely to induce uninsured people to enroll.

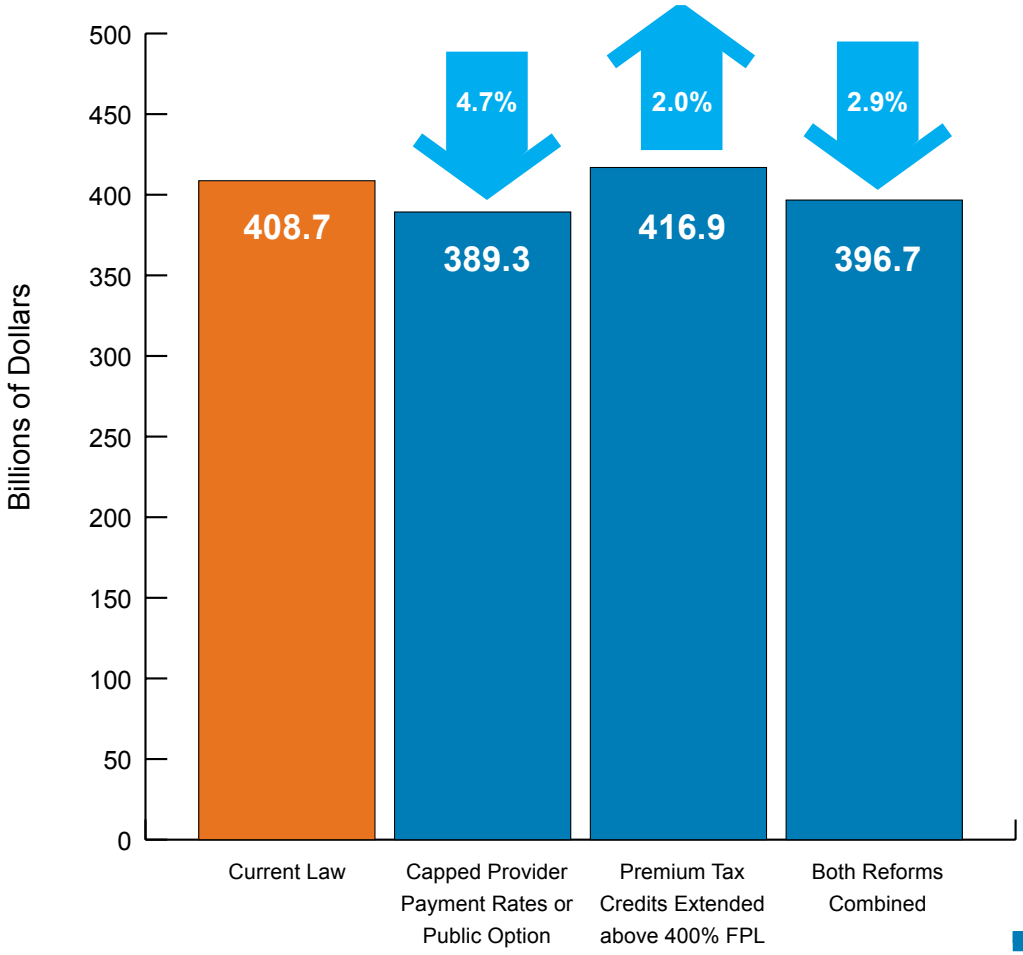
Nearly all people eligible for a new tax credit and already enrolled in ACA compliant nongroup coverage would take advantage of being able to purchase the same type of coverage they would buy on their own but at a reduced price. Consequently, the number of people able to enroll in their current coverage more affordably far outweighs the number of people becoming insured because of the expanded tax credit eligibility. In addition, some people purchasing STLDs under current law would find the new tax credits attractive enough to move from their lower-benefit, higher cost-sharing STLD plans into ACA-compliant coverage.

Effects on Federal Spending on Marketplace Tax Credits and Medicaid/CHIP Acute Care for the Nonelderly

Capped provider payment rates/public option. The first policy, on its own, would lower federal spending on health care by $19.4 billion, or 4.7 percent, compared with current-law federal spending on marketplace tax credits and Medicaid/CHIP acute care for the nonelderly (Figure 1). The savings would vary across states, however, with the largest decreases in states with little competition and high marketplace premiums that have not expanded Medicaid under the ACA (meaning federal funding is lower under current law). As shown in table 3, these states include Florida (14.0 percent decrease), Nebraska (19.5 percent decrease), and Wyoming (23.3 percent decrease). States that have substantial insurer competition in their marketplaces and have expanded Medicaid under the ACA would experience little change in federal funding, including the District of Columbia, Massachusetts, New Mexico, and Ohio.

