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Obamacare Subsidies: Six Reasons Congress Should Not Make Temporary Increases Permanent

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KEY TAKEAWAYS

Congress recently expanded Obamacare with temporary subsidy increases. Liberal lawmakers are already trying to make these expansions permanent.

A permanent Obamacare subsidy expansion would benefit primarily the rich, those who already have private coverage, and insurance companies.

It may also induce employers to drop employees' existing coverage, forcing workers into a government program with high cost-sharing and narrow physician networks.

The recently enacted American Rescue Plan Act (ARPA) spent an estimated $90 billion in subsidizing free health insurance to the unemployed and making some of the nation's highest-paid workers eligible for government premium assistance.

According to an analysis by the Congressional Budget Office (CBO), this money did little to increase the number of people with coverage. It did, however, increase the amount the government pays to health insurers on behalf of millions of people who already have subsidized coverage. And it induced millions more people who had insurance to shift to government-subsidized coverage.

These provisions are temporary. Some expire later this year, others at the end of 2022. With the American Families Plan (AFP), President Biden has proposed to

enlarge the premium assistance program in the Affordable Care Act (ACA) to make bigger payments to insurance companies on behalf of those who already have subsidized coverage. He has also proposed a permanent entitlement to government assistance for everyone, including those in the top two income quintiles.

Congress should not have enacted these temporary expansions. It would be worse to make them permanent. Doing so would do little to increase health insurance coverage. Instead, it would establish an entitlement to premium assistance for the wealthiest households and funnel hundreds of billions of additional taxpayer money to insurance companies on behalf of people who already have coverage. It would also create perverse incentives that could further increase premiums and induce employers to stop sponsoring coverage for their workers.

ACA Premium Subsidies Before ARPA

The ACA created premium subsidies for certain people who did not qualify for employer-sponsored coverage or other federal health care programs. The ACA provided government subsidies only to those with incomes between 100 percent and 400 percent of the federal poverty level (FPL)—that is, $12,880–$51,520 for an individual in 2021.[1]

The subsidies limit the amount an individual must pay for premiums for the benchmark plan, which is the second-lowest-cost Silver plan in the region. For example, in 2021, the average premium for benchmark ACA coverage is $452.[2] An individual with income at 100 percent of the FPL would pay no more than 2.07 percent of income for this plan. That would mean a $22 per month premium, with the federal government paying the balance of $430 to the individual's insurance company. An individual with income at 250 percent of the FPL ($32,200) would pay a monthly premium of $224 (8.33 percent of income).

ARPA Temporarily Increased Premium Subsidies

ARPA, enacted in March 2021, temporarily enlarged the ACA premium subsidies in two ways.[3] First, it increased subsidy checks sent by the federal government to insurance companies. It did so on behalf of those who already had subsidized coverage (i.e., those with incomes between 100 percent and 400 percent of the FPL). Second, it made people whose earnings exceed 400 percent of the FPL eligible for subsidies. Both expansions expire on December 31, 2022.

TABLE 1

Premium Subsidies Under the Affordable Care Act (ACA) and the American Rescue Plan Act (ARPA)

Income (as percentage of federal poverty level)	Maximum premium as percent of income (ACA)	Maximum premium as percent of income (ARPA)
<100%	Ineligible for subsidies	Ineligible for subsidies
100%–138%	2.07%	0%
138%–150%	3.10%–4.14%	0%
150%–200%	4.14%–6.52%	0%–2%
200%–250%	6.52%–8.33%	2%–4%
250%–300%	8.33%–9.83%	4%–6%
300%–400%	9.83%	6%–8.5%
>400%	Ineligible for subsidies	8.5%

SOURCE: Daniel McDermott, Cynthia Cox, and Krutika Amin, "Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums," Kaiser Family Foundation, March 15, 2021, https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/ (accessed May 13, 2021).

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Table 1 compares premium subsidies under the ACA and ARPA . The first column presents income categories as a percentage of the FPL. The ACA bars federal premium subsidies to individuals with income below the poverty line, a ban that ARPA retains.[4] Before ARPA, an individual with income between 100 percent and 150 percent of the FPL would spend no more than 2.07 percent of income for benchmark coverage. A person with income at 300 percent of the FPL would pay no more than 9.83 percent of that income for benchmark coverage. Those with incomes above 400 percent of the FPL were ineligible for subsidies.

