



# Changing the “Family Glitch” Would Make Health Coverage More Affordable for Many Families

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Under the Affordable Care Act (ACA), families are generally ineligible for Marketplace premium tax credits (PTCs) if a family member is offered worker-only coverage through an employer that is deemed affordable. The cost of covering the entire family, however, is not considered and may be unaffordable. Coverage is considered affordable if employee contributions for worker-only coverage do not exceed 9.83 percent of family income.<sup>1</sup> In this brief, we investigate the impact of a proposed change that some legal experts believe the US Treasury Department and Internal Revenue Service could make through administrative action or that could be made through legislation: If family coverage is unaffordable, all family members except workers with affordable offers of single coverage would be eligible for Marketplace PTCs.

We find that if this change were made,

- 4.8 million people would be made eligible for premium tax credits (90 percent of them are already purchasing health coverage at more than 9.83 percent of their family income);
- not all of those gaining eligibility for PTCs would be better off switching, but 710,000 more people would enroll in Marketplace coverage with PTCs; in addition, just over 90,000 family members—mainly children—would newly enroll in Medicaid or the Children’s Health Insurance Program (CHIP) owing to their parents seeking Marketplace coverage;
- most new Marketplace, Medicaid, and CHIP enrollees would switch from employer-sponsored insurance (ESI), but there would be 190,000 fewer uninsured people;
- families switching from ESI would save about \$400 per person in premiums on average, accounting for the tax advantage of ESI; families with incomes below 200 percent of the federal poverty level (FPL) would save \$580 per person;

- health insurance premiums in the nongroup market would decline nationwide by about 1 percent, on average, because the new enrollees would generally be healthier than existing ones; and
- the change would cost the federal government \$2.6 billion a year, a 0.6 percent increase in federal spending on acute health care for the nonelderly. This includes new federal spending on health care, offset by additional tax revenue, and savings on uncompensated care spending. State government spending would increase by \$121 million, a 0.1 percent increase. This would be partially offset by additional state and local tax revenue, which we are unable to compute.

## Introduction

Since 2014, the health insurance Marketplaces established in every state by the ACA have become an important and stable source of health coverage for millions of Americans. Enrollment has been steady through two changes in presidential administration and years of major policy changes and uncertainties. In 2020, Marketplace enrollment reached its highest level since 2016,<sup>2</sup> and the American Rescue Plan Act is expected to increase enrollment even further in the next two years.

More than four-fifths of Marketplace enrollees receive federal financial assistance (Buettgens and Banthin 2020). Under the ACA, people with incomes between 100 percent and 400 percent of FPL may qualify for PTCs that reduce the cost of purchasing private health coverage in the Marketplaces.<sup>3</sup> If their income is below 250 percent of FPL, they may also receive cost-sharing reductions (CSRs) that lower their out-of-pocket health spending. Since the enactment of the ACA, millions of Americans have enrolled in private health coverage with PTCs and CSRs.

But there are important restrictions on eligibility for this assistance other than income. PTC recipients must be lawfully present in the United States. PTCs are not available to those eligible for Medicaid or other types of public coverage. As a result, the lower limit for PTC eligibility is 138 percent of FPL (or higher) in states that have expanded eligibility under the ACA. Finally, to be eligible, a family must generally not have a family member with an affordable offer of employer coverage, as defined by the law. This controversial test is the subject of this brief. Under current rules, employer-sponsored insurance is deemed affordable if the cost of employee-only coverage is no more than 9.83 percent of family income in 2021. All family members are ineligible for PTCs to purchase Marketplace coverage if just one family member has an affordable offer of coverage (and family coverage is available) from an employer. This is the case even if the cost of coverage for the whole family is greater than 9.83 percent of family income. This problem is often called the “family glitch.”