Extension of premium tax credits to people with incomes above 400 percent of FPL. The second policy alone would increase federal health care spending by $8.2 billion, or 2.0 percent, relative to current-law federal spending on marketplace tax credits and Medicaid/CHIP acute care for the nonelderly (Figure 1). States with larger numbers of uninsured people with incomes above 400 percent of FPL, as well as those with more higher-income nongroup market

Figure 1 . Federal Spending on Marketplace Premium Tax Credits and Medicaid/CHIP Acute Care for the Nonelderly under Current Law and Reforms



enrollees (i.e., lower rates of employer-based insurance), would experience the largest increases in federal spending under this policy. Larger numbers of higher-income nongroup enrollees mean more state residents already in the market would be eligible for and almost always take up the new tax credits. Larger numbers of higher-income uninsured people mean a state has more potential new enrollees under the policy. And to the extent that premiums in a state are high, the tax credits would tend to be larger. Premiums may be high because of lack of market competition, but more of the people newly eligible for tax credits may face higher premiums if they tend to be older. As shown in table 3, the largest percentage increases in federal funding would occur in Nebraska (9.8 percent), South Dakota (6.9 percent), and Wyoming (15.4 percent).

Both policies combined. Taken together, the two policies would decrease federal health care spending by $12.0 billion, because the cost of larger numbers of people receiving premium tax credits would be more than offset by federal savings on all premium tax credits because of the lower provider payment rates (Figure 1). Savings are greater than the sum of the two policies because the additional spending introduced by extending the premium tax credits would be reduced by the capped provider payment rate/public option policy. States with the largest percentage decreases in federal funding would again be Nebraska and Wyoming, both experiencing decreases of approximately 15 percent. Alabama and Florida would each have 9 to 10 percent lower federal spending in their state under the combined policy.

Effects on the Distribution of Federal Spending on Premium Tax Credits

Table 4 shows the distribution of marketplace premium tax credits under current law and the reform policies by family income.

Capped provider payment rates/public option. Either capping provider payment rates or introducing a public option, along with increasing rebates for prescription drugs, would lower federal spending on marketplace tax credits by $20.1 billion in 2020. The distribution of that spending by income group would not change appreciably, with 71 percent of the total going to those with incomes under 200 percent of FPL and 29 percent going to people with incomes between 200 and 400 percent of FPL. The percentage decrease in premium tax credits for the highest-income group (300 to 400 percent of FPL) is greater than that for the lower-income groups because the lower premiums make some people no longer eligible for tax credits (when the full premium falls below 9.86 percent of income).

Extension of premium tax credits to people with incomes above 400 percent of FPL. Extending the tax credits to higher-income groups as a standalone policy would increase federal spending on tax credits by $8.1 billion in 2020. With this change, tax credits totaling $5.8 billion would go to people in families with incomes between 400 and 600 percent of FPL and $2.1 billion would go to those with incomes above 600 percent of FPL. Still, 60 percent of marketplace tax credit dollars would go to those with incomes below 200 percent of FPL and 28 percent would go to those with incomes between 200 and 400 percent of FPL.

Both policies combined. Implementing both policies simultaneously would decrease federal spending on tax credits by $12.9 billion, or 21.3 percent. New spending on tax credits for some higher-income families would be more than offset by lower spending on all tax credit recipients resulting from the capped payment rates or public option. Again, most tax credits would remain devoted to lower-income families, with 65 percent going to families with incomes below 200 percent of FPL and 27 percent to those with incomes between 200 and 400 percent of FPL.

Effects on Aggregate Nonelderly Household Spending on Premiums and Out-of-Pocket Costs by Income Group

Table 5 shows the effect of each policy on aggregate household health care spending by income group.

Capped provider payment rates/public option. In total, capping provider payment rates or introducing a public option, along with increasing rebates for prescription drugs in the nongroup market, would decrease household premium and out-of-pocket spending by $10.9 billion, or about 1.9 percent of current-law spending. These savings would be spread across the income distribution but would be largest for higher-income groups, where current-law health care spending is highest. For example, families with incomes below 150 percent of FPL would save a total of $0.8 billion in 2020 (1.4 percent of current-law spending), and families with incomes above 600 percent of FPL would save $3.8 billion, or 2.5 percent.

Extension of premium tax credits to people with incomes above 400 percent of FPL. As would be expected, only households with incomes above 400 percent of FPL would have measurable savings under extended marketplace premium tax credits. The savings, approximately $1.7 billion in 2020, would be almost completely concentrated among families with incomes between 400 and 600 percent of FPL. Among those with incomes above 600 percent of FPL, relatively few people would be eligible for a nonzero tax credit because their full premiums would tend to be less than the 9.86 percent of income cap, and any credits that they qualify for would tend to be small compared with their income. These advanced premium tax credits, as well as lower premiums for those choosing nongroup coverage, would offset the increased number of people buying nongroup coverage, leaving overall health spending for the

Table 3. Federal Spending on Marketplace Premium Tax Credits and Medicaid/CHIP Acute Care for the Nonelderly under Current Law and Reforms, by State, 2020 (Millions of Dollars)

State	Current Law	Capped Provider Payment Rates or Public Option			Premium Tax Credits Extended above 400% FPL			Both Reforms Combined		
	Federal Spending	Federal Spending	Change from Current Law	Percent Change from Current Law	Federal Spending	Change from Current Law	Percent Change from Current Law	Federal Spending	Change from Current Law	Percent Change from Current Law
Alabama	5,309	4,749	-560	-10.5%	5,420	111	2.1%	4,850	-458	-8.6%
Alaska	1,372	1,280	-92	-6.7%	1,431	59	4.3%	1,286	-86	-6.3%
Arizona	11,396	11,074	-323	-2.8%	11,597	201	1.8%	11,268	-129	-1.1%
Arkansas	5,291	5,214	-77	-1.5%	5,328	37	0.7%	5,248	-43	-0.8%
California	50,327	49,591	-736	-1.5%	51,293	965	1.9%	49,959	-368	-0.7%
Colorado	6,149	5,939	-210	-3.4%	6,413	265	4.3%	6,198	50	0.8%
Connecticut	4,847	4,683	-164	-3.4%	4,945	98	2.0%	4,728	-119	-2.5%
Delaware	1,475	1,392	-83	-5.6%	1,515	40	2.7%	1,412	-63	-4.3%
District of Columbia	1,452	1,450	-2	-0.1%	1,457	5	0.4%	1,450	-2	-0.1%
Florida	25,089	21,585	-3,504	-14.0%	25,748	659	2.6%	22,570	-2,519	-10.0%
Georgia	10,738	9,935	-802	-7.5%	10,968	230	2.1%	10,174	-564	-5.3%
Hawaii	1,183	1,140	-42	-3.6%	1,204	21	1.8%	1,153	-29	-2.5%
Idaho	1,997	1,866	-131	-6.6%	2,057	59	3.0%	1,950	-47	-2.4%
Illinois	9,574	8,991	-583	-6.1%	9,918	344	3.6%	9,266	-308	-3.2%
Indiana	8,609	8,447	-162	-1.9%	8,667	58	0.7%	8,495	-114	-1.3%
Iowa	3,905	3,751	-155	-4.0%	4,116	210	5.4%	3,863	-43	-1.1%
Kansas	2,189	1,994	-194	-8.9%	2,298	110	5.0%	2,086	-103	-4.7%
Kentucky	8,884	8,700	-184	-2.1%	8,945	61	0.7%	8,745	-139	-1.6%
Louisiana	7,801	7,608	-193	-2.5%	7,887	86	1.1%	7,673	-128	-1.6%
Maine	2,122	2,036	-86	-4.0%	2,170	48	2.3%	2,084	-38	-1.8%
Maryland	7,437	7,053	-383	-5.2%	7,614	178	2.4%	7,168	-269	-3.6%
Massachusetts	7,839	7,772	-67	-0.8%	7,867	28	0.4%	7,787	-52	-0.7%
Michigan	14,193	13,973	-219	-1.5%	14,298	106	0.7%	14,108	-85	-0.6%
Minnesota	6,923	6,820	-103	-1.5%	7,015	92	1.3%	6,852	-70	-1.0%
Mississippi	4,883	4,559	-325	-6.6%	4,959	76	1.6%	4,624	-259	-5.3%
Missouri	8,350	7,854	-497	-5.9%	8,521	171	2.0%	7,981	-369	-4.4%
Montana	2,308	2,222	-86	-3.7%	2,374	66	2.9%	2,292	-16	-0.7%
Nebraska	1,808	1,456	-353	-19.5%	1,986	178	9.8%	1,539	-270	-14.9%
Nevada	3,256	3,073	-183	-5.6%	3,317	61	1.9%	3,137	-119	-3.6%
New Hampshire	1,007	942	-65	-6.4%	1,034	27	2.7%	986	-22	-2.1%
New Jersey	7,192	6,967	-224	-3.1%	7,233	41	0.6%	7,014	-178	-2.5%
New Mexico	5,392	5,354	-38	-0.7%	5,412	20	0.4%	5,377	-15	-0.3%
New York	28,824	28,159	-665	-2.3%	29,061	236	0.8%	28,474	-351	-1.2%
North Carolina	15,863	14,142	-1,720	-10.8%	16,373	510	3.2%	14,407	-1,456	-9.2%
North Dakota	520	491	-28	-5.4%	541	22	4.2%	512	-8	-1.6%
Ohio	14,649	14,465	-184	-1.3%	14,770	120	0.8%	14,639	-10	-0.1%
Oklahoma	5,019	4,534	-485	-9.7%	5,215	196	3.9%	4,716	-303	-6.0%
Oregon	6,237	6,057	-180	-2.9%	6,337	100	1.6%	6,161	-76	-1.2%
Pennsylvania	16,375	15,777	-598	-3.7%	16,652	277	1.7%	16,080	-295	-1.8%
Rhode Island	1,347	1,290	-57	-4.2%	1,354	7	0.5%	1,297	-50	-3.7%
South Carolina	5,592	4,877	-715	-12.8%	5,737	145	2.6%	4,979	-613	-11.0%
South Dakota	887	801	-86	-9.7%	949	61	6.9%	844	-43	-4.9%
Tennessee	8,620	7,981	-639	-7.4%	8,835	215	2.5%	8,204	-416	-4.8%
Texas	33,106	31,743	-1,363	-4.1%	33,657	551	1.7%	32,465	-642	-1.9%
Utah	3,503	3,182	-321	-9.2%	3,603	100	2.9%	3,327	-176	-5.0%
Vermont	1,203	1,162	-42	-3.5%	1,210	6	0.5%	1,169	-35	-2.9%
Virginia	9,297	8,574	-723	-7.8%	9,579	282	3.0%	8,980	-317	-3.4%
Washington	8,197	7,989	-208	-2.5%	8,454	257	3.1%	8,173	-24	-0.3%
West Virginia	2,999	2,913	-86	-2.9%	3,041	43	1.4%	2,954	-45	-1.5%
Wisconsin	5,575	5,283	-292	-5.2%	5,807	231	4.1%	5,518	-58	-1.0%
Wyoming	583	447	-136	-23.3%	673	90	15.4%	496	-87	-15.0%
Total	**408,690**	**389,338**	**-19,352**	**-4.7%**	**416,854**	**8,164**	**2.0%**	**396,713**	**-11,977**	**-2.9%**

