Expanding Premium Tax Credits to Middle-Income Families Would Reduce the Number of People Uninsured and Increase Marketplace Enrollment

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Most people under age 65, even if they are ineligible for Medicaid or some other public program, are eligible for various tax subsidies such as exclusions, deductions, and credits that reduce the cost of purchasing private health insurance. One group excluded from receiving tax subsidies under current law is people without access to an offer of employer-sponsored insurance (ESI) and whose incomes exceed the eligibility threshold for premium tax credits in the Marketplace.[1] In this brief, we analyze a policy that would expand Marketplace premium tax credits to some people in this group.

Most people with family incomes from 400 to 600 percent of the federal poverty level (FPL) are covered by health insurance through an employer-sponsored plan.[2] The small share of people in this group without access to coverage through an employer generally purchase a plan in the nongroup market, but some are uninsured. In the nongroup market, however, people must pay the full gross premium of any plan they choose because they are ineligible for the premium tax credits that reduce out-of-pocket premiums for people with lower incomes enrolling in coverage through the Marketplaces. Under current law, premium tax credits are available in the Marketplaces only for people with incomes from 100 to 400 percent of FPL who also meet other requirements. A policy that expands premium tax credits by raising the eligibility cutoff from 400 to 600 percent of FPL would lessen the financial burden of high premiums for such families and increase Marketplace enrollment for this group.

A potential drawback of expanding premium tax credit eligibility to those with incomes up to 600 percent of FPL is that some employers might stop offering ESI to their workers. Small employers, in particular, are potentially the most likely to stop offering insurance, because their workforces tend to be lower income than those of large employers, and they are exempt from the employer responsibility

requirements of the Affordable Care Act (ACA). Were employers to stop offering insurance because of an expansion of premium tax credits to higher-income workers, not all of their workers would necessarily enroll in alternative insurance options through the nongroup market or other public programs. If enough employers were to stop offering health insurance coverage to their workers, then the expansion policy might result in an increase in the number of uninsured, the opposite of its intended effect. However, as we detail below, we find such concerns unwarranted.

We find expanding premium tax credits to families with incomes up to 600 percent of FPL would reduce the number of people uninsured while substantially increasing Marketplace-based nongroup insurance coverage. Our results show very few employers currently offering insurance to their workers would find it advantageous to stop offering coverage if tax credits were expanded in this way. Our results are also consistent with evidence that employers have not responded to the ACA by dropping coverage: Ever since the ACA was first proposed, some policymakers have worried the subsidies available in the nongroup market would encourage employers to stop offering ESI to their employees. Contrary to that prediction, however, research shows most employers responded to the ACA by increasing the rates at which they offer insurance to their employees, and total ESI coverage has increased since 2014 (Gangopadhyaya and Garrett 2020; McMorrow, Blumberg, and Holahan 2020).

The policy examined here would make Marketplace coverage more affordable and eliminate the subsidy cliff (the abrupt elimination of premium tax credits) that occurs at the current cutoff threshold of 400 percent of FPL. Under current law, as a family's income increases by $1 above 400 percent of FPL, their premium tax credit falls from as much as several thousand dollars (depending on family size and age of the family members) to $0. Such cliffs can create disincentives for families to take on more work or switch to higher-paying jobs, because the loss of federal subsidies would worsen their net finances. The policy proposed here would shift the subsidy cliff to higher income levels, reducing its size and affecting fewer people.

A Reform to Expand Eligibility for Premium Tax Credits

The policy we analyze would expand the population eligible for premium tax credits under the ACA from individuals and families with incomes from 100 to 400 percent of FPL to those with incomes from 400 to 600 percent of FPL. If the policy were implemented in 2020, premiums for the Marketplace benchmark plan for newly eligible households would have been limited to 9.78 percent of income, matching the percentage-of-income limit applied to enrollees with incomes from 300 to 400 percent of FPL.[3] The subsidy shrinks as incomes rise, so the new subsidies would be smaller than those available to lower-income families. Other eligibility exclusions under current law would still apply: immigrants without documentation, people with an ESI offer deemed affordable to them, and people eligible for Medicaid, the Children's Health Insurance Program, or Medicare would be ineligible.