## Changing the Family Glitch

Some legal experts believe the Treasury Department has administrative authority to alter the affordability test to consider the cost of family coverage as it affects family members. These experts argue that because the affordability of employer-sponsored insurance is described in different language

in different sections of the ACA, the Treasury Department has discretion to interpret the statutory language either way. Under this scenario, the department would interpret the statute in such a way that a spouse or a child in a family with an affordable offer for the employee but an unaffordable offer of family coverage would be eligible for PTCs to enroll in the Marketplace. The employee would continue to be ineligible for the subsidies. In this brief, we consider the impact of such a change on health insurance coverage and costs. Such a change could be also be made through legislation if a change through administrative action is not possible.

One limitation of the proposed change is that the amount of the PTC would not be adjusted for the cost of employee-only employer coverage. Accordingly, maintaining coverage for the entire family would generally require purchasing employee-only coverage through an employer and contributing to Marketplace coverage for the dependents up to the maximum amount required based on family income. As a result, the family might still need to pay more than 9.83 percent of income for coverage when the cost of coverage for the worker is added to the cost of Marketplace coverage for the other family members. This cost of paying two premiums is sometimes called “premium stacking” and limits the potential savings of the policy change for many families.

Another important factor that limits the potential gain in affordability from changing the family glitch is the exclusion from taxes of employer-provided health insurance benefits. When workers receive health insurance through their jobs, the value of the benefit is not counted as income for tax purposes. The value of the tax exclusion increases with the worker’s income, and for high-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 (Maag et al. 2012). A family moving from family employer coverage to a combination of single employer and family Marketplace coverage must weigh the difference in premiums after accounting for all tax savings.<sup>4</sup> Since PTC amounts are larger for families with lower incomes, the combination of these two relationships means that among families with incomes between 100 percent and 400 percent of FPL who gain eligibility for tax credits, those with lower incomes are more likely to benefit from the proposed change than families with higher incomes.

In this study, we used the Urban Institute’s Health Insurance Policy Simulation Model to estimate the number of people who would gain eligibility for tax credits under the proposed change, how health coverage would change as a result, the savings in health care costs among those taking advantage of their new eligibility, and effects on health spending and the federal deficit. The proposed change would be permanent, so we conduct this analysis without including the temporary enhancements to Marketplace subsidies in the American Rescue Plan Act.

## Methods

This study updates our 2016 estimates of the effects of changing the family glitch (Buettgens, Dubay, and Kenney 2016). A key difference from that earlier study is that we consider only a change in eligibility for tax credits for the dependents of a worker with an affordable offer of single coverage if family coverage is too expensive or unavailable. The worker with an affordable offer of single coverage

remains ineligible for tax credits, and so the impact on employer decisions to offer coverage is small. Under option 1 in the 2016 paper, which made the entire family eligible for PTCs if family coverage was unaffordable, employer decisions to offer insurance coverage changed to a larger degree than under the policy analyzed here. There have also been five years of premium growth since then. Premiums for employer-sponsored health coverage have increased faster than the affordability threshold, so more people would gain eligibility under the proposed change than in earlier years.<sup>5</sup> Our current model captures differences in health coverage since 2016, particularly the increase in the number of states that have expanded Medicaid eligibility and regulatory changes that have expanded the coverage of non-ACA-compliant coverage. The federal income tax brackets and rates changed in 2018, so the computation of the tax advantage of employer-sponsored health insurance is somewhat different. Finally, our estimates assume that the COVID-19 pandemic's effects on employment will bleed into 2022, a consideration that did not exist earlier.

We produced these 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 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 incorporates timely, real-world data to the extent they are available. 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 younger than 65, and reforms are presented as if fully implemented in 2022. These estimates include the residual economic impacts of the COVID-19 pandemic on health coverage in that year but do not include the temporary enhancements to Marketplace premiums under the American Rescue Plan Act.<sup>6</sup>

For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and continuous coverage provisions in the Families First Coronavirus Response Act would have expired before 2022. But in a January 2021 letter to governors, 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.<sup>7</sup> This means the continuous coverage requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, is expected to last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently,

Medicaid enrollment may be higher in early 2022 than indicated in our estimates. But enrollment 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.

## Results

We begin by estimating the number of people who would gain eligibility under the proposed fix to the family glitch, along with their current health coverage, ages, and family incomes. We then simulate the coverage decisions of families affected by the change and show how the distribution of health coverage would change. We show the amount that those families who switch from employer to Marketplace coverage would save on health insurance premiums, considering the important tax advantage of financing health coverage through an employer. Finally, we show the overall impact of the proposed change on health care spending and the federal deficit. For all these results, we assume that Marketplace PTCs would be at their permanent levels under the ACA, without the temporary enhancements in the American Rescue Plan Act.

### Families Affected by the Family Glitch

We estimate that the proposed change would make 4.8 million people eligible for Marketplace PTCs (table 1). These are members of families in which at least one member is offered single coverage deemed affordable under the law, but health coverage for the entire family costs more than 9.83 percent of family income. The workers with affordable offers of single coverage would remain ineligible for Marketplace coverage with tax credits. We estimate there would be 3.6 million workers connected to family members gaining PTC eligibility but who themselves would still be disqualified by offers of single coverage that are deemed affordable (data not shown).

TABLE 1

Characteristics of Those Who Would Gain Eligibility If the Family Glitch Were Eliminated

	Dependents gaining eligibility	
	N (thousands)	Share of total
<b>Current health coverage</b>		
ESI	4,052	84.4%
Nongroup	124	2.6%
Uninsured	462	9.6%
STLDs	161	3.4%
Total	4,799	100.0%
<b>Age</b>		
0–18	2,197	45.8%
19–34	1,133	23.6%
35–54	976	20.3%
55–64	492	10.3%

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

Note: ESI = employer-sponsored insurance; STLDs = short-term, limited-duration policies, or nongroup coverage that is not compliant with the Affordable Care Act.

Most of those gaining access to Marketplace subsidies are in families who currently value health insurance enough to pay roughly 10 percent of their income or more for coverage. About 84 percent are currently enrolled in employer coverage. Just under 10 percent are uninsured, and the remainder have nongroup coverage, whether ACA compliant or not. Similarly, almost 90 percent of the workers disqualified by affordable offers of single coverage already have insurance. Thus, the most common scenario among those affected by the proposed change is a family currently covered through an employer plan who can now choose between that coverage and a combination of single coverage for those with affordable single offers and subsidized Marketplace coverage for other family members.

Nearly 2.2 million children who do not qualify for Medicaid or CHIP would gain eligibility for Marketplace subsidies under the proposed change to the family glitch. This amounts to almost 46 percent of those gaining eligibility. By definition, those gaining eligibility are dependents of workers, so it is not surprising that many would be children. This result occurs despite substantial past expansions of eligibility for children under Medicaid and CHIP. For example, child eligibility thresholds range from close to 200 percent of FPL in many states to 405 percent of FPL in New York.<sup>8</sup>

## Changes in Health Coverage

Those gaining eligibility for PTCs would not necessarily be better off taking them. That depends on the amount of PTCs available at their income level, the cost of single coverage for the worker with an affordable offer, the tax advantage of financing the family's health coverage through an employer, and the difference in out-of-pocket health costs for the family. Not all of those who save money would necessarily switch. When our model accounts for these factors, we estimate that 710,000 more people would enroll in nongroup coverage with PTCs if the family glitch were changed (table 2). There would also be a small decrease in full-pay nongroup enrollment, as a few current nongroup enrollees would gain PTC eligibility. We estimate that the new Marketplace enrollees would be healthier than current enrollees, on average, and would lower nongroup premiums slightly. Nationally, the average reduction would be about 1 percent (data not shown). In addition to lowering premiums for those not receiving PTCs, this would reduce federal PTC costs without affecting the costs of those receiving PTCs.