Source: Urban Institute Health Insurance Policy Simulation Model, 2019.

Table 4. Federal Health Care Spending on Marketplace Premium Tax Credits, (Billions of Dollars), Current Law Versus Reform, 2020

	Current Law ACA		Capped Provider Payment Rates or Public Option				Extend Premium Tax Credits above 400% FPL				Both Reforms Combined			
	Dollars	Percent	Dollars	Percent	Difference from Current Law	Percent Difference from Current Law	Dollars	Percent	Difference from Current Law	Percent Difference from Current Law	Dollars	Percent	Difference from Current Law	Percent Difference from Current Law
Total Federal Spending	**60.4**	**100%**	**40.2**	**100%**	**-20.1**	**-33.4%**	**68.4**	**100%**	**8.1**	**13.3%**	**47.5**	**100%**	**-12.9**	**-21.3%**
Family income below 150% FPL	21.0	35%	14.7	37%	-6.3	-30.0%	21.0	31%	0.0	0.1%	15.8	33%	-5.2	-24.6%
Family income 150 to 200% FPL	*19.9*	*33%*	*13.9*	*35%*	*-6.0*	*-30.1%*	*20.0*	*29%*	*0.0*	*0.2%*	*14.9*	*31%*	*-5.0*	*-25.1%*
Family income 200 to 300% FPL	*13.1*	*22%*	*8.2*	*20%*	*-4.9*	*-37.5%*	*13.1*	*19%*	*0.0*	*0.2%*	*9.0*	*19%*	*-4.1*	*-31.4%*
Family income 300 to 400% FPL	6.3	10%	3.4	9%	-2.9	-46.0%	6.4	9%	0.0	0.3%	3.9	8%	-2.5	-38.9%
Family income 400 to 600% FPL	0.0	0%	0.0	0%	0.0	nc	5.8	9%	5.8	na	3.0	6%	3.0	na
Family income above 600% FPL	0.0	0%	0.0	0%	0.0	nc	2.1	3%	2.1	na	0.8	2%	0.8	na

Source: Urban Institute Health Insurance Policy Simulation Model, 2019.

Notes: ACA = Affordable Care Act. FPL = federal poverty level.

Table 5. Aggregate Household Health Care Spending on Premiums and Out-of-Pocket Costs for the Nonelderly Population, by Income, (Billions of Dollars), Current Law Versus Reform, 2020

	Current Law ACA		Capped Provider Payment Rates or Public Option				Extend Premium Tax Credits above 400% FPL				Both Reforms Combined			
	Dollars	Percent	Dollars	Percent	Difference from Current Law	Percent Difference from Current Law	Dollars	Percent	Difference from Current Law	Percent Difference from Current Law	Dollars	Percent	Difference from Current Law	Percent Difference from Current Law
Household Health Care Spending	**561.3**	**100%**	**550.3**	**100%**	**-10.9**	**-1.9%**	**559.6**	**100%**	**-1.7**	**-0.3%**	**552.0**	**100%**	**-9.2**	**-1.6%**
Family income below 150% FPL	59.1	11%	58.2	11%	-0.8	-1.4%	59.1	11%	0.0	0.0%	58.5	11%	-0.6	-1.0%
Family income 150 to 200% FPL	*39.7*	*7%*	*39.1*	*7%*	*-0.6*	*-1.4%*	*39.8*	*7%*	*0.0*	*0.1%*	*39.2*	*7%*	*-0.5*	*-1.2%*
Family income 200 to 300% FPL	*92.7*	*17%*	*91.1*	*17%*	*-1.6*	*-1.7%*	*92.7*	*17%*	*0.1*	*0.1%*	*91.3*	*17%*	*-1.4*	*-1.5%*
Family income 300 to 400% FPL	88.5	16%	87.3	16%	-1.2	-1.4%	88.6	16%	0.0	0.1%	87.5	16%	-1.0	-1.2%
Family income 400 to 600% FPL	127.0	23%	124.0	23%	-2.9	-2.3%	125.2	22%	-1.8	-1.4%	123.8	22%	-3.1	-2.5%
Family income above 600% FPL	154.3	27%	150.5	27%	-3.8	-2.5%	154.3	28%	0.0	0.0	151.7	27%	-2.6	-1.7%

