IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

AMERICAN ASSOCIATION OF ANCILLARY BENEFITS, et al.,	§	
Plaintiffs,	§	Case No. 24-CV-783
v.	§	Judge Sean D. Jordan
ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*,	§	
Defendants.	§	

PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO EXTEND STAY

NOW COME Plaintiffs AMERICAN ASSOCIATION OF ANCILLARY BENEFITS and PREMIER HEALTH SOLUTIONS, LLC (collectively, "Plaintiffs"), by and through their counsel, and for their Response to Defendants' Motion to Extend Stay (Dkt. No. 70), pursuant to the Order of this Court (Dkt. No. 71), and state as follow:

Introduction

This Court should deny Defendants' wayward and prejudicial invitation to delay any progress in this case for another six months, all while Plaintiffs and consumers alike continue to be harmed by the challenged regulation that took effect on September 1, 2024. Defendants' Motion (i) is bereft of any supporting factual or legal authority, (ii) is not remotely responsive to this Court's February 18, 2025 Order that granted the original ninety (90) day stay (Dkt. No. 66)], and (iii) is so vague, imprecise and non-committal as to the Defendants' future potential actions – or inactions - that it provides no basis on which this Court can rely, particularly given the

irreparable harm Plaintiffs and consumers continue sustain from this wholly insupportable regulation.

In this regard, consistent with this Court's prior scheduling order, briefing on Plaintiffs' motion for summary judgment regarding this Biden Administration Rule for Short-Term Limited Duration Insurance ("STLDI") plans has been completed since January 10, 2025—as per the Court's October 2024 briefing schedule. (Dkt. Nos. 30, 54). This is Defendants' second request for a stay—which now seeks an incredible indulgence to stay the case for an additional six months until a week before Thanksgiving 2025 (Dkt. Nos. 61, 66, 70). Meanwhile, Plaintiffs and health insurance consumers across the country continue to be harmed by the regulation that took effect on September 1, 2024, and will continue to be further prejudiced by Defendants disregarding this Court's February Order (Dkt. No. 69) and instead asking for a motion to stay during which consumers will remain unable to secure a longer duration STLDI policy under the prior Trump Administration rule to bridge them until the end of the year.

Indeed, the motion at issue seeks to prohibit this Court from exercising its authority to adjudicate the merits of Plaintiffs' claims with respect to the Biden Administration Rule. At this juncture, a stay would render the Court impotent in a way prohibited by *Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024). For the following reasons, this Court should deny the unnecessary request for a six-month extension of the stay of this matter.

Relevant Procedural History

Five months ago, Defendants previously sought an extension of fifteen days to "master the details" of the case to file the Reply in Support of their Cross-Motion for Summary Judgment (Dkt. No. 61, Jan. 23, 2025, at p. 1). Then, in February, Defendants sought an additional three months "to evaluate the government's position in this case and determine how to proceed," or alternatively two weeks to file their reply brief in support of their Cross-Motion for Summary

Judgment motion. (Dkt. No. 66, Feb. 18, 2025, at p. 1). In granting the prior 90-day stay, the Court was clear when it "further ORDERED that, on or before May 19, 2025, the Government Defendants must provide the Court with an advisory concerning the results of their evaluation of their position in this case" and "how the Government Defendants intend to proceed" in this case. (Dkt. No. 69, Order). Although Defendants were granted the 90-day stay over objection of the Plaintiffs, they failed to comply with the clear and explicit edicts of this Court, without any explanation or justification.

Argument

Defendants ignored this Court's Order. Defendants' submission failed to provide this Court, or Plaintiffs, "with an advisory concerning an evaluation of the underlying merits in *this case* and how they intend to proceed." The May 19th submission is devoid of any mention of Defendants' evaluation, which was ordered to be included in Defendants' submission. More incredibly, the Government Defendants waited until the last possible moment of the Court's 90-day extension to file its three-paragraph wholly deficient response. It cannot be argued that the perfunctory response provided this Court or the parties with any definitive steps that Defendants will take regarding the STLDI plans or how Defendants will address the issues raised in this lawsuit. Indeed, Defendants' request is so vague, imprecise and non-committal as to Defendants' future potential actions – or inactions - that it provides absolutely no guidance to the Court or Plaintiffs' as to Defendants' intentions, all as required by this Court's prior Order. Thus, Defendants have ignored the Court's explicit order to provide their evaluation and to communicate how the government's position in the case may have evolved.

Second, Defendants failed to provide any specifics as to how they intend to proceed. Even construing Defendants' submission liberally, at best, Defendants only provided a vague and

noncommittal admission of uncertainty. Namely, Defendants "cannot presently estimate when . . . rulemaking is likely to be completed" and want six more months. (Dkt. No. 70, at pp. 1-2). Ostensibly not having a legal position and not providing any certainty as to how they intend to proceed—Defendants, rather, "intend to revisit the rule challenged here in a new rulemaking" and half a year from now may be able to inform the Court of an anticipated timeline for some potential rulemaking. (*Id.*). That blatantly ignores what this Court ordered. (Dkt. No. 69). Defendants did not explain *any* position at issue with the 2024 Rule: arbitrary and capriciousness, regulatory flexibility analysis, impermissible uncertainty, non-delegation doctrine, State's rights under the McCarran Ferguson Act, or the major questions doctrine. (Dkt. No. 33).

Defendants' principal plan is a possibility of further potential agency rulemaking. That only perpetuates the issue of what "Short-Term Limited Duration Insurance" means where Congress has not defined it. *See Garland v. Cargill*, 602 U.S. 406, 413, 428 (2024) (cleaned up) (striking down administrative agency's final rule, reasoning "it is never our job to rewrite statutory text under the banner of speculation about what Congress might have done."). No matter how purportedly well-meaning the past Administration might have been, Congress did not define STLDI, and "limited duration" does not mean "nonrenewable." *See Id.* at 429 (Alito, J., concurring, something that "highlights the need to amend a law does not itself change the law's meaning."). *See Ass'n for Cmty. Affiliated Plans v. United States Dep't of the Treasury* ("ACAP"), 966 F.3d 782, 789 (D.C. Cir. 2020) (rejecting argument that "limited duration' actually means 'nonrenewable.'").

Plaintiffs previously opposed Defendants' Motion for a Stay, explaining that these delays perpetuate uncertainty and "'significant harm to insured[s] and the healthcare insurance industry' including Plaintiffs, policy holders, state regulators, STLDI issuers, and the public" and that "the relief sought will cause significant harm to Plaintiffs, the consumers of these plans," for "STLDI

plan issuers." (*See* Dkt. #68, at pp. 2-3 (quoting Dkt. No. 63) (noting Defendants' own *Amicus* cautioned of an incoming administration's different positions exacerbating the issues in this case).

In a recent Executive Order, "ADDITIONAL RESCISSIONS OF HARMFUL EXECUTIVE ORDERS AND ACTIONS," the present Administration has sought to "prioritize the interests of American citizens" and rescind "harmful executive actions issued by the prior administration" in order to "restore effective government." roughly one hundred "radical" and "wasteful regulations" and oversteps of the past administration among "Biden's failed policies"—such as this Biden-Administration Rule at issue. Fact Sheet: *President Donald J. Trump Rescinds Additional Harmful Biden Executive Actions* (Mar. 14, 2025).[1] This STLDI regulatory-overstep was one more of those many "failed policies." *Id.*

Defendants' request to stay the case demonstrates that they agree with Plaintiffs that the Biden-Administration Rule is deficient and Defendants do not wish to keep it. (*See* Dkt. No. 70: "they intend to revisit the [Biden-Administration] Rule challenged here in a new rulemaking . . . ."). But in the meantime, Plaintiffs and consumers alike continue to be harmed by the Biden-Administration Rule, and the Motion does not provide any way of knowing *what* another new rule might comprise; nor, in fact, *when* a proposed rule, let alone a final rule, might be released. Further, because Congress never defined STLDI, the lack of meaning persists.

An indefinite stay to prolong the Court from resolution only perpetuates uncertainty—leaving it unresolved—further depriving the public and the Judiciary of a settled plain meaning of "short-term limited duration," where Congress did not define it. Rather, it is the foundation of the Judiciary's independent duty "to say what the law is" and to "interpret the act of Congress, in order to ascertain the rights of the parties." *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369,

[1] https://www.whitehouse.gov/fact-sheets/2025/03/fact-sheet-president-donald-j-trump-rescinds-additional-harmful-biden-executive-actions/.

385 (2024) ("the Framers structured the Constitution to allow judges to exercise that judgment independent of influence from the political branches.") (quoting *Marbury v. Madison*, 1 Cranch 137, 177 (1803); *Decatur v. Paulding*, 14 Pet. 497, 515 (1840)). The public rights continue to mount.

Defendants' continuing requests to stay this litigation compounds the major questions and public harm at hand at a time in which Congress' One Big Beautiful Bill Act, as currently drafted, will create periods of transition for American consumers, who remain hampered by the duration of term and renewability contractions plus other restrictions that were shoehorned in by the past administration in its final months. Additionally, it is well known that Congress is enacting federal spending bills that will drastically reduce subsidies for the ACA and reduce the number of individuals who are eligible for Medicaid. Many agencies and groups have devoted significant time and energy analyzing the effects of cuts to federal health insurance subsidies and the impact on the insurance market. It is important that this Court have the most relevant data, which was absent from Defendants' Motion. Indeed, there is no mention of the impact of the current budget legislation that will only increase the need for and use of STLDI plans. The analysis cited herein only solidifies the major questions doctrine arguments raised by Plaintiffs. The analysis and reports are matters of public record and should be considered by this Court in denying the second Motion to Stay. By way of example and not an exhaustive list, here are some notable reports and resources:

- At a baseline, last year, the Congressional Budget Office (CBO) baseline projections previously estimated that uninsured people would increase from 27.3 to 30.3 million from this year to 2026. (Ex. 1, CBO June 2024 Baseline Projections, at p. 2) (available at: https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf)).[2]

[2] Plaintiffs have included the physical exhibits and the hyperlink sources for ease of Court review.

- In June 2024, the Urban Institute had projected "7.2 million more people will receive subsidized Marketplace coverage under enhanced PTCs in 2025 than if original PTCs had stayed in place," and it estimated that noncompliant nongroup plans would cover 2.4 million people in 2025. (Ex. 2, Jessica Banthin, Matthew Buettgens, Michael Simpson, and Jason Levitis, *Who Benefits from Enhanced Premium Tax Credits in the Marketplace?*, Urban Institute pp. 2, 13 (Jun. 2024) (available at: https://www.urban.org/sites/default/files/2024-06/Who_Benefits_from_Enhanced_Premium_Tax_Credits_in_the_Marketplace.pdf))

- In December 2024, CBO analyzed that "[w]ithout an extension through 2026, CBO estimates, the number of people without insurance will rise by 2.2 million in that year," and "[w]ithout a permanent extension, CBO estimates, the number of uninsured people will rise by 2.2 million in 2026, by 3.7 million in 2027, and by 3.8 million, on average, in each year over the 2026-2034 period." (Ex. 3, CBO, Dec. 5, 2024, at p. 3) (available at: https://www.cbo.gov/publication/59230)).

- The Center on Budget and Policy Priority (CBPP) estimates that "[r]oughly 15 million people (and likely more) by 2035" will "lose health coverage and become uninsured because of the Medicaid cuts" due to the reconciliation bill. (Ex. 4, CBPP, p. 1) (available at: https://www.cbpp.org/sites/default/files/5-19-25health-bythenumbers.pdf)).

- The Kaiser Family Foundation estimates a greater amount than both the CBO and the CBPP if the Reconciliation Bill is Passed and ACA Enhanced Tax Credits Expire, affecting 13.7 million uninsured people. *See* (Ex. 5, Kaiser Fmaily Foundation, May 20, 2025, at pp. 1-3) (Alice Burns, Jared Ortaliza, Justin Lo, Matthew Rae, and Cynthia Cox, *How Will the 2025 Reconciliation Bill Affect the Uninsured Rate in Each State?*: *Allocating CBO's Partial Estimates of Coverage Loss*, KFF (May 20, 2025)) (reporting that "About half (46%) of the 13.7 million more people who would be uninsured in this scenario live in Florida (1.8M), Texas (1.6M), California (1.5M), New York (800k), and Georgia (610k). Texas (2.8M Marketplace growth), Florida (2.8M) and Georgia (1.0M) experienced the most ACA Marketplace growth since 2020, the year before the enhanced premium tax credits became available.") (available at: https://www.kff.org/affordable-care-act/issue-brief/how-will-the-2025-reconciliation-bill-affect-the-uninsured-rate-in-each-state-allocating-cbos-partial-estimates-of-coverage-loss/))

- The Paragon Health Institute, reported that there were 4.8 million marketplace enrollees to receive improper subsidies in 2024, based on representations of income. *See Private Health Reform Initiative*, (Ex. 6, Paragon Health Institute, at pp. 13, 49(estimating "4.84 million fraudulently enrolled people at 100 percent to 150 percent FPL, but only in 21 states as the other states, which include New York and Minnesota that rely on the BHP for coverage for this population, do not meet the above criteria.").(available at: https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/)).

- On May 7, 2025, the CBO issued its analysis and anticipated that over the next nine years—by way of the One Big Beautiful Bill Act—new limits on state taxes on health care providers will cause an increase of 8.6 million uninsured people. (Ex. 7, CBO, at p. 7) (available at https://www.cbo.gov/publication/61377)).

The common thread for the above-referenced figures is that the anticipated spending and subsidies cuts by Congress will leave a void in the health insurance market, which can be filled, in large part, by STLDI plans. However, the Biden Administration Rule has rendered these plans functionally useless and will serve to eliminate other health insurance options to those who cannot afford an unsubsidized ACA plan or qualify for Medicaid. Thus, the harm of the Biden Administration STLDI Rule cannot be overstated.

Contrast these realities with Defendants' principal request for the rest of this year is to try and figure out further agency action—while an illegal Biden Administration Rule will, without a shred of doubt, continue to cause harm to millions of Americans, precluding the citizens there among, who may otherwise wish to opt for STLDI plans from that option. The next Open Enrollment Period (OEP) starts November 2025. Granting Defendants' request effectively prohibits the Court from resolving anything before then. The current administration has already announced a contraction in the OEP to end on December 15, 2025 (rather than January 15, 2026), reduced substantially the funding for OEP federal advertising and budgeted navigators, making it much more likely many consumers may miss their window to keep or enroll in new ACA coverage. If the 6-month motion to stay is granted, that will leave some American consumers without a choice that fits their individual needs in the individual market and without a coverage choice of more than 4 months if they missed OEP or cannot afford an ACA plan..

In fact, the lack of guidance and specificity from Defendants is a tacit admission that the STLDI Rule at issue is one "of deep 'economic and political significance'" i.e., a major question, "that is central to this statutory scheme." *See King v. Burwell*, 576 U.S. 473, 486 (2015) ("had

Congress wished to assign that question to an agency, it surely would have done so expressly."); *see also Biden v. Nebraska*, 600 U.S. 477, 505–06 (2023) ("Because the interpretation of the provision was 'a question of deep 'economic and political significance' that is central to the statutory scheme,' we said, we would not assume that Congress entrusted that task to an agency without a clear statement to that effect," and "[t]hat the statute at issue involved government benefits made no difference in *King*, and it makes no difference here.") (cleaned up); *see also Loper Bright*, 603 U.S. at 405 ("Even where . . . procedural hurdles are cleared, substantive ones remain. Most notably, *Chevron* does not apply if the question at issue is one of 'deep 'economic and political significance.'") (quoting *Burwell*, 576 U.S. at 486).

Defendants' May 19th filing lacks any citation to caselaw or statutory support to justify such extraordinary relief when there is an unprecedented Rule being imposed on millions of health insurance consumers. Instead, Defendants are seeking to continue onward, indefinitely without a settled rule for STLDI.

By any estimates, millions are affected by the prior administration's actions, and millions more will continue to be affected by Defendants' inaction. A healthcare matter that "involv[es] billions of dollars in spending each year and affect[s]the price of health insurance for millions of people" is a major question. *King v. Burwell*, 576 U.S. 473, 485 (2015). And "[i]n extraordinary cases . . . there may be reason to hesitate before concluding that Congress has intended such an implicit delegation . . . This is one of those cases." *Id.*

Conclusion

While "many regulatory priorities competing for limited resources" continue their administrative competition outside of this Court (Dkt. #70, at p. 1), Plaintiffs, consumers, policy holders, state regulators, STLDI issuers, and millions of STLDI-holders will continue to suffer

"agency action in an eternal fog of uncertainty." *Loper Bright*, 603 U.S. at 411. A stay cannot be granted.

In contemplation of a path forward that does not take away Defendants' abilities to do what it did explain in its Motion: (1) the Court may deny Defendants' Motion and provide Defendants the alternate relief, an opportunity to respond on the merits in order to allow the Court to issue its ruling as to the pending dispositive motions; or (2) alternatively—the Court should enjoin the Biden Administration Rule reverting back to the 2018 STLDI Rule, until the current Administration can accomplish its rulemaking goals for STLDI plans.

If a judicial resolution of Plaintiffs' Motion for Summary Judgment strikes down the Biden Administration's Rule—the decision will not leave a vacuum. Under 5 U.S.C. § 706 vacatur, the status quo would revert for the time being to Defendants' Rule that was in place before the Biden-Administration Rule—the 2018 Rule— which the D.C. Circuit upheld. *See ACAP*, 966 F.3d 782, 794 (D.C. Cir. 2020) ("Having concluded that the [2018] STLDI Rule is neither contrary to law nor arbitrary and capricious"); *see also Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 412 (2024) ("we do not call into question prior cases that relied on the Chevron framework."). Therefore, "'limited duration' does not mean 'nonrenewable.'" *ACAP*, 966 F.3d at 789.

A judicial ruling on the meaning of STLDI, will provide Defendants with a settled meaning and a foundational basis upon which they may proceed constitutionally—consistent with *Loper Bright*—in their "intended rulemaking," at their own pace at some future date. (Dkt. #70).

WHEREFORE, for the above and foregoing reasons, PLAINTIFFS AMERICAN ASSOCIATION OF ANCILLARY BENEFITS and PREMIER HEALTH SOLUTIONS, LLC'S, respectfully requests that this Honorable Court enter an Order denying Defendants' Motion to

Extend Stay, an award of attorneys' fees for responding to this motion, and for any further relief this Court deems fair and just.

Respectfully submitted:

By: ***/s/ Dominick L. Lanzito***

Lead Counsel for Plaintiffs
GONZALES TAPLIN PA
s/Dominick L. Lanzito

Alex Gonzales
Dominick L. Lanzito
Texas State Bar No. 24144951
Illinois State Bar No. 6277856
Attorneys for the AMERICAN ASSOCIATION OF ANCILLARY BENEFITS AND PREMIER HEALTH SOLUTIONS, LLC
P.O. Box 171267
Austin, Texas 78717
Tele: (512) 492-5251 (for A. Gonzales)
(312)724-8035 (for D. Lanzito)
Emails: agonzales@gonzalestaplin.com
dlanzito@pjmlaw.com

Michael J. Smith
Local Counsel for Plaintiffs

THE FOWLER LAW FIRM, P.C.
/s/ Michael J. Smith

Michael J. Smith
Texas State Bar No. 24037517
3301 Northland Drive, Suite 101
Austin, Texas 78731
Telephone: 512.441.1411
Facsimile: 512.469.2975
Email: msmith@thefowlerlawfirm.com

CERTIFICATE OF SERVICE

I hereby certify that on May 27, 2025, I caused the foregoing documents to be filed with the Clerk for the Eastern District of Texas through the ECF system. Participants in the case who are not registered ECF users will be served through email.

Date: _____, 2025

Respectfully submitted,

/s/Dominick L. Lanzito

Lead Counsel for Plaintiffs
GONZALES TAPLIN PA
s/Dominick L. Lanzito

Alex Gonzales
Dominick L. Lanzito
Texas State Bar No. 24144951
Illinois State Bar No. 6277856
Texas State Bar No. 24144951
Attorneys for the AMERICAN ASSOCIATION OF ANCILLARY BENEFITS AND PREMIER HEALTH SOLUTIONS, LLC
P.O. Box 171267
Austin, Texas 78717
Tele: (512) 492-5251 (for A. Gonzales)
(312)724-8035 (for D. Lanzito)
Emails: agonzales@gonzalestaplin.com
dlanzito@pjmlaw.com

Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress

Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections

JUNE | 2024

The Congressional Budget Office and the staff of the Joint Committee on Taxation regularly prepare baseline projections of the federal costs associated with each kind of federal health insurance subsidy and of the number of people with health insurance coverage through different sources. The projections reflect the assumption that current laws governing taxes and spending generally remain unchanged. These tables present the latest of those projections. The estimates in the tables underlie CBO's June 2024 baseline projections. The estimates are based on an assumption that legislation enacted through May 12, 2024, remains in place.

Table 1. CBO's June 2024 Projections of Health Insurance Coverage, by Source

Table 2. CBO and JCT's June 2024 Projections of Net Federal Subsidies for Health Insurance

EXHIBIT 1

Table 1.

CBO's June 2024 Projections of Health Insurance Coverage, by Source

Millions of people, by calendar year

	2023[a]	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Total population	338.4	342.3	346.2	349.5	351.9	353.7	355.4	357.1	358.7	360.3	361.8	363.3
Insured people	314.1	315.9	318.9	319.1	319.9	321.3	322.9	324.7	326.5	328.0	329.7	330.9
Uninsured people[b]	24.3	26.4	27.3	30.3	32.1	32.4	32.5	32.3	32.1	32.3	32.2	32.4
Employment-based coverage[c]	164.2	164.1	164.1	165.5	167.1	167.6	168.0	168.5	169.0	169.4	170.0	170.3
Medicaid and CHIP[d]												
People age 65 or older in Medicaid	6.0	5.6	5.6	5.8	6.1	6.2	6.3	6.4	6.5	6.5	6.6	6.7
Blind and disabled people in Medicaid	8.1	7.8	7.7	7.8	8.0	8.1	8.2	8.2	8.3	8.3	8.4	8.4
Children in Medicaid	34.7	30.5	30.1	30.0	29.9	29.8	29.7	29.6	29.6	30.0	31.0	31.1
Adults made eligible for Medicaid by the ACA	17.7	13.3	12.9	13.1	13.2	13.3	13.4	13.5	13.7	13.8	13.9	14.0
Adults otherwise eligible for Medicaid	18.4	14.5	14.1	14.2	14.3	14.3	14.3	14.4	14.4	14.5	14.5	14.5
CHIP	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	6.3	4.6	4.4
Subtotal	92.0	78.7	77.6	78.2	78.6	78.8	79.0	79.3	79.5	79.4	79.0	79.2
Medicare[e]	60.1	61.4	62.9	64.4	66.0	67.4	68.8	70.0	71.1	72.1	73.0	73.9
Nongroup coverage[f]												
Purchased through marketplaces												
Subsidized	14.7	20.1	21.3	15.7	14.1	13.8	13.7	13.4	13.4	13.4	13.8	13.9
Unsubsidized	1.5	1.6	1.5	3.2	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1
Subtotal, purchased through marketplaces	16.2	21.6	22.8	18.9	16.0	15.8	15.7	15.4	15.4	15.4	15.9	16.0
Purchased outside marketplaces	2.9	3.1	3.2	3.7	3.9	4.0	4.0	4.2	4.2	4.3	4.3	4.3
Subtotal, nongroup coverage	19.1	24.7	26.0	22.5	20.0	19.7	19.7	19.7	19.6	19.7	20.2	20.3
Basic Health Program[g]	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.4	1.5	1.5	1.5	1.5
Other coverage[h]	6.1	6.4	7.0	7.3	7.3	7.1	7.0	7.1	7.1	7.1	7.1	7.2
Memorandum:												
People with multiple sources of coverage	28.7	20.8	20.1	20.3	20.6	20.9	21.1	21.2	21.2	21.2	21.1	21.4
Uninsured people with Medicare Part A or Part B only	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.8	0.8	0.8
Share of the population that is uninsured (percent)	7.2	7.7	7.9	8.7	9.1	9.2	9.1	9.0	9.0	9.0	8.9	8.9

Data source: Congressional Budget Office. See www.cbo.gov/data/baseline-projections-selected-programs#6.

The table shows coverage for the Social Security area population—the relevant population for the calculation of Social Security payroll taxes and benefits. Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies. Estimates for each source of health insurance exclude people with supplemental or partial coverage that, on its own, would not provide financial protection against major medical expenses and thus would not meet the CBO's definition of health insurance. For a fuller discussion, see Congressional Budget Office, *Federal Subsidies for Health Insurance: 2023 to 2033* (September 2023), Appendix B, www.cbo.gov/publication/59613. The components exceed the total population because some people enroll in multiple sources of coverage, and for this table, CBO did not assign them to a primary source.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL = federal poverty level; VA = Department of Veterans Affairs.

a. Actual amounts are estimated on the basis of preliminary data and are subject to revision.

b. CBO considers people uninsured if they are not covered by an insurance plan or enrolled in a government program that provides financial protection from major medical expenses. Estimates include people enrolled only in Medicare Part A or Part B, people receiving only partial Medicaid benefits, and people enrolled in some short-term plans.

c. Includes enrollees in the military's TRICARE program and the VA's health care but does not include people with Medicare wraparound coverage provided through a former employer.

d. Medicaid enrollment includes only enrollees with full benefits. Estimates have been adjusted to account for people enrolled in more than one state.

e. Includes only people who are enrolled in both Medicare Part A and Part B.

f. The marketplaces established under the ACA are operated by the federal government, state governments, or partnerships between the two. Estimates do not include enrollees in supplemental medigap plans.

g. Created under the ACA, the Basic Health Program allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the FPL. The federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace. Only Minnesota and Oregon currently operate such a program. Estimates include enrollment in New York's Essential Plan, which is funded through an ACA waiver and mirrors the Basic Health Program, with eligibility up to 250 percent of the FPL.

h. In 2024, the other sources that cover the most people are student health plans (3 million) and correctional facilities (2 million). The Indian Health Service and foreign sources of coverage account for most of the remaining people in this category.

Table 2.

CBO and JCT's June 2024 Projections of Net Federal Subsidies for Health Insurance

Billions of dollars, by fiscal year

	2023[a]	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	Total, 2025–2034
Employment-based coverage													
Tax exclusion for employment-based coverage[b,c]	n.a.	384	414	477	518	542	567	594	623	653	683	714	5,784
Income tax deduction for self-employment health insurance	n.a.	5	6	8	9	9	10	10	11	11	12	12	98
Small-employer tax credits[c]	n.a.	*	*	*	*	*	*	*	*	*	*	*	*
Gross collections of penalty payments by employers[d]	n.a.	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-11
Subtotal	n.a.	389	419	484	525	550	575	603	633	663	694	725	5,871
Medicaid and CHIP[e]													
People age 65 or older in Medicaid	111	118	120	124	131	140	148	156	163	170	178	186	1,516
Blind and disabled people in Medicaid	177	191	192	193	201	211	222	232	243	255	268	281	2,298
Children in Medicaid	73	70	70	71	73	76	80	84	88	92	101	106	841
Adults made eligible for Medicaid by the ACA	130	114	110	113	119	127	136	145	155	165	176	187	1,433
Adults otherwise eligible for Medicaid	62	56	53	54	56	59	62	66	69	73	77	82	652
CHIP	18	19	19	19	20	20	21	21	22	22	15	15	194
Subtotal	571	568	564	575	600	634	668	703	739	778	815	858	6,935
Medicare[f]	825	891	923	986	1,054	1,124	1,201	1,284	1,376	1,473	1,595	1,719	12,734
Premium tax credits and related spending													
Outlays for premium tax credits	70	98	107	84	86	89	91	93	97	101	107	111	966
Revenue reductions from premium tax credits	n.a.	16	22	24	15	15	15	16	16	17	18	19	176
Outlays for 1332 waivers and the Basic Health Program[g]	12	16	16	16	17	18	18	19	20	21	22	9	177
Collections for risk adjustment	-9	-11	-14	-16	-15	-15	-15	-16	-16	-17	-18	-19	-162
Payments for risk adjustment	8	10	12	15	16	15	15	15	16	17	18	18	158
Subtotal	n.a.	129	143	123	118	122	125	128	133	139	147	138	1,316
Other federal subsidies associated with supplemental or partial benefits[h]	n.a.	42	44	48	52	55	58	62	66	69	74	78	606
Net subsidies	**n.a.**	**2,019**	**2,093**	**2,216**	**2,350**	**2,485**	**2,627**	**2,780**	**2,946**	**3,122**	**3,325**	**3,518**	**27,462**
Memorandum:													
Net subsidies as a percentage of GDP	n.a.	7.1	7.0	7.2	7.4	7.5	7.6	7.8	8.0	8.1	8.3	8.5	n.a.

Data sources: Congressional Budget Office; staff of the Joint Committee on Taxation. See www.cbo.gov/data/baseline-projections-selected-programs#6.

The table shows federal subsidies for the Social Security area population—the relevant population for the calculation of Social Security payroll taxes and benefits. The table excludes discretionary outlays and outlays made by the federal government in its capacity as an employer.

Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; GDP = gross domestic product; JCT = Joint Committee on Taxation; n.a = not available; * = less than $500 million.

a. Actual amounts are estimated on the basis of preliminary data and subject to revision

b. The estimates shown, produced by JCT, reflect the tax value of the exclusion of employment-based health insurance from federal income and payroll taxes, as well as penalty payments by employers but not the tax value of the exclusion associated with Medicare wrap-around coverage for former employees. The tax value represents the change in tax revenues that would result if the exclusion from federal income and payroll taxes was repealed and the total compensation paid by the employer (including the employer's payroll taxes) remained constant by increasing wages. The estimates differ from those of the tax expenditure for the exclusion. The tax expenditure represents the change in tax revenues if the amount of excluded compensation was taxed and was larger than the tax value.

c. Include increases in outlays and reductions in revenues.

d. Exclude the associated effects on revenues of changes in taxable compensation, which are included in the estimates of the tax exclusion for employment-based insurance. If those effects were included, net revenues from penalty payments by employers would total $8 billion over the 10-year period.

e. For Medicaid, spending reflects medical services for enrollees who have full Medicaid benefits.

f. Spending for Medicare beneficiaries enrolled in both Part A and Part B. Estimates include Part D benefits, which are calculated net of premiums and certain other payments to the government, and have been adjusted to exclude the effects of shifts that occur in the timing of monthly payments when October 1 falls on a weekend.

g. Under section 1332 of the ACA, states may apply for waivers from some of the rules governing insurance markets or programs offering health insurance established by the ACA. To obtain a waiver, a state's proposal must be budget neutral and provide comparable levels of insurance coverage.

h. Include federal subsidies for people with supplemental or partial coverage that, on its own, would not provide financial protection against major medical expenses and thus would not meet CBO's definition of health insurance. Estimates include the tax value of the exclusion associated with Medicare wraparound coverage provided to former employees; Medicare spending on enrollees who receive only Part A or Part B benefits; and Medicaid spending on enrollees who receive partial benefits, such as beneficiaries who are also eligible for Medicare for whom Medicaid pays only Medicare premiums or cost sharing.

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Who Benefits from Enhanced Premium Tax Credits in the Marketplace?

Jessica Banthin, Matthew Buettgens, Michael Simpson, and Jason Levitis

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Enhanced premium tax credits (PTCs) were a key element of the American Rescue Plan Act (ARPA) passed by Congress in March 2021, which aimed to expand and stabilize health insurance coverage during the COVID-19 pandemic. The enhanced PTCs substantially increased the subsidies available for people to buy insurance in the Marketplace: they reduced net premiums to zero for some people with low incomes and made subsidies available to people with higher incomes for the first time. The ARPA provisions regarding enhanced PTCs are temporary and were set to expire after 2022, but the Inflation Reduction Act (IRA) of 2022 extended them through 2025. As a result, Marketplace enrollment steadily increased and, during the 2024 open enrollment period, jumped by 5 million people, or 31 percent.[1] Soon, Congress will debate whether to extend enhanced PTCs again, or possibly make them permanent.

In this brief, we estimate the impact of the ARPA/IRA enhanced PTCs on coverage for 2025, the last year in which they are authorized under current law. The year 2025 is also the year when we expect to see the largest impact from enhanced PTCs on coverage, since we project Marketplace enrollment in 2025 will continue at the high levels seen in 2024. We compare coverage with and without enhanced PTCs to isolate the number of people who have gained Marketplace coverage due to this provision of the law. When estimating coverage under a policy without enhanced PTCs, we assume an alternate scenario in which the original Affordable Care Act PTCs would have remained in effect.

We also calculate household net premiums (after subsidies) with and without enhanced PTCs to measure the improvements in affordability among those receiving premium subsidies. We show how all

EXHIBIT 2

income groups have benefitted from this change in law and how impacts have varied by state. We find that enhanced PTCs have helped several million people gain coverage and have improved the affordability of coverage for all Marketplace enrollees.

Our key findings are as follows:

- Because enhanced PTCs make coverage more affordable to more people, we project that 7.2 million more people will receive subsidized Marketplace coverage under enhanced PTCs in 2025 than if original PTCs had stayed in place.
- Under enhanced PTCs, we project that there will be 4.0 million fewer uninsured people in 2025 relative to a policy under original PTCs, a difference of 14 percent.
- In 2025, we project that household net premiums will be lower by 50 to 100 percent for the lowest income groups under a policy of enhanced PTCs compared with a policy of original PTCs. Net premiums will be lower by about one-quarter for people with higher incomes who receive subsidized Marketplace coverage.
- In five states—Texas, South Carolina, Mississippi, Louisiana, and Georgia—we project the nongroup market in 2025 will be roughly double the size under the enhanced PTCs compared with original PTCs, leading to declines in the number of uninsured of 21 percent or greater.

Background

The Affordable Care Act of 2010 transformed the nongroup market by prohibiting exclusions for preexisting conditions; requiring community-rated premiums that vary only by age, region, and smoking status; regulating what types of polices can be sold; and defining a set of minimum essential health benefits. The Affordable Care Act also established Marketplaces where eligible people could access premium tax credits that subsidized the cost of coverage. The original PTCs provided subsidies that progressively declined with income and limited the share of household income that individuals owed toward their net premium, ranging from 2.07 percent of income for people with the lowest incomes to 9.83 percent of income for people with incomes between 300 and 400 percent of the federal poverty level (FPL) as of 2021, the last year in which they were in effect (appendix A, table A1). People with incomes below 100 percent of FPL and above 400 percent of FPL were not eligible for the original PTCs.

Effective in April 2021, the ARPA changed the premium subsidy schedule by lowering the limits on the share of household income people pay for premiums (see appendix A, table A1). The IRA then extended this change through 2025. Under the original PTCs, for example, people with incomes below 150 percent of the federal poverty line (FPL) would have to pay as much as 3.64 percent of their income toward premiums for a benchmark plan (the second lowest-cost silver plan in their rating area) in 2025. Under the ARPA/IRA enhanced PTCs, they pay zero percent of their income. The ARPA reduced payment thresholds across all income categories, which substantially reduced net premiums for households. The ARPA also extended eligibility for PTCs to higher income groups. Under the original

PTCs, people with incomes over 400 percent of FPL were not eligible for any premium tax credits. Under the enhanced PTCs, eligible people in this group pay no more than 8.5 percent of their income.

In response to the enhanced PTCs, Marketplace plan selections during the annual open enrollment period have grown steadily since 2021, from 12 million in 2021 to 14.5 million in 2022 to 16.4 million in 2023.[2] In 2024, plan selections jumped 31 percent to a total of 21.4 million people signing up for coverage. Changes in the number of plan selections provide a good estimate of the trend but do not accurately measure actual enrollment. Numbers drop when the first monthly premiums are due and there is often mid-year attrition. In this report, we present estimates of average monthly enrollment, a more accurate measure of coverage.

Although the trend in Marketplace enrollment is clear, it is nonetheless difficult to assess the full impact of enhanced PTCs on coverage because of simultaneous changes in Medicaid rules. Between 2020 and 2023, Medicaid enrollment grew to unprecedented levels due to the pandemic-related continuous coverage requirement that prohibited states from disenrolling people from Medicaid. It is likely that expanded Medicaid enrollment dampened the response to the enhanced PTCs as people stayed on Medicaid instead of switching to the Marketplace once they found jobs. However, when the continuous coverage requirement ended in March 2023, states began redetermining eligibility for Medicaid and disenrolling ineligible people. We expect this so-called unwinding to extend into 2025, and it has already led to more people switching from Medicaid to Marketplace coverage (Buettgens, Carter, Banthin, and Levitis 2024). Looking to 2025, we project that Marketplace enrollment will remain at the same high levels as in 2024.

Data and Methods

We used the Urban Institute's Health Insurance Policy Simulation Model to produce our analysis of the effects of ARPA/IRA's enhanced PTCs on coverage and household spending in 2025.[3] The Health Insurance Policy Simulation Model is a microsimulation model of the US health care system focused on the nonelderly population and is designed to estimate the cost and coverage effects of proposed policy changes. The model's baseline is regularly updated to reflect changes in law, state policies such as Medicaid expansion, premium increases, population growth, general inflation, and the most recent published Medicaid and Marketplace enrollment and costs in each state. We project the model's baseline to 2025, the final year of enhanced PTCs under current law, and the year in which we expect to find their largest impact.

For this report, we updated the Health Insurance Policy Simulation Model using 2024 Marketplace premiums and state-level Marketplace enrollment data from the 2024 Open Enrollment Period Report snapshot released by the Centers for Medicare & Medicaid Services.[4] We adjust the Open Enrollment Period Report snapshot numbers downward to more accurately represent average monthly Marketplace enrollment for the entire year. These adjustments reflect the "effectuation" of plan choices, midyear attrition, and recent evidence that some 2024 plan selection data was inflated due to the actions of certain brokers.[5] We also incorporated Marketplace data from mid-2023 to show the

distribution of plan selections by metal tiers (bronze, silver, gold, and platinum), which reflect the generosity of plan benefits.

To isolate the effects of the ARPA/IRA subsidies, we compare the enhanced PTCs to a policy without them using the Health Insurance Policy Simulation Model to simulate coverage and household spending in 2025 as if the original PTCs indexed to 2025 were in effect. Our estimates for 2025 under enhanced PTCs assume Marketplace coverage will be at similar levels to coverage in 2024. For more information on the Health Insurance Policy Simulation Model see Buettgens and Banthin 2022.

Results

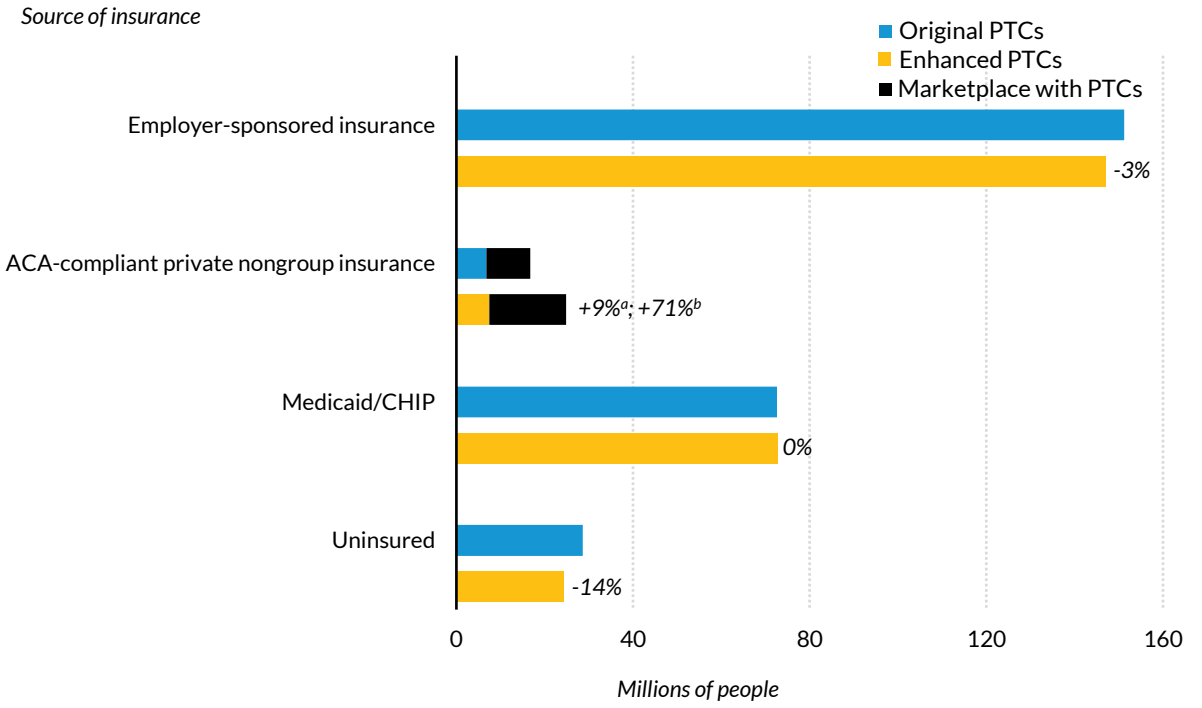
Our analysis of the ARPA/IRA's enhanced PTCs compared with original PTCs resulted in the following projections.

Decrease in Uninsured People and Increase in Marketplace Enrollment

Enhanced PTCs will reduce the number of uninsured people in the US by 4.0 million and increase Marketplace enrollment of people receiving PTCs by 7.2 million in 2025. By making coverage more affordable to more people, the subsidized Marketplace will expand to cover 17.4 million people under enhanced PTCs in 2025, compared with 10.2 million people had original PTCs stayed in effect, a large difference of 7.2 million, or 71 percent (figure 1). The total nongroup market—which includes the subsidized and unsubsidized Marketplace, other nongroup coverage that complies with federal standards purchased outside of the Marketplace, and the Basic Health Program—will cover 24.9 million people under enhanced PTCs, compared with 17.1 million people if original PTCs had stayed in effect, a difference of 7.9 million or 46 percent (appendix A, table A2).

FIGURE 1

Projected Coverage of the Nonelderly under Original and Enhanced Marketplace Subsidies, 2025



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Source: The Urban Institute, Health Insurance Policy Simulation Model, 2024.
Notes: PTC = Premium Tax Credit; CHIP = Children's Health Insurance Program. [a] = Basic Health Program, full-pay Marketplace, and other ACA compliant nongroup; [b] = Marketplace with Premium Tax Credit. Percentages are the differences between enhanced and original premium tax credits per FPL category.

Enhanced PTCs attract people to the Marketplace, drawing them about equally from two categories: people who are uninsured and people who have employer-sponsored insurance coverage. We estimate that enhanced PTCs will reduce the number of uninsured people by 4.0 million in 2025 compared with a policy with original PTCs, a decline of about 14 percent (see figure 1). Uninsured people who qualify for zero or very low premiums under the enhanced PTCs will find it much more affordable to purchase coverage. In addition, we estimate employer-sponsored insurance will shrink by 4 million people, a decline of about 3 percent. In some cases, people with unaffordable employer-sponsored insurance offers who qualify for Marketplace subsidies and who previously stayed in employer-sponsored insurance will make the switch to the Marketplace when premiums are made lower under the enhanced PTCs. In other cases, some small firms will decide against offering health coverage to their employees when enhanced PTCs make the Marketplace more attractive than similar policies offered by the firm.

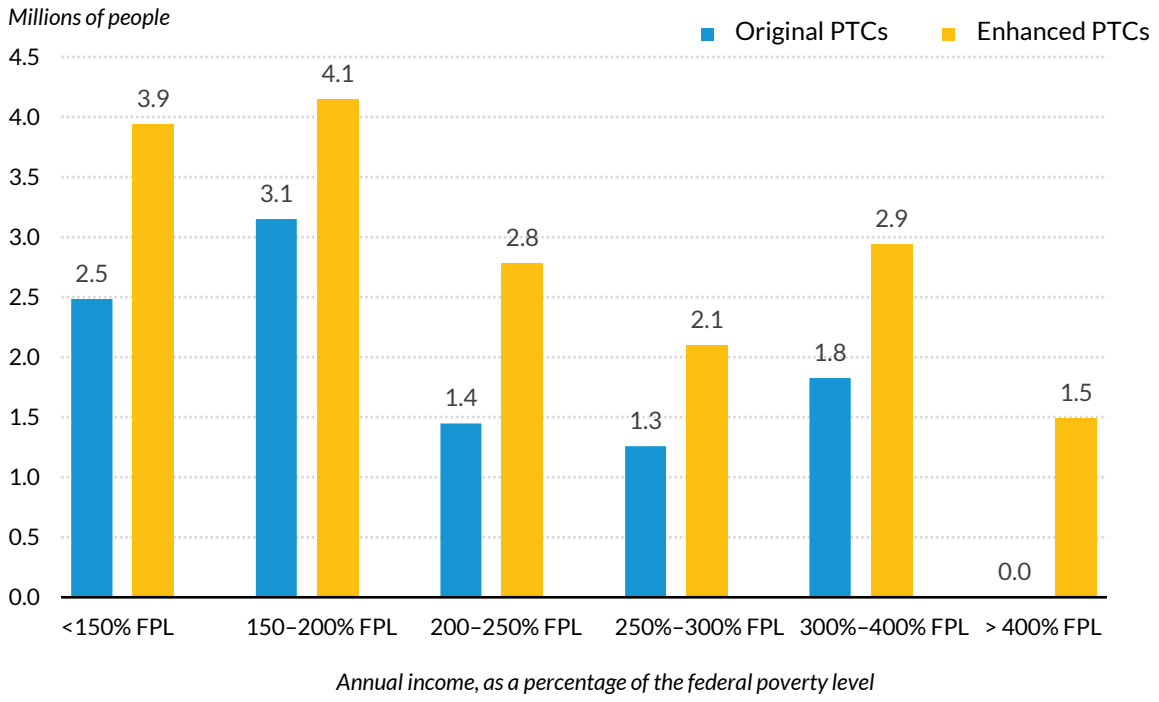
Under enhanced PTCs, there will be almost no change in the number of people enrolled in Medicaid in 2025, compared with a policy with original PTCs, according to our projections.

Greater Marketplace Enrollment and Affordability

Enhanced PTCs lead to greater Marketplace enrollment in all income categories. We estimate greater Marketplace enrollment across all income categories in 2025, a result of enhanced PTCs replacing original PTCs (figure 2). Among people with incomes below 150 percent of FPL, we project an increase of 1.5 million people or 59 percent. Among people with incomes between 150 and 200 percent of FPL, we project an increase of 1.0 million people or 32 percent. Among people with incomes between 200 and 250 percent of FPL, we project an increase of 1.3 million people, almost double the number of enrolled people if original PTCs had stayed in place. We project similar enrollment increases in higher income categories.

FIGURE 2

Projected Subsidized Marketplace Coverage with Original and Enhanced Premium Tax Credits by Federal Poverty Level Category, 2025



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Source: The Urban Institute, Health Insurance Policy Simulation Model, 2024.
Note: PTC = premium tax credit; FPL = federal poverty level. FPL varies by year and household size; for 2024 FPL is $15,060 for an individual and $31,200 for a family of 4, and 400% of FPL is $60,240 for an individual and $124,800 for a family of 4. People above 400% of FPL with PTCs under original subsidies are projected to receive a state-funded premium tax credit.

Among people with incomes above 400 percent of FPL, we project a substantial increase in Marketplace enrollment in 2025. Under original PTCs, people in this group would not be eligible for any federal subsidies.[6] Under the enhanced PTCs enacted in 2021, this group became eligible for subsidies

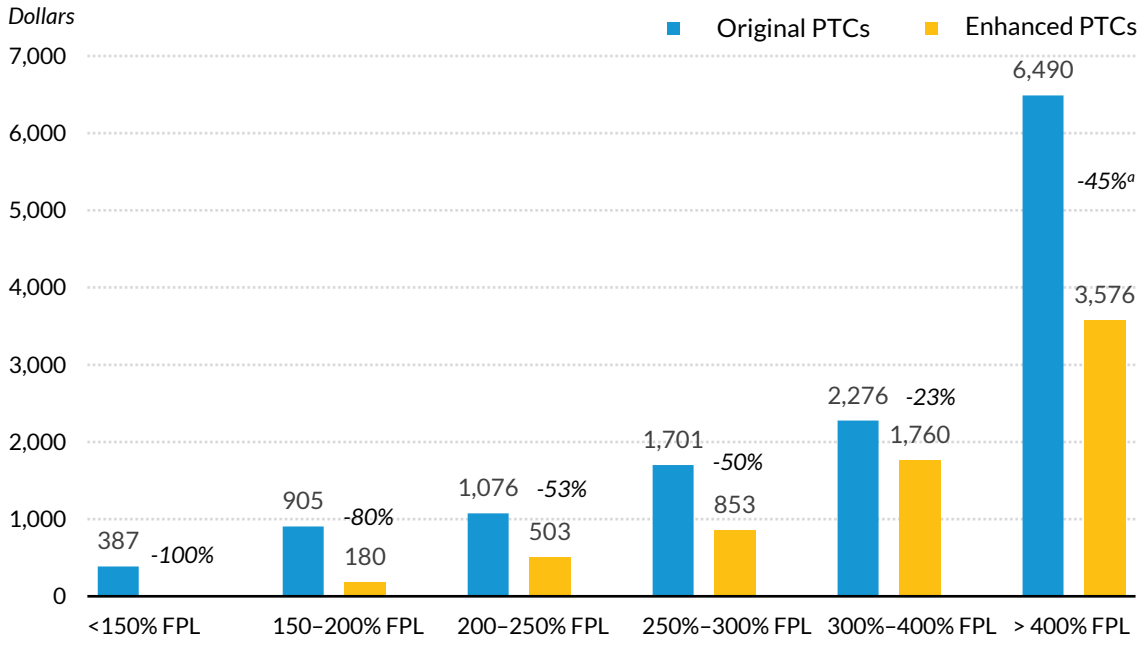
for the first time. In 2025, we project that subsidized Marketplace enrollment will jump to 1.5 million people for this income category.

Enhanced PTCs substantially improve the affordability of Marketplace premiums across all income categories. Enhanced PTCs directly reduce the premiums paid by individuals and families who enroll in Marketplace coverage by applying a more generous subsidy schedule that lowers the threshold (or share) of family income owed for the premium. Enhanced PTCs further reduce premiums indirectly by attracting substantially more and healthier people to the Marketplace, which lowers the average health risk of the nongroup population and also encourages increased competition among insurers. We project that under enhanced PTCs, average total Marketplace premiums (before subsidies) will be 5 percent lower on average across all states in 2025 compared with total Marketplace premiums under a policy of original PTCs (data not shown).

Accounting for both factors, we project substantial declines in net premiums. People with incomes below 150 percent of FPL will typically pay no premiums in 2025 under enhanced PTCs compared with $387 under original PTCs (figure 3). The premium cost is notably low because people in this income category are eligible for zero-premium plans. We project that people with incomes between 150 and 200 percent of FPL will pay $180 in average annual premiums in 2025 under enhanced PTCs compared with $905 under original PTCs, a decline of 80 percent. Among people with incomes between 200 and 250 percent of FPL, we project $503 in average annual premiums under enhanced PTCs compared with $1,076 under original PTCs, a decline of 53 percent. We project a decline of 50 percent for people with incomes between 250 and 300 percent of FPL and a decline of 23 percent for people with incomes between 300 and 400 percent of FPL.

FIGURE 3

Projected Average Annual Premiums Paid by People with Subsidized Marketplace Coverage under Original and Enhanced Premium Tax Credits, by Federal Poverty Level Category, 2025



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Source: The Urban Institute, Health Insurance Policy Simulation Model, 2024.
Notes: PTC = premium tax credit; FPL = federal poverty level. FPL varies by year and household size; for 2024 FPL is $15,060 for an individual and $31,200 for a family of 4, and 400% of FPL is $60,240 for an individual and $124,800 for a family of 4. Percentages are the differences between enhanced and original premium tax credits per FPL category.
[a] No federal subsidies are available to people above 400% of FPL under original PTCs, so premiums shown are for unsubsidized Marketplace participants in that income group.

Policies under both enhanced and original PTCs require that household premium contributions get larger as income increases. This pattern is seen in figure 3, where we see that people with incomes over 400 percent of FPL pay the highest average premiums. People in this income category are eligible for federal subsidies under enhanced PTCs but not under original PTCs. We project they will pay $3,576 in average annual premiums in 2025 under enhanced PTCs.

Effect on Cost Sharing

Enhanced PTCs do not alter cost-sharing expenses directly for Marketplace enrollees but do allow some people to switch to more generous plans that have lower cost-sharing obligations (appendix A, table A3). Once enrolled in Marketplace coverage, individuals and families incur out-of-pocket costs when they use health care services, which is called cost sharing. Cost-sharing expenses include deductibles and copays and vary by the type of plan enrollees choose. The Marketplace offers plans labeled bronze,

silver, gold, and platinum that cover 60, 70, 80, and 90 percent of expected health care costs on average, respectively. These are referred to as the metal tiers of Marketplace plans. We project that 2.7 million subsidized Marketplace enrollees, or 16 percent, will choose gold plans in 2025 under enhanced PTCs, compared with 0.9 million enrollees, or 9 percent, under original PTCs (table 1).

TABLE 1

Projected Metal Tier Distribution of Subsidized Marketplace Beneficiaries under Original and Enhanced Subsidies, 2025

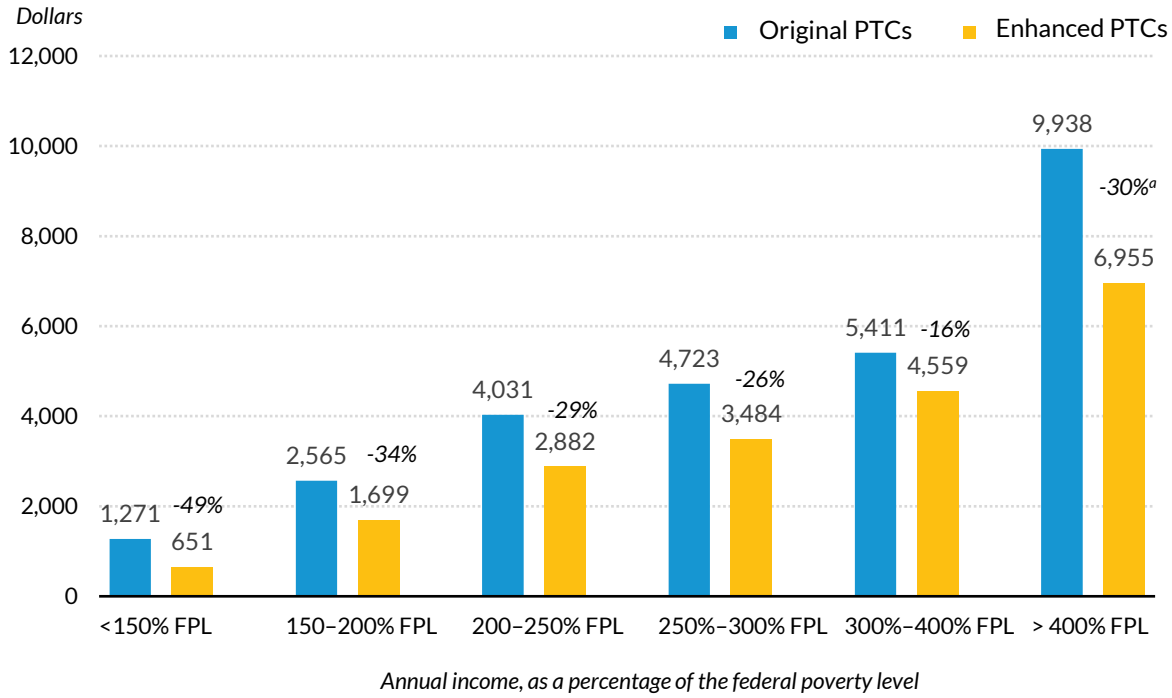
		Bronze	Silver	Gold
Original subsidies	(millions)	3.8	5.4	0.9
	(percent)	38%	54%	9%
Enhanced subsidies	(millions)	6.5	8.2	2.7
	(percent)	37%	47%	16%

Source: The Urban Institute, Health Insurance Policy Simulation Model, 2024.
Note: Plan selections for Platinum are less than 1 percent and are therefore included together with Gold.

Combining all household expenses (premium payments and cost-sharing expenses), we project that subsidized Marketplace enrollees will spend less on total health care spending under enhanced PTCs than under original PTCs in 2025 in every income category (figure 4). However, some of the lower average spending on cost sharing is due to the lower average health risk of newly enrolled people, which we do not show separately. For example, people with incomes below 150 percent of FPL will pay $651 in total health care spending in 2025 under enhanced PTCs compared with $1,271 under original PTCs, according to our projections. The difference of $619 includes lower premium payments, lower cost sharing for people who switched to more generous plans, and lower spending on cost sharing for healthier people who will enroll in the Marketplace when premiums are reduced under the enhanced PTCs.

FIGURE 4

Projected Annual Average Health Spending for People with Subsidized Marketplace Coverage under Original and Enhanced Premium Tax Credits by Federal Poverty Level Category, 2025



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Source: The Urban Institute, Health Insurance Policy Simulation Model, 2024.
Notes: PTC = premium tax credit; FPL = federal poverty level. FPL varies by year and household size; for 2024 FPL is $15,060 for an individual and $31,200 for a family of 4, and 400% of FPL is $60,240 for an individual and $124,800 for a family of 4. People above 400% of FPL with PTCs under original subsidies are projected to receive a state-funded premium tax credit. Percentages are the differences between enhanced and original premium tax credits per FPL category.
[a] No federal subsidies are available to people above 400% of FPL under original PTCs, so premiums shown are for unsubsidized Marketplace participants in that income group.

State Coverage

States with the largest percent increases in nongroup coverage under enhanced PTCs will see the largest percent declines in the number of uninsured people in 2025. We find substantial variation by state in terms of how enhanced PTCs will increase overall nongroup market coverage and reduce the number of uninsured people compared with a policy without enhanced PTCs. Five states—Texas, South Carolina, Mississippi, Louisiana, and Georgia—are projected to have the largest percent differences in nongroup coverage in 2025; this includes the Marketplace. Four of these five states have not expanded Medicaid eligibility to 138 percent of FPL as allowed under the Affordable Care Act, so there are more people eligible to enroll in the Marketplace. In these five states, the nongroup market will be roughly double the size under the enhanced PTCs compared with original PTCs (appendix A, table A4). At the same time, we project these five states plus Alabama, Arkansas, Ohio, and Tennessee will see the

sharpest percent drops in the number of uninsured people, of 21 percent or more, under enhanced PTCs compared with the number of uninsured people under original PTCs. At the other end of the spectrum, we find that states with a Basic Health Program, including New York and Minnesota, or additional state subsidies, including California and Massachusetts, have much smaller coverage effects from the enhanced PTCs compared with original PTCs. The Basic Health Program and the additional state subsidies make Marketplace coverage more affordable and help reduce the number of uninsured people.

Discussion

The enhanced PTCs originally enacted under ARPA in 2021 and extended through 2025 by IRA have dramatically increased enrollment in the Marketplace. In this report, we switch the comparison from change over time to a scenario without enhanced PTCs to demonstrate the full impact of the tax credits. We project that in 2025, enhanced PTCs will increase subsidized Marketplace enrollment by 7.2 million compared to a scenario under original PTCs. By making premiums for Marketplace coverage significantly more affordable, these subsidies will also reduce the number of uninsured by 4.0 million people, a 14 percent decline compared with a policy of original PTCs.

The substantial impacts of enhanced PTCs may be larger than many policymakers expected, because growing Medicaid enrollment from 2021 through early 2023 partially masked the changes in Marketplace enrollment and overall coverage during the first years of enhanced PTCs. Medicaid enrollment grew by more than 20 million people from April 2020 through March 2023 as a result of the continuous coverage requirement. When Congress ended the requirement on March 31, 2023, and allowed states to resume eligibility redeterminations, midyear enrollments in the Marketplace increased in the second and third quarters of 2023 above previous trends.[7] Then, during the 2024 open enrollment period, plan selections jumped by 5 million people or 31 percent compared with 2023.

Our projections for 2025 assume most of the surge in enrollment represents real demand for coverage, spurred by more affordable coverage from the enhanced PTCs. The affordability of Marketplace premiums is substantially improved by the enhanced PTCs in two ways. First, the subsidy schedule directly lowers the share of income that must be paid toward premiums. Second, the lower premiums attract people with lower health risk to enroll in the Marketplace, which reduces average premiums, increases the size of the market, and encourages more competition among insurers. When premiums are lower, many healthy people who might otherwise have risked going uninsured are willing to pay for coverage.

We find that the enhanced PTCs substantially reduce premium costs across all income groups. Net premiums are lower by 50 to 100 percent in the lowest income groups, below 300 percent of FPL. Net premiums are lower by about one-quarter for people with incomes above 300 percent of FPL. Moreover, lower premiums allow some people to switch to more generous plans; we find that the share of people choosing gold plans doubles under enhanced PTCs compared with original PTCs.

Finally, the enhanced PTCs will make the overall nongroup market, including the Marketplace, a larger, more stable market over time. Compared with the fluctuation and instability of premiums in the nongroup market before the Affordable Care Act, this is a significant and sometimes overlooked benefit. A larger market encourages more competition from insurers, resulting in more choices and lower premium increases than a smaller nongroup market. A larger market is more protected against the risk of disruption should an insurer leave the market. Although market size doesn't protect against rising health care costs, it may offer space for state policy innovations.

Conclusion

Since the enhanced PTCs were first enacted in 2021, they have led to record-high enrollment in the Marketplaces at all income levels. We will see their greatest impact on coverage in 2025, the final year in which they will be in effect unless they are extended by Congress. Enhanced PTCs result in lower premiums for Marketplace consumers at all income levels and set zero-cost premiums for many low-income consumers. Even those not eligible for PTCs see lower premiums with enhanced PTCs because the additional enrollment has improved the nongroup market risk pool. If Congress does not extend enhanced PTCs after 2025, we project that these gains will be reversed, and 4 million people could become uninsured.

Appendix A: Supplemental Tables

TABLE A1

Premium Tax Credit Percentage-of-Income Limits for Benchmark Coverage under the Affordable Care Act and the American Rescue Plan Act/Inflation Reduction Act Enhancements

Income (% of FPL)	Original (pre-ARPA) schedule, 2021 (% of income)	Original (pre-ARPA) schedule, 2025 (% of income)	ARPA/IRA schedule (% of income)
<138	2.07	1.82	0.0
138–150	3.10–4.14	2.73–3.64	0.0
150–200	4.14–6.52	3.64–5.73	0.0–2.0
200–250	6.52–8.33	5.73–7.33	2.0–4.0
250–300	8.33–9.83	7.33–8.65	4.0–6.0
300–400	9.83	8.65	6.0–8.5
>400	n/a	n/a	8.5

Sources: Internal Revenue Service; US Department of Health and Human Services; and American Rescue Plan Act of 2021, Pub. L. No. 117-2.

Notes: FPL = federal poverty level; ARPA = American Rescue Plan Act; IRA = Inflation Reduction Act; n/a = not applicable (no subsidies are available at this income level). Pre-ARPA caps are indexed for each year. The ARPA enhanced subsidy schedules' percentage-of-income limits are not indexed.

TABLE A2

Projected Health Insurance Coverage Distribution of the Nonelderly under Original and Enhanced Premium Tax Credits, 2025

Thousands of people

	People covered under original PTCs	People covered under enhanced PTCs	Change	Percent difference
Insured (MEC)	**249,535**	**253,601**	**4,065**	**2%**
Employer	151,176	147,142	-4,034	-3%
ACA compliant private nongroup	17,050	24,926	7,875	46%
Basic Health Program	1,459	1,467	8	1%
Marketplace with PTC, <150% of FPL	2,485	3,939	1,454	59%
Marketplace with PTC, 150–200% of FPL	3,150	4,147	997	32%
Marketplace with PTC, 200–250% of FPL	1,449	2,784	1,336	92%
Marketplace with PTC, 250–300% of FPL	1,258	2,097	840	67%
Marketplace with PTC, 300–400% of FPL	1,827	2,943	1,116	61%
Marketplace with PTC, > 400% of FPL	0	1,494	1,494	n/a
Full-pay Marketplace	1,366	1,562	195	14%
Other nongroup	4,058	4,493	435	11%
Medicaid/CHIP	72,575	72,799	224	*
Other public	8,734	8,734	0	0%
Uninsured (no MEC)	**30,869**	**26,804**	**-4,065**	**-13%**
Uninsured	28,362	24,394	-3,968	-14%
Noncompliant nongroup	2,507	2,410	-97	-4%

Source: The Urban Institute, Health Insurance Policy Simulation Model, 2024.

Notes: MEC = minimum essential coverage; ACA = Affordable Care Act; PTC = premium tax credit; CHIP = children's health insurance program; n/a = not applicable; * = less than +/-0.5%; FPL = federal poverty level; FPL varies by year and household size; for 2024, FPL is $15,060 for an individual and $31,200 for a family of 4, and 400 percent of FPL is $60,240 for an individual and $124,800 for a family of 4.

TABLE A3

Cost Sharing under the Affordable Care Act and the American Rescue Plan Act/Inflation Reduction Act Enhancements

Actuarial value of plans for those enrolled in silver-level coverage

Income (% of FPL)	Original (pre-ARPA) schedule (% of total costs paid by plan)	ARPA/IRA schedule (% of total costs paid by plan)
<138	94	94
138–150	94	94
150–200	87	87
200–250	73	73
>250	70	70

Sources: Internal Revenue Service; US Department of Health and Human Services; and American Rescue Plan Act of 2021, Pub. L. No. 117-2.

Notes: FPL = federal poverty level; ARPA = American Rescue Plan Act; IRA = Inflation Reduction Act.

TABLE A4

Projected Difference and Percentage Difference in Private Nongroup Insurance Coverage and Uninsurance under Enhanced Premium Tax Credits Compared with Original Tax Credits, by State, 2025

	Private Nongroup Insurance		Uninsurance	
State	Difference (thousands of people)	% change from original PTCs	Difference (thousands of people)	% change from original PTCs
Total	**7,875**	**46%**	**-3,968**	**-14%**
Alabama	171	72%	-131	-25%
Alaska	8	35%	-3	-3%
Arizona	120	37%	-103	-14%
Arkansas	64	52%	-49	-23%
California	263	12%	-174	-6%
Colorado	47	15%	-35	-8%
Connecticut	22	15%	-9	-5%
Delaware	17	45%	-5	-7%
District of Columbia	2	11%	*	**
Florida	1,378	59%	-453	-17%
Georgia	665	103%	-336	-24%
Hawaii	3	8%	*	**
Idaho	60	71%	-35	-20%
Illinois	65	13%	-45	-4%
Indiana	103	43%	-88	-18%
Iowa	33	27%	-22	-16%
Kansas	67	51%	-66	-19%
Kentucky	55	65%	-47	-18%
Louisiana	154	111%	-92	-24%
Maine	7	11%	-3	-4%
Maryland	49	20%	-25	-6%
Massachusetts	41	11%	-8	-3%
Michigan	122	31%	-76	-15%
Minnesota	24	8%	-16	-5%
Mississippi	156	118%	-112	-30%
Missouri	140	52%	-51	-11%
Montana	17	24%	-7	-11%
Nebraska	31	29%	-14	-12%
Nevada	18	14%	-11	-3%
New Hampshire	14	23%	-10	-15%
New Jersey	115	38%	-75	-10%

	Private Nongroup Insurance		Uninsurance	
State	Difference (thousands of people)	% change from original PTCs	Difference (thousands of people)	% change from original PTCs
New Mexico	5	6%	2	1%
New York	37	2%	6	**
North Carolina	304	65%	-74	-8%
North Dakota	10	22%	-4	-6%
Ohio	169	45%	-140	-22%
Oklahoma	122	75%	-59	-14%
Oregon	34	18%	-20	-6%
Pennsylvania	66	13%	-32	-5%
Rhode Island	5	13%	-3	-6%
South Carolina	338	121%	-142	-25%
South Dakota	11	39%	-8	-11%
Tennessee	254	82%	-197	-28%
Texas	2,119	133%	-1,039	-21%
Utah	90	32%	-15	-5%
Vermont	6	15%	-2	-3%
Virginia	122	34%	-47	-7%
Washington	49	17%	-35	-6%
West Virginia	24	51%	-16	-15%
Wisconsin	65	26%	-30	-7%
Wyoming	12	29%	-11	-13%

Source: The Urban Institute, Health Insurance Policy Simulation Model, 2024.
Note: PTC = premium tax credit; * = less than +/-500 people; ** = less than +/-0.5%.

Notes

[1] Marketplace Open Enrollment Period Public Use Files for 2021-2024; Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services. https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.

[2] Marketplace Open Enrollment Period Public Use Files for 2021-2024; Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services. https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.

[3] Urban Institute, "The Health Insurance Policy Simulation Model," in "Quantitative Data Analysis," accessed May 14. 2024, https://www.urban.org/research/data-methods/data-analysis/quantitative-data-analysis/microsimulation/health-insurance-policy-simulation-model-hipsm.

[4] "Marketplace 2024 Open Enrollment Period Report: National Snapshot," Centers for Medicare & Medicaid Services, January 10, 2024. https://www.cms.gov/newsroom/fact-sheets/marketplace-2024-open-enrollment-period-report-national-snapshot-0.

[5] Julie Appleby, "Lawsuit Alleges Obamacare Plan-Switching Scheme Targeted Low-Income Consumers," *KFF Health News* (blog), April 16, 2024, https://kffhealthnews.org/news/article/federal-lawsuit-unauthorized-aca-obamacare-plan-enrollment-switching/.

[6] California previously offered premium subsidies to persons with incomes over 400 percent of FPL but discontinued the program when ARPA/IRA subsidies became available. New Jersey currently offers limited premium subsidies to persons with incomes up to 600 percent of FPL. See Louise Norris, "Which States Offer Their Own Health Insurance Subsidies," Healthinsurance.org, May 8, 2024, https://www.healthinsurance.org/faqs/which-states-offer-their-own-health-insurance-subsidies/.

[7] Jared Ortaliza, Cynthia Cox, and Krutika Amin, "Another Year of Record ACA Marketplace Signups, Driven in Part by Medicaid Unwinding and Enhanced Subsidies," KFF, January 24, 2024, https://www.kff.org/policy-watch/another-year-of-record-aca-marketplace-signups-driven-in-part-by-medicaid-unwinding-and-enhanced-subsidies/.

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About the Authors

Jessica S. Banthin is a senior fellow in the Health Policy Center, where she studies the effects of health insurance reform policies on coverage, costs, and households' financial burdens. Before joining the Urban Institute, she served more than 25 years in the federal government, most recently as deputy director for health at the Congressional Budget Office. During her eight-year term at the Congressional Budget Office, Banthin directed the production of numerous major cost estimates of legislative proposals to modify the Affordable Care Act. Banthin has also conducted significant research on a wide range of topics such as the burdens of health care premiums and out-of-pocket costs on families, prescription drug spending, and employer and nongroup market premiums. She has special expertise in the design of microsimulation models for analyzing health insurance coverage and an extensive background in the design and use of household and employer survey data.

Matthew Buettgens is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington, and by the federal government. His recent work includes several research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance

coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage.

Michael Simpson is a principal research associate at the Health Policy Center at the Urban Institute. He has 25 years of experience developing economic models and using survey and administrative data. His current work focuses on using Urban's Health Insurance Policy Simulation Model to project health insurance coverage and spending both in the baseline and under policy alternatives. Before joining Urban, Simpson developed the Congressional Budget Office's long-term dynamic microsimulation model. He analyzed numerous policy reform proposals, investigated differences between various projections of Social Security finances and benefits, quantified the importance of Monte Carlo variation in model results, and created multiple methods to demonstrate uncertainty in projections.

Jason Levitis is a senior fellow in the Health Policy Center at the Urban Institute and a nonresident senior fellow at Yale Law School's Solomon Center for Health Law and Policy. He conducts research on health insurance policy and provides technical assistance to state health officials. Levitis's research focuses on federal and state policies affecting private health coverage, the Affordable Care Act, and the intersection of health care and tax law. He has worked extensively on federal and state financing and regulation of private health coverage, health insurance subsidies, Section 1332 waivers, and interactions with federal tax law. He is deeply versed in operational issues and approaches to minimizing consumers' administrative burdens. Levitis served at the US Treasury Department from 2009 to 2017. He represented the Treasury on the interagency team that helped craft the ACA and later led the Treasury's ACA implementation as counselor to the assistant secretary for tax policy.

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500 L'Enfant Plaza SW
Washington, DC 20024
www.urban.org

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CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

December 5, 2024

Honorable Ron Wyden
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

Honorable Richard Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Honorable Jeanne Shaheen
U.S. Senate
Washington, DC 20510

Honorable Lauren Underwood
U.S. House of Representatives
Washington, DC 20515

Re: The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums

Dear Chairman Wyden, Ranking Member Neal,
Senator Shaheen, and Congresswoman Underwood:

You have asked the Congressional Budget Office to discuss the effects on health insurance coverage and premiums that will result from not extending—either for one year or permanently—the expanded premium tax credit structure provided in the American Rescue Plan Act of 2021 (ARPA, Public Law 117-2).

ARPA reduced the maximum amount eligible enrollees must contribute toward premiums for health insurance purchased through the marketplaces established by the Affordable Care Act, and it extended eligibility to people whose income is above 400 percent of the federal poverty level (FPL). Those provisions were extended through calendar year 2025 in the 2022 reconciliation act (P.L. 117-169).

CBO expects that not extending the credit will increase the number of people without health insurance and raise the average gross benchmark premiums for plans purchased through the marketplaces.

EXHIBIT 3

Structure of the Premium Tax Credit

The premium tax credit is an advanceable, refundable credit that lowers the out-of-pocket cost of health insurance premiums for people who obtain insurance through the marketplaces.[1] The credit is calculated as the difference between the benchmark premium (that is, the premium for the second-lowest-cost silver plan available in a region) and a maximum contribution per household, calculated as a percentage of household income and adjusted over time.[2]

Until 2021, the premium tax credit was available to people who met the following criteria:

- Their modified adjusted gross income was between 100 percent and 400 percent of the FPL,
- They were lawfully present in the United States,
- They were not eligible for public coverage, such as Medicaid, and
- They did not have an affordable offer of employment-based coverage.

For 2021 and 2022, ARPA expanded eligibility to include enrollees whose income was above 400 percent of the FPL and lowered the maximum household contribution. The 2022 reconciliation act extended those provisions through calendar year 2025.

1. See Joint Committee on Taxation, "Description of Subtitle H—Social Safety Net: Budget Reconciliation Recommendations," JCX-39-21 (September 11, 2021), www.jct.gov/publications/2021/jcx-39-21.

2. For more information on those percentages of household income, see Congressional Budget Office, letter to the Honorable Jodey Arrington and the Honorable Jason Smith concerning the effects of permanently extending the expansion of the premium tax credit and the costs of that credit for deferred action for childhood arrivals recipients (June 24, 2024), https://www.cbo.gov/publication/60437.

   In most marketplaces, people can choose among plans—bronze, silver, gold, and platinum—for which the average percentage of the total cost of covered medical expenses paid by the insurer (that is, the actuarial value of the plan) differs. The share of medical expenses that is not paid by the insurer is paid by enrollees in the form of deductibles and other cost sharing.

Effects on the Uninsured Population

CBO estimates that, relative to extending the tax credits, not extending them—either for a year or permanently—will increase the number of people without health insurance. The agency expects some people will exit the marketplaces and become uninsured because of higher out-of-pocket costs for health insurance premiums.

Without an extension through 2026, CBO estimates, the number of people without insurance will rise by 2.2 million in that year.

Without a permanent extension, CBO estimates, the number of uninsured people will rise by 2.2 million in 2026, by 3.7 million in 2027, and by 3.8 million, on average, in each year over the 2026-2034 period.[3] (The initial increase is significantly smaller because CBO expects that some people will remain temporarily enrolled after the expanded credits expire at the end of 2025. CBO assumes enrollees would need time to fully respond to the expiration, for example, because of automatic renewal policies.)

Effects on Average Gross Benchmark Premiums

CBO estimates that, relative to extending the premium tax credits, not extending them—either for a year or permanently—will lead to higher gross benchmark premiums, on average, in marketplace plans. (Those premiums reflect the amount before the tax credits are accounted for.) CBO expects that healthier-than-average people will exit the marketplaces if the expanded credits are no longer available and, in response, insurers will raise premiums for the remaining enrollees.

Without an extension through 2026, CBO estimates, gross benchmark premiums will increase by 4.3 percent, on average, for that year.

Without a permanent extension, CBO estimates, gross benchmark premiums will increase by 4.3 percent in 2026, by 7.7 percent in 2027, and by 7.9 percent, on average, over the 2026-2034 period. (Similar to the

3. Because of rounding, the effects of not extending the policy in 2026 appear to be the same as those estimated to occur without a permanent extension. CBO estimates that a larger number of employers will not offer health insurance in response to a permanent extension than would be the case under a temporary one.

effects on the uninsured population, the initial increase is significantly smaller because some people will remain temporarily enrolled.)

I hope this information is helpful. Please contact me if you have further questions.

Sincerely,

Phillip L. Swagel
Director

cc: Honorable Mike Crapo
Ranking Member
Senate Committee on Finance

Honorable Jason Smith
Chairman
House Committee on Ways and Means

By the Numbers: House Bill Takes Health Coverage Away From Millions of People and Raises Families' Health Care Costs

Center on Budget and Policy Priorities

The House reconciliation bill now taking shape would take health coverage away from millions of people and dramatically raise health care costs for millions more. Here are some of the impacts:

- Roughly 15 million people (and likely more) by 2034 would lose health coverage and become uninsured because of the Medicaid cuts, the bill's failure to extend enhanced premium tax credits for Affordable Care Act (ACA) marketplace coverage, and other harmful ACA marketplace changes, according to estimates from the Congressional Budget Office (CBO). This figure could rise as provisions of the House bill grow harsher.
    - CBO estimates project that 7.6 million people would become uninsured due to Medicaid policies passed by the Energy and Commerce Committee (E&C).
    - 1.8 million people would become uninsured due to codification of the Trump Administration marketplace rule provisions, which the E&C Committee also passed.
    - 2.1 million people would become uninsured as a result of marketplace policies passed by the Ways and Means Committee.
    - An additional 4.2 million people would lose marketplace coverage because the legislation fails to extend the premium tax credit (PTC) enhancements.
- When people lose their health coverage, they lose access to preventive and primary care, care for life-threatening conditions, and treatments for chronic conditions. For example, a person with diabetes who loses health coverage would lose the ability to properly manage their condition so they can maintain their health as well as their employment.

Medicaid

- According to CBO, the bill would cut Medicaid by at least $716 billion, the largest cut in the program's history.
- Between 9.7 million and 14.4 million people in the expansion population would be at risk of losing Medicaid under a provision that takes coverage away from people who don't meet a harsh work requirement.
    - Estimates of how many of those at risk will lose coverage vary. We estimate that if coverage losses mirror those experienced in Arkansas when it implemented similar requirements, some 7 million people would lose coverage.
    - Two-thirds of people aged 19-64 receiving Medicaid in 2023 worked during the year, and many of those who didn't were taking care of a family member or had an illness or disability.
    - This expansive work requirement will harm parents, people with disabilities, and those with other chronic illnesses because past experience shows that exemptions don't work. Even people who are supposed to be protected — and those who are working — lose coverage when they get caught in bureaucratic red tape.
- One provision would take Medicaid coverage away from people, mostly seniors and those with disabilities who also have Medicare, due to provisions that make it harder to get and stay enrolled in Medicaid.
- Some people would also lose coverage due to new requirements that expansion enrollees re-prove their eligibility every six months (instead of annually). These requirements frequently end up pushing eligible people off Medicaid because they don't receive or submit the necessary paperwork, or because the state fails to process the paperwork.
- Forcing states to implement the work requirement, along with all the other sludge this bill adds to the enrollment process, puts all Medicaid enrollees at risk of having their coverage held up and their questions left unanswered because of the burden on state agencies.

EXHIBIT 4

- At the same time that states need to implement all these changes and will have more uninsured people, some states would lose federal funds due to new restrictions on how they finance their Medicaid programs, and all states would be limited in how they can finance their programs in the future.

- More than 30 states would see large federal funding cuts for their Medicaid expansion if they continued to provide health coverage to people who do not meet the very restrictive "qualified alien" immigration eligibility requirement created under a 1996 law. This would include states that have optional coverage programs for children or pregnant adults that were authorized by the Children's Health Insurance Program. CBO found an earlier version of this policy, impacting just 14 states, would lead to 1.4 million uninsured people. Updated estimates are not yet available. (Note: The federal Medicaid funding that would be cut under this policy is not currently used to cover this group.)

- The legislation would also raise costs for Medicaid expansion enrollees and will lead many of them to defer needed care. The bill requires states to charge working people with incomes just above the poverty line — $16,000 year for an individual — new cost-sharing charges when they go to the doctor.

ACA Marketplace Coverage

- About 22 million people, including 3 million small business owners and self-employed workers, will see their health coverage costs skyrocket or lose coverage altogether in 2026 because so far the House bill does not extend the PTC enhancements — even while extending huge tax cuts for millionaires — which are critical to making health coverage in the ACA marketplace more affordable.

    - Without an extension of this vital credit, an estimated 4.2 million people will lose their health insurance when costs rise to an unaffordable level.

    - Onerous marketplace changes in the House bill will make it harder for millions of working people to enroll in affordable health coverage.

- The legislation also would *take PTCs and Medicare away entirely* from many immigrants who live and work in the U.S. lawfully. (People without a documented status are already ineligible.)

    - Those who would be affected include people with immigration statuses designed to help people in humanitarian need, like those granted refugee or asylee status and victims of trafficking or domestic violence.

Updated May 21, 2025

KFF

The independent source for health policy research, polling, and news.

How Will the 2025 Reconciliation Bill Affect the Uninsured Rate in Each State?: Allocating CBO's Partial Estimates of Coverage Loss

Alice Burns (https://www.kff.org/person/alice-burns/), Jared Ortaliza (https://www.kff.org/person/jared-ortaliza/), Justin Lo (https://www.kff.org/person/justin-lo/), Matthew Rae (https://www.kff.org/person/matthew-rae/), and Cynthia Cox (https://www.kff.org/person/cynthia-cox/)

Published: May 20, 2025

(https://www.kff.org/tag/medicaid-watch/)House Republicans are currently considering a reconciliation package that would make significant changes to Medicaid and the Affordable Care Act (ACA) Marketplaces. While the House version is evolving rapidly and there are not yet public estimates of the effect of the uninsured across all pieces of the legislation, the Congressional Budget Office (CBO) estimates (https://democrats-energycommerce.house.gov/sites/evo-subsites/democrats-energycommerce.house.gov/files/evo-media-document/cbo-emails-re-e%26c-reconcilation-scores-may-11%2C-2025.pdf) that the part of the legislation passed by the Energy and Commerce Committee (E&C) could increase the number of people without health insurance by 8.6 million, due largely to changes to Medicaid and the ACA.

This research is part of KFF's Medicaid Watch, featuring policy research, polling, and news about the Medicaid financing debate and related issues. View more.

Additionally, these legislative changes come at a time when enhanced premium tax credits for ACA Marketplace enrollees are set to expire later this year. When combining the E&C provisions with the effect of the expected expiration of the ACA's enhanced premium tax credits, CBO expects 13.7 million more people will be uninsured in 2034.

This analysis apportions the increase in the number of uninsured across the 50 states and DC and shows that number as a percentage of each state's population. The number of newly uninsured as a percent of the population is equivalent to the percentage point increase in the 2034 uninsured rate. Nationally, CBO projected an uninsured rate (https://www.cbo.gov/publication/60383) of under 10% in 2034 under current law, which assumed the enhanced ACA premium tax credits would expire. The analysis here includes two maps: one showing the effect of the E&C provisions in the House Reconciliation package, and another showing those effects combined with expiration of the ACA enhanced premium tax credits.

Because CBO projections for the entire package are not yet available, the maps below do not include any increases in the uninsured rate that could arise from provisions not included in the E&C score. For example, Ways and Means Committee provisions that would require pre-enrollment verification of ACA eligibility – effectively ending automatic renewals of coverage – or remove repayment limits on excess premium tax credits could further increase (https://chirblog.org/the-sleeper-provision-in-the-reconciliation-bill-that-could-hobble-the-aca-marketplaces/) the number of people without insurance coverage. The estimates are also likely to change as the reconciliation bill works its way through Congress, as CBO finalizes its estimates and with amendments to the bill itself.

Anticipating how states will respond to changes in Medicaid policy is a major source of uncertainty (https://www.cbo.gov/publication/60984) in CBO's cost estimates. Instead of making state-by-state predictions about policy responses, CBO estimates the percentage of the affected population that lives in states with different types of policy responses. For example, in the E&C bill, Medicaid work requirements account for nearly half of the federal savings on Medicaid, suggesting they may contribute to the largest loss of insurance coverage in CBO's estimates. However, different states might choose to implement a work requirement with reporting

EXHIBIT 5

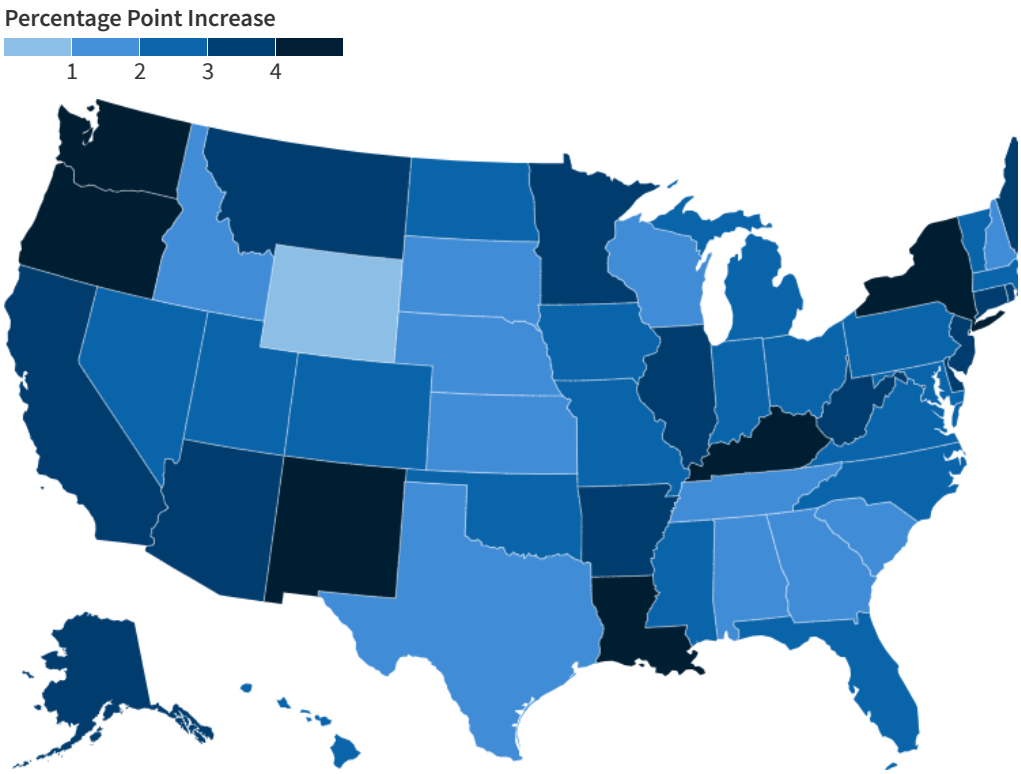
requirements that are easier or harder for enrollees to comply with. Reflecting the uncertainty, this analysis illustrates the potential variation by showing a range of enrollment effects in each state, varying by plus or minus 25% from a midpoint estimate.

The interactive tables at the end are sortable by state and size of coverage loss.

Figure 1

An Additional 8.6M People Nationwide Could be Uninsured if the Energy & Commerce (E&C) Reconciliation Bill is Passed

Percentage Point Increase in the Uninsured Population if the E&C Reconciliation Bill is Finalized Based on Partial CBO Numbers, by State, 2034



Note: This map takes into account the effects on the uninsured population of passing the Energy & Commerce (E&C) Reconciliation Bill. The bill features provisions related to ACA Marketplace integrity and changes to Medicaid financing. See methods for details.

Source: KFF analysis of population data from Weldon Cooper Center for Public Service; estimates of uninsured population growth by policy change from CBO, and KFF estimates of how the uninsured increase would be allocated across states (see Methods for additional sources and details). • Get the data • Download PNG

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The biggest increase in uninsured by percentage point is in DC (5 percentage points), which also has expanded Medicaid eligibility up to 215% of poverty. 10 states and DC would have increases in their uninsured rates of 3 percentage points or more (DC, Washington, Oregon, Kentucky, New York, Louisiana, New Mexico, Connecticut, Illinois, Rhode Island, and California).

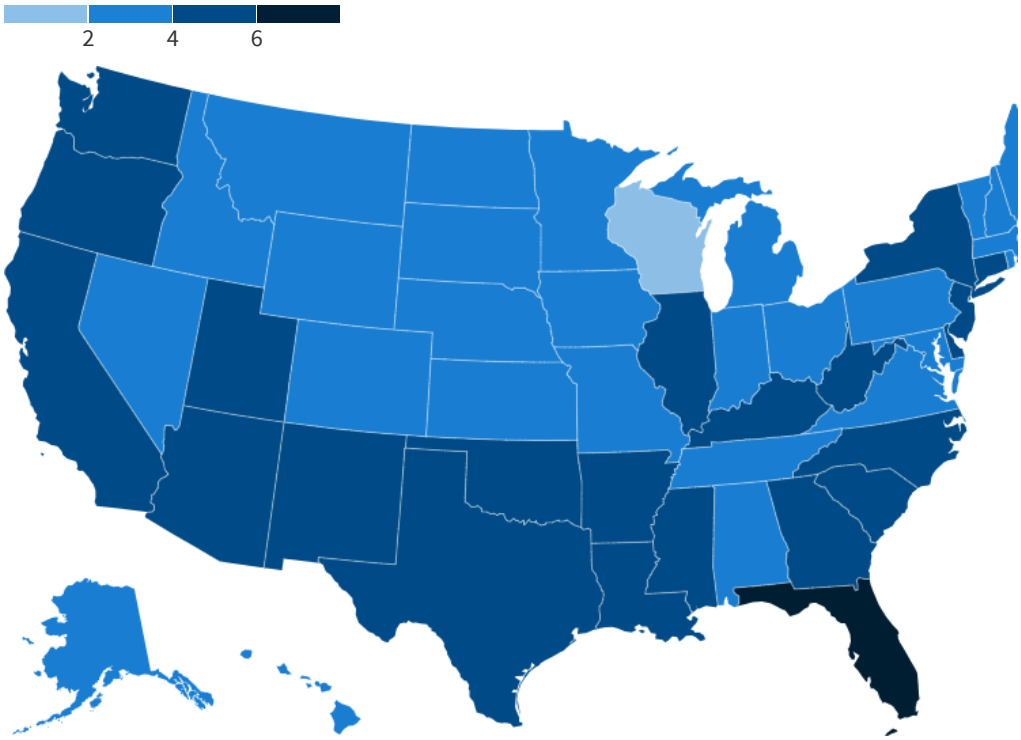
In terms of increases in the number of uninsured people, California and New York are the top two states (1.4M and 810k, respectively). Florida, Illinois, and Texas would follow at 520K, 430k, and 430k, respectively.

Figure 2

An Additional 13.7M People Nationwide Could be Uninsured if the Energy and Commerce (E&C) Reconciliation Bill is Passed and ACA Enhanced Tax Credits Expire

Percentage Point Increase in the Uninsured Population After Medicaid and ACA Marketplace Changes Based on Partial CBO Numbers, by State, 2034

Percentage Point Increase



Note: This map takes into account the combined effects on the uninsured population of the enhanced premium tax credits expiring, along with Medicaid provisions in the E&C Reconciliation Bill and the proposed 2025 Marketplace Affordability and Integrity rules. See methods for details.

Source: KFF analysis of population data from Weldon Cooper Center for Public Service; estimates of uninsured population growth by policy change from CBO, and KFF estimates of how the uninsured increase would be allocated across states (see Methods for additional sources and details). • Get the data • Download PNG

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The combined effects of the House Reconciliation package with the expiration of the ACA enhanced tax credits, compared to a scenario where the enhanced subsidies are in place and the proposed integrity rule was not in effect, results in the greatest increases in Florida, Louisiana, Georgia, Mississippi, and Washington, where the uninsured rate is expected to increase by at least 5 percentage points. 30 states and the District of Columbia may see an increase in their uninsured rates of 3 percentage points or more.

About half (46%) of the 13.7 million more people who would be uninsured in this scenario live in Florida (1.8M), Texas (1.6M), California (1.5M), New York (800k), and Georgia (610k). Texas (2.8M Marketplace growth), Florida (2.8M) and Georgia (1.0M) experienced the most ACA Marketplace growth since 2020, the year before the enhanced premium tax credits became available.

Methods

This analysis first separates the number of newly uninsured people into two groups: those newly uninsured because of changes in Medicaid (7.7 million) and those newly uninsured because of changes in the Affordable Care Act exchanges (0.9 million or 6.0 million depending on the scenario). Increases in the number of uninsured by policy change were sourced from Congressional Budget Office (CBO) estimates (https://democrats-energycommerce.house.gov/sites/evo-subsites/democrats-energycommerce.house.gov/files/evo-media-document/cbo-emails-re-e%26c-reconcilation-scores-may-11%2C-2025.pdf).

Changes in Medicaid

CBO estimates (https://d1dth6e84htgma.cloudfront.net/E_and_C_Markup_Subtitle_D_Part_I_5_12_25_4628d60c2a.pdf?source=email) that changes in Medicaid from the Energy & Commerce reconciliation bill are expected to trigger two types of health insurance loss. First, an estimated 10.3 million people are expected to lose Medicaid. Second, an estimated 1.4 million people are expected to lose coverage provided to immigrants regardless of immigration status through programs financed entirely by the states. KFF uses the ratio of those numbers to first allocate the newly uninsured population (7.7 million) to Medicaid or state-funded coverage categories.

This analysis allocates the newly uninsured population stemming from a loss of Medicaid across the states proportionally to each state's estimated federal funding loss. In a prior analysis (https://www.kff.org/medicaid/issue-brief/state-level-context-for-federal-medicaid-cuts-of-625-billion-and-enrollment-declines-of-10-3-million/), KFF estimated how the federal Medicaid cuts would be allocated across the states using prior modeling work and state-level data. Data sources include:

- KFF's projections (https://www.kff.org/medicaid/issue-brief/a-medicaid-per-capita-cap-state-by-state-estimates/)of Medicaid enrollment and spending in FY 2024
- KFF's 5 Key Facts about Medicaid and Provider Taxes (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/)
- KFF's 2024 Budget Survey, Provider Rates and Taxes (https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-provider-rates-and-taxes/)
- KFF's State Health Coverage for Immigrants and Implications for Health Coverage and Care (https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/)
- KFF's Status of State Medicaid Expansion Decisions (https://www.kff.org/status-of-state-medicaid-expansion-decisions/)

The analysis allocates the newly uninsured stemming from a loss of state-funded coverage across the states proportionally to the federal spending reductions resulting from the new penalty on ACA expansion states that offer state-funded coverage.

Changes in the ACA Marketplaces

The effects of the E&C's codification of the Trump administration's proposed program integrity rule are distributed across state based on a table in the proposed rule. CBO estimates that 1.8 million more people will be uninsured if the proposed rule is codified than if these policy changes do not go into effect. However, because the policy changes have already been proposed through regulation, CBO assigns half of the effect (https://www.cbo.gov/publication/61119) of codifying the proposed rule (900,000 increase in uninsured) to the reconciliation legislation. Therefore, this analysis considers only half of the estimated state-level impact from the proposed rule for Figure 1 (900,000), and the whole effect in Figure 2 (1.8 million). In both figures, CBO totals of the estimated newly uninsured people from the integrity rule are distributed across states that exceed the average take-up rate of low-income people, as shown in Table 15 of the proposed rule (https://www.federalregister.gov/d/2025-04083/p-784).

To estimate the effect of the expiration of the enhanced premium tax credits by state, CBO's estimate of the increase in the uninsured population (4.2 million) is proportionally allocated to each state based on their growth in the ACA Marketplaces from 2020 to 2025, obtained from the Open Enrollment Period Public Use Files (https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products).

Population Estimates

Decennial state-level population projections (https://www.coopercenter.org/national-population-projections) from the Weldon Cooper Center for Public Service are used to interpolate the population in 2034 assuming compound population growth. The percentage point increase of the uninsured population per state reflects the estimated increase in the uninsured as a share of the projected population. The total impact from all changes were aggregated then rounded to two significant figures, with the percentage point increase in the uninsured population rounded to the nearest whole number.

Table 1

The Energy & Commerce (E&C) Reconciliation Bill Would Increase the Number of Uninsured by 8.6 Million

Estimates of the Increase in the Uninsured by Policy Changes Based on Partial CBO Numbers, 2034

Geography	Medicaid Expansion Status	E&C Reconciliation Bill Uninsured Increase	E&C Reconciliation Bill Uninsured Increase Uncertainty	E&C Reconciliation Bill Percentage Point increase	Rec… a
United States		**8,600,000**			
Alabama	Not Adopted	53,000	(39,000 - 66,000)	1%	
Alaska	Adopted	21,000	(16,000 - 26,000)	3%	
Arizona	Adopted	230,000	(180,000 - 290,000)	3%	
Arkansas	Adopted	87,000	(65,000 - 109,000)	3%	
California	Adopted	1,400,000	(1,000,000 - 1,700,000)	3%	
Colorado	Adopted	140,000	(100,000 - 170,000)	2%	
Connecticut	Adopted	120,000	(90,000 - 150,000)	3%	
Delaware	Adopted	30,000	(23,000 - 38,000)	3%	
District of Columbia	Adopted	38,000	(29,000 - 48,000)	5%	
Florida	Not Adopted	520,000	(390,000 - 650,000)	2%	
Georgia	Not Adopted	160,000	(120,000 - 200,000)	1%	
Hawaii	Adopted	32,000	(24,000 - 40,000)	2%	
Idaho	Adopted	31,000	(23,000 - 39,000)	1%	
Illinois	Adopted	430,000	(320,000 - 540,000)	3%	
Indiana	Adopted	150,000	(120,000 - 190,000)	2%	
Iowa	Adopted	56,000	(42,000 - 71,000)	2%	
Kansas	Not Adopted	22,000	(16,000 - 27,000)	1%	
Kentucky	Adopted	180,000	(140,000 - 230,000)	4%	
Louisiana	Adopted	190,000	(140,000 - 230,000)	4%	

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Note: Estimates of the uninsured are rounded to the nearest 10,000. Uninsured rate increases are rounded to the nearest whole percent. Estimates may not sum up to total due to rounding. See methods for details.

Source: KFF analysis of population data from Weldon Cooper Center for Public Service; estimates of uninsured population growth by policy change from CBO, and KFF estimates of how the uninsured increase would be allocated across states (see Methods for additional sources and details). • Get the data • Download PNG

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NAVIGATION

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The Great Obamacare Enrollment Fraud

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The Paper

This paper discusses the substantial increase in fraudulent enrollment in ACA exchange plans, driven by enhanced subsidies and administrative actions, and proposes measures to mitigate improper and fraudulent enrollments.

EXECUTIVE SUMMARY

What This Paper Covers

The Affordable Care Act (ACA) provided large subsidies for lower-income people to buy coverage in the exchanges. President Biden signed legislation that increased these subsidies through 2025, making plans fully-subsidized for enrollees with income between 100 percent and 150 percent of the federal poverty line (FPL). Enrollees in this income range also qualify for a cost-sharing reduction program that raises plan actuarial value to 94 percent with minimal deductibles and cost-sharing

EXHIBIT 6

people claiming income between 100 percent to 150 percent FPL who sign-up for coverage with the likely number of people who are eligible for this coverage within that income grouping. Then, this paper discusses the problematic incentives facing brokers and insurers for improper enrollment. The paper concludes with a set of recommendations to minimize improper and fraudulent enrollment and spending.

What We Found & Why It Matters

Nearly half of exchange sign-ups during the 2024 open enrollment period reported income between 100 percent and 150 percent FPL, qualifying for fully-subsidized, 94 percent actuarial value plans. The percentage of people signing up who report income in this range has increased substantially since the enhanced subsidies took effect.

In nine states (Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah), the number of sign-ups reporting income between 100 percent and 150 percent FPL exceed the number of potential enrollees. The problem is particularly acute in Florida, where we estimate there are four times as many enrollees reporting income in that range as meet legal requirements.

The problem of fraudulent exchange enrollment is much more severe in states that have not adopted the ACA's Medicaid expansion as well as in states that use the federal exchange (HealthCare.gov). In states that use HealthCare.gov, 8.7 million sign-ups reported enrollment between 100 percent and 150 percent FPL compared to only 5.1 million people likely eligible for such coverage, or 1.7 sign-ups for every eligible person.

Overall, fraudulent exchange enrollment appears to be a significant problem in nearly half of states. We estimate that fraudulent enrollment at 100 percent to 150 percent FPL is likely upwards of four to five million people in 2024. We estimate, conservatively, that this cost will likely be upwards of $15 to $20 billion this year.

In all states, there is an incentive for people who have income between 200 and 400 percent of the FPL to report income between 100 and 150 percent of the FPL. They qualify for a larger advanced subsidy and a plan with much lower cost-sharing, and the Internal Revenue Service only recaptures a portion of the excess subsidy when they file their taxes.

In non-Medicaid-expansion states, there is a large incentive for people, particularly older people, to overestimate their income. These individuals

exchange. Evidence suggests that part of the issue is that state-based exchanges have done a more thorough job of re-evaluating people for exchange coverage who were no longer eligible for Medicaid after the public health emergency unwinding than states that use HealthCare.gov.

Unscrupulous brokers are certainly contributing to fraudulent enrollment and the enhanced direct enrollment feature of HealthCare.gov appears to be a problem. Brokers just need a person's name, date of birth, and address to enroll them in coverage, and reports indicate that many people have been recently removed from their plan and enrolled in another plan by brokers who earn commissions by doing so.

Health insurers are a primary beneficiary of the surge in improper enrollment from people misestimating income. The larger subsidies mean that consumers are less sensitive to prices of plans and are more likely to enroll, and it's much easier for insurers to collect subsidies from the U.S. Treasury than customers.

What We Recommend

We recommend six steps to reduce fraudulent exchange enrollment:

1. Congress should permit the enhanced subsidies to expire after 2025;
2. Congress should raise subsidy recapture limits to reduce incentives for people to misestimate their income;
3. Congress or the next administration should limit automatic re-enrollment into exchange plans and end it for people moving from or into fully-taxpayer subsidized plans;
4. Congress should appropriate cost-sharing reduction payments and prohibit silver-loading;
5. Congress should conduct aggressive oversight of the Biden administration's management of HealthCare.gov, enhanced direct enrollment, and insurer and broker actions to take advantage of misestimating income;
6. Congress or the next administration should reverse policies of the Biden administration that enabled such widespread fraudulent enrollment, particularly the continuous open-enrollment period for people who report they have income below 150 percent FPL.

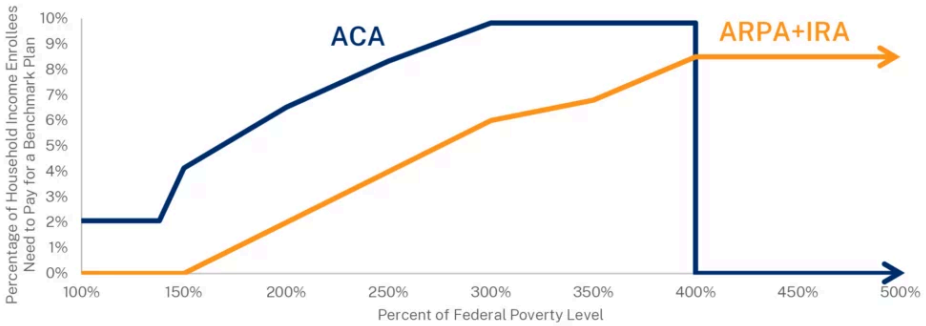
BACKGROUND

Medicaid expansion (as there is a large incentive to overestimate income in those states) and states that are using the federal exchange platform for enrollment, HealthCare.gov.

Enrollment in the exchanges has grown substantially over the past few years, driven by increased subsidies. The subsidies, structured as premium tax credits (PTCs), reduce the percentage and amount of income that a person must pay for a benchmark plan — the second-lowest-cost silver plan[1] available to them.

President Biden signed the American Rescue Plan Act of 2021 (ARPA) in March 2021 and the Inflation Reduction Act of 2022 (IRA) in August 2022, which increased the subsidies through 2025.[2] As a result, people who claim that their income is between 100 percent and 150 percent[3] of the federal poverty level (FPL) now pay $0 for benchmark plans, meaning that their coverage is fully paid by taxpayers. The ACA limited the PTCs to enrollees in households with income below 400 percent FPL, but the legislation signed by President Biden lifted that cap, extending the subsidies to households in the top two quintiles. Figure 1 shows the percentage of income that households at a given percentage of the FPL had to pay for benchmark plans under the original ACA and from 2021 to 2025 under the increased subsidies.

Figure 1: Legislation Signed by President Biden Significantly Increased ACA Subsidies by Lowering Enrollee Premium Share



SOURCES: CMS, *Plan Year 2023 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces*, October 26, 2022, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2023QHPPremiumsChoiceReport.pdf.

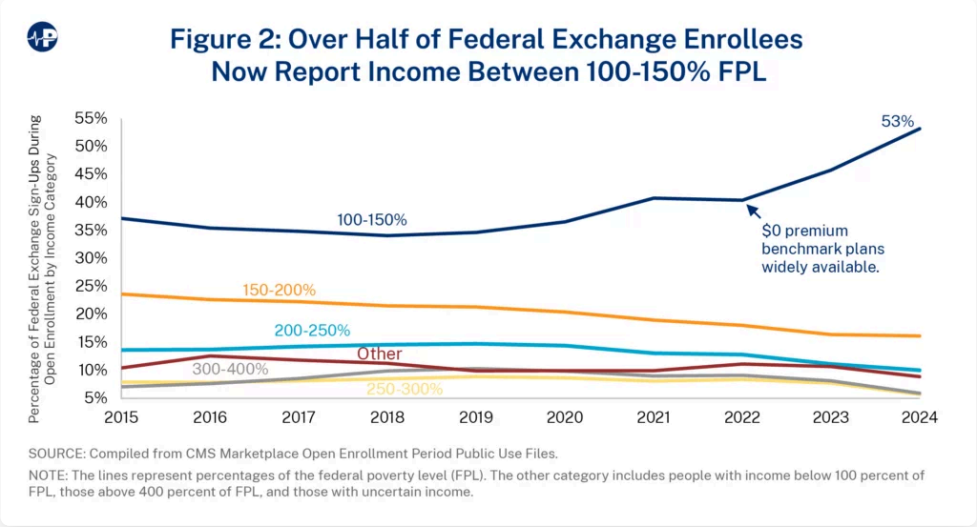
NOTE: ARPA is the American Rescue Plan Act and IRA is Inflation Reduction Act.

The ACA subsidies are generally payments directly from the U.S. Treasury to health insurers on behalf of enrollees who select plans in the exchanges. In official terminology, the subsidies are advance PTCs (APTCs), as they are credited to individuals based on their estimated household income and then sent to insurers. The PTCs are refundable[4]

average percentage of expenses paid by the plan — to 94 percent. For silver plan enrollees with income between 150 percent and 200 percent FPL, the CSR program raises the actuarial value to 87 percent.

The PTC structure, particularly after the enhancement, creates numerous problems, which we have explored in other papers.[6] The focus of this piece, however, is to present data on how the PTC structure — particularly after President Biden signed legislation increasing the subsidies and making fully subsidized plans with very limited cost-sharing available to enrollees with income between 100 percent and 150 percent FPL — has led to far more people enrolling in the lowest income category than are eligible.

Figure 2 demonstrates the shift in overall enrollment to the lowest-income category in the states that use HealthCare.gov. In 2022, the fully subsidized plans were first readily available during that year's open enrollment period. In 2024, 53 percent of people who signed up for coverage during open enrollment reported that their income was between 100 percent and 150 percent FPL. This figure shows only the federal exchange sign-ups, because not all states with state-based exchanges reported sign-ups by income grouping prior to 2022.



Overall, when including states with their own exchanges, 47 percent of people who selected plans during open enrollment reported income between 100 percent and 150 percent FPL in 2024. The reason for the decline when including states that established their own exchanges is that all those states expanded Medicaid under the ACA. In those states,

period, they, likely with the assistance of brokers or navigators working with them on their applications, estimate their household income for the following year.

The APTC is a function of this estimated income, so people generally qualify for larger subsidies if they underestimate their income, although there is an incentive for some people in states that have not expanded Medicaid to overestimate income (see discussion below). When a person files his or her subsequent tax return (generally in April of the year after the coverage), the APTC amount gets reconciled with the amount of the PTC that person was entitled because of actual income. People who received excessive subsidies would owe the excess back when they file their taxes, subject to limits discussed below. Those who received subsidies that were too small would receive additional credit against their taxes when they file.

In Medicaid expansion states, able-bodied, working-age adults with income below 138 percent FPL are eligible for Medicaid. Therefore, in expansion states, only enrollees who estimate their income between 138 percent and 150 percent FPL are eligible for fully subsidized benchmark plans.

In states that have not expanded their Medicaid programs, enrollees with income between 100 percent and 150 percent FPL are eligible for fully subsidized benchmark plans, as able-bodied, working-age enrollees are generally not eligible for Medicaid in those states. If their income is below 100 percent FPL, they also are ineligible for PTCs. This creates an incentive for able-bodied adults with income below the poverty line to overestimate their earnings. By estimating that their earnings are between 100 percent and 150 percent FPL, such an individual can claim a PTC that now covers the entire premium for a benchmark plan that would also have a very low deductible, cost-sharing amounts, and out-of-pocket limit because of the CSR program. By misstating their income, these individuals get generous coverage at zero cost to them — instead of being ineligible for any subsidies at all.

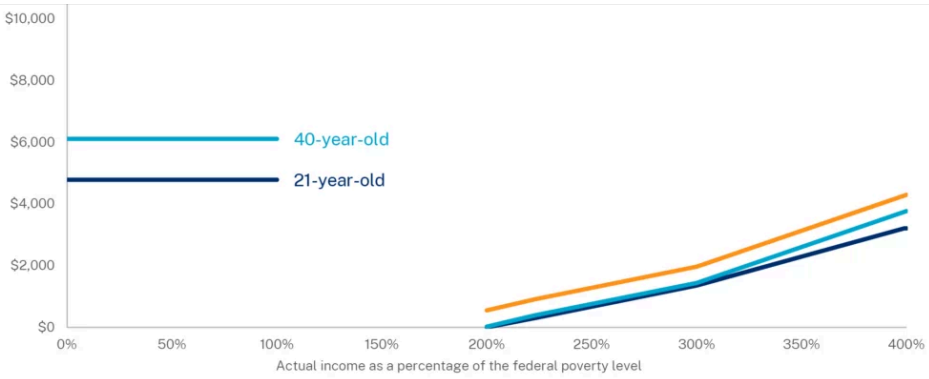
The incentives to misstate income are magnified because the law limits the amount that people need to repay when they file their taxes. For 2024, the amount that single filers must pay back to the Internal Revenue Service (IRS) is capped at $375 for individuals between 100 percent and 200 percent FPL, $950 for those between 200 percent and 300 percent FPL, and $1,575 for those between 300 percent and 400 percent FPL.[7]

under 150 percent FPL is $1,438 on average in the United States. He would receive an APTC of $5,723 to cover the full premium of insurance coverage with an actuarial value of 94 percent. At 290 percent FPL, he was eligible for a PTC of $3,355—receiving $2,368 of excessive subsidy for much less generous coverage (70 percent actuarial value). He would need to repay $950, which would leave him better off by $1,418 in premium subsidies due to underestimating his income and the added benefit of having coverage with much less cost-sharing.

The incentives to overestimate income in non-expansion states are much larger for older enrollees, as the PTC structure limits premium payment to a certain percentage of household income, regardless of the premium amount. Because premiums are three times more for enrollees near 65 than for enrollees in their 20s, the subsidies are also much larger. Nationally, the average PTC for a 21-year-old is $4,478 and the average PTC for a 64-year old is $13,434.[8] Older enrollees demand more medical services all else equal, and some may be looking to retire before the age of 65. These factors contribute to a larger incentive for them to overestimate income to earn a PTC.

Given how the subsidy structure works, there is not much differential incentive for older people to underestimate their income to gain a higher subsidy. In fact, the only differential occurs because the value of the cost-sharing reduction subsidy, which we explain below, is greater for older enrollees than younger enrollees.

Figure 3 demonstrates the age dynamic. The incentive to underestimate income is minimal for enrollees with income below 200 percent FPL, so the figure starts showing the benefit of underestimating income at 200 percent FPL. The benefit gradually increases as household income increases until the benefit ceases at 400 percent FPL. Figure 3 includes an estimate of the taxpayer cost for enrollees who underestimate their income to qualify for the CSR program and a 94 percent actuarial value plan.[9]



SOURCES: KFF Marketplace Subsidy Calculator and IRS.

NOTE: For those under 100 percent FPL, incentives for older populations increase, because the cost of a benchmark plan increases by age. Those between 100 and 150 percent of FPL are correctly reporting income and so gain no benefit. There are minimal effects for people 150 percent to 200 percent FPL. Enrollees over 200 percent FPL have an incentive to underestimate income and the differences in the lines account for a greater benefit that older enrollees receive from the 94 percent actuarial value plan through the CSR program.

People who estimate their income to be at least 100 percent FPL at the time of enrollment but end up earning less than 100 percent FPL do not have to pay any of the APTC back. In that circumstance, the IRS considers the person to be qualified for the PTC so long as the income estimate was not made "with intentional or reckless disregard for the facts."[10] Therefore, people with income below 100 percent FPL in non-Medicaid expansion states have an even more significant incentive to overestimate their income to qualify for a large PTC, as they would not need to pay any of it back. Such enrollees who overestimate their income to an amount greater than 100 percent FPL receive a full subsidy. In other words, they pay zero premium for plans with actuarial values of 94 percent.

In 2024, a 40-year-old enrollee reporting income between 100 percent to 150 percent FPL would receive an average subsidy of $5,869 in Florida, $5,556 in Georgia, and $5,700 in Texas.[11] For a 60-year-old enrollee, the amounts in these states would be $12,464, $11,799, and $12,104.[12] And their cost-sharing would be far more generous than what all but a few Americans get through their employer-sponsored insurance. These estimates of the benefit of misestimating their income are conservative, because they do not factor in the additional value of the CSR program that benefits them. However, Figure 3 accounts for the extra benefits of the CSR program and the 94 percent actuarial value plan to which enrollees who report income between 100 percent and 150 percent FPL are entitled.

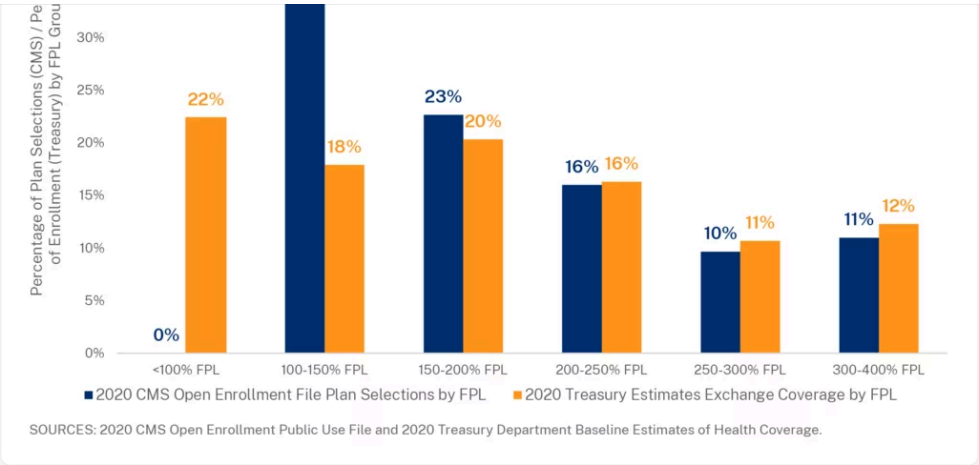
Analysis Confirms People Are Misestimating Income

New research shows that people have been misestimating their income — with a particularly high concentration in Florida — since the ACA's key provisions took effect. In a 2024 piece using 2015-2017 federal exchange

The authors continued, "The precise incomes reported by marketplace enrollees suggest that they were aware of the cutoff for PTC eligibility at the FPL. Consider single-person households in non-expansion states in 2015, for whom the lower bound for eligibility for the PTCs was $11,670.... [S]o many enrollees reported income between $11,670 and $12,500 to Healthcare.gov that actual marketplace enrollment was 136% of estimated potential enrollment in that range. Furthermore, many of these enrollees reported [modified adjusted gross income] precisely equal to $11,670, $11,700, or $12,000, suggesting that they were aware of the cutoff for PTC eligibility and reported just enough income to exceed it. Other spikes correspond to round values, like $15,000, or inflation-adjusted round values from 2014." Such precision on a widespread scale suggests significant counseling of income manipulation by outside entities aware of the program rules.

The authors conclude: "Taken together, these facts suggest that many people who eventually earned less than 100% FPL reported that they expected to earn more than this amount when enrolling in marketplace insurance and were able to receive PTCs. This implies that many people who earned less than the FPL (or, in the ACS [American Community Survey], reported earning less) were effectively eligible for PTCs."

In 2019 (the most recent year Treasury published this analysis), the Treasury Department estimated that over one-fourth of all PTCs — an amount equal to $11.32 billion — would be paid to insurers on behalf of households with income below 100 percent FPL in 2020.[14] Treasury estimates that roughly 1.70 million tax filers receiving PTCs would have income under 100 percent FPL, and 1.38 million who would receive PTCs would have income between 100 percent and 150 percent FPL. This data shows that the reported income data that the Centers for Medicare and Medicaid Services (CMS) uses has major problems, as CMS enrollment data did not include any enrollment for people with income below 100 percent FPL. Figure 4 highlights the discrepancy between Treasury estimates and CMS plan selection data. This data shows that misestimating income for people with income below 100 percent FPL was a problem before the enhanced subsidies. That problem was made worse given the access to fully subsidized plans, while the problem with people above 150 percent FPL underestimating income was made more severe.



It is worth noting that people also have incentives to report lower income in order to enroll in Medicaid in expansion states. Medicaid has extremely low (if any) cost-sharing, and the plans are similar to exchange plans in terms of providers accepting the coverage. Our analysis, which focuses on exchange enrollment, excludes this dynamic and thus makes expansion states look better than non-expansion states on these fraudulent enrollment statistics.

The Data and Methodology

We contrast sign-ups during open enrollment by state for people claiming income across FPL categories with estimates of the number of people who would be eligible for exchange plans and PTCs in each FPL category. The first set of tables is for the lowest-income category: 100-150 percent FPL. We show the number of 100-150 percent FPL sign-ups and the number of state residents between 19 and 64 years of age who report income between 100 percent and 150 percent FPL and who also do not report having Medicare or Medicaid. We exclude those ages 19-64 in this income category who reported coverage in Medicaid or Medicare, because they are likely on federal disability programs with that coverage (and thus precluded from eligibility for PTCs in the exchange) or live in expansion states and are on Medicaid.[15] We exclude children age 18 and under because they are eligible for Medicaid or the Children's Health Insurance Program (CHIP) if their incomes are in this range and are thus precluded from exchange coverage and PTC eligibility.[16] We exclude seniors, because they are almost certainly enrolled in Medicare and are precluded from exchange coverage. People who have either Medicare or Medicaid are also precluded from exchange coverage.[17]

The data set we use is the 2022 ACS 1-Year Public Use Microdata Sample file. This survey is a nationally representative survey from the U.S. Censu

compare this estimate to the number of plan selections on the exchanges in 2024 by FPL from the CMS Marketplace Open Enrollment Public Use File. We exclude New York and Minnesota from the analysis due to their Basic Health Programs (BHP), which provide coverage for this lower-income exchange population. We exclude the District of Columbia, as most of its reporting in the open enrollment file does not report income.

For our analysis, we have attempted to be overly inclusive of the population with income between 100 percent and 150 percent FPL eligible for exchange coverage with APTCs. We do not exclude individuals who report employer coverage. Excluding these people would further reduce the number of people potentially eligible for exchange coverage. ACS data generally undercounts people in lower income brackets,[19] but we make other assumptions that include people as potential enrollees between 100 percent and 150 percent FPL who would not be eligible for an exchange plan with a PTC. Much of our analysis is on the fraudulent enrollment comparisons across states, which means that our findings of differences across states should be largely unaffected by the ACS undercount — assuming that there is not large variation in the undercount across states.[20]

We are unable to exclude unauthorized immigrants, people who receive veterans' health care, and anyone who might have an offer of affordable coverage from an employer. Additionally, this analysis does not account for individuals who are unaware that they have Medicaid coverage, which represented nearly 30 percent of Medicaid enrollees in 2022.[21] Accounting for these limitations would result in an even smaller number of exchange-eligible people, which are additional reasons why our estimates are overly inclusive.

LARGE-SCALE EXCHANGE ENROLLMENT FRAUD

Table 1 compares the number of people ages 19-64 who sign up for exchange plans and report income between 100 percent and 150 percent FPL with the projected maximum number of people who would be eligible for such coverage.

California	SBE	Adopted	278,204	676,577	41.1%
Colorado	SBE	Adopted	14,786	105,073	14.1%
Connecticut	SBE	Adopted	12,991	45,615	28.5%
Delaware	HC.gov	Adopted	8,374	16,292	51.4%
Florida	HC.gov	Not Adopted	2,718,501	676,297	402.0%
Georgia	HC.gov	Not Adopted	834,058	338,044	246.7%
Hawaii	HC.gov	Adopted	3,006	27,349	11.0%
Idaho	SBE	Adopted	8,193	55,863	14.7%
Illinois	HC.gov	Adopted	111,131	232,030	47.9%
Indiana	HC.gov	Adopted	112,127	140,930	79.6%
Iowa	HC.gov	Adopted	23,908	54,344	44.0%
Kansas	HC.gov	Not Adopted	82,256	83,391	98.6%
Kentucky	SBE	Adopted	8,534	82,820	10.3%
Louisiana	HC.gov	Adopted	93,833	107,669	87.1%
Maine	SBE	Adopted	4,581	19,696	23.3%
Maryland	SBE	Adopted	21,599	92,608	23.3%
Massachusetts	SBE	Adopted	30,595	78,527	39.0%
Michigan	HC.gov	Adopted	122,597	179,256	68.4%
Mississippi	HC.gov	Not Adopted	210,749	104,613	201.5%
Missouri	HC.gov	Adopted	154,459	170,544	90.6%
Montana	HC.gov	Adopted	8,522	25,591	33.3%
Nebraska	HC.gov	Adopted	25,158	53,877	46.7%
Nevada	SBE	Adopted	22,471	85,772	26.2%
New Hampshire	HC.gov	Adopted	8,484	15,449	54.9%
New Jersey	SBE	Adopted	69,867	134,985	51.8%
New Mexico	SBE	Adopted	6,747	44,995	15.0%
North Carolina	HC.gov	Adopted	507,098	304,295	166.6%
North Dakota	HC.gov	Adopted	3,770	16,468	22.9%
Ohio	HC.gov	Adopted	166,814	209,037	79.8%
Oklahoma	HC.gov	Adopted	120,013	130,807	91.7%
Oregon	HC.gov	Adopted	11,190	81,209	13.8%
Pennsylvania	SBE	Adopted	81,714	206,033	39.7%
Rhode Island	SBE	Adopted	6,117	14,238	43.0%
South Carolina	HC.gov	Not Adopted	301,553	147,569	204.3%
South Dakota	HC.gov	Adopted	8,821	23,677	37.3%
Tennessee	HC.gov	Not Adopted	310,781	207,288	149.9%
Texas	HC.gov	Not Adopted	2,133,460	1,097,793	194.3%
Utah	HC.gov	Adopted	133,065	79,712	166.9%
Vermont	SBE	Adopted	2,227	6,979	31.9%
Virginia	SBE	Adopted	110,912	152,173	72.9%
Washington	SBE	Adopted	21,588	126,253	17.1%
West Virginia	HC.gov	Adopted	17,243	38,859	44.4%
Wisconsin	HC.gov	Not Adopted	64,398	112,084	57.5%
Wyoming	HC.gov	Not Adopted	8,054	15,952	50.5%
TOTAL			9,406,586	7,045,733	133.5%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

In nine states, more people signed up for coverage than would be eligible, meaning that the number of people who enrolled in a plan with zero premium and very low cost-sharing plans exceeded the number of eligible adults in that income range. Seven of these nine states did not expand their Medicaid programs — an indication that a large part of the issue is people in non-Medicaid expansion states overestimating their income in order to qualify for fully subsidized, low cost-sharing plans. This outcome is expected considering people with incomes between 100 percent and 138 percent FPL in the 100 percent to 150 percent FPL range do not legally qualify for APTCs in expansion states. Florida is a clear outlier, enrolling more than four times as many people in this income category as we estimate are eligible. Georgia, Mississippi, and South Carolina enrolled more than twice as many people in this income category as estimated

health coverage on the exchanges in 2024 and that the cost of improper enrollment is likely upward of $15-$20 billion this year.

We estimate improper enrollment separately for Medicaid expansion and non-Medicaid expansion states. In non-Medicaid expansion states, we count improper enrollment as any enrollment above the total potential enrollees (i.e., the number of 19-64-year-olds with income in that category as reported by the ACS). In expansion states, we count improper enrollment as any enrollment above half the number of potential enrollees. As a reminder, only those with income between 138 percent to 150 percent FPL would be eligible for exchange coverage in this income category. We believe both estimates are conservative.

This method yields 4.84 million fraudulently enrolled people at 100 percent to 150 percent FPL, but only in 21 states as the other states, which include New York and Minnesota that rely on the BHP for coverage for this population, do not meet the above criteria. Since there is some degree of improper enrollment in every state, and our methodology is designed to yield a conservative estimate, the number of improperly enrolled people at 100 to 150 percent FPL is likely higher than this four to five million people range.

Taking a conservative estimate of five million people improperly enrolled in fully subsidized plans, we estimate that 60 percent of enrollees have income below 100 percent of the FPL and are receiving $6,000 worth of subsidy to which they are not entitled. Of the remaining 40 percent of enrollees who have underestimated their income, we estimate they have received an excess subsidy of $1,000.[22] Putting these together yields about $20 billion of improper PTCs for 2024.

The main reason these estimates are conservative is because we use a $6,000 average subsidy, which is the subsidy for a 40-year-old. The average age of an exchange enrollee is older than 40 and, as Figure 3 shows, the PTC is much larger for older enrollees. If the average PTC for improperly enrolled people is $8,000 (which may be more realistic), then the estimated cost of improper enrollment would be $26 billion in 2024.

An additional reason the $20 billion is a conservative estimate is that the number of people who have overestimated their income in non-expansion states who are receiving fully subsidized PTCs to which they are not entitled (by far the biggest contributor to improper spending) almost certainly exceeds 3.0 million people. In seven non-expansion states, ther

Using a similar methodology for the more expansive set of potential enrollees for the 100 percent to 150 percent FPL group, consistent with Table 3 below, produces estimates of roughly 4 million improper enrollees in this category at a cost of about $15 billion in 2024. We believe that this estimate is a lower bound of total fraudulent enrollment in the 100 percent to 150 percent group and the associated cost.

Fraudulent Enrollment in North Carolina

North Carolina expanded Medicaid on December 1, 2023, and was the only state to adopt the ACA's expansion of the program during the 2024 ACA open enrollment period, which started on November 1, 2023.

As of May 5, 2024, 451,194 people enrolled under North Carolina's Medicaid expansion.[23] While enrollment in Medicaid expansion has been substantial, at the same time significantly more North Carolinians reporting income between 100 percent and 150 percent FPL enrolled in exchange plans in the 2024 open enrollment period (507,098) than selected plans in 2023 (347,551).

Combining 2024 exchange plan selections in open enrollment with the number of Medicaid expansion enrollees totals 958,292 individuals. This is 28.2 percent higher than the 2023 ACS estimate for the number of people in North Carolina under 150 percent FPL ages 19-64 who did not report having Medicaid or Medicare — which is an upper bound on the number of individuals potentially eligible for the exchanges or Medicaid expansion.[24]

The data indicates that many North Carolinians were (and likely still are) simultaneously enrolled in Medicaid and the exchanges. Because North Carolina transitioned its Medicaid program to managed care in 2021,[25] this suggests that insurers are potentially reaping windfall profits from dual enrollment. It also suggests that enrollees in North Carolina are at substantial risk of financial penalties, as the state put out the following guidance: "If you qualify for full Medicaid, you will not be able to get financial help with the cost of your Marketplace plan. Therefore, you probably will not want to keep your Marketplace coverage because it will cost more than coverage through NC Medicaid."[26]

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 and 2023 Open Enrollment File and North Carolina Office of the Governor, "NC Medicaid Expansion Hits 450,000 Enrollees in Just Five Months," press release, May 9, 2024, https://governor.nc.gov/news/press-releases/2024/05/09/nc-medicaid-expansion-hits-450000-enrollees-just-five-months.

Table 3 shows the same results as Table 1, except it compares the number of people who signed up for coverage during open enrollment reporting income between 100 percent and 150 percent FPL with all potential enrollees who are residents ages 19-64 by state. The difference with Table 1 is that we include people who report either Medicaid or Medicare in this income category as potential exchange enrollees with PTCs. We do this because it is possible that people are confusing exchange plans with Medicaid plans.[27] In many states, exchange plans are very similar to Medicaid plans, and many of these enrollees use little if any health care and are not highly engaged or knowledgeable about their coverage.[28] So Table 3 provides conservative estimates on the extent of the fraudulent enrollment problem and likely represents a lower bound on the degree of improper enrollment in the income category of 100 percent to 150 percent FPL.

Table 3 illustrates that fraudulent enrollment is so acute in several states that there are more people signing up for exchange plans than could possibly be eligible, even under expansive assumptions that raise the number of potential enrollees. These states include Florida, Georgia, Texas, South Carolina, Mississippi, Utah, and North Carolina, but fraudulent enrollment is certainly occurring to a significant degree in many other states as well. The states with the most severe problems are all states that use HealthCare.gov, and most are states that did not expand Medicaid. Of the 20 states that have fewer than 20 percent of the 19-64 year old, 100 percent to 150 percent of the FPL population enrolling in exchange plans during open enrollment (from Table 3's calculation), 14 are states with state-based exchanges. For context, there are only 16 state-based exchange states in our analysis, as we have excluded Minnesota, New York, and the District of Columbia.[29]

California	SBE	Adopted	278,204	1,501,964	18.5%
Colorado	SBE	Adopted	14,786	183,259	8.1%
Connecticut	SBE	Adopted	12,991	111,731	11.6%
Delaware	HC.gov	Adopted	8,374	28,953	28.9%
Florida	HC.gov	Not Adopted	2,718,501	952,666	285.4%
Georgia	HC.gov	Not Adopted	834,058	453,044	184.1%
Hawaii	HC.gov	Adopted	3,006	47,574	6.3%
Idaho	SBE	Adopted	8,193	89,492	9.2%
Illinois	HC.gov	Adopted	111,131	447,001	24.9%
Indiana	HC.gov	Adopted	112,127	261,413	42.9%
Iowa	HC.gov	Adopted	23,908	115,741	20.7%
Kansas	HC.gov	Not Adopted	82,256	109,945	74.8%
Kentucky	SBE	Adopted	8,534	200,601	4.3%
Louisiana	HC.gov	Adopted	93,833	246,452	38.1%
Maine	SBE	Adopted	4,581	46,939	9.8%
Maryland	SBE	Adopted	21,599	170,883	12.6%
Massachusetts	SBE	Adopted	30,595	203,664	15.0%
Michigan	HC.gov	Adopted	122,597	393,876	31.1%
Mississippi	HC.gov	Not Adopted	210,749	150,673	139.9%
Missouri	HC.gov	Adopted	154,459	251,022	61.5%
Montana	HC.gov	Adopted	8,522	46,007	18.5%
Nebraska	HC.gov	Adopted	25,158	82,415	30.5%
Nevada	SBE	Adopted	22,471	138,250	16.3%
New Hampshire	HC.gov	Adopted	8,484	32,356	26.2%
New Jersey	SBE	Adopted	69,867	250,657	27.9%
New Mexico	SBE	Adopted	6,747	106,051	6.4%
North Carolina	HC.gov	Adopted	507,098	444,838	114.0%
North Dakota	HC.gov	Adopted	3,770	25,512	14.8%
Ohio	HC.gov	Adopted	166,814	446,496	37.4%
Oklahoma	HC.gov	Adopted	120,013	199,569	60.1%
Oregon	HC.gov	Adopted	11,190	169,456	6.6%
Pennsylvania	SBE	Adopted	81,714	439,826	18.6%
Rhode Island	SBE	Adopted	6,117	32,294	18.9%
South Carolina	HC.gov	Not Adopted	301,553	217,740	138.5%
South Dakota	HC.gov	Adopted	8,821	31,161	28.3%
Tennessee	HC.gov	Not Adopted	310,781	313,721	99.1%
Texas	HC.gov	Not Adopted	2,133,460	1,371,752	155.5%
Utah	HC.gov	Adopted	133,065	106,353	125.1%
Vermont	SBE	Adopted	2,227	18,527	12.0%
Virginia	SBE	Adopted	110,912	270,980	40.9%
Washington	SBE	Adopted	21,588	237,173	9.1%
West Virginia	HC.gov	Adopted	17,243	89,695	19.2%
Wisconsin	HC.gov	Not Adopted	64,398	204,105	31.6%
Wyoming	HC.gov	Not Adopted	8,054	20,769	38.8%
TOTAL			9,406,586	11,978,289	78.5%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

Fraudulent Enrollment Much Greater in Non-Expansion States and HealthCare.gov States

Table 4 shows the enrollment estimates broken down by expansion states and non-expansion states and states using the federal exchange (HealthCare.gov) and those states that established their own exchanges. The data clearly indicates that fraudulent enrollment is much more severe in states that did not expand Medicaid as well as in states that use the HealthCare.gov platform. As expected, the number of people misestimating their income is much greater in non-expansion states, as there is both an incentive for people above 200 percent FPL to report lower income and an incentive for people with income below 100 percent FPL to report higher income.

Expansion and HC.gov	1,812,767	2,174,064	83.4%	3,939,756	46.0%
Non-expansion and HC.gov	6,892,693	2,943,461	234.2%	4,036,240	170.8%
SBE	701,126	1,928,208	36.4%	4,002,293	17.5%
Medicaid Expansion	2,513,893	4,102,272	61.3%	7,942,049	31.7%
Expansion and SBE	701,126	1,928,208	36.4%	4,002,293	17.5%
Expansion and HC.gov	1,812,767	2,174,064	83.4%	3,939,756	46.0%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

More surprising is that fraud is much greater in HealthCare.gov states. In states that used HealthCare.gov, 8.7 million sign-ups reported enrollment between 100 percent and 150 percent FPL compared to only 5.1 million people likely eligible for such coverage, or 1.7 signups for every eligible person.

Unique deficiencies with HealthCare.gov are shown when controlling for whether states expanded Medicaid. All states with state-based exchanges did expand Medicaid, but many expansion states also used HealthCare.gov. Isolating the analysis to expansion states excludes the states where fraudulent enrollment is severe. The percentage of open enrollment sign-ups reporting income between 100 percent and 150 percent FPL relative to all those ages 19-64 eligible for such coverage is more than twice as high in expansion states with HealthCare.gov than in expansion states with state-based exchanges.

Some state-based exchanges verify income using alternative data sources, such as state tax data.[30] In 2017, the Government Accountability Office reviewed processes in three states — Idaho, Maryland, and Rhode Island — to verify eligibility for APTCs and found "few indications of potentially improper enrollments."[31] States using alternative data or state-specific data to verify eligibility could contribute to observed differences in fraudulent enrollment between the federal and state-based exchanges.

Some of the differences appear to be in how states have handled the removal of Medicaid enrollees (the "unwinding" process) who were no longer eligible for that program after the conclusion of the public health emergency. For the duration of the public health emergency, which lasted for more than three years, states did not remove enrollees from Medicaid regardless of whether they gained other coverage or earned income making them ineligible.[32]

or not. In contrast, in states with state-based exchanges, only 16 percent of people who lost Medicaid or CHIP during the unwinding were enrolled in an exchange plan. In states with state-based exchanges, a far lower percentage of enrollees was deemed eligible for PTCs and a far lower percentage of enrollees deemed eligible for PTCs enrolled in coverage. This data strongly suggests that HealthCare.gov eased the flow of people from Medicaid to the exchanges, potentially without proper verification, including through more fraudulent claims of income between 100 percent and 150 percent FPL.

Table 5: Ex-Medicaid Enrollees Far More Likely to Move to Exchange Plans in HealthCare.gov states (as of January 2024)

Category	Federal Exchange		State-Based Exchange	
		% of Removed from Medicaid/CHIP		% of Removed from Medicaid/CHIP
All States				
Removed from Medicaid/CHIP	4,788,553		2,936,872	
Determined exchange eligible	4,236,031	88%	2,192,908	75%
Determined eligible for APTC	3,759,747	79%	1,282,878	44%
Consumers with a plan selection	3,341,758	70%	482,231	16%
Expansion States				
Removed from Medicaid/CHIP	2,084,714		2,936,872	
Determined exchange eligible	1,795,737	86%	2,192,908	75%
Determined eligible for APTC	1,577,138	76%	1,282,878	44%
Consumers with a plan selection	1,417,478	68%	482,231	16%

SOURCES: CMS Unwinding Monthly Update Files. Most recent data is available for January 2024.

NOTES: Excludes DC, MN, and NY, and VA. VA is excluded because of data issues due to converting to SBE within the year. At the state level, SBE results widely vary, but are particularly driven by CA.

Examining the Population Between 138 Percent and 150 Percent FPL States

While the majority of this analysis focuses on incentives that occur for populations under 100 percent FPL, there is an incentive for people in expansion states to report income between 138 percent and 150 percent FPL in order to gain fully subsidized exchange plans. Table 6 presents similar findings to previous tables, focusing on people reporting income between 138 percent and 150 percent FPL. Plan sign-ups are calculated from the 2024 open enrollment files, and this table focuses on working-age adults (19-64) who do not report Medicaid or Medicare enrollment (and so corresponds to Table 1).

California	SBE	Adopted	191,029	179,304	106.5%
Colorado	SBE	Adopted	10,754	29,431	36.5%
Connecticut	SBE	Adopted	4,196	10,691	39.2%
Delaware	HC.gov	Adopted	5,465	6,160	88.7%
Florida	HC.gov	Not Adopted	462,458	175,008	264.2%
Georgia	HC.gov	Not Adopted	124,074	89,563	138.5%
Hawaii	HC.gov	Adopted	1,888	10,525	17.9%
Idaho	SBE	Adopted	5,362	16,655	32.2%
Illinois	HC.gov	Adopted	75,082	63,636	118.0%
Indiana	HC.gov	Adopted	79,886	40,403	197.7%
Iowa	HC.gov	Adopted	18,114	15,702	115.4%
Kansas	HC.gov	Not Adopted	16,614	20,181	82.3%
Kentucky	SBE	Adopted	5,710	26,170	21.8%
Louisiana	HC.gov	Adopted	68,566	31,425	218.2%
Maine	SBE	Adopted	2,832	5,762	49.1%
Maryland	SBE	Adopted	11,895	25,591	46.5%
Massachusetts	SBE	Adopted	14,134	21,937	64.4%
Michigan	HC.gov	Adopted	90,585	43,078	210.3%
Mississippi	HC.gov	Not Adopted	28,905	25,822	111.9%
Missouri	HC.gov	Adopted	106,913	49,044	218.0%
Montana	HC.gov	Adopted	5,792	7,574	76.5%
Nebraska	HC.gov	Adopted	17,479	20,148	86.8%
Nevada	SBE	Adopted	11,732	25,180	46.6%
New Hampshire	HC.gov	Adopted	5,994	4,764	125.8%
New Jersey	SBE	Adopted	32,762	33,289	98.4%
New Mexico	SBE	Adopted	2,807	9,422	29.8%
North Carolina	HC.gov	Adopted	168,594	79,020	213.4%
North Dakota	HC.gov	Adopted	2,426	3,073	78.9%
Ohio	HC.gov	Adopted	117,548	55,245	212.8%
Oklahoma	HC.gov	Adopted	77,306	38,379	201.4%
Oregon	HC.gov	Adopted	8,160	21,420	38.1%
Pennsylvania	SBE	Adopted	37,821	65,519	57.7%
Rhode Island	SBE	Adopted	2,148	3,935	54.6%
South Carolina	HC.gov	Not Adopted	48,395	41,080	117.8%
South Dakota	HC.gov	Adopted	4,313	6,071	71.0%
Tennessee	HC.gov	Not Adopted	49,375	55,420	89.1%
Texas	HC.gov	Not Adopted	281,332	289,384	97.2%
Utah	HC.gov	Adopted	81,644	19,748	413.4%
Vermont	SBE	Adopted	1,387	592	234.4%
Virginia	SBE	Adopted	54,018	40,812	132.4%
Washington	SBE	Adopted	16,396	37,046	44.3%
West Virginia	HC.gov	Adopted	12,529	10,409	120.4%
Wisconsin	HC.gov	Not Adopted	17,827	32,866	54.2%
Wyoming	HC.gov	Not Adopted	1,715	4,556	37.6%
TOTAL			2,547,416	1,916,982	132.9%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

Regardless of expansion status, many states have more exchange sign-ups reporting income between 138 percent and 150 percent FPL than potentially eligible individuals in this income range. Utah is an outlier at more than four times as many people reporting income in this category than would be eligible. Twenty-two states have more people signing up who report income between 138 percent and 150 percent FPL than are potentially eligible.

Again, there is a drastic difference between federal exchange states and state-based exchange states in fraudulent enrollment rates — as noted in Table 7. In federal exchange states, sign-ups reporting income between 138 percent and 150 percent FPL are 155 percent of the eligible population. In states with state-based exchanges, sign-ups are 76 percer of the eligible population. In expansion states using HealthCare.gov, sign

Enrollees More Severe in States Using HealthCare.gov

State	Exchange Sign-Ups (1)	Total Potential Enrollees (2)	Percentage (1)/(2)
HC.gov	2,142,433	1,385,646	154.6%
Expansion and HC.gov	1,075,846	606,387	177.4%
Non-expansion and HC.gov	1,066,587	779,260	136.9%
SBE	404,983	531,335	76.2%
Medicaid Expansion	1,480,829	1,137,722	130.2%
Expansion and SBE	404,983	531,335	76.2%
Expansion and HC.gov	1,075,846	606,387	177.4%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

Big Money for Insurers and Brokers

The Biden administration has made a political decision to prioritize enrollment in public programs and neglect program integrity issues. For example, the administration extended the COVID public health emergency into the spring of 2023 to delay Medicaid redeterminations and removals.[33] This led to approximately 18 million ineligible Medicaid enrollees in March 2023.[34] The administration has created a continuous open enrollment period for the exchanges for people below 150 percent FPL.[35] As should be apparent from the analysis above, because half of exchange enrollees are claiming income below 150 percent FPL, this open enrollment period is almost certainly subject to widespread abuse. The administration has also been sympathetic to self-attestation rather than verification of information.[36]

In 2021, a federal district court stopped four provisions of the 2019 Notice of Benefit and Payment Parameters (NBPP),[37] which would have required people to submit additional information to verify their income if they reported income above the FPL and administrative data suggests that their income is below that level.[38] In City of Columbus, et al. v. Norris Cochran, the cities of Columbus, Baltimore, Cincinnati, Chicago, and Philadelphