Cost and Coverage Implications of Five Options for Increasing Marketplace Subsidy Generosity

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An estimated 21 million people have gained health insurance coverage under the Affordable Care Act (Blumberg et al. 2020). Since 2014, the law's expansion of Medicaid eligibility (taken up by 37 states and pending in 2 more as of February 2021) and provision of subsidies for modest-income people purchasing private nongroup insurance coverage have been the two largest sources of coverage increases. And though national surveys show affordability of coverage has improved and households' concerns with health care financial burdens have decreased significantly,[1] nonetheless, affordability remains the greatest barrier to further gains in coverage (Haley and Wengle 2021; Pollitz et al. 2020).

Some uninsured people are likely unaware of the availability of subsidized insurance and their eligibility for it, but cost remains a barrier for many (Haley and Wengle 2021). Evidence indicates program participation among those eligible for free or almost free public insurance through Medicaid and the Children's Health Insurance Program (CHIP) is high (Simpson 2020), as is enrollment among those eligible for the most generous Marketplace subsidies. However, the value of these subsidies declines with income, and subsidies are unavailable for those with incomes above 400 percent of the federal poverty level (FPL). Thus, enrollment in subsidized coverage is lower among people with higher incomes. For example, consistent with public Marketplace data on enrollment by income group, the Urban Institute estimates more than 60 percent of otherwise uninsured people with incomes below 200 percent of FPL and eligible for Marketplace subsidies enroll in such coverage, compared with only 24 percent of their counterparts with incomes between 200 and 400 percent of FPL (data not shown).

But, even among some enrolled in subsidized Marketplace coverage, out-of-pocket cost requirements (i.e., deductibles, coinsurance, copayments) can pose significant barriers to accessing care (KFF 2020).

Consequently, policy experts and policymakers have proposed enhancing the generosity of Marketplace subsidies and extending them to more people, such as those with incomes above 400 percent of FPL.[2] The trade-offs of enhancing Marketplace subsidies are clear: More generous subsidies and expanded eligibility will reduce both the number of uninsured people and the financial burdens on enrollees. However, the greater the generosity of the subsidies and the more people eligible, the higher the cost to the government.

Research and real-world experience are also clear: Universal coverage cannot be reached through generous subsidies alone. Some people will remain uninsured even if coverage is offered at no cost to enrollees. Still, increased assistance, coupled with substantial education and outreach efforts and qualified enrollment assistance, will increase insurance coverage. And, lower out-of-pocket cost requirements will provide greater access to care for people with modest incomes.

Here, we explore the implications of five alternative Marketplace subsidy schedules, all providing more generous premium tax credit and cost-sharing assistance than that available under current law. All options would extend financial assistance to those with incomes above 400 percent of FPL, but how much they increase assistance for people in different income groups varies. We show the implications of each alternative subsidy schedule for overall insurance coverage, coverage by income group, and federal government costs. Each approach would also provide additional financial assistance to those enrolled in nongroup insurance coverage, and we provide findings for that population as well.

This brief does not address one of the most significant health insurance gaps under current law: that facing many adults with incomes below the federal poverty level who live in states that have not expanded Medicaid eligibility under the ACA. Adults in these states who are not categorically eligible for Medicaid under pre-ACA rules and have incomes too low to qualify for Marketplace assistance are denied eligibility for Medicaid because their states have chosen not to expand eligibility to them. Other Urban Institute analyses provide estimates of the implications of these states expanding or extending subsidized coverage to this population through the Marketplaces (Blumberg et al. 2019; Buettgens 2021).

Methods

The estimates presented here are produced using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). 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. The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years.

HIPSM is based on two years of the American Community Survey, which provides a representative sample of families large enough for us to produce estimates for individual states and smaller regions, such as cities. The model is designed to incorporate timely, real-world data to the extent they are available. In particular, we regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models, as assessed by outside experts (Glied, Arora, and Solís-Román 2015). A detailed description of HIPSM can be found on the Urban Institute website (Buettgens and Banthin 2020).

All estimates are for US residents under age 65, and reforms are presented as if fully implemented in 2022.

For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.[3] This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates. However, it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

Policies Simulated

Consistent with current law, the alternative subsidy schedules we analyze are structured as premium tax credits and cost-sharing reductions. The premium tax credits limit the share of income a single person or family must pay to enroll in benchmark insurance coverage. Under current law, the benchmark plan is the silver plan (70 percent actuarial value) with the second-lowest premium offered in an enrollee's area of residence. Under each alternative option, the benchmark plan would be the second-lowest-premium gold plan (80 percent actuarial value) offered in an area of residence. People choosing to enroll in a lower-priced plan would pay less, and those choosing a more expensive plan would pay the full difference between their plan's premium and that for benchmark coverage.

Cost-sharing subsidies are available to income-eligible people enrolling in benchmark *level* coverage (i.e., silver today, but gold under the alternatives estimated). These subsidies increase the actuarial value of the insurance enrollees receive for the premiums they pay for benchmark-level coverage, thereby lowering household out-of-pocket costs associated with the coverage.

Table 1 shows premium tax credit and cost-sharing schedules under current law and the five alternative options modeled.

TABLE 1

Current-Law and Alternative Marketplace Subsidy Schedules Modeled

	Premium Tax Credit Percentage-of-Income Limits for Benchmark Coverage					
	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Benchmark plan	**Silver**	**Gold**	**Gold**	**Gold**	**Gold**	**Gold**
Income (% of FPL)						
< 138	2.07	0.0–1.0	0.0	0.0	0.0	0.0
138–150	3.10–4.14	1.0–2.0	0.0	0.0	0.0	0.0
150–200	4.14–6.52	2.0–4.0	0-3.0	0-3.0	0.0–3.0	0.0–3.0
200–250	6.52–8.33	4.0–6.0	3.0-4.0	3.0–4.0	3.0–4.0	3.0-4.0
250–300	8.33–9.83	6.0–7.0	4.0–6.0	4.0–6.0	4.0–6.0	4.0–6.0
300–400	9.83	7.0-8.5	6.0–8.5	6.0–8.5	6.0–8.5	6.0–8.5
400–500	—	8.5	8.5–10.0	8.5	8.5–10.0	8.5–10.0
500–600	—	8.5	10.0–12.0	8.5	10.0–12.0	10.0
600+	—	8.5	12.0	8.5	12.0	10.0
	Cost-Sharing Reductions: Actuarial Value of Plan Provided to Eligible Enrollees in Benchmark-Level Plans (%)					
	Current Law	Option 1	Option 2	Option 3	Option 4	Option 5
Income (% of FPL)						
< 138	94	95	94	94	95	94
138–150	94	95	94	94	95	94
150–200	87	95	87	87	95	87
200–250	73	90	87	87	90	87
250–300	70	90	87	87	90	87
300–400	70	85	80	80	85	80
400–500	70	80	80	80	80	80
500–600	70	80	80	80	80	80
600+	70	80	80	80	80	80

Source: Current-law premium tax credit percentage-of-income limits are data provided by the Internal Revenue Service and available at https://www.irs.gov/pub/irs-drop/rp-20-36.pdf.

Notes: FPL = federal poverty level. Dashes are used for the income ranges ineligible for premium tax credits under current law.

All reform options simulated maintain current-law prohibitions on providing Marketplace subsidies to people not legally residing in the US, people with offers of employer-sponsored insurance deemed affordable in the family, and people eligible for public insurance coverage. The only people with incomes below the federal poverty level eligible for Marketplace subsides are those who have legally immigrated to the US within the prior five years and would be eligible for Medicaid if they had been in the US longer.

Results

Coverage

Under current law, we estimate 30.8 million people will be uninsured in 2022, approximately 11 percent of the nonelderly population (table 2). An additional 2.6 million people are estimated to have short-term, limited-duration plans, which do not comply with ACA regulatory rules, such as coverage of essential health benefits, guaranteed issue to all applicants, and modified community rating.[4] Thus, an estimated 33.3 million nonelderly people will go without minimum essential coverage in 2022.

All of the alternative premium tax credit schedules and cost-sharing subsidy schedules simulated are more generous than those offered under current law. However, their generosity varies at different points in the income distribution. Options 2 through 5 are more generous than option 1 for those with incomes up to 400 percent of FPL, and options 1 and 3 are more generous for those with incomes above 400 percent of FPL. Options 1 and 4 include more generous cost-sharing subsidies for people with incomes up to 400 percent of FPL than do options 2, 3, and 5.

Though the generosity of the alternative schedules differs by income, each option would significantly increase the number of people with insurance coverage. Across the five options, the number of people uninsured would fall by 4.2 to 4.4 million. The largest decrease would result from option 1, under which approximately 4.4 million fewer people would be uninsured and another 160,000 people would move from short-term, limited-duration plans to minimum essential coverage. Consequently, the uninsurance rate would fall to about 9.5 percent of the nonelderly population.

TABLE 2

Coverage among the Nonelderly Population under Current Law and Alternative Subsidy Schedules, 2022

Coverage under current law and reforms (thousands of people)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Insured (minimum essential coverage)	**244,113**	**248,629**	**248,368**	**248,413**	**248,638**	**248,385**
Employer	*149,325*	*148,272*	*148,588*	*148,563*	*148,238*	*148,580*
Private nongroup	*14,960*	*20,198*	*19,637*	*19,703*	*20,240*	*19,660*
Basic Health Program	864	*866*	866	866	*866*	866
Marketplace with PTC	8,483	*14,034*	13,119	13,616	*13,698*	13,304
Marketplace without PTC	1,268	*1,015*	1,086	1,024	*1,058*	1,062
Non-Marketplace	4,346	*4,283*	4,567	4,197	*4,619*	4,428
Medicaid/CHIP	*71,162*	*71,494*	*71,479*	*71,482*	*71,494*	*71,480*
Other public	*8,665*	*8,665*	*8,665*	*8,665*	*8,665*	*8,665*
Uninsured (no minimum essential coverage)	***33,333***	***28,817***	***29,078***	***29,033***	***28,808***	***29,061***
Uninsured	30,766	26,413	26,598	26,560	26,433	26,583
Short-term, limited-duration plans	2,567	2,405	2,480	2,473	2,375	2,478
Total	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**

Change from current law (thousands of people)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Insured (minimum essential coverage)	**—**	**4,516**	**4,256**	**4,300**	**4,525**	**4,272**
Employer	—	*-1,053*	*-738*	*-763*	*-1,087*	*-745*
Private nongroup	—	*5,237*	*4,677*	*4,743*	*5,280*	*4,700*
Basic Health Program	—	2	2	2	2	2
Marketplace with PTC	—	5,551	4,635	5,133	5,215	4,821
Marketplace without PTC	—	-253	-181	-244	-210	-206
Non-Marketplace	—	-63	221	-148	273	83
Medicaid/CHIP	—	*332*	*317*	*320*	*332*	*318*
Other public	—	*0*	*0*	*0*	*0*	*0*
Uninsured (no minimum essential coverage)	**—**	**-4,516**	**-4,256**	**-4,300**	**-4,525**	**-4,272**
Uninsured	—	-4,353	-4,168	-4,206	-4,333	-4,183
Short-term, limited-duration plans	—	-163	-87	-94	-192	-89
Total	**—**	**0**	**0**	**0**	**0**	**0**

Change from current law (%)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Insured (minimum essential coverage)	**—**	**1.8**	**1.7**	**1.8**	**1.9**	**1.8**
Employer	—	*-0.7*	*-0.5*	*-0.5*	*-0.7*	*-0.5*
Private nongroup	—	*35.0*	*31.3*	*31.7*	*35.3*	*31.4*
Basic Health Program	—	0.2	0.2	0.2	0.2	0.2
Marketplace with PTC	—	65.4	54.6	60.5	61.5	56.8
Marketplace without PTC	—	-19.9	-14.3	-19.2	-16.6	-16.3
Non-Marketplace	—	-1.5	5.1	-3.4	6.3	1.9
Medicaid/CHIP	—	*0.5*	*0.4*	*0.5*	*0.5*	*0.4*
Other public	—	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
Uninsured (no minimum essential coverage)	**—**	**-13.5**	**-12.8**	**-12.9**	**-13.6**	**-12.8**
Uninsured	—	-14.2	-13.5	-13.7	-14.1	-13.6
Short-term, limited-duration plans	—	-6.3	-3.4	-3.7	-7.5	-3.5
Total	**—**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Source: Health Insurance Policy Simulation Model, 2021.

Notes: PTC = premium tax credit. CHIP = Children's Health Insurance Program. A dash indicates the column heading does not apply. Reforms simulated in 2022.

The Uninsured by Income Group

Table 3 shows the number of uninsured in four income groups under current law and each alternative subsidy schedule analyzed. Under any option, the largest reductions in the number of uninsured people would occur within the 200 to 400 percent of FPL income group; roughly 2.5 million additional people in that group would have insurance coverage, about a 30 percent increase. This increase is

largest because all of the alternative schedules would provide significantly more financial assistance for this income group, which has a large number of uninsured people (8.1 million) under current law.

TABLE 3

The Uninsured Nonelderly Population under Current Law and Alternative Subsidy Schedules, 2022

	Income Group				
	< 138% of FPL	138–200% of FPL	200–400% of FPL	> 400% of FPL	All incomes
Current law					
Thousands of people	13,523	5,057	8,062	4,124	30,766
Percentage of income group	16.5	16.4	11.0	4.5	11.1
Option 1					
Thousands of people	13,251	4,395	5,523	3,244	26,413
Percentage of income group	16.1	14.2	7.6	3.6	9.5
Change from current law					
Thousands of people	-272	-663	-2,539	-880	-4,353
Percent	-2.0	-13.1	-31.5	-21.3	-14.2
Option 2					
Thousands of people	13,252	4,469	5,592	3,285	26,598
Percentage of income group	16.1	14.5	7.6	3.6	9.6
Change from current law					
Thousands of people	-271	-589	-2,470	-839	-4,168
Percent	-2.0	-11.6	-30.6	-20.4	-13.5
Option 3					
Thousands of people	13,252	4,469	5,592	3,246	26,560
Percentage of income group	16.1	14.5%	7.7	3.6	9.6
Change from current law					
Thousands of people	-271	-589	-2,470	-877	-4,206
Percent	-2.0	-11.6%	-30.6	-21.3	-13.7
Option 4					
Thousands of people	13,252	4,378	5,521	3,283	26,433
Percentage of income group	16.1	14.2%	7.6	3.6	9.5
Change from current law					
Thousands of people	-271	-680	-2,542	-841	-4,333
Percent	-2.0%	-13.4	-31.5	-20.4	-14.1
Option 5					
Number	13,252	4,469	5,592	3,270	26,583
Percent of income group	16.1	14.5	7.7	3.6	9.6
Change from current law					
Thousands of people	-271	-589	-2,470	-854	-4,183
Percent	-2.0	-11.6	-30.6	-20.7	-13.6

Source: Health Insurance Policy Simulation Model, 2021.

Notes: FPL = federal poverty level. Reforms simulated in 2022.

The next largest reduction in uninsurance would occur among people in families with incomes over 400 percent of FPL. Each alternative schedule would make people in this income group eligible for Marketplace subsidies for the first time, but the number of uninsured people in this income group under current law is about half that in the 200 to 400 percent of FPL group. Uninsurance would fall by

840,000 to 880,000 people in this higher-income group, a roughly 20 percent reduction relative to current law.

The number of uninsured people with incomes below 138 percent of FPL would change little for several reasons. First, the approach analyzed here does not fill in the Medicaid eligibility gap in the 14 states that have not expanded Medicaid eligibility under the ACA. People with incomes from 138 to 200 percent of FPL would also make modest gains in coverage under these alternative schedules. Marketplace enrollment is already high among those with incomes below 200 percent of FPL, who are eligible for subsidies under current law. Thus, potential gains in health coverage from increasing subsidies for this group are limited.[5]

Spending

Table 4 shows the implications of each option for health care spending by households, federal and state governments, employers, and providers (in the form of uncompensated care) in 2022.

Households. Premium spending would fall under each option, leading to household premium savings ranging from $6.4 billion under option 1 to $9.1 billion under option 3, the most generous of the premium tax credit schedules. Out-of-pocket spending would increase under each option, as more people are insured and more nongroup insurance enrollees face lower cost-sharing requirements, leading both groups to use more medical care than they do under current law. The five options simulated use only two different cost-sharing schedules, and either would increase household spending by less than 1 percent overall. National household health care spending would fall by $5.0 to $8.1 billion, depending on the option. Option 4 offers households the greatest savings and option 2 offers the least, yet all alternatives would lead to significant savings for nongroup insurance enrollees relative to current law.

Federal government. Additional federal government spending would be $23.0 billion (under option 1) to $25.7 billion (under option 4) higher than under current law, depending on the option. The more generous premium tax credits, which are more costly to provide than the more generous cost-sharing subsidies, account for most of increased spending under each option. Federal spending on Medicaid/CHIP would increase very modestly, mostly from more adult Marketplace applicants discovering that their children are eligible for Medicaid or CHIP. As coverage increases under any option, the demand for uncompensated care decreases, leading to some federal savings that offset the cost increases of publicly subsidized programs. We estimate the full potential federal savings on uncompensated care, but decreased demand does not translate directly to decreased spending on uncompensated care. Explicit policy action is required to fully realize these savings.

TABLE 4

Health Care Spending for the Nonelderly Population under Current Law and Alternative Subsidy Schedules, 2022

Spending under current law and reforms (millions of dollars)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Household						
Premiums	300,270	293,821	292,511	291,175	292,029	292,052
Other health care spending	287,587	287,858	290,392	290,453	287,720	290,411
Subtotal	*587,856*	*581,680*	*582,903*	*581,629*	*579,749*	*582,463*
Federal government						
Medicaid/CHIP	376,113	377,907	377,831	377,849	377,903	377,838
Marketplace PTC and reinsurance	59,591	78,877	81,879	83,725	81,406	82,464
Marketplace CSR	0	7,756	4,798	4,798	7,796	4,798
Uncompensated care	31,400	25,597	25,856	25,745	25,691	25,827
Subtotal	*467,105*	*490,137*	*490,364*	*492,118*	*492,796*	*490,928*
State government						
Medicaid/CHIP	199,944	200,714	200,684	200,693	200,711	200,689
Marketplace PTC	398	0	0	0	0	0
Marketplace CSR	46	0	0	0	0	0
Reinsurance	357	0	0	0	0	0
Uncompensated care	19,625	15,998	16,160	16,091	16,057	16,142
Subtotal	*220,370*	*216,713*	*216,844*	*216,783*	*216,768*	*216,830*
Employers						
Premium contributions	800,116	794,048	795,866	795,713	793,865	795,819
Providers						
Uncompensated care	27,475	22,397	22,624	22,527	22,480	22,598
Total, all payers	2,102,923	2,104,975	2,108,602	2,108,769	2,105,658	2,108,639

Change from current law (millions of dollars)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Household						
Premiums	—	-6,448	-7,759	-9,094	-8,240	-8,218
Other health care spending	—	272	2,805	2,867	133	2,825
Subtotal	—	*-6,177*	*-4,954*	*-6,228*	*-8,107*	*-5,393*
Federal government						
Medicaid/CHIP	—	1,794	1,717	1,736	1,789	1,725
Marketplace PTC and reinsurance		19,286	22,288	24,134	21,815	22,873
Marketplace CSR	—	7,756	4,798	4,798	7,796	4,798
Uncompensated care	—	-5,803	-5,545	-5,656	-5,709	-5,574
Subtotal	—	*23,032*	*23,259*	*25,013*	*25,691*	*23,823*

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
State government						
Medicaid/CHIP	—	771	741	749	768	745
Marketplace PTC	—	-398	-398	-398	-398	-398
Marketplace CSR	—	-46	-46	-46	-46	-46
Reinsurance	—	-357	-357	-357	-357	-357
Uncompensated care	—	-3,627	-3,465	-3,535	-3,568	-3,484
Subtotal	—	*-3,658*	*-3,526*	*-3,587*	*-3,602*	*-3,540*
Employers						
Premium contributions	—	-6,068	-4,250	-4,403	-6,251	-4,296
Providers						
Uncompensated care	—	-5,078	-4,852	-4,949	-4,996	-4,877
Total, all payers	**—**	**2,052**	**5,679**	**5,847**	**2,735**	**5,716**

Change from current law (%)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Household						
Premiums	—	-2	-3	-3	-3	-3
Other health care spending	—	0	1	1	0	1
Subtotal	—	*-1*	*-1*	*-1*	*-1*	*-1*
Federal government						
Medicaid/CHIP	—	0	0	0	0	0
Marketplace PTC and reinsurance		32	37	40	37	38
Marketplace CSR	—	—	—	—	—	—
Uncompensated care	—	-18	-18	-18	-18	-18
Subtotal	—	*5*	*5*	*5*	*6*	*5*
State government						
Medicaid/CHIP	—	0	0	0	0	0
Marketplace PTC	—	-100	-100	-100	-100	-100
Marketplace CSR	—	-100	-100	-100	-100	-100
Reinsurance	—	-100	-100	-100	-100	-100
Uncompensated care	—	-18	-18	-18	-18	-18
Subtotal	—	*-2*	*-2*	*-2*	*-2*	*-2*
Employers						
Premium contributions	—	-1	-1	-1	-1	-1
Providers						
Uncompensated care	—	-18	-18	-18	-18	-18
Total, all payers	**—**	**0**	**0**	**0**	**0**	**0**

Source: Health Insurance Policy Simulation Model, 2021.

Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. A dash in the current law column indicates the column is irrelevant to measuring change. A dash in the percent change row for Marketplace CSRs indicates a percent change cannot be calculated because the current-law value is zero. Reforms simulated in 2022.

We also assume state-specific reinsurance programs, to which the federal government currently contributes some pass-through funds to account for premium tax credit savings, would be eliminated under each option. We assume this because reinsurance programs currently subsidize premiums for people paying the full costs associated with nongroup insurance coverage. Because the reform options considered here would provide premium subsidies for people with incomes above 400 percent of FPL spending more than a specified percentage of income, the reinsurance programs would no longer be needed.

State government. A few state governments provide supplemental Marketplace subsidies to some residents, and the reforms considered here would allow them to save those state funds. Though state Medicaid/CHIP spending would increase slightly, as explained above, state savings resulting from the decrease in demand for uncompensated care could more than offset it. Consequently, state government spending on health care is estimated to decrease by roughly $3.5 billion under each option. However, state spending on uncompensated care does not automatically fall commensurate with decreased demand for it; to fully realize such savings, state policymakers must act to decrease spending on uncompensated care.

Employers. We estimate modest declines in employer-sponsored insurance coverage as the generosity of nongroup subsidies increases under the reform options. Consequently, we estimate employer spending on health insurance premiums would fall by about 1 percent under each option.

Providers. Provider in-kind spending on uncompensated care is estimated to be directly related to the number of uninsured people in the US. As coverage increases with greater subsidy generosity, demand for uncompensated care will fall. We estimate provider spending on uncompensated care would fall by approximately $5.0 billion nationally under each reform approach.

Average household spending by nongroup enrollees. Table 5 shows average household spending on premiums and out-of-pocket costs for people enrolled in nongroup insurance coverage under current law and each alternative subsidy schedule. Spending is computed as the per person average within each household for people with nongroup insurance coverage under current law and each reform option.

In 2022, average per person household premium spending for nongroup coverage under current law is estimated to be $2,768 and average out-of-pocket spending on health care is estimated to be $2,157, totaling just under $5,000. Each alternative subsidy schedule analyzed would lower average total household health care spending for nongroup insurance enrollees by more than $1,100 annually, with most of those savings attributable to lower household premium contributions. Option 4, which heavily subsidizes costs for the lowest-income enrollees and uses the more generous cost-sharing subsidy schedule of the two analyzed, would lead to the largest average savings, almost $1,400 per year. Option 2, the approach that would use the same premium tax credit schedule as option 4 but with a less generous cost-sharing subsidy, would lead to the smallest average savings, $1,182.

TABLE 5

Average per Person Household Spending on Premiums and Out-of-Pocket Health Care Costs for Nonelderly People with Nongroup Coverage under Current Law and Alternative Subsidy Schedules, 2022

	Premiums	Out-of-Pocket Costs	Total
Current Law			
Dollars	2,768	2,157	4,926
Option 1			
Dollars	1,850	1,813	3,663
Change from current law			
Dollars	-919	-344	-1,263
Percent	-33.2	-15.9	-25.6
Option 2			
Dollars	1,799	1,945	3,744
Change from current law			
Dollars	-970	-212	-1,182
Percent	-35.0	-9.8	-24.0
Option 3			
Dollars	1,728	1,949	3,677
Change from current law			
Dollars	-1,040	-208	-1,249
Percent	-37.6	-9.7	-25.3
Option 4			
Dollars	1,761	1,802	3,563
Change from current law			
Dollars	-1,008	-355	-1,363
Percent	-36.4	-16.5	-27.7
Option 5			
Dollars	1,774	1,946	3,721
Change from current law			
Dollars	-994	-211	-1,205
Percent	-35.9	-9.8	-24.5

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Note: Reforms simulated in 2022.

Table 6 shows the same measure, average total household health care spending for nongroup enrollees, but the averages are computed separately for three income groups. We find different subsidy schedules would lead to different distributions of savings across nongroup enrollees with different incomes. For example, options 1 and 3 would provide the largest premium subsidies to enrollees with higher incomes, resulting in the group with incomes above 400 percent of FPL saving the most, on average, under these approaches. Option 4 provides the most generous premium and cost-sharing subsidies to enrollees with lower incomes and would therefore lead to the highest average savings for people with incomes below 400 percent of FPL. On average, option 1's higher cost-sharing subsidies offset its somewhat lower premium subsidies for enrollees with lower incomes relative to other reform options.

Enrollment in gold plans would be expected to increase substantially, whereas enrollment in silver plans could fall, because the premium tax credits and cost-sharing assistance would be tied to the higher-value coverage under all approaches. Bronze-plan enrollment could also be expected to fall, because the more generous assistance would make this coverage less attractive for many current enrollees. However, the number of people able to enroll in bronze plans for no premium contribution would increase significantly under these approaches. Increased education and enrollment assistance would be necessary to ensure prospective and current enrollees (1) understand the trade-offs in premiums and out-of-pocket liabilities of choosing different actuarial-value plans and (2) can make enrollment decisions best suited to their needs.