Source: Urban Institute Health Insurance Policy Simulation Model, 2019.

Notes: ACA = Affordable Care Act. FPL = federal poverty level.

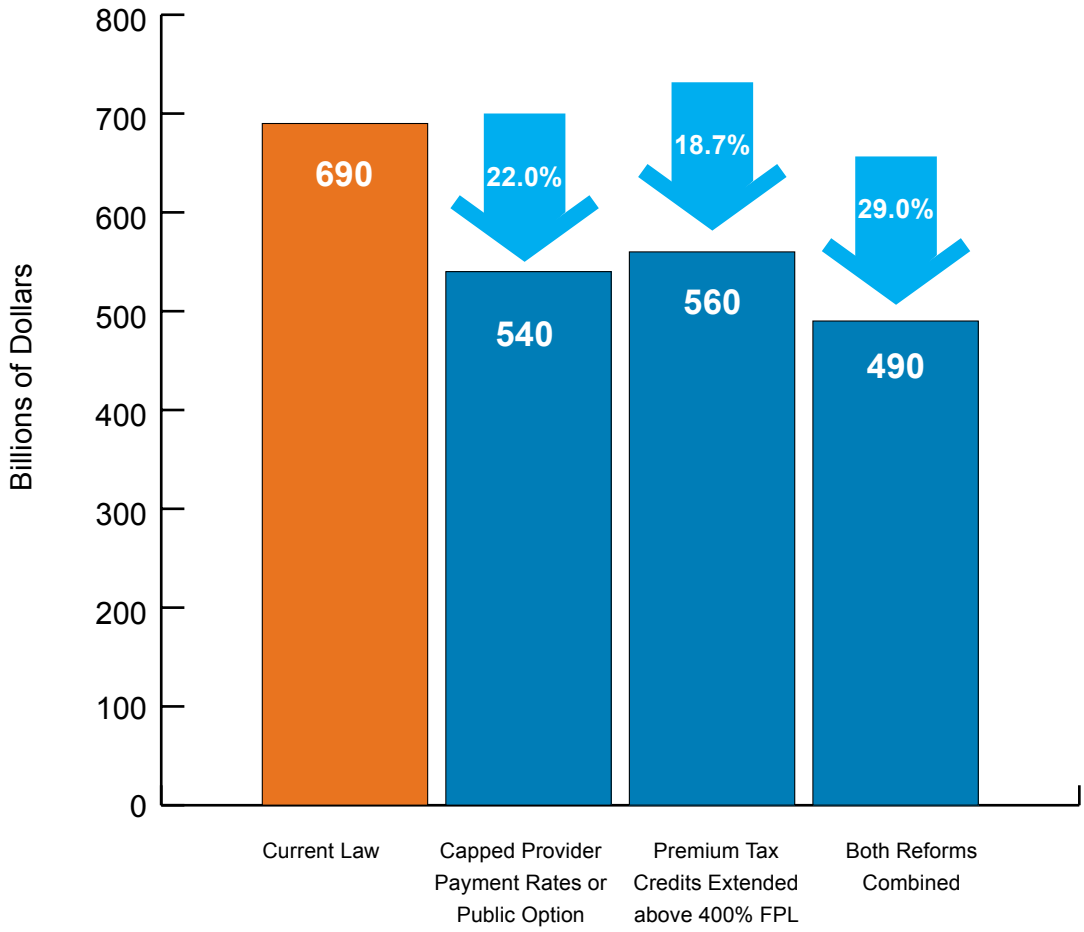
group essentially unchanged.

Both policies combined. With both policies in place, household spending on health care would fall by $9.2 billion in total, or 1.6 percent. The savings are similar to those under the provider payment rate cap/public option alone for those with incomes below 400 percent of FPL. People with incomes between 400 and 600 percent of FPL would save from both components of the reform. Among those with incomes above 600 percent of FPL, costs associated with larger numbers of people enrolling in insurance coverage would offset some of the savings from the provider payment rate cap/public option, saving those households $2.6 billion on health care.