The policy is intended to extend tax subsidies to one of the few groups of people without widespread access to subsidies under current law and improve affordability for those paying very high

premiums.[4] We expect the policy would modestly increase overall insurance coverage. Though the uninsurance rate is already quite low in this income group, the policy would increase coverage by attracting some people into the Marketplace who have found ACA-compliant insurance unaffordable and chosen to either remain uninsured or purchase non-ACA-compliant insurance, such as short-term, limited-duration (STLD) policies.

ACA-noncompliant plans have lower premiums than ACA-compliant plans, but they typically exclude coverage for preexisting conditions and limit or exclude coverage for certain services, such as prescription drugs, maternity care, mental health treatment, and substance use disorder treatment. Such plans can end up costing families more if they are unlucky enough to experience an illness that requires treatment not covered under the minimal benefits in the STLD plan.

By specifying a cap on the percentage of income households are asked to spend on nongroup insurance premiums, premium tax credits under the ACA are structured so that as incomes rise, the amount of the subsidy falls and the amount paid directly by the enrollee increases. Under the policy analyzed here, Marketplace enrollees with incomes from 400 to 600 percent of FPL would pay more for the same coverage and receive smaller subsidies than similar families with lower incomes.[5] For example, a family of two 45-year-olds with family income just below 400 percent of FPL ($68,960 in 2020) would pay $6,744 annually for the average benchmark plan (table 1). A similar family with income just below 500 percent of FPL ($86,200 in 2020) would receive no subsidy today: under current law they would pay the full premium, or $11,600 annually, for the average benchmark plan. Under a policy of expanded eligibility for tax credits, the same family with income just below 500 percent of FPL would pay $8,430 in premiums annually. A similar family with income just below 600 percent of FPL ($103,440 in 2020) would pay $10,116 annually.

As noted above, under current law, some families face a subsidy cliff at 400 percent of FPL. When their income falls at or just below that level, they are eligible for tax subsidies to purchase insurance, but if they earn just a few dollars more than that threshold, they are ineligible for any subsidy. If the example family above earned a few dollars more than $68,960, they would lose their premium tax credit of $6,744 and be faced with the full cost of coverage—in this case, about $11,600.

By extending the cutoff on premium tax credit eligibility to 600 percent of FPL, the reform would reduce the size of the cliff and the number of people facing it. First, there are fewer families and individuals with incomes near 600 percent of FPL than with incomes near 400 percent of FPL, so fewer people would be potentially exposed to the cliff.[6] Second, the size of the cliff, measured by the value of premium tax credits, shrinks as incomes rise. Fewer families with incomes above 400 percent of FPL would face a full premium exceeding 9.78 percent of their income.[7] In the example above, for instance, a family with income slightly exceeding 400 percent of FPL would lose $4,856 in annual insurance subsidies under current law (table 1). Under the reform, a family with income slightly exceeding 600 percent of FPL would lose only about one-third that amount, $1,484 in annual insurance subsidies.[8]

TABLE 1

Household Premium Contributions for an Illustrative Marketplace Benchmark Plan under Current Law versus under a Reform Extending Eligibility for Premium Tax Credits to 600 Percent of FPL for a Family of Two 45-Year-Olds, by Family Income Relative to FPL, 2020

Income as a percentage of FPL	Income	Income cap under current law	Household premium contribution under current law	Premium assistance credit
Under current law				
150%	$25,860	4.12%	$1,065	$10,535
200%	$34,480	6.49%	$2,238	$9,362
250%	$43,100	8.29%	$3,573	$8,027
300%	$51,720	9.78%	$5,058	$6,542
400%	$68,960	9.78%	$6,744	$4,856
500%	$86,200	NA	$11,600	$0
600%	$103,440	NA	$11,600	$0
Under reform				
500%	$86,200	9.78%	$8,430	$3,170
600%	$103,440	9.78%	$10,116	$1,484

Source: Authors' calculations using data from the Health Insurance Policy Simulation Model, 2020.
Notes: FPL = federal poverty level. NA = not applicable. A full (pretax credit) premium is based on the national average of the second-lowest-priced silver plan premium in each rating region. Income dollar amounts are measured as modified adjusted gross income, consistent with Affordable Care Act eligibility determination rules.