Under ARPA, a person with income between 100 percent and 150 percent of the FPL would get a free benchmark policy, while someone at 300 percent of the FPL would pay no more than 6 percent of income for benchmark coverage. Table 2 compares the premium subsidies for individual health insurance before and after ARPA, using dollar figures rather than percentages of the FPL.

It is important to note that Table 2 presents *average* premiums for benchmark coverage. Those premiums—and, thus, subsidies—vary

TABLE 2

Premiums and Subsidies for Average Affordable Care Act Benchmark Coverage

		AFFORDABLE CARE ACT (PRE-AMERICAN RESCUE PLAN ACT)		AMERICAN RESCUE PLAN ACT	
Income (by federal poverty level)	**Annual income range for individual**	**Maximum monthly share of premium paid by enrollee**	**Monthly subsidy payment to insurance company**	**Maximum monthly share of premium paid by enrollee**	**Monthly subsidy payment to insurance company**
100%–138%	$12,880–$17,774	$22–$31	$421–$430	$0	$452
139%–150%	$17,775–$19, 320	$46–$67	$385–$406	$0	$452
151%–200%	$19,321–$25,760	$67–$140	$312–$385	$0–$43	$409–$452
201%–250%	$25,761–$32,200	$140–$224	$228–$312	$43–$107	$345–$409
251%–300%	$32,201–$38,640	$224–$317	$135–$228	$107–$193	$259–$345
301%–400%	$38,641–$51,520	$317–$421	$34–$135	$193–$258	$194–$259
>400%	>$51,520	$452	$0	$365*	$87*

* Figures were calculated assuming income at 401% of FPL. The statute caps the maximum share of premium paid by enrollees with incomes greater than 400% of FPL at 8.5% of income. As income rises, the maximum dollars an enrollee pays in premiums rises as well.

NOTE: Figures were calculated using the national average monthly premium for a benchmark plan ($452).

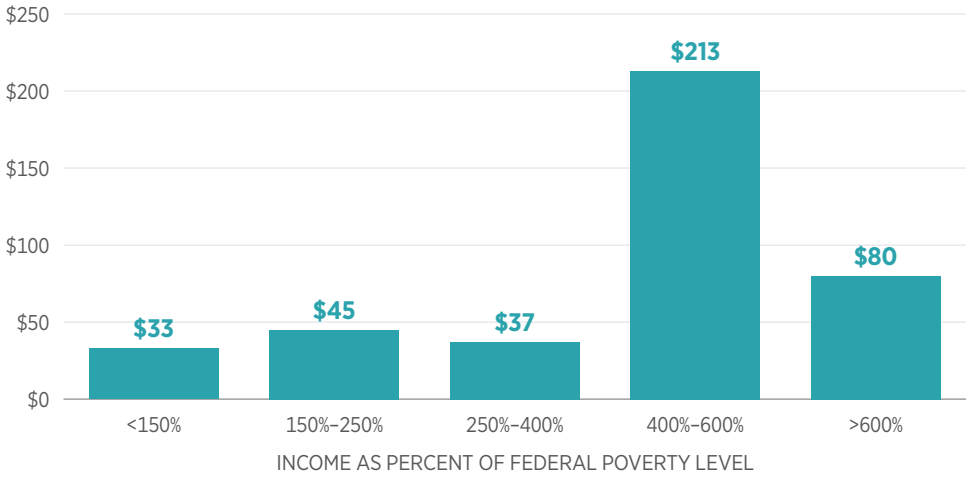
SOURCES: U.S. Department of Health and Human Services, "2021 Poverty Guidelines," January 26, 2021, https://aspe.hhs.gov/2021-poverty-guidelines (accessed May 13, 2021); Internal Revenue Service, "26 CFR 601.105: Examination of Returns and Claims for Refund, Credit or Abatement; Determination of Correct Tax Liability," p. 2, https://www.irs.gov/pub/irs-drop/rp-20-36.pdf (accessed May 13, 2021); Kaiser Family Foundation, "Marketplace Average Benchmark Premiums, 2014–2021," https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&selectedDistributions=2021&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed May 13, 2021); and Congress.gov, "HR 1319, Section 9661," https://www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf (accessed May 19, 2021).

geographically. In places where the premium for benchmark coverage is higher, subsidies are higher. The subsidy equals the difference between the benchmark plan premium and a percentage of the beneficiary's income. For example, under ARPA, an individual with income at 300 percent of the FPL ($38,640) living in an area where the benchmark plan cost $452 would get a monthly subsidy of $194 ($452–$258). The recipient can apply that $194 subsidy to any plan sold on the exchange, including policies that cost less than the benchmark plan.[5]

Table 2 also shows that ARPA now provides full subsidies to people with incomes below 150 percent of the FPL ($32,200) who enroll in benchmark plans. Instead of paying $67 per month for benchmark coverage, an individual at 150 percent of the FPL ($19,320) now gets free health insurance. It is free because the government gives more money to the insurance company—in this case, $452 instead of $385.