TABLE 2

## Health Insurance Coverage Distribution of the Nonelderly Population (Thousands of People)

	ACA before ARPA		Family glitch corrected		Change	Percentage-point change	Percent difference
<b>Insured (MEC)</b>	<b>244,113</b>	<b>88.0%</b>	<b>244,303</b>	<b>88.1%</b>	<b>190</b>	<b>0.1%</b>	<b>0.1%</b>
Employer	149,325	53.8%	148,740	53.6%	-585	-0.2%	-0.4%
<b>Private nongroup</b>	<b>14,960</b>	<b>5.4%</b>	<b>15,643</b>	<b>5.6%</b>	<b>682</b>	<b>0.2%</b>	<b>4.6%</b>
Basic Health Program	864	0.3%	865	0.3%	1	0.0%	0.1%
Marketplace with PTC	8,484	3.1%	9,194	3.3%	710	0.3%	8.4%
Other nongroup	5,613	2.0%	5,584	2.0%	-29	0.0%	-0.5%
<b>Medicaid/CHIP</b>	<b>71,162</b>	<b>25.6%</b>	<b>71,255</b>	<b>25.7%</b>	<b>93</b>	<b>0.0%</b>	<b>0.1%</b>
Disabled	9,436	3.4%	9,438	3.4%	2	0.0%	0.0%
Medicaid expansion	14,845	5.4%	14,851	5.4%	5	0.0%	0.0%
Traditional nondisabled adult	12,680	4.6%	12,683	4.6%	3	0.0%	0.0%
Nondisabled Medicaid/CHIP child	34,161	12.3%	34,243	12.3%	82	0.0%	0.2%
State-funded program	40	0.0%	40	0.0%	0	0.0%	0.0%
Other public	8,665	3.1%	8,665	3.1%	0	0.0%	0.0%
<b>Uninsured (No MEC)</b>	<b>33,333</b>	<b>12.0%</b>	<b>33,144</b>	<b>11.9%</b>	<b>-190</b>	<b>-0.1%</b>	<b>-0.6%</b>
Uninsured	30,766	11.1%	30,577	11.0%	-190	-0.1%	-0.6%
Noncompliant nongroup	2,567	0.9%	2,567	0.9%	0	0.0%	0.0%
<b>Total</b>	<b>277,446</b>	<b>100.0%</b>	<b>277,446</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>0.0%</b>

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

Notes: ACA = Affordable Care Act; ARPA = American Rescue Plan Act; CHIP = Children's Health Insurance Program; MEC = minimum essential coverage; PTC = premium tax credit. Results are simulated for 2022 without the American Rescue Plan Act's enhanced PTCs.

There would be an increase of 93,000 in Medicaid and CHIP enrollment, including 82,000 more children. Parents and other family members gaining Marketplace subsidy eligibility will be more likely to seek coverage. When they do so, children and other dependents will be screened for Medicaid and CHIP eligibility as well. That is why enrollment increases in these programs, even though eligibility has not changed. The increase is modest mainly because child Medicaid and CHIP participation rates are already high (Haley et al. 2020).

Changing the family glitch would reduce employer coverage by 585,000 people, roughly 0.4 percent of the total number of people covered through employers. Thus, most of the increase in Marketplace, Medicaid, and CHIP enrollment would be from those currently enrolled in employer coverage. These families currently pay more than 9.83 percent of their family incomes on this coverage. The number of people switching from employer coverage is notably lower than the number of people with employer coverage gaining eligibility because of premium stacking and the tax advantage of financing health insurance through an employer that increases with family income. Expanded access to Marketplace subsidies for dependents would not noticeably change employers' decisions to offer coverage because employer coverage would still be the only alternative for workers with affordable offers of single coverage.

There would be 190,000 fewer uninsured people under the proposed change. Around 462,000 uninsured people gain Marketplace subsidy eligibility (table 1), and 42 percent of those would enroll. Under the proposed change, at least one family member (the worker with an affordable offer of coverage) would be left out of subsidy eligibility and must pay for coverage through an employer or pay the full single premium for nongroup coverage, so this is a less attractive option than if the entire family were made eligible.

### **Premium Savings among New Marketplace PTC Enrollees**

Among families who switch from employer coverage to a combination of Marketplace coverage and employer coverage for workers ineligible for PTCs, we estimate they currently spend \$2,481 per person on premiums (table 3). After the proposed change to the family glitch, they would spend \$1,028 less per person on premiums. But they would also lose most of their current tax advantage for employer coverage, about \$625 per person. On net, families switching coverage in response to fixing the family glitch would save \$403 per family member. Not all those who gain eligibility under this policy change would be better off switching, but those who do see substantial savings.



