Robert Wood Johnson Foundation

URBAN INSTITUTE

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022

Jessica Banthin, Matthew Buettgens, Michael Simpson, and Robin Wang

APRIL 2021

Introduction

The recently enacted American Rescue Plan Act (ARPA) includes several provisions designed to expand access to affordable health insurance coverage in 2021 and 2022, while the economy continues recovering from the COVID-19 pandemic and recession. One provision is the expansion of Affordable Care Act (ACA) marketplace subsidies over that period, which can improve health insurance affordability for people whose incomes have fallen due to reduced employment opportunities during the pandemic. Expanding these subsidies could substantially reduce household spending on health care, reduce the number of people uninsured, and increase marketplace enrollment, but the new subsidies' effects may be limited by their brief availability.

In this paper, we seek to show the maximum potential impact of the ARPA's enhanced marketplace subsidies on health insurance coverage and set the stage for next steps by policymakers. To do so, we show the enhanced subsidies' effects on coverage as if they were permanent changes (instead of limited to 2021 and 2022), and we assume people, employers, and insurers have fully responded to the new subsidies. Because of our approach, our estimates differ from those by the Congressional Budget Office (CBO). Adhering to their mandate, the CBO estimated the ARPA as written, including the temporary nature of changes to marketplace subsidies. Given that a permanent change in subsidies would be expected to have a larger effect than one that is temporary, our estimate of the reduction in the number of people uninsured is more than three times as large as the CBO's.

If the ARPA's temporary enhancements to marketplace subsidies were made permanent and consumers, employers, and insurers had fully adjusted to the new coverage options, we find that in 2022:

- 4.2 million fewer people would be uninsured;
- 5.1 million more people would enroll in the subsidized marketplace; and
- Nongroup premiums would be 15 percent lower.

American Rescue Plan Act Coverage Provisions Effective in 2022

In early 2021, the United States had 10 million fewer jobs than a year earlier, before the pandemic.[1] To ensure people who have lost their jobs can continue to access health insurance coverage during the ongoing crisis, the ARPA includes several provisions to expand eligibility to and reduce the costs of health insurance coverage. Some of these provisions are limited to 2021,[2] but we focus here on the health care provision that remains in place in 2022: enhanced premium tax credits in the ACA marketplace.

The ARPA includes two major changes for people who enroll in coverage through the marketplace (Table 1). It enhances premium tax credits for those previously eligible for subsidies and expands eligibility for subsidies to individuals and families previously ineligible because their incomes were greater than 400 percent of the federal poverty level (FPL).[3] The new subsidy schedule substantially reduces households' premium payments. Under the ARPA, everyone eligible for tax credits with income below 150 percent of FPL can select a free silver health plan. As another example, the Kaiser Family Foundation (KFF) estimates that an illustrative 64-year-old just above 400 percent of FPL would pay $12,698 per year before the ARPA and $4,394 after the ARPA.[4]

The ARPA does not change the marketplace's cost-sharing reduction schedule (Table 1). Under current law, cost-sharing reductions (CSRs) are available to people who have incomes from 100 to 250 percent of FPL and who enroll in a silver plan through the marketplace. A silver plan has an actuarial value of about 70 percent. The subsidies work by increasing the actuarial value of a silver plan to 73 percent, 87 percent, or 94 percent, depending on income, thus lowering out-of-pocket costs for consumers.

The ARPA includes the first major federal expansion of marketplace subsidies since the ACA's enactment in 2010. In the eight years since it first opened for enrollment in late 2013, the marketplace survived several policy changes and continues to serve nearly 11 million people.[5] In 2020, effectuated enrollment was 10.7 million.[6] Projections that the marketplace would shrink or fail in certain areas of the country, especially in the wake of large premium increases in 2018, have not borne out. Yet,

though the national average benchmark premium has fallen for three years in a row, indicating stability, premium levels vary considerably across states. Not all states and rating regions have robust insurer participation. The ARPA's enhanced premium tax credits could have a range of positive impacts on the marketplace by increasing marketplace enrollment that could lead to greater insurer participation, improvements in the overall risk pool, and result in lower premiums.