Methods

For this analysis, we use the Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models how changes in one insurance market sometimes cause changes in other markets. HIPSM is based on two years of the American Community Survey, which provides data on a large, representative sample of families. For this analysis, we also incorporate data from the Tax Policy Center to estimate (1) federal and state marginal tax rates and (2) the value of the tax exclusion for ESI.

To model firms' decisions to offer ESI to their workers, we group workers with the same employment characteristics, such as firm size and industry, into synthetic firms. The distribution of synthetic firms mimics the known distribution of employers by size, industry, region, and baseline ESI offer status. We simulate firm decisions about ESI offers in response to policy changes. Based on economic theory and evidence, HIPSM assumes firm decisions will reflect the combined preferences and characteristics of the workers in each firm and their dependents, who might also obtain coverage through the employer. Firm responses are benchmarked to estimates drawn from the literature that show smaller firms are much more elastic in response to changes in costs than are larger firms (Buettgens and Banthin 2020).

Employers' Decisions about Offering Coverage to Employees

Consistent with economic research and the approaches taken by other microsimulation modelers, such as the Congressional Budget Office and the Joint Committee on Taxation, we assume employers aim to attract the best available workers at the lowest possible cost by offering a mix of cash wages and noncash benefits such as vacation time, retirement benefits, and health insurance (CBO 2012). Because health insurance is a popular benefit and most eligible workers take up coverage when it is offered, many employers include health insurance in employee compensation. When employers offer insurance to their workers, they effectively lower their employees' health insurance costs, because it is more costly for employees to purchase coverage independently. Medium and large employers can offer insurance to their workers for a much lower administrative cost than that for similar coverage in the nongroup market (McCue, Hall, and Liu 2013); the administrative cost for ESI is typically less than half the administrative cost of similar coverage in the nongroup market. In addition, when workers receive health insurance through their jobs, the value of this benefit is not counted as income for tax purposes. Employer and, often, employee contributions to health insurance premiums are excluded from income when calculating income and payroll taxes owed.[9] The value of the tax exclusion increases with the income (and marginal tax rate) of the worker. For higher-income workers, this tax subsidy can add up to as much as 40 percent of the cost of premiums, when accounting for both federal and state taxes (CBO 2012; Maag et al. 2012).[10]

In addition to attracting workers, employers have another incentive to offer health insurance to their employees. Under current law, employers with more than 50 workers may be subject to penalties if they do not offer health insurance to their employees that meets minimum standards. The penalties may be imposed if any worker enrolls in Marketplace coverage and receives a premium tax credit. However, the availability of premium tax credits in the Marketplace weighs against a firm's decision to offer health insurance, because the subsidies are limited to families who lack an offer of affordable coverage from an employer and have incomes from 100 to 400 percent of FPL. An employer with a low-wage workforce may decide against offering health insurance so its employees would be eligible for Marketplace subsidies.

Again using an example of a family of two 45-year-olds, table 2 shows ESI subsidies are typically larger than Marketplace subsidies for higher-wage workers, even under a policy that would extend Marketplace subsidy eligibility up to 600 percent of FPL. Table 2 compares the costs of a typical ESI plan with an actuarial value of 85 percent with an average benchmark plan in the Marketplace with an actuarial value of 70 percent. In our example, the ESI premium is $18,000 (including both employer and employee contributions), and expected out-of-pocket costs are about $3,100 for the example family. The Marketplace plan has a premium of $11,600, and expected out-of-pocket costs are $2,700.