Effect on Average Higher-Income Nongroup Enrollee Spending on Premiums and Out-of-Pocket Costs

Figure 2 shows how national average monthly health care spending (premiums plus out-of-pocket costs) by higher-income marketplace enrollees would be affected by the reform options. We focus this analysis on ACA-compliant nongroup enrollees with incomes above 400 percent of FPL because they would be most affected by the reforms, separately and combined: The capped provider payment rate/public option lowers spending the most for people paying the full premium out of pocket (e.g., those with incomes too high to qualify for premium tax credits under current law). In addition, the extension

Figure 2. Average Per Enrollee Monthly Spending on Premiums and Out-of-Pocket Costs by Nongroup Enrollees with Incomes above 400 Percent of the Federal Poverty Level (Dollars)



of the premium tax credits specifically increases affordability for some people with incomes above 400 percent of FPL.

We also show the average effects by state in Table 6, because the reforms' effects vary significantly across geographic areas. People living in states with higher premiums because of less competition would tend to save more with the capped rates/public plan than people living in states with highly competitive nongroup markets. The average savings from the extended tax credits would vary with the level of premiums under current law and the income distribution of nongroup enrollees with incomes above 400 percent of FPL (because tax credits decrease as income increases).

Capped provider payment rates/ public option. With capped provider payment rates or a public option, along with increased prescription drug rebates,

Table 6. Average Per Enrollee Monthly Spending on Premiums and Out-of-Pocket Costs by Nongroup Enrollees with Incomes above 400 Percent of the Federal Poverty Level (Dollars), by State, Current Law Versus Reform, 2020

State	Current Law	Capped Provider Payment Rates or Public Option			Extend Premium Tax Credits above 400% FPL			Both Reforms Combined		
	Dollars	Dollars	Difference	Percent Difference from Current Law	Dollars	Difference	Percent Difference from Current Law	Dollars	Difference	Percent Difference from Current Law
Alabama	710	415	-300	-41.8%	550	-165	-23.0%	415	-295	-41.6%
Alaska	1,240	710	-530	-42.8%	840	-400	-32.3%	640	-600	-48.5%
Arizona	685	500	-180	-26.6%	540	-145	-20.9%	480	-200	-29.5%
Arkansas	670	545	-120	-18.3%	615	-55	-8.2%	540	-130	-19.3%
California	650	595	-55	-8.3%	555	-95	-14.3%	515	-130	-20.5%
Colorado	870	690	-180	-20.4%	675	-195	-22.2%	615	-255	-29.3%
Connecticut	710	535	-175	-24.5%	580	-130	-18.3%	485	-225	-31.8%
Delaware	875	505	-375	-42.6%	590	-290	-32.8%	455	-420	-47.9%
District of Columbia	555	510	-50	-8.6%	530	-30	-5.3%	400	-160	-28.5%
Florida	750	560	-190	-25.3%	585	-165	-21.7%	505	-240	-32.2%
Georgia	640	460	-180	-27.8%	525	-115	-17.9%	440	-200	-31.2%
Hawaii	660	455	-200	-30.7%	545	-115	-17.3%	425	-230	-35.0%
Idaho	655	520	-135	-20.5%	490	-165	-25.3%	445	-210	-31.8%
Illinois	705	510	-195	-27.7%	560	-145	-20.3%	470	-230	-33.0%
Indiana	685	455	-225	-33.2%	620	-65	-9.2%	470	-215	-31.5%
Iowa	940	680	-260	-27.7%	580	-360	-38.2%	500	-440	-46.7%
Kansas	800	565	-235	-29.4%	575	-225	-28.4%	495	-305	-38.0%
Kentucky	725	465	-255	-35.4%	605	-120	-16.6%	460	-265	-36.7%
Louisiana	735	520	-215	-29.6%	620	-115	-15.5%	495	-240	-33.0%
Maine	845	665	-180	-21.2%	620	-230	-27.1%	565	-285	-33.4%
Maryland	675	415	-260	-38.4%	580	-95	-14.0%	435	-240	-35.6%
Massachusetts	575	535	-35	-6.3%	555	-20	-3.6%	520	-55	-9.5%
Michigan	585	505	-80	-13.5%	520	-60	-10.6%	485	-100	-17.0%
Minnesota	625	510	-110	-17.9%	545	-80	-12.9%	465	-160	-25.8%
Mississippi	860	430	-430	-50.2%	675	-185	-21.7%	440	-420	-49.0%
Missouri	705	465	-235	-33.6%	555	-150	-21.1%	445	-255	-36.4%
Montana	825	640	-185	-22.5%	565	-260	-31.4%	515	-310	-37.4%
Nebraska	900	570	-330	-36.5%	530	-370	-41.1%	420	-480	-53.2%
Nevada	705	435	-270	-38.1%	585	-120	-17.2%	460	-240	-34.3%
New Hampshire	640	465	-175	-27.3%	535	-105	-16.3%	465	-175	-27.6%
New Jersey	575	455	-120	-21.1%	550	-25	-4.1%	460	-115	-20.1%
New Mexico	635	520	-115	-18.0%	540	-90	-14.5%	485	-145	-23.0%
New York	765	700	-65	-8.8%	670	-95	-12.6%	630	-135	-17.8%
North Carolina	770	500	-275	-35.5%	520	-255	-32.8%	420	-350	-45.4%
North Dakota	715	540	-180	-24.9%	560	-155	-21.7%	500	-220	-30.5%
Ohio	630	525	-105	-16.7%	555	-75	-11.9%	520	-110	-17.7%
Oklahoma	660	455	-205	-31.1%	410	-250	-38.0%	355	-305	-46.1%
Oregon	635	495	-140	-21.9%	520	-115	-18.1%	460	-170	-27.0%
Pennsylvania	710	525	-185	-26.1%	580	-130	-18.6%	485	-225	-31.8%
Rhode Island	680	475	-205	-30.3%	615	-65	-9.8%	470	-210	-30.8%
South Carolina	715	445	-275	-38.2%	515	-200	-28.0%	410	-310	-43.0%
South Dakota	755	560	-195	-25.9%	535	-220	-29.0%	465	-290	-38.4%
Tennessee	645	435	-210	-32.7%	475	-170	-26.2%	395	-250	-38.5%
Texas	590	470	-120	-20.5%	485	-100	-17.4%	440	-150	-25.7%
Utah	590	470	-125	-21.0%	410	-180	-30.4%	385	-210	-35.2%
Vermont	745	545	-205	-27.2%	705	-40	-5.7%	555	-195	-25.9%
Virginia	720	520	-200	-27.7%	560	-160	-22.5%	490	-230	-32.2%
Washington	845	695	-150	-17.8%	685	-160	-18.9%	610	-235	-27.6%
West Virginia	830	440	-395	-47.2%	600	-230	-27.9%	455	-375	-45.1%
Wisconsin	810	670	-140	-17.4%	595	-215	-26.3%	560	-250	-31.0%
Wyoming	1,155	675	-480	-41.6%	635	-520	-45.2%	520	-635	-54.9%
National Average	**690**	**540**	**-150**	**-22.0%**	**560**	**-130**	**-18.7%**	**490**	**-200**	**-29.0%**