Data and Methods

We produce our estimates using the Urban Institute's 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. 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. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models.[7]

We model the effects of the ARPA's enhanced marketplace subsidies on coverage in 2022 as if they were permanent changes and as if consumers, employers, and insurers have fully responded to the new subsidy schedule. In other words, our analysis assumes expanded marketplace subsidies are permanent and fully phased in.

We provide additional information on the model and its underlying data in the appendix. There we explain how we calibrated the model to project distributions of coverage in 2022 before ARPA as a baseline against which to measure the effects of the ARPA's enhanced marketplace subsidies. We also explain other key assumptions regarding the pandemic's economic effects.

Table 1. Subsidy Schedules before ARPA and American Rescue Plan, 2022

Income (% of FPL)	Before ARPA	American Rescue Plan
Premium Tax Credit Percent of Income Limits for Benchmark Coverage		
< 138	2.07	0.0-0.0
138–150	3.10-4.14	0.0-0.0
150–200	4.14-6.52	0.0-2.0
200–250	6.52-8.33	2.0-4.0
250–300	8.33-9.83	4.0-6.0
300–400	9.83	6.0-8.5
400–500	n.a.	8.5-8.5
500–600	n.a.	8.5-8.5
600+	n.a.	8.5-8.5
Benchmark Plan	Silver	Silver
Cost-Sharing Reductions: Actuarial Value of Plan Provided to Eligible Enrollees (%)		
< 138	94	94
138–150	94	94
150–200	87	87
200–250	73	73
250–300	70	70
300–400	70	70
400–500	70	70
500–600	70	70
600+	70	70

SOURCES: Internal Revenue Service, Health and Human Services Department, and American Rescue Plan Act of 2021, Pub. L. No. 117-2.
Notes: FPL is federal poverty level. Percentage-of-income caps applied in 2022; before-ARPA caps are for 2021 and are indexed each year. Annual adjustments to caps have been modest and are not made until close to the end of year open enrollment period.

Findings

Changes in Coverage and the Number of People Uninsured

We find the number of people uninsured would drop by 4.2 million, or almost 14 percent, in 2022 if the ARPA's enhanced marketplace subsidies were permanent and consumers, employers, and insurers responded to the new subsidy schedule as if it were fully phased in (Table 2). In addition, about 317,000 people with non-ACA-compliant nongroup coverage would switch to ACA-compliant plans. Some enrollees in noncompliant coverage are attracted to such plans by their lower premiums. Under the ARPA, many of these people are newly eligible for premium tax credits that reduce premiums for marketplace plans and would therefore switch to the more comprehensive ACA-compliant plans.

Most of the previously uninsured people would be attracted to the marketplace by the enhanced subsidies. We estimate subsidized marketplace enrollment would increase by 5.1 million people, an increase of 60 percent in 2022, if the ARPA were permanent.

In response to the newly enhanced marketplace subsidies, we estimate 475,000 fewer people would be covered by employer-sponsored insurance (ESI). Most of the people who would leave ESI are those whose firms would still sponsor health insurance but whose offers are not deemed affordable; a very small number are those whose firms would stop offering health coverage. The ARPA does not change the ACA's so-called "firewall," which makes families with workers who have offers of affordable employer coverage ineligible for marketplace subsidies. Of the 475,000 people leaving ESI, nearly all would be attracted to the nongroup market because of newly

Table 2. Coverage Distribution of the Nonelderly before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