TABLE 6

Average per Person Household Spending on Premiums and Out-of-Pocket Health Care Costs for Nonelderly People with Nongroup Coverage under Current Law and Alternative Subsidy Schedules, by Income Group, 2022

	Income Group			
	< 200% FPL	200–400% FPL	> 400% FPL	All incomes
Current Law				
Average household spending	2,482	5,339	8,919	4,926
Option 1				
Average household spending	1,837	3,503	6,799	3,663
Change from current law				
Dollars	-645	-1836	-2121	-1263
Percent	-26.0	-34.4	-23.8	-14.2
Option 2				
Average household spending	1,833	3,503	7,142	3,744
Change from current law				
Dollars	-649	-1836	-1777	-1182
Percent	-26.2	-34.4	-20.4	-24.0
Option 3				
Average household spending	1,833	3,504	6,814	3,677
Change from current law				
Dollars	-649	-1836	-2105	-1249
Percent	-26.1	-34.4	-23.6	-25.3
Option 4				
Average household spending	1,655	3,271	7,113	3,563
Change from current law				
Dollars	-827	-2068	-1807	-1363
Percent	-33.3	-38.7	-20.3	-27.7
Option 5				
Average household spending	1,833	3,503	7,028	3,721
Change from current law				
Dollars	-650	-1836	-1891	-1205
Percent	-26.2	-34.4	-21.2	-24.5

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: FPL = federal poverty level. Reforms simulated in 2022.

Conclusion

Evidence shows many uninsured people find the insurance coverage available to them too expensive to purchase, even though the ACA has lowered those costs for many and reduced other barriers to accessing coverage (Haley and Wengle 2021; Pollitz et al. 2020). Some uninsured people may find premiums affordable but opt to remain uninsured because out-of-pocket costs are unaffordable. In other words, the premiums do not purchase coverage they can use.

Here we have delineated the coverage and health care spending implications of five premium tax credit and cost-sharing subsidy options for enhancing Marketplace financial assistance. Enhancing the generosity of these subsidies alone would not address all of the coverage gaps identified under current law, such as those related to states that have not expanded Medicaid, high premiums in noncompetitive insurer and provider markets, and high premiums facing some with employer-based insurance offers. However, any of these approaches could reduce the number of uninsured Americans by more than 4 million people. The largest number of newly insured people would be those with modest incomes, 200 to 400 percent of FPL, who are eligible for Marketplace financial assistance today but for whom that assistance is limited. Still, under any of these approaches, almost 1 million of the newly insured would be people with middle incomes (over 400 percent of FPL), who are currently ineligible for any assistance at all.

Accounting for potential offsets due to reduced demand for uncompensated care, we estimate $23 to $26 billion in additional spending in 2022 would be necessary to implement one of these options. This roughly equals $289 to $322 billion over 10 years, depending on the approach chosen. As noted, however, federal uncompensated care spending would not fall automatically with the decrease in demand for such care when coverage expands; fully realizing these federal savings requires policy action.

The value of the increase in federal spending would be increased numbers of people insured and significantly reduced financial burdens for those already enrolled in nongroup insurance coverage, with savings averaging more than $1,000 per year per nongroup enrollee.

These reforms can be implemented quickly (i.e., the 2022 plan year), because they would constitute only a change in computation of subsidies and eligibility; the structure in which they would be used is already in place. Marketplace insurers would need to develop new cost-sharing reduction plans to correspond to the new subsidy schedule chosen. Enrollment would be expected to shift away from bronze and silver plans to gold plans.

Notes

[1] See, for example, Glied, Ma, and Borja (2017) and Long and colleagues (2017).

[2] See, for example, Blumberg and Holahan (2015) and Jost and Pollack (2015). See also the Patient Protection and Affordable Care Enhancement Act, H.R. 1425, 116th Cong. (2020), and the Consumer Health Insurance Protection Act of 2019, S. 1213, 116th Cong. (2019).

[3] Norris Cochran (acting secretary, US Department of Health and Human Services), letter to governors regarding the public health emergency, January 22, 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf.

[4] Such noncompliant coverage is ineligible for premium tax credits or cost-sharing reductions.

[5] We estimate the participation rate for those eligible for Marketplace subsidies with incomes below 200 percent of FPL is around 62 percent. This is high, considering participation rates for adults eligible for free or nearly free Medicaid coverage under the ACA's Medicaid expansion are around 73 percent (Buettgens 2021).

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