Source: Urban Institute Health Insurance Policy Simulation Model, 2019.

Notes: ACA = Affordable Care Act.

the average higher-income nongroup enrollee would spend $150 less per month in premiums and out-of-pocket costs than under current law. Average monthly savings range from $530 in Alaska, a particularly high-cost, low-competition state (current-law average spending for this group is $1,240 per month) and $480 in Wyoming (current-law average spending of $1,155 per month) and down to $35 in Massachusetts, $50 in the District of Columbia, and $55 in California, states with considerably lower current-law spending and competitive nongroup insurance markets.

Extension of premium tax credits to people with incomes above 400 percent of FPL. Average monthly savings per higher-income enrollee with the extended tax credits alone would be similar to those under the capped provider payment rates/public option reform, at $130. However, the savings would be distributed somewhat differently because the enrollee income distribution above 400 percent FPL would play a bigger role here, in addition to current-law premium levels. Average spending would be more than 35 percent lower compared with current law in Iowa, Oklahoma, Nebraska, and Wyoming, all of which have high current-law premiums and are not high-income states. Alaska, Delaware, Montana, and North Carolina enrollees with incomes above 400 percent of FPL would also see large relative savings for similar reasons. At the other end of the spectrum, states like the District of Columbia, Massachusetts, New Jersey, and Vermont that have lower current-law premiums and higher income distribution above 400 percent of FPL would experience very little savings.

Both policies combined. The two policies combined would lead to average enrollee health care savings greater than either policy implemented in isolation. Average higher-income household savings under the combined approach would exceed 45 percent in nine states: Alaska, Delaware, Iowa, Mississippi, Nebraska, North Carolina, Oklahoma, West Virginia, and Wyoming. States where enrollees would save the least in percentage terms include Massachusetts (9.5 percent), Michigan (17.0 percent), and Ohio (17.7 percent).

Discussion

An array of improvements to the ACA and more comprehensive reforms to the health insurance system have been introduced in Congress and are being debated in the context of the 2020 presidential election. All provide particular advantages and tradeoffs. Centrally, the greater the increases in household affordability, the greater the additional federal government cost. Simultaneously, there is a growing recognition that high premiums in some geographic areas are driven by high average payment rates to health care providers, because of consolidation of hospital and health systems, lack of competition among insurers, or a combination of the two.

Consequently, we present a limited package of reforms that, when taken together, would improve health insurance coverage affordability among a limited population without necessitating an increase in government revenues. This set of reforms would extend the top ACA premium tax credit percent-of-income cap above 400 percent of FPL and would either cap the provider payment rates insurers in the ACA-compliant nongroup insurance markets pay at approximately Medicare levels or introduce a public plan option in those markets that would pay providers at those same rates.

The chief beneficiaries of this set of reforms would be those currently ineligible for ACA premium tax credits in the nongroup market because their incomes exceed 400 percent of FPL. We estimate that the number of people with comprehensive health insurance coverage would increase by 1.2 million, and the average monthly health care spending by nongroup insurance enrollees with incomes above 400 percent of FPL would decrease by $200 in 2020, or 29 percent. In addition, federal government spending would decrease by $12.0 billion in 2020, or 2.9 percent of current-law spending on marketplace subsidies and Medicaid acute care for the nonelderly.

In these estimates, we assume that either a public option or capped provider payment rates in the nongroup insurance market would bring down the marketplace benchmark premiums to approximately Medicare payment rate levels. Though this is possible, levels at which insurers pay providers vary widely in the current commercial insurance markets, and there would certainly be political resistance from providers in reducing payment levels. The nongroup market is a small part of total health care spending, and thus system-wide disruption to limiting payment rates only in these markets would likely be very small. However, the efficient level of pricing across providers of different types and across geographic areas is not knowable, a priori, and maintaining sufficient access to and quality of care may require higher payment rates at least in some areas (e.g., rural areas) and to some types of providers. In that case, federal and household savings from these types of policies would be somewhat lower than estimated here. In addition, if the federal government did not require prescription drug rebates as large as those assumed here, federal and household savings would be lower as well.

Extending the premium tax credits alone, without regulation of rates or a public option, would increase federal government costs by $8.2 billion in 2020 and would reduce household health care spending by nongroup purchasers in this higher-income group by about 19 percent. Still, limiting provider payment rates or introducing a public option using payment rates lower than the current private insurer average but still somewhat higher than Medicare's rates could improve affordability for this population while producing some smaller government savings.

Appendix. Eligibility for Advanced Premium Tax Credits under Extension and Enrollment in Nongroup Coverage among People in Families with Income above 400 Percent of the Federal Poverty Level, by Current-Law Insurance Status, 2020 (People in Thousands)

				Enrollment in Nongroup Coverage after Extension of APTCs	
	Number (Thousands)	% of Total with That Current Law Coverage Type		Number (Thousands)	Percent Enrolling in Nongroup Coverage under Extension of Credits
Number of People with Incomes above 400 Percent of FPL Enrolled in ACA-Compliant Nongroup Market under Current Law	**3,900**	**100%**		**3,894**	**100%**
Not technically eligible for APTC (not legally present or has an affordable ESI offer in family)	1,486	38%		1,483	100%
Technically eligible for APTC (legally present and without an affordable ESI offer; before testing income vs. premium)	2,414	62%		2,411	100%
Income too high to qualify for APTC greater than zero	1,126	29%		1,124	100%
Newly eligible for nonzero APTC under the extended tax credit	1,288	33%		1,288	100%
Eligible for an APTC that would lower their premium by less than 20%	262	7%		262	100%
Eligible for an APTC that would lower their premium by 20% to 40%	293	8%		293	100%
Eligible for an APTC that would lower their premium by 40% to 60%	284	7%		284	100%
Eligible for an APTC that would lower their premium more than 60%	449	12%		449	100%
Number of Uninsured People with Incomes above 400 Percent of FPL	3,179	100%		514	16%
Not technically eligible for APTC (not legally present or has an affordable ESI offer in family)	1,482	47%		15	1%
Technically eligible for APTC (legally present and without an affordable ESI offer; before testing income vs. premium)	1,698	53%		499	29%
Income too high to qualify for APTC greater than zero	830	26%		73	9%
Newly eligible for nonzero APTC under the extended tax credit	868	27%		429	49%
Eligible for an APTC that would lower their premium by less than 20%	210	7%		32	15%
Eligible for an APTC that would lower their premium by 20% to 40%	214	7%		87	40%
Eligible for an APTC that would lower their premium by 40% to 60%	184	6%		119	65%
Eligible for an APTC that would lower their premium more than 60%	259	8%		191	74%
Number of People with Incomes above 400 Percent of FPL Currently Enrolled in Noncompliant Coverage	1,038	100%		347	33%
Not technically eligible for APTC (not legally present or has an affordable ESI offer in family)	418	40%		5	1%
Technically eligible for APTC (legally present and without an affordable ESI offer; before testing income vs. premium)	621	60%		343	55%
Income too high to qualify for APTC greater than zero	303	29%		150	50%
Currently noncompliant insured, newly eligible for nonzero APTC under the extended tax credit	318	31%		192	60%
Eligible for an APTC that would lower their premium by less than 20%	69	7%		26	38%
Eligible for an APTC that would lower their premium by 20% to 40%	82	8%		47	57%
Eligible for an APTC that would lower their premium by 40% to 60%	74	7%		50	68%
Eligible for an APTC that would lower their premium more than 60%	94	9%		69	74%

Source: Urban Institute Health Insurance Policy Simulation Model, 2019.

Notes: FPL = federal poverty level. ACA = Affordable Care Act. APTC = advanced premium tax credit. ESI = employer-sponsored insurance.

NOTES

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