Thousands of people

	Before ARPA		Alternative Subsidies		Change	Change (%)
Insured (Minimum Essential Coverage)	**244,113**	**88.0%**	**248,617**	**89.6%**	**4,504**	**1.8%**
Employer	149,325	53.8%	148,850	53.7%	-475	-0.3%
Private Nongroup	14,960	5.4%	19,574	7.1%	4,613	30.8%
Basic Health Program	*864*	*0.3%*	*866*	*0.3%*	*2*	*0.2%*
Marketplace with PTC	*8,458*	*3.0%*	*13,535*	*4.9%*	*5,076*	*60.0%*
Nongroup Coverage without PTC	*5,638*	*2.0%*	*5,174*	*1.9%*	*-465*	*-8.2%*
Medicaid/CHIP	71,162	25.6%	71,528	25.8%	366	0.5%
Disabled	*9,436*	*3.4%*	*9,437*	*3.4%*	*1*	*0.0%*
Medicaid Expansion	*14,845*	*5.4%*	*14,986*	*5.4%*	*141*	*0.9%*
Traditional Nondisabled Adult	*12,680*	*4.6%*	*12,855*	*4.6%*	*175*	*1.4%*
Nondisabled Medicaid/CHIP Child	*34,161*	*12.3%*	*34,210*	*12.3%*	*49*	*0.1%*
State-funded Program	*40*	*0.0%*	*40*	*0.0%*	*0*	*0.0%*
Other Public	8,665	3.1%	8,665	3.1%	0	0.0%
Uninsured (No MEC)	**33,333**	**12.0%**	**28,829**	**10.4%**	**-4,504**	**-13.5%**
Uninsured	30,766	11.1%	26,579	9.6%	-4,188	-13.6%
Noncompliant Nongroup	2,567	0.9%	2,251	0.8%	-317	-12.3%
Total	**277,446**	**100.0%**	**277,446**	**100.0%**	**0**	**0.0%**

SOURCE: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: PTC is premium tax credit. CHIP is Children's Health Insurance Program. MEC is minimum essential coverage.

Table 3. Uninsured Nonelderly before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, by Income Group, 2022

Thousands of people

	Before ARPA	Alternative Subsidies	Change	Change (%)
Below 138% of FPL	14,530	14,218	-312	-2.1%
Between 138% and 200% of FPL	4,581	3,942	-639	-13.9%
Between 200% and 400% of FPL	7,712	5,298	-2,414	-31.3%
Above 400% of FPL	3,943	3,120	-823	-20.9%
Total, all incomes	**30,766**	**26,579**	**-4,188**	**-13.6%**

SOURCE: Urban Institute Health Insurance Policy Simulation Model, 2021.
Note: Income groups are based on computations for Medicaid eligibility.

enhanced subsidies and lower premiums. We estimate fewer than 10,000 people would become newly uninsured because of the ARPA (data not shown), nearly all of whom would be eligible for Medicaid or marketplace subsidies but would choose not to enroll coverage.

We project that Medicaid and Children's Health Insurance Program (CHIP) enrollment would increase by about 366,000 people as a result of the ARPA's enhanced subsidies. These increases would result from increased enrollment in the nongroup market by family members and from eligibility determinations that send some people to Medicaid when they sought coverage after passage of the ARPA.

Changes in Marketplace Premiums

This substantial increase in marketplace enrollment under the ARPA's enhanced subsidies would also reduce average health risk scores in the entire nongroup market. We estimate that lower health risk scores would reduce premiums by about 15 percent on average in 2022, if the changes were fully phased in immediately (data not shown). The main reason average health risk would fall under the ARPA's enhanced subsidies is that those with higher health care needs are more likely to have already purchased coverage before ARPA. The enhanced subsides, estimated here, are more likely to attract uninsured people with average or lower health needs, including younger enrollees.

The Uninsured by Income Group

The ARPA would substantially reduce the number of people uninsured in 2022, and most people gaining coverage would have incomes below 400 percent of FPL. People with modest incomes, between 200 and 400 percent of FPL, would experience the largest reductions in uninsurance under the ARPA, 2.4 million people, a decline of 31 percent (Table 3). The number of uninsured people with incomes between 138 and 200 percent of FPL would drop about 14 percent, or by 639,000. And the number of uninsured people with incomes below 138 percent of FPL would drop 2 percent, or by 312,000. Improvements are smaller in this group because the ARPA does not address the Medicaid gap by extending subsidies to people below 100 percent FPL who live in states that have not expanded Medicaid.

Under the ARPA, people with incomes above 400 percent of FPL, who meet other eligibility criteria, are newly eligible for marketplace subsidies for the first time since its inception in 2014. The number of uninsured people with income in this range would drop by 823,000, or by about 21 percent.