TABLE 2

Comparison of Costs of ESI and Marketplace Coverage for a Family of Two 45-Year-Olds under a Reform Extending Eligibility for Premium Tax Credits to 600 Percent of FPL, by Family Income Relative to FPL, 2020

Income as a percentage of FPL	Income	Marginal tax rate	Subsidy for ESI Due to Tax Exclusion (85% AV ESI plan)[a]	Marketplace Subsidy under Reform (70% AV silver plan)[b]
300%	$51,720	34%	$6,100	$6,500
400%	$68,960	34%	$6,100	$4,900
500%	$86,200	35%	$6,300	$3,200
600%	$103,440	41%	$7,300	$1,500

Source: Authors' calculations using data from the Health Insurance Policy Simulation Model and the Tax Policy Center, 2020.
Notes: ESI = employer-sponsored insurance. FPL = federal poverty level. AV = actuarial value. Marginal tax rates include federal income and payroll taxes plus representative state income taxes. State income taxes are from an example state (New Jersey) with a marginal income tax rate slightly above the national average. Some states have no income tax, and others have marginal tax rates greater than those used in this example. The subsidy for ESI due to tax exclusion would be smaller in states with low rates and greater in states with high rates.
[a] The example ESI plan has an $18,000 total annual premium (including both employer and employee contributions) before subsidies.
[b] The example silver plan has an $11,600 annual premium before subsidies.

The ESI plan has a higher premium because it has a higher actuarial value than the Marketplace plan, which translates into lower cost sharing in the form of deductibles and copayments. The typical ESI plan may also have a larger provider network and fewer utilization-management restrictions, and it may pay higher prices to providers than does the Marketplace benchmark plan. Despite the typical ESI plan's higher actuarial value, its expected out-of-pocket costs are also higher than those for a Marketplace plan. These higher out-of-pocket costs reflect higher utilization levels, higher provider payments, and the preferences of workers enrolled in such coverage. Some workers, especially those who are older or in poor health, prefer the more expensive health plan if they can afford it because it provides more coverage and choices. In contrast, younger and healthier workers may not want to pay more for a generous health plan they are less likely to use.

Table 2 also shows that the subsidy for ESI due to the tax exclusion grows from $6,100, if the example family's income equals 300 percent of FPL, to $7,300, if the couple's income equals 600 percent of FPL. As noted above, the ESI tax subsidy grows with income and with the level of the benefit, creating an incentive for employers to offer generous health insurance to their employees. In the example, premium tax credits would decline from $6,500 for a family with income equaling 300 percent of FPL to $1,500 for a family with income equaling 600 percent of FPL. Couples with incomes equaling 300 percent of FPL receive a larger subsidy in the Marketplace, whereas those with incomes equaling 500 and 600 percent of FPL receive substantially larger subsidies for ESI than for Marketplace coverage.

Expanding Marketplace subsidies is unlikely to cause many employers to stop offering coverage to their employees because of (1) the substantial value of the ESI subsidy under the current tax structure

and (2) stable rates of employers offering coverage after ACA implementation. In 2013, the year before implementation of most of the ACA's coverage reforms, about 85 percent of all employers offered health insurance to their employees; offer rates remained steady in the wake of the newly available Marketplace subsidies (Gangopadhyaya and Garrett 2020; McMorrow, Blumberg, and Holahan 2020; Miller, Keenan, and Vistnes 2019). Over 2014 and 2015, some small firms (50 or fewer workers) that had previously offered insurance dropped coverage, while others that had not offered insurance began offering it, resulting in stable patterns of coverage among small firms (Vistnes et al. 2017). Among medium-size firms (51 to 100 workers), about 27 percent added and 3 percent dropped offers of coverage during this period. Ninety-eight percent of large firms (100 or more workers) offered insurance in 2013. Between 2014 and 2018, offer rates increased among both medium and large firms (Miller, Keenan, and Vistnes 2019).

Results

Under a reform that extends eligibility for ACA premium tax credits up to 600 percent of FPL, we find the number of people uninsured would fall by 116,000, a 0.4 percent decrease (table 3). In addition, 48,000 people with noncompliant coverage, such as STLD plans, would gain ACA-compliant coverage by enrolling in Marketplace plans. Some enrollees in noncompliant coverage are attracted to such plans by their lower premiums. Under reform, when many of these enrollees would become newly eligible for premium tax credits that reduce premiums for Marketplace plans, many would therefore switch to the more comprehensive ACA-compliant plans. Together, these effects would move 164,000 people into plans providing minimum essential coverage.

The reform analyzed would also increase the number of people receiving tax credits to purchase nongroup insurance in the Marketplace by 1.0 million, or 11.0 percent. This number would include both those newly enrolling in Marketplace coverage and 720,000 people who were already buying nongroup insurance outside the Marketplace who do not qualify for a tax credit under current law. Total private nongroup coverage, including both subsidized and unsubsidized enrollment, would increase by 313,000 people, or 2.1 percent. We project no meaningful changes in coverage for those with Medicaid, Children's Health Insurance Program, or other public coverage.

Under reform, we estimate 153,000 fewer people would have ESI, a 0.1 percent decrease (table 3). This group includes both those who would newly choose to enroll in nongroup coverage and those who would become uninsured once their firms stop offering health insurance coverage in response to the expanded eligibility for subsidies.[11] More than two-thirds of the people switching out of ESI (about 110,000 people) would become newly eligible for Marketplace subsidies, even though the so-called "firewall," or prohibition against workers with offers of affordable employer coverage from receiving Marketplace subsidies, would remain in place under this policy. People leaving ESI include those whose firms stop offering health coverage and those whose firms still sponsor health insurance, but whose offers are not deemed affordable. Given the new subsidy, these workers and their dependents would find Marketplace insurance more attractive even as their employers continue offering

insurance. The workers who leave ESI because their employers stop offering health insurance are examined more closely in table 4.

TABLE 3

Health Insurance Coverage for the Nonelderly under Current Law and a Reform Extending Eligibility for Premium Tax Credits to 600 Percent of FPL, 2020

	Prepandemic Baseline		Extend ACA Premium Tax Credit Eligibility to 600% of FPL		Change		
	1,000s of people	%	1,000s of people	%	1,000s of people	Percentage point	%
Insured (MEC)	**244,346**	**88.7**	**244,510**	**88.8**	**164**	**0.1**	**0.1**
Employer	151,117	54.9	150,964	54.8	-153	-0.1	-0.1
Private nongroup	15,131	5.5	15,444	5.6	313	0.1	2.1
Subsidized	9,435	3.4	10,469	3.8	1,033	0.4	11.0
Unsubsidized	5,696	2.1	4,976	1.8	-720	-0.3	-12.6
Medicaid/CHIP	69,478	25.2	69,482	25.2	3	0.0	0.0
Other public	8,619	3.1	8,619	3.1	0	0.0	0.0
Uninsured (no MEC)	**31,128**	**11.3**	**30,964**	**11.2**	**-164**	**-0.1**	**-0.5**
Uninsured	28,596	10.4	28,480	10.3	-116	0.0	-0.4
Noncompliant nongroup	2,532	0.9	2,485	0.9	-48	0.0	-1.9
Total	**275,474**	**100.0**	**275,474**	**100.0**	**0**	**0.0**	**0.0**

Source: Authors' calculations using data from the Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. FPL = federal poverty level. MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. Results simulated for 2020 on prepandemic baseline.

TABLE 4

Health Insurance Coverage for People in Families Affected by an Employer Dropping Health Insurance, 2020

	Prepandemic Baseline	Extend ACA Premium Tax Credit Eligibility to 600% of FPL	Change	
	1,000s of people	1,000s of people	1,000s of people	%
Insured (MEC)	**106**	**91**	**-15**	**0.1**
Employer	57	17	-41	-0.1
Private nongroup	13	37	23	2.1
Medicaid/CHIP	32	34	3	0.0
Other public	4	4	0	0.0
Uninsured (no MEC)	**17**	**31**	**15**	**-0.5**
Uninsured	15	30	15	-0.4
Noncompliant nongroup	1	1	0	-1.9
Total	**123**	**123**	**0**	**0.0**

Source: Authors' calculations using data from the Health Insurance Policy Simulation Model, 2020.
Notes: FPL = federal poverty level. MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. Results simulated for 2020 on prepandemic baseline.

We estimate firms employing about 50,000 workers would stop offering insurance because of this policy.[12] However, not all of those workers and their dependents are enrolled in an employer plan under current law. In table 4, we provide a closer look at the resulting changes in coverage among those workers and their family members, a group totaling 123,000 people. We estimate less than half of this group (57,000 workers and dependents) are enrolled in ESI under current law. Others are enrolled in nongroup coverage (13,000) and Medicaid (32,000), whereas 15,000 are uninsured (table 4). Also, some families that would lose coverage under the policy would have access to another offer of ESI through a spouse, which we estimate most would take up. Under the policy, we estimate 41,000 people would ultimately lose ESI coverage. Of those losing ESI, 23,000 would move to nongroup coverage and 3,000 would enroll in Medicaid. We expect 15,000 people would become uninsured.

These changes in coverage would increase federal spending by $4.0 billion. Premium tax credit spending would increase by $4.5 billion, or 8 percent, but would be offset somewhat by a $0.5 billion drop in spending on uncompensated care as the number of people uninsured falls. The increase in the federal deficit from the additional spending would also be offset by $0.3 billion in increased federal revenues, because people who lose ESI are expected to receive higher taxable wages in lieu of employer-paid premiums.

Discussion

We find a policy that extends premium tax credits to people with incomes up to 600 percent of FPL would reduce the number of people uninsured by 116,000 and newly provide minimum essential coverage to almost another 50,000 people currently buying lower-value STLD plans. It would also improve affordability of coverage among targeted families without access to affordable employer-sponsored coverage and reduce the subsidy cliff by shifting it to 600 percent FPL and decreasing its size. Expanding eligibility for premium tax credits as described here is a relatively small reform that would cost $4.0 billion in federal spending.

We estimate about 15,000 people would become newly uninsured under this reform, about 6,000 of whom have incomes below 400 percent of FPL. Most of these 15,000 people would be eligible for subsidized coverage in the Marketplace. If this premium tax credit expansion were combined with other reforms, however, that number might be reduced. For example, a reform that increases outreach and enrollment assistance to people eligible for subsidized coverage but uninsured could reduce the number of people becoming uninsured. Also, firms that do not offer ESI might assist employees in signing up for Marketplace coverage or Medicaid, further increasing coverage.

In addition to immediate effects on affordability and coverage, the policy may have longer-term effects that would promote competitiveness and stability in nongroup insurance markets. The number of people receiving premium tax credits through the Marketplace would increase notably by 1.0 million, or more than 10 percent. The larger market size might encourage insurers to newly enter the market, expand their existing participation to new rating areas, or increase plan offerings.

Notes

[1] Self-employed people in this group may benefit from the self-employment tax deduction of health insurance premiums.

[2] For a family of two adults, this FPL represents income between $67,640 and $101,460.

[3] These caps change slightly from year to year. In 2021, the cap is 9.83 percent of income.

[4] A small number of self-employed people take advantage of the deduction for health insurance allowed under current law.

[5] Families are referred to here as being similar if they have the same number of members of the same age and live in the same premium rating region.

[6] According to the Health Insurance Policy Simulation Model, 2.6 million people under age 65 have incomes between 395 and 405 percent of FPL, including 143,000 uninsured people and 131,000 people with nongroup coverage. About 1.3 million people in this age range have incomes between 595 and 605 percent of FPL, including 44,000 uninsured people and 43,000 people with nongroup coverage.

[7] People who might face premiums exceeding 9.78 percent of their income include those who are older, have large families, or live in geographic areas with higher premiums.

[8] Elimination or reduction of the premium tax credit subsidy cliff would reduce disincentives to work for people with incomes near the cliff, but other incentives could offset this change for people in the new subsidy income range. People leaving ESI to take up the nongroup subsidy would see an increase in their effective marginal tax rate as they lose the tax preference for their health premiums.

[9] Employee contributions to Flexible Spending Accounts, Health Savings Accounts, and Health Reimbursement Arrangements are also excluded from income and payroll taxes. See "Reduce Tax Subsidies for Employment-Based Health Insurance," Congressional Budget Office, December 13, 2018, https://www.cbo.gov/budget-options/54798.

[10] This estimate reflects savings after accounting for federal and state income and payroll taxes and uses New Jersey to represent the median state tax rate.

[11] This group also includes a very small number of people who would enroll in Medicaid.

[12] About 95 percent of those firms are estimated to have fewer than 25 employees.

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