CHART 1

Average ARPA Premium Subsidy by Income Level



SOURCE: Kaiser Family Foundation, "How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured," https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/ (accessed May 19, 2021).

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Thus, one significant effect of ARPA was to enlarge government payments to insurance companies on behalf of people who already have subsidized coverage. Insurance companies, already profiting from tens of billions in federal cash, are the biggest beneficiaries of the temporary increases in those payments.

A second major effect was to make people in the top two income quintiles eligible for subsidized health insurance.[6] The ACA did not provide premium assistance to the wealthiest households. ARPA removed the income limit, making 3.5 million people in the top two income quintiles eligible for premium subsidies.[7] Of these, 1.1 million have incomes above 600 percent of the FPL (incomes of at least $77,280 for individuals and $159,000 for families of four).[8]

The Kaiser Family Foundation report also finds that people in the top two income quintiles derive the highest average subsidies from the expansion, as Chart 1 illustrates.

In addition to accounting for 40 percent of new exchange enrollees, people in the top two quintiles collect ARPA's largest average premium subsidies.[9] Those with incomes between 400 percent and 600 percent of the FPL receive average monthly ARPA subsidies of $213, a figure that is nearly seven times as high as the increased subsidy provided by ARPA to those with incomes less

than 150 percent of the FPL. The wealthiest recipients—those with incomes exceeding 600 percent of the FPL—get average ARPA subsidies nearly two-and-a-half times as large as the lowest-income recipients.[10]

These temporary expansions come at great cost to the federal government. The CBO estimates the combined revenue and outlay effects of the premium subsidies at $34.2 billion, with the bulk of the spending occurring during fiscal year (FY) 2022.[11]

Most of that new spending, as noted above, will come in the form of federal payments to insurance companies on behalf of people who already have health insurance. The CBO estimates that the subsidies will cost a total of $21.9 billion in spending and forgone revenues in FY 2022 and cover 1.3 million previously uninsured people.[12] That works out to an average of $16,825 per newly insured person.

The AFP Would Make ARPA Subsidy Increases Permanent

The AFP would make the ARPA premium subsidies permanent.[13] In a fact sheet advancing the proposal, the Administration makes two dubious claims: that it would reduce the number of uninsured people by 4 million and that it would cost the federal government $200 billion (presumably over 10 years).

The Administration's estimate of the coverage effect of the AFP is more than three times higher than the CBO's estimate for ARPA. It seems highly unlikely that permanently extending the ARPA subsidies would reduce the number of uninsured by that amount.

A May 2021 analysis of the Administration's proposal by the Penn Wharton School Budget Model estimates the 10-year costs of extending the premium subsidy at $378 billion, a figure nearly twice the Administration's estimate.[14] The CBO has not yet estimated the cost or coverage effects of these provisions.

Why Congress Should Not Make the ARPA Subsidy Increases Permanent

Congress should reject the Administration's proposal to make the ARPA subsidy increases permanent. Here are six reasons why.

1. Costly Solution in Search of a Problem

The pandemic and government policies that shuttered schools, businesses, and churches were widely believed to have massively increased

the number of uninsured. A July 2020 Urban Institute report, for example, estimated that 10.1 million people would lose coverage tied to a job and that 3.5 million of them would not find another source of insurance.[15] Such forecasts motivated Congress to enact the temporary expansion of premium subsidies in ARPA.

We now know that such forecasts of a surge in uninsurance were erroneous. An analysis by Heritage Foundation experts of administrative data on actual coverage during 2020 found that *5.7 million more people had coverage* in December 2020 than in December 2019.[16] Net enrollment in private coverage (group and non-group) decreased by 2 million individuals, or 1.2 percent, while enrollment in public coverage (Medicaid and the Children's Health Insurance Program) increased by 7.8 million individuals, or 10.9 percent.[17] Furthermore, the analysis found that enrollment in individual market plans increased by 605,000 individuals (or 4.4 percent)—an increase that occurred before Congress increased ACA premium subsidies.

Thus, the underlying premise of the temporary subsidies was faulty. Congress has committed tens of billions of dollars in unnecessary temporary spending that has done little to increase coverage. It should not double down on its error by making the subsidies permanent.

2. Benefits for the Already Insured

Of the new deficit spending authorized by ARPA, $22.5 billion would go to people already enrolled in marketplace plans.[18] The remaining $13 billion would go to new enrollees, many of whom would migrate from some other form of coverage.

For example, a 30-year-old couple with two children and income at 500 percent of the FPL ($132,500) currently buying an unsubsidized insurance policy now qualifies for a subsidy of $4,433.[19] Subsidizing the already insured is an inefficient use of federal money.

3. Benefits for the Wealthy

ARPA made the wealthiest people eligible for subsidized coverage and gave them the biggest average benefits.

This temporary provision has disproportionately benefited high-income earners, particularly those in their 50s and 60s. Because ACA premiums vary by age and family composition, middle-aged and older workers qualify for the most significant subsidies, even when their income is quite high.

TABLE 3

Percent of Monthly Insurer Revenues from Government Subsidies, First Half of 2020

Premium Revenue	$6,061,754,195
Subsidy Revenue	$4,474,218,987
Subsidy as Percent of Revenue	**73.8%**

SOURCE: U.S. Centers for Medicare and Medicaid Services, "Effectuated Enrollment for the First Half of 2020," https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Effectuated-Enrollment-First-Half-2020.pdf (accessed May 19, 2021).

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Under ARPA, a family of four headed by a 45-year-old couple and with income of around $106,000 qualifies for a $10,000 premium subsidy.[20] A 60-year-old couple with the same family composition and income receives more than $20,000 in government premium subsidies.[21] That couple still gets a $10,000 subsidy if its income rises above $230,000. Even at $318,000 of income, the household would qualify for a subsidy of nearly $1,900.[22]

Congress should not have provided subsidies, even temporarily, to the wealthiest households, most of whom already had health insurance.

4. Boon for Insurance Companies

While the government pays subsidies *on behalf of* people who enroll in exchange-based coverage, the government pays those subsidies *to insurance companies*. And since subsidies rise dollar for dollar with benchmark premiums, the higher the premiums, the more government money insurers pocket.

It is no coincidence, then, that the ACA touched off an upward spiral in premiums. Nationally, the average premium paid for individual coverage rose by 129 percent—or more than doubled—between 2013 and 2019.[23]

Not surprisingly, profits rose with those premiums. Average monthly per-enrollee gross margins for insurers in the individual market was $158 through the first nine months of 2020. That was far higher than the $92 monthly margin insurers made on their group business.[24]

Unlike their group business, the lion's share of insurance company revenue in the exchange-based individual market comes from the government, not enrollees.

Table 3 is based on a Centers for Medicare and Medicaid Services (CMS) analysis of enrollment in exchange-based coverage through the first half of 2020.[25]

According to the CMS, more than 10.5 million people had exchange-based coverage during the first half of 2020. Of those, 9.1 million received premium subsidies. Premiums averaged $575, while premium subsidies averaged $491.

Table 3 presents the monthly premium revenue for exchange-based coverage by multiplying the average premium by the number of enrollees. The monthly subsidy revenue is calculated by multiplying the number of subsidy recipients by the average value of the subsidy.

As of June 2020, monthly insurance company revenue from exchange-based coverage averaged $6.1 billion, while monthly government subsidies paid to insurers were just under $4.5 billion. Thus, insurers that sold through the exchanges derived 73.8 percent of their revenue from direct payments from the federal treasury.[26]

By increasing subsidies to people who already receive them and extending them to higher-income households, ARPA will increase government payments to certain insurers for certain government-approved products—and so increase the share of revenue those companies derive from those federal payments.

Enriching insurers without substantially increasing coverage is misguided as a temporary expedient. It is even more misguided as permanent law.

5. Inflationary Effect on Premiums

Federal premium subsidies rise dollar for dollar with the price of premiums for benchmark coverage. That likely contributed to the law's inflationary effects.

The law also dulls consumer price sensitivity by limiting what a subsidized beneficiary pays in premiums for a benchmark policy to a percentage of income. Once that percentage is determined, a consumer has little incentive to worry about a plan's premium, especially if he or she enrolls in the benchmark plan or one with a lower premium. That is especially true with ARPA, where subsidies equal 100 percent of the premium for a benchmark plan for millions of consumers.

The CMS presents this as a feature, not a bug. Its fact sheet on the ARPA premium subsidies states: "Four out of five enrollees will be able to find a plan for $10 or less/month after premium tax credits, and over 50% will be able to find a Silver plan for $10 or less." The statement envisions two overlapping groups of people. More than half of those in

the second group pay $10 or less for their exchanged-based insurance. That is mainly because those with incomes between 100 percent and 150 percent of the FPL now pay $0 for benchmark coverage. Since people with incomes in the 100 percent to 200 percent of the FPL range are disproportionately represented on the exchanges, it is easy to see how more than half the participants have such low premiums.[27]

The reason 80 percent of participants can obtain coverage for less than $10 is that they can apply their subsidies to plans that cost less than the benchmark plan. As discussed above, the subsidy is computed by subtracting the maximum out-of-pocket premium contribution from the benchmark premium. For a person with earnings of 250 percent of the FPL, subtract $107 (4 percent of income) from the cost of the benchmark plan. Assuming the premium for the benchmark plan is at the national average ($452), the subsidy would equal $345 ($452–$107). The premium for the average Bronze plan is $328.[28] If the individual chose a Bronze plan, the coverage would be less generous, but the premium would be $0. The value of the subsidy ($345) exceeds the cost of the policy ($328).[29]

ARPA's temporary expanded subsidies thus create perverse incentives for buyers and sellers alike. Many buyers will be less price sensitive, especially those whose subsidies are equal to or close to the benchmark coverage cost. Sellers have incentives to keep benchmark premiums high, as the larger the benchmark premium, the larger the subsidy.[30]

Right now, that dynamic is temporary, affecting only bids for the 2022 plan year. If Congress makes the ARPA subsidy structure permanent, however, these inflationary effects would be much more likely.

6. Induces Employers to Drop Coverage

Under the ACA, individuals whose employers offer them health insurance that meets certain federal requirements may not receive subsidized exchange-based coverage.[31] This so-called firewall—coupled with the high premiums, high cost-sharing, and narrow networks associated with ACA plans—has helped dissuade firms from dropping their plans. Moreover, employers with at least 50 full-time workers face tax penalties for failing to offer coverage to employees and their children or if the self-only insurance does not meet federal standards of minimum value and affordability.[32]

The ARPA subsidies, according to the CBO, did not change this dynamic. In its analysis of the legislation, the CBO wrote that it did not "anticipate that many employers would change their decision to offer health insurance given the temporary nature of the enhanced subsidy."

Making those subsidies permanent would change the calculus. Once employers know that government will subsidize coverage for workers regardless of their income, they may have fewer inhibitions about dumping their employees into the exchanges, where the government pays a portion of the premiums.

Smaller firms that are exempt from the employer mandate, especially those with older or lower-paid workers, will have strong incentives to discontinue job-based coverage. The ACA made group health insurance more expensive, and the government does not subsidize the premiums.[33] Coverage among small firms dropped abruptly with the ACA's enactment in 2010 and has never recovered. A permanently revamped federal subsidy program might induce firms that have continued to cover their workers to rethink that decision.

In addition to being more costly to the government, such a change would be a bad deal for workers, especially those with average or above average medical expenses. Employer-sponsored coverage is far more generous than ACA coverage, not only in terms of actuarial value but also in establishing broader networks of physicians and other medical providers.

Conclusion

The decision to temporarily increase federal premium subsidies was ill-considered. It was based on the false premise that millions of workers and their dependents had lost coverage due to government lockdowns. It poured almost all resources into subsidizing the premiums of people who already had insurance. It made the nation's highest earners eligible for government premium assistance. It enlarged federal payments to insurance companies in one of their most profitable lines of business and created perverse incentives to inflate premiums. Making these subsidies permanent not only would double down on these bad policies but could also result in millions of Americans losing their employer-sponsored coverage.

Congress erred in enlarging premium subsidies last March. It should not compound that error by making that expanded subsidy structure permanent.

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Endnotes

1. Internal Revenue Service, "26 CFR 601.105: Examination of Returns and Claims for Refund, Credit or Abatement; Determination of Correct Tax Liability," p. 2, https://www.irs.gov/pub/irs-drop/rp-20-36.pdf (accessed May 13, 2021).
2. Kaiser Family Foundation, "Marketplace Average Benchmark Premiums, 2014–2021," https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&selectedDistributions=2021&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed May 13, 2021).
3. H.R. 1319 § 9661, https://www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf (accessed May 20, 2021)
4. Although people with incomes under 100 percent of the FPL are banned from premium assistance, they may be eligible for Medicaid, depending on where they live. Most states have expanded their Medicaid programs to include non-aged, nondisabled, childless adults. In those states, people under 138 percent of the FPL are enrolled in Medicaid. Some states have not expanded their programs. The ACA prohibits assistance to the poorest residents of those states. The ACA established the ban, and neither ARPA nor President Biden's American Families Act proposal would lift it. That arrangement essentially makes low-income residents of those states hostages in a test of wills between the federal government and the governments of those states. Unless a state expands Medicaid, the federal government refuses to help finance their medical care. The best way out of this impasse would be for Congress to adopt the Health Care Choices Proposal (HCCP). Under this proposal, the money the federal government now spends on ACA premium subsidies and Medicaid expansion would be allocated to states based on the proportion of their low-income populations. States could use this money to subsidize coverage to their poorest residents, as well as to those with costly preexisting medical conditions. A detailed summary of the proposal can be found at "Health Care Choices 2020," https://www.healthcarechoices2020.org/ (accessed May 15, 2021).
5. Those with incomes between 100 percent and 200 percent of the FPL get much more generous coverage—but *only* if they enroll in benchmark plans. Coverage for people in that income range has an actuarial value of either 94 percent (for people with incomes between 100 percent and 150 percent of the FPL) or 87 percent (for people with incomes between 150 percent and 200 percent of the FPL). That is more generous than Silver plan coverage (70 percent actuarial value) and much more generous than Bronze coverage (60 percent actuarial value). The lower the actuarial value, the higher the deductible and other cost-sharing requirements. People with incomes above 200 percent of the FPL are not eligible for coverage with actuarial values of 87 percent or 94 percent. They might choose to take advantage of the lower premiums in Bronze plans, despite the higher cost-sharing requirements.
6. Kaiser Family Foundation, "Distribution of Total Population by Federal Poverty Level, 2019," https://www.kff.org/other/state-indicator/distribution-by-fpl/ (accessed May 13, 2021).
7. Matthew Rae et al., "How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured," Figure 2, https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/ (accessed May 13, 2021).
8. Ibid.
9. Congressional Budget Office, "Reconciliation Recommendations of the House Committee on Ways and Means," revised February 17, 2021, p. 13, https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf (accessed May 13, 2021).
10. Rae et al., "How the American Rescue Plan Affects Subsidies," Figure 3. It should be noted that the lowest income individuals are also eligible for ACA subsidies, while those in the top two income quintiles are not. *Total* premium subsidies (ACA subsidies + ARPA) cover the full costs of premiums for those with incomes less than 150 percent of the FPL, as noted above.
11. Congressional Budget Office, "Estimated Budgetary Effects of HR 1319, American Rescue Plan Act—Detailed Tables," Table 9, March 6, 2021, https://www.cbo.gov/publication/57056 (accessed May 13, 2021). In addition, ARPA made people receiving unemployment benefits eligible for free ACA coverage, increasing deficits by an additional $4.5 billion. Finally, ARPA provides free coverage under COBRA through September 30, 2021, increasing the deficit by $51.5 billion ($14.4 billion in outlays and $37.2 billion in forgone revenue). All told, ARPA commits more than $90 billion, the bulk of it in FY 2021 and FY 2022, to subsidizing health insurance coverage.
12. Congressional Budget Office, "Reconciliation Recommendations of the House Committee on Ways and Means," pp. 12–13.
13. The White House, "Fact Sheet: The American Families Plan," April 28, 2021, https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/28/fact-sheet-the-american-families-plan/ (accessed May 13, 2021).
14. Penn Wharton Budget Model, "President Biden's American Families Plan: Budgetary and Macroeconomic Effects," May 5, 2021, Table A-1, https://budgetmodel.wharton.upenn.edu/issues/2021/5/5/biden-american-families-plan (accessed May 13, 2021).
15. Jessica Banthin et al., "Changes in Health Insurance Coverage Due to the COVID-19 Recession," Urban Institute, July 13, 2020, https://www.urban.org/research/publication/changes-health-insurance-coverage-due-covid-19-recession (accessed May 13, 2021).
16. Edmund Haislmaier, "COVID-19: Effects of the Response on Health Insurance Coverage in 2020," Heritage Foundation *Issue Brief* No. 6079, May 14, 2021, https://www.heritage.org/public-health/report/covid-19-effects-the-response-health-insurance-coverage-2020.
17. Ibid.
18. Congressional Budget Office, "Reconciliation Recommendations of the House Committee on Ways and Means," p. 11.

19. Brian Blase, "Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality," Galen Institute, February 2021, p. 10, https://galen.org/assets/Expanded-ACA-Subsidies-Exacerbating-Health-Inflation-and-Income-Inequality.pdf (accessed May 13, 2021).
20. Ibid., Figure 1, p. 9.
21. Ibid.
22. Ibid, Table 5, p. 13.
23. Edmund Haislmaier and Abigail Slagle, "Obamacare Has Doubled the Cost of Individual Health Insurance," Heritage Foundation *Issue Brief* No. 6068, March 21, 2021, .https://www.heritage.org/health-care-reform/report/obamacare-has-doubled-the-cost-individual-health-insurance.
24. Daniel McDermott et al., "Health Insurer Financial Performance Through September 2020," Kaiser Family Foundation, December 16, 2020, https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-through-september-2020/ (accessed May 13, 2021).
25. Centers for Medicare and Medicaid Services, "Effectuated Enrollment for the First Half of 2020," https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Effectuated-Enrollment-First-Half-2020.pdf (accessed May 13, 2021).
26. It is important to note that the exchanges do not constitute the entire individual health insurance market. Insurers sell some ACA-compliant policies outside the exchanges. There are no premium subsidies for those policies. Also, some states still allow those with "grandfathered" non-ACA-compliant plans to continue their coverage. The government does not subsidize premiums for those policies. Exchange-based coverage nevertheless represents the lion's share of the individual health insurance market.
27. People in that income range, in addition to paying little or nothing for insurance, get policies with coverage that is far more generous than are available to people earning more than 200 percent of the FPL—but only if they choose benchmark coverage sold on the exchanges. The actuarial value of Silver plan is 73 percent for someone with income between 200 percent and 250 percent of the FPL and 70 percent for people with incomes greater than 250 percent of the FPL. Those with incomes between 100 percent and 150 percent of the FPL who select benchmark plans get insurance with an actuarial value of 94 percent. The actuarial value of benchmark coverage is 87 percent for those with incomes between 150 percent and 200 percent of the FPL. The increase in actuarial value for those in these income ranges means that they have much lower deductibles and cost-sharing than those at higher income levels but only if they enroll in benchmark coverage sold through the exchanges.
28. Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018–2021," https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/ (accessed May 13, 2021).
29. There is, of course, a trade-off. A beneficiary who chooses a fully subsidized Bronze plan over a Silver plan that requires him or her to pay a portion of the premium gets a policy whose actuarial value is 60 percent rather than 70 percent. The Bronze policy is free, but the deductibles and cost-sharing requirements are significantly higher. The trade-off is sensible for someone who anticipates little or no medical expenses but is less sensible for an enrollee who anticipates incurring average or above average medical expenses.
30. This problem might be mitigated by new entrants into the market because benchmark rates are competitively set. Nevertheless, it is in the interest of all bidders to have high benchmark premiums, as that increases the premium subsidies that the government pays them directly.
31. To meet the law's definition of *minimum essential coverage*, an employer-sponsored plan must have an actuarial value of at least 60 percent and not require a worker to contribute more than 9.83 percent of wages to participate in the plan. The affordability requirement varies annually. The threshold for 2020, for example, was 9.78 percent and for 2019 was 9.86 percent. Stephen Miller, "IRS Raises 2021 Employer Health Plan Affordability Threshold to 9.83% of Pay," Society for Human Resource Management, July 24, 2020, https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/irs-raises-2021-affordability-threshold-for-employer-health-plans.aspx (accessed May 13, 2021).
32. Ibid.
33. The Small Employer Health Insurance Tax Credit has benefited few businesses. Stephen Miller, "ACA's Small Business Tax Credit Goes Largely Unused," Society for Human Resource Management, March 29, 2016, https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/small-biz-tax-credit.aspx (accessed May 13, 2021).