Changes in Federal and Household Spending

Because of the coverage changes outlined above, we estimate federal spending would increase by $17.6 billion in 2022 (Table 4). This includes increased spending on marketplace subsidies and Medicaid and CHIP that is offset slightly by reductions in uncompensated care.[8]

One of the ARPA's largest impacts would be the decrease in household health care spending for people enrolled in the marketplace (Table 5). Average spending on premiums would drop nearly 50 percent among nongroup enrollees with incomes below 200 percent of FPL, declining from $1,182 to $624 per person. Average total spending on both premiums and out-of-pocket expenses would drop 32 percent among people in this income group, falling from $2,496 to $1,689 per person. Families in other income groups would experience slightly smaller declines in spending. Among all nongroup market enrollees, total spending on both premiums and out-of-pocket expenses would decline 23 percent, from $4,926 to $3,788 per person.

Coverage Effects by State

Table 6 shows changes in the number of people uninsured by state in 2022. All states would see significant reductions in the number of people uninsured, ranging from a 681,000 decline in Texas to a 4,000 decline in Vermont. Other states with the largest decreases in the number people of uninsured are California (419,000), Georgia (193,000), Ohio (190,000), New York (163,000), and Arizona (158,000). The percent declines in the number of people uninsured range from 28 percent in West Virginia to 3 percent in Florida. Other states with large percent decreases in uninsurance are Ohio (26%), New Hampshire (25%), Arkansas (23%), Louisiana (23%), and Indiana (21%).

Table 4. Federal Health Care Spending for the Nonelderly before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

Millions of dollars

	Before ARPA	Alternative Subsidies	Change
Medicaid and CHIP	376,113	378,098	1,985
Marketplace PTC	58,277	76,701	18,424
Reinsurance	1,314	1,314	0
Uncompensated Care	15,700	12,913	-2,787
Total	**451,405**	**469,026**	**17,622**

SOURCE: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: CHIP is Children's Health Insurance Program. PTC is premium tax credit. Uncompensated care includes federal spending that will shrink in proportion to reductions in the number of uninsured (largely Medicare Disproportionate Share Hospital payments).

Table 5. Household Spending for the Nonelderly with Nongroup Coverage before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, by Income Group, 2022

Dollars

	Spending per Enrollee			
	Before ARPA	Alternative Subsidies	Change	Change (%)
Household Spending on Premiums				
Below 200% of FPL	1,182	624	-559	-47.2%
Between 200% and 400% of FPL	2,619	1,609	-1,009	-38.5%
Above 400% of FPL	5,864	4,173	-1,691	-28.8%
All Incomes	**2,768**	**1,850**	**-919**	**-33.2%**
Household Out-of-Pocket Spending				
Below 200% of FPL	1,314	1,065	-248	-18.9%
Between 200% and 400% of FPL	2,691	2,158	-533	-19.8%
Above 400% of FPL	3,022	2,970	-51	-1.7%
All Incomes	**2,157**	**1,938**	**-219**	**-10.1%**
Total Household Spending				
Below 200% of FPL	2,496	1,689	-807	-32.3%
Between 200% and 400% of FPL	5,309	3,767	-1,542	-29.0%
Above 400% of FPL	8,885	7,143	-1,742	-19.6%
All Incomes	**4,926**	**3,788**	**-1,138**	**-23.1%**

SOURCE: Urban Institute Health Insurance Policy Simulation Model, 2021.
Note: FPL is federal poverty level.

Table 6. Number of People Uninsured before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