TABLE 3

### Annual Premium and ESI Tax Subsidies per Family Member for Families Switching from ESI to Marketplace Coverage with ESI for Ineligible Workers

	Premiums per person	Tax subsidy change per person <sup>a</sup>	Total per person
<b>ACA before ARPA</b>			
Income below 200% of FPL	\$1,763	\$0	\$1,763
Income from 200% to 400% of FPL	\$2,855	\$0	\$2,855
All incomes	\$2,481	\$0	\$2,481
<b>Family glitch corrected</b>			
Income below 200% of FPL	\$743	\$441	\$1,184
Income from 200% to 400% of FPL	\$1,823	\$720	\$2,544
All incomes	\$1,453	\$625	\$2,078
<b>Change</b>			
Income below 200% of FPL	-\$1,021	\$441	-\$580
Income from 200% to 400% of FPL	-\$1,031	\$720	-\$311
All incomes	-\$1,028	\$625	-\$403

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

Notes: ACA = Affordable Care Act; ARPA = American Rescue Plan Act; ESI = employer-sponsored insurance; FPL = federal poverty level. Results are simulated for 2022 without the American Rescue Plan Act's enhanced PTCs.

<sup>a</sup> Only changes in tax subsidies (not tax subsidies under the baseline) are computed.

These savings are highest at low income levels because PTCs are more generous at lower incomes and the tax advantage for employer coverage tends to increase with income. Switching families with incomes below 200 percent of FPL save \$580 per person, while those with higher incomes save \$311 per person.

## Health Care Spending and Federal Spending

Because of new subsidized enrollment in Marketplace coverage (partially offset by modestly lower Marketplace premiums), the federal government would spend \$3.0 billion more in premium tax credits (table 4). Additional Medicaid enrollment would cost the federal government \$349 million.

TABLE 4

## Total Spending on Acute Care for the Nonelderly, Millions of Dollars

	ACA before ARPA	Family glitch corrected	Difference	Percent difference
<b>Household</b>				
Premiums	\$300,270	\$299,019	-\$1,251	-0.4%
Other health care spending	\$287,587	\$287,879	\$292	0.1%
Subtotal, household	\$587,856	\$586,897	-\$959	-0.2%
<b>Federal government</b>				
Medicaid	\$376,113	\$376,463	\$349	0.1%
Marketplace PTC	\$58,277	\$61,304	\$3,027	5.2%
Marketplace CSR	\$0	\$0	\$0	0.0%
Additional	\$1,314	\$1,314	\$0	0.0%
Uncompensated care demand	\$31,400	\$31,208	-\$192	-0.6%
Subtotal, federal government	\$467,105	\$470,289	\$3,184	0.7%
<b>State government</b>				
Medicaid	\$199,944	\$200,100	\$156	0.1%
Marketplace PTC	\$398	\$420	\$22	5.5%
Marketplace CSR	\$46	\$48	\$3	5.9%
Additional	\$357	\$357	\$0	0.0%
Uncompensated care demand	\$19,625	\$19,505	-\$120	-0.6%
Subtotal, state government	\$220,370	\$220,431	\$61	0.0%
<b>Employers</b>				
Premium contributions	\$800,116	\$798,115	-\$2,001	-0.3%
<b>Providers</b>				
Uncompensated care	\$27,475	\$27,307	-\$168	-0.6%
<b>Total, all payers</b>	<b>\$2,102,923</b>	<b>\$2,103,038</b>	<b>\$116</b>	<b>0.0%</b>

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

Notes: ACA = Affordable Care Act; ARPA = American Rescue Plan Act; CSR = cost-sharing reduction; PTC = premium tax credit. Results are simulated for 2022 without the American Rescue Plan Act's enhanced PTCs.

We estimate that the demand for uncompensated care funded by the federal government would decline by \$192 million. But uncompensated care is funded by many federal programs. Medicare Disproportionate Share Hospital is the only one for which we can count on savings being automatically realized when the number of uninsured people declines. Thus, the actual savings will likely be only half the decline in demand, about \$96 million (table 5).

Another offset to new federal spending is that federal tax revenue would increase as fewer workers take up employer coverage. We estimate that there would be about \$714 million in new tax revenue. Thus, the policy would require about \$2.6 billion in new federal spending, a 0.6 percent increase in federal spending on acute health care for the nonelderly.

New Medicaid enrollment would increase state spending by \$156 million (table 4). New nongroup enrollment would increase spending by \$25 million in California, Massachusetts, and Vermont, which have state-funded supplemental subsidy programs. The demand for state-funded uncompensated care would fall by \$120 million. States fund uncompensated care in diverse ways, and it is difficult to

estimate how much states would save. For table 4, we assume that nationwide, half the change in demand would be realized as savings. That results in \$60 million of uncompensated care savings to states. The net change in state spending is thus \$121 million, a 0.1 percent increase in spending on acute health care for the nonelderly. This spending would be at least partially offset by increased tax revenue because of higher wages in response to lower employer coverage. But we cannot compute state and local taxes.

Household spending on health care decreases by about \$1 billion, or 0.2 percent. The health care cost savings of people switching from employer coverage are partially offset by the spending of those previously uninsured who newly enroll in private coverage. They are now paying premiums and consuming more health care.

Employer spending decreases slightly, by about \$2 billion, or 0.3 percent. The number of people switching from employer coverage is only about 0.1 percent of the total covered population, so the change in total spending is negligible.

**TABLE 5**  
**Net Federal Deficit Impact, 2022**

	Difference (millions)
<b>Federal government</b>	
Medicaid	\$349
Marketplace PTC	\$3,027
Uncompensated care (Medicare DSH)	-\$96
Federal tax change	-\$714
<b>Total</b>	<b>\$2,566</b>

**Source:** The Urban Institute’s Health Insurance Policy Simulation Mode, 2021.

**Notes:** DSH = disproportionate share hospital; PTC = premium tax credit. Results are simulated for 2022 without the American Rescue Plan Act’s enhanced PTCs.

## Conclusions

We simulate the impact of a proposed change to the ACA that would address the family glitch by extending eligibility for Marketplace subsidies to dependents of workers offered affordable single coverage when the cost of family coverage is more than 9.83 percent of family income.

We find that addressing the family glitch through this change would make 4.8 million people eligible for tax credits, nearly half of whom would be children who are not eligible for Medicaid or CHIP. Nine-tenths of those gaining eligibility already have family health coverage through their employer that would be considered unaffordable using the ACA threshold.

The change would increase Marketplace coverage with PTCs by 710,000 people and Medicaid/CHIP coverage by 93,000 people. Most of these would switch from employer coverage, but

that represents only about 0.4 percent of the total number with employer-sponsored health insurance. We find that the proposed change would reduce the number of uninsured people by about 190,000.

The biggest impact of changing the family glitch would be to make health coverage more affordable for hundreds of thousands of families. Not all the families gaining PTC eligibility would be better off switching, but we estimate that the families who do switch from family employer coverage would save just over \$400 per person in premiums on average, accounting for the tax advantage of financing health coverage through an employer. Switching families with incomes below 200 percent of FPL would save \$580 per person, while switching families at higher incomes would save \$311 per person.

We estimate that changing the family glitch would increase federal government spending by about \$2.6 billion annually, a 0.6 percent increase in spending on acute health care for the nonelderly. State spending would increase by \$121 million, which is only a 0.1 percent increase in state spending on acute health care for the nonelderly. This new spending will be partially offset by additional tax revenue. But HIPSM does not compute state and local taxes.

In summary, changing the family glitch would lower health care premiums for hundreds of thousands of affected families without undermining employer coverage. There would be a modest increase in health coverage, but the biggest effect would be to improve affordability. There would be a small increase in federal government spending and a tiny increase in state spending that would be at least partially offset by additional tax revenue.

## Appendix

TABLE A.1

Those Who Would Gain PTC Eligibility If the Family Glitch Were Changed, by State

State	Number gaining PTC eligibility (thousands)	Share of total gaining eligibility	Share of nonelderly population
Alabama	74	1.6%	1.8%
Alaska	14	0.3%	2.0%
Arizona	162	3.4%	2.6%
Arkansas	47	1.0%	1.8%
California	655	13.7%	1.9%
Colorado	64	1.3%	1.3%
Connecticut	22	0.5%	0.7%
Delaware	13	0.3%	1.7%
District of Columbia	2	0.0%	0.3%
Florida	432	9.0%	2.5%
Georgia	203	4.2%	2.1%
Hawaii	11	0.2%	0.9%
Idaho	47	1.0%	3.1%
Illinois	106	2.2%	1.0%
Indiana	94	2.0%	1.7%
Iowa	31	0.7%	1.2%
Kansas	52	1.1%	2.1%
Kentucky	72	1.5%	1.9%

State	Number gaining PTC eligibility (thousands)	Share of total gaining eligibility	Share of nonelderly population
Louisiana	48	1.0%	1.2%
Maine	19	0.4%	1.8%
Maryland	44	0.9%	0.8%
Massachusetts	44	0.9%	0.8%
Michigan	146	3.0%	1.9%
Minnesota	58	1.2%	1.2%
Mississippi	68	1.4%	2.7%
Missouri	95	2.0%	1.8%
Montana	12	0.3%	1.4%
Nebraska	41	0.8%	2.5%
Nevada	51	1.1%	1.8%
New Hampshire	11	0.2%	1.0%
New Jersey	55	1.2%	0.7%
New Mexico	20	0.4%	1.1%
New York	72	1.5%	0.4%
North Carolina	218	4.5%	2.4%
North Dakota	18	0.4%	2.9%
Ohio	196	4.1%	2.1%
Oklahoma	88	1.8%	2.6%
Oregon	42	0.9%	1.2%
Pennsylvania	111	2.3%	1.1%
Rhode Island	11	0.2%	1.3%
South Carolina	104	2.2%	2.5%
South Dakota	21	0.4%	2.9%
Tennessee	125	2.6%	2.2%
Texas	600	12.5%	2.3%
Utah	77	1.6%	2.6%
Vermont	6	0.1%	1.2%
Virginia	126	2.6%	1.7%
Washington	66	1.4%	1.0%
West Virginia	18	0.4%	1.2%
Wisconsin	69	1.4%	1.4%
Wyoming	17	0.4%	3.2%
<b>Total</b>	<b>4,797</b>	<b>100.0%</b>	<b>1.7%</b>

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

Note: PTC = premium tax credit.

## Notes

- <sup>1</sup> The percentage of household income that defines an affordable offer of coverage is updated each year.
- <sup>2</sup> “Marketplace Effectuated Enrollment and Financial Assistance,” Kaiser Family Foundation, accessed May 4, 2021, <https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/>.
- <sup>3</sup> Legal immigrants who are ineligible for Medicaid solely because of immigration restrictions—most commonly, they have been resident in the US for less than five years—may also qualify for Marketplace subsidies, even if their incomes are less than 100 percent of FPL.
- <sup>4</sup> In addition, in accordance with economic theory, we assume that families who decide to decline family coverage will be compensated by their employers with higher wages or additional tax-free benefits. Our model

automatically incorporates these changes to compensation into workers' decisions regarding health insurance enrollment.

- <sup>5</sup> See the Medical Expenditure Panel Survey Insurance/Employer Component summary tables, series I.C and I.D at "Summary Data Tables," Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, last updated October 26, 2020, [https://www.meps.ahrq.gov/data\\_stats/quick\\_tables.jsp](https://www.meps.ahrq.gov/data_stats/quick_tables.jsp).
- <sup>6</sup> See the methodology appendix in Blumberg et al. (2020).
- <sup>7</sup> 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>.
- <sup>8</sup> "Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level," Kaiser Family Foundation, accessed May 4, 2021, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

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