Thousands of people

State	Before ARPA	Alternative Subsidies	Change	Change (%)
Alabama	486	427	-58	-12.0%
Alaska	95	77	-18	-18.7%
Arizona	755	596	-158	-21.0%
Arkansas	230	177	-53	-23.1%
California	3,682	3,262	-419	-11.4%
Colorado	484	396	-87	-18.1%
Connecticut	203	177	-26	-12.6%
Delaware	67	60	-6	-9.3%
District of Columbia	43	38	-5	-11.9%
Florida	2,641	2,563	-78	-3.0%
Georgia	1,401	1,209	-193	-13.7%
Hawaii	114	96	-18	-15.7%
Idaho	161	144	-17	-10.7%
Illinois	1,073	937	-136	-12.7%
Indiana	499	393	-106	-21.3%
Iowa	144	115	-29	-20.0%
Kansas	341	298	-43	-12.7%
Kentucky	294	233	-61	-20.8%
Louisiana	381	294	-87	-22.9%
Maine	54	47	-6	-11.6%
Maryland	420	387	-34	-8.0%
Massachusetts	248	228	-19	-7.8%
Michigan	552	457	-95	-17.2%
Minnesota	291	253	-39	-13.2%
Mississippi	371	314	-57	-15.3%
Missouri	676	565	-110	-16.3%
Montana	79	64	-16	-19.9%
Nebraska	135	117	-18	-13.4%
Nevada	397	326	-71	-17.8%
New Hampshire	74	56	-19	-25.0%
New Jersey	731	643	-88	-12.0%
New Mexico	216	174	-42	-19.3%
New York	1,106	944	-163	-14.7%
North Carolina	1,179	1,059	-120	-10.2%
North Dakota	75	61	-14	-18.6%
Ohio	724	534	-190	-26.2%
Oklahoma	597	527	-70	-11.7%
Oregon	346	282	-64	-18.5%
Pennsylvania	693	571	-122	-17.6%
Rhode Island	60	54	-6	-9.7%
South Carolina	572	483	-89	-15.5%
South Dakota	95	77	-18	-18.7%
Tennessee	731	588	-143	-19.5%
Texas	4,996	4,316	-681	-13.6%
Utah	299	282	-17	-5.6%
Vermont	44	39	-4	-10.1%
Virginia	755	660	-94	-12.5%
Washington	597	489	-108	-18.1%
West Virginia	109	78	-31	-28.3%
Wisconsin	366	335	-32	-8.7%
Wyoming	85	74	-11	-13.4%
Total	**30,766**	**26,579**	**-4,188**	**-13.6%**

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

Discussion

If the ARPA's temporary enhancements to marketplace subsidies were made permanent and consumers, employers, and insurers had fully adjusted to the new coverage options, 4.2 million fewer people would be uninsured in 2022. Subsidized marketplace enrollment would increase by 5.1 million people, a 60 percent jump, and household financial burdens among the 13.5 million subsidized marketplace enrollees would fall substantially because of lower premiums.[9]

If the ARPA's expanded marketplace subsidies were permanent, increased enrollment would also reduce health risk scores, leading to premium reductions of 15 percent in the entire nongroup market. Moreover, permanent enhancement of subsidies would likely encourage additional insurer participation in the marketplace as result of higher enrollment. The marketplace is working well in most states and national average benchmark premiums fell for the third consecutive year in 2021. Still, average state benchmark premiums vary by a factor greater than two. Research shows increased insurer participation tends to drive premiums to more competitive levels. In this way the ARPA's enhanced subsidies could ultimately work to improve stability and competitiveness in the entire nongroup market.[10]

Employer Responses to Permanently Enhanced Subsidies

Some worry that permanently expanding premium tax credit eligibility to those with incomes above 400 percent of FPL could cause some employers to stop offering ESI to their workers. Small employers, in particular, are potentially the most likely to stop offering insurance, because their workers tend to have lower incomes than those of large employers and they are exempt from the ACA's employer responsibility requirements. Since the ACA was first proposed, some policymakers have worried the subsidies available in the nongroup market would encourage employers to stop offering ESI. 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 increased in the years following implementation of the marketplace in 2014.[11] Our analysis of the ARPA's expanded marketplace subsidy schedule is consistent with the latest research on employers, and we estimate very few employers currently offering insurance to their workers would find it advantageous to stop offering coverage. This partially owes to the substantial value of the ESI subsidy under the current tax structure and employee preferences for broad provider networks.[12]

Comparing Our Estimates with CBO's Estimates

Our estimates of the ARPA's coverage effects in 2022 are not directly comparable with such estimates from the CBO because our estimates rely on different assumptions. We aim to estimate the maximum potential impact of the ARPA's enhanced marketplace subsidies to set the stage for policymakers' next steps. We modeled our results as if the ARPA's changes to marketplace subsidies were permanent and consumers, employers, and insurers have fully adjusted their behavior in response.

Adhering to its mandate, on the other hand, the CBO estimated the ARPA's health care provisions as written.[13] Interpreting the provisions as temporary, the CBO likely estimates the effects of the ARPA's enhanced marketplace subsidies to be substantially lessened by several factors such as enrollees' confusion or lack of awareness of the new subsidies, possible difficulties enrolling, inertia, and other barriers. The CBO stated employers would be less likely to change their decisions to offer coverage to their employees if the enhanced subsidies were temporary. In addition, the CBO may consider that limiting the enhanced subsidies to two years could mean insurers are less likely to newly enter or expand their participation in a market, adjust their estimates of their enrollees' average health risk, or develop plans to attract newly eligible enrollees in response to the new law.

The CBO estimated that, as written, the ARPA's temporary enhanced marketplace subsidy schedule would reduce the number of uninsured people by 1.3 million in 2022, compared to our estimate of 4.2 fewer million uninsured people from a permanent change. The CBO also finds increased marketplace enrollment of 1.7 million people in 2022, much less than our estimate of 5.1 million people with new subsidized marketplace coverage.

Regarding ESI, the CBO estimates that 100,000 people with ESI would switch to the marketplace because of new subsidies, while we estimate 475,000 people with ESI would switch to other sources of coverage, with 335,000 people moving to the subsidized marketplace. As noted, the CBO does not believe employers would change coverage decisions given the ARPA's temporary nature. We estimate that employers would be unlikely to change coverage decisions whether the ARPA's enhanced marketplace subsidies were temporary or permanent, but that employees who face high ESI premium contributions and are offered generous marketplace subsidies would change coverage if the policies were permanent.

Lastly, the CBO estimates the ARPA's enhanced marketplace subsidies would increase federal outlays and reduce revenues, increasing the deficit by $21.9 billion in 2022. We estimate net federal spending to increase by $17.6 billion in 2022 under our assumption of a permanent change in law. One likely reason for the difference in costs is that, under our assumptions, we estimate nongroup premiums would fall by 15 percent.

Data and Methods Appendix

We produced our estimates using HIPSM. 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. Our earlier work provides detailed information on the model's design.[14]

The pre-pandemic version of HIPSM was calibrated to state-specific targets for marketplace enrollment following the 2020 open enrollment period, 2020 marketplace premiums, and late 2019 Medicaid enrollment from the Centers for Medicare & Medicaid Services monthly enrollment snapshots.[15] Aging our projections to 2022 involved several steps. First, we aged the 2020 population to 2022 using projections from the Urban Institute's Mapping America's Futures program. We then inflated incomes and health costs to 2022. Because the pandemic has reduced use of expensive care, we assume costs for private nongroup health insurance and Medicaid are flat in 2021 but return to default inflation assumptions in 2022.[16,17] Under our default assumptions, we estimate Medicaid will grow at five percent per year, and out-of-pocket spending and uncompensated care will grow at three percent per year.

Given uncertain economic conditions in 2020, we use a 2022 baseline, a year when conditions should be more stable. We thereby assume, consistent with CBO projections,[18] that the economy will have partly recovered from the pandemic by then. We assume the characteristics of people who remain unemployed at that time are largely consistent with the distribution identified in U.S. Department of Labor data from August 2020, which showed high-wage jobs had recovered to a much greater extent than low-wage jobs. Our 2022 baseline preceded the enactment of the ARPA. We compare this baseline with an alternative policy that makes the ARPA's enhanced premium tax credits permanent.

HIPSM accounts for relevant state regulations, such as banning short-term, limited-duration plans.[19] Our estimates account for the federal individual mandate penalties being set to $0 beginning in plan year 2019, as well as the fact that California, the District of Columbia, Massachusetts, and New Jersey have their own individual mandate penalties. We treat Missouri and Oklahoma, where the ACA Medicaid expansion has been approved by ballot initiative but not yet implemented, as Medicaid nonexpansion states. We do this because the political environments surrounding expansion, even once ballot initiatives are passed, remain uncertain, and the timing and implementation of these expansions are therefore still unknown.

For this analysis, we assume the Medicaid enhanced Federal Medical Assistance Percentage (FMAP) 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 U.S. Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.[20] This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, is expected to last through January 2022. After that, the increased Medicaid enrollment from prohibiting disenrollment will start to phase out, as states resume normal eligibility determinations and process the backlog from the maintenance-of-effort provision. How fast this will happen is uncertain, so Medicaid enrollment may be higher in early 2022 than our estimates indicate. Also, the enhanced FMAP is expected to be available through March 2022. Thus, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

Endnotes

1 Powell J. Getting Back a Strong Labor Market. Economic Club of New York; 2021. https://www.federalreserve.gov/newsevents/speech/powell20210210a.htm. Speech Delivered February 10, 2021.

2 One provision subsidizes the cost of COBRA coverage through September 2021, and another provision guarantees the most generous premium tax credits to anyone who has an unemployment insurance claim in 2021.

3 To be eligible for marketplace subsidies, a person must be lawfully present, not eligible for public coverage, and not have an affordable offer of coverage in the family.

4 Pollitz K. How the American Rescue Plan Will Improve Affordability of Private Health Coverage. https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-will-improve-affordability-of-private-health-coverage. Published March 17, 2021. Accessed March 29, 2021.

5 Policy changes include the reduced length of open enrollment; reduced funding for outreach, advertising, and enrollment assistance; elimination of payments for mandatory cost-sharing reductions; and elimination of the penalty associated with the individual mandate among other changes.

6 Centers for Medicare & Medicaid Services. *Early 2020 Effectuated Enrollment Snapshot*. Baltimore, MD: CMS; 2020. https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Early-2020-2019-Effectuated-Enrollment-Report.pdf. Published July 23, 2020. Accessed March 29, 2021.

7 Glied SA, Arora A, Solis-Roman C. The CBO's crystal ball: How well did it forecast the effects of the Affordable Care Act? Commonwealth Fund. 2015. https://www.commonwealthfund.org/publications/issue-briefs/2015/dec/cbos-crystal-ball-how-well-did-it-forecast-effects-affordable. Published December 15, 2015. Accessed March 29, 2021.

8 Savings from uncompensated care are mainly from lower Medicare Disproportionate Share Hospital spending. Federal costs for uncompensated care are also paid by a number of other agencies including HHS, VA, and IHS; we assume their funding will not automatically shrink in proportion to the reduction in the number of uninsured or the resulting change in demand for uncompensated care.

9 In a recently published report, we estimated coverage effects of a policy (labeled option 3) with similar marketplace subsidies to those under ARPA described in this report. Option 3 would offer more generous CSR subsidies than ARPA, but slightly smaller premium subsidies for lower income households. Its effects on coverage overall are nearly identical. As expected, in comparing the coverage effects of the two policies, we find that option 3 would result in somewhat smaller reductions in the number of uninsured people below 200 percent FPL than ARPA because of slightly less generous premium subsidies for that group. We also find that option 3 would result in somewhat larger reductions in the number of uninsured people above 200 percent FPL, relative to ARPA, due to more generous CSR subsidies for that group. The impact on coverage of the enhanced CSRs at higher incomes in option 3 is limited because of the so-called firewall. See Blumberg, Linda J,. et al. Cost and Coverage Implications of Five Options for Increasing Marketplace Subsidy Generosity. Urban Institute. 2021. https://www.urban.org/sites/default/files/publication/103604/cost-and-coverage-implications-of-five-options-for-increasing-marketplace-subsidy-generosity_0.pdf. Accessed April 12, 2021.

[10] Holahan J, Wengle E, Elmendorf C. Marketplace Premiums and Insurer Participation: 2017 – 2020. Washington: Urban Institute; 2020. https://www.urban.org/research/publication/marketplace-premiums-and-insurer-participation-2017-2020. Published January 15, 2020. Accessed March 29, 2021.

Jacobs P, Banthin J, Trachtman S. Insurer Competition in Federally Run Marketplaces is Associated with Lower Premium. *Health Affairs*. 2015;34:2027-2035. https://doi.org/10.1377/hlthaff.2015.0548. Published December 2015. Accessed March 29, 2021.

[11] Gangopadhyaya A, Garrett B. How Workers Fared under the ACA. *Journal of Health Politics, Policy and Law*. 2020;45 (5): 863–87. https://doi.org/10.1215/03616878-8543322. Published October 1, 2020. Accessed March 29, 2021.

McMorrow S, Blumberg L, Holahan J. Ten Years Later: Reflections on Critics' Worst-Case Scenarios for the Affordable Care Act. *Journal of Health Politics, Policy and Law*. 2020;45 (4): 465–83. https://doi.org/10.1215/03616878-8255421. Published August 1, 2020. Accessed March 29, 2021.

Miller GE, Keenan P, Vistnes J. Trends in Health Insurance at Private Employers, 2008–2018. Statistical brief 524. Rockville, MD: Agency for Healthcare Research and Quality; 2019. https://meps.ahrq.gov/mepsweb/data_files/publications/st524/stat524.shtml.

Vistnes J, Rohde F, Miller GE, Cooper P. Substantial Churn in Health Insurance Offerings by Small Employers, 2014–15. *Health Affairs*. 2017;36 (9): 1632–36. https://doi.org/10.1377/hlthaff.2017.0431. Published September 2017. Accessed March 29, 2021.

[12] Banthin J, Simpson M. Expanding premium tax credits to middle-income families would reduce the number of people uninsured and increase marketplace enrollment. Urban Institute. 2021. https://www.urban.org/research/publication/expanding-premium-tax-credits-middle-income-families-would-reduce-number-people-uninsured-and-increase-marketplace-enrollment. Published February 22, 2021. Accessed March 29, 2021.

[13] Congressional Budget Office. *Reconciliation Recommendations of the House Committee on Ways and Means*. Washington, DC: CBO; 2021. https://www.cbo.gov/publication/57005. Published February 15, 2021. Accessed March 29, 2021.

[14] Buettgens M, Banthin J. *The Health Insurance Policy Simulation Model for 2020*. Washington: Urban Institute; 2020. https://www.urban.org/research/publication/health-insurance-policy-simulation-model-2020. Accessed March 29, 2021.

[15] Buettgens M, Banthin J. *The Health Insurance Policy Simulation Model for 2020*. Washington: Urban Institute; 2020. https://www.urban.org/research/publication/health-insurance-policy-simulation-model-2020. Accessed March 29, 2021.

[16] Wolfson BJ. Covered California announces record-low-rate hike for 2021. *California Healthline*. August 4, 2020. https://californiahealthline.org/news/covered-california-announces-record-low-rate-hike-for-2021. Accessed March 29, 2021.

[17] New York State Department of Financial Services. *DFS Announces 2021 Health Insurance Premium Rates, Protecting Consumers during COVID-19 Pandemic*. Albany, NY: New York State Department of Financial Services; 2020. https://www.dfs.ny.gov/reports_and_publications/press_releases/pr202008132. Accessed March 29, 2021.

[18] We calculate job losses as the difference in 2022 employment rates between the pre- and postpandemic economic forecasts from CBO. Prepandemic forecasts are from the Congressional Budget Office. *The Budget and Economic Outlook: 2020 to 2030*. Washington: Congressional Budget Office; 2020. https://www.cbo.gov/publication/56020. Accessed March 29, 2021; postpandeic forecasts are from Congressional Budget Office. *An Update to the Economic Outlook: 2020 to 2030*. Washington: Congressional Budget Office; 2020. https://www.cbo.gov/publication/56442. Accessed March 29, 2021.

[19] Blumberg LJ, Buettgens M, Wang R. Updated estimates of the potential impact of short-term, limited duration policies. Washington: Urban Institute; 2018. https://www.urban.org/research/publication/updated-estimates-potential-impact-short-term-limited-duration-policies. Published August 16, 2018. Accessed March 29, 2021.

[20] 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.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ERRATA

This brief was corrected April 20, 2021. On page 3, the income range in the first row of table 3 is "below 138 percent of FPL"; a previous version stated the range as "100 to 138 percent of FPL." On the same page, the fourth sentence of "The Uninsured by Income Group" section now refers to "people with incomes below 138 percent of FPL."

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Jessica Banthin and Matthew Buettgens are Senior Fellows, Michael Simpson is a Senior Research Associate, and Robin Wang is a Research Associate, all from the Urban Institute's Health Policy Center. The authors are grateful to Linda Blumberg and Steven Zuckerman for helpful comments and suggestions and to Rachel Kenney for editorial assistance.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information specific to the Urban Institute's Health Policy Center, its staff, and its recent research, visit http://www.urban.org/policy-centers/health-policy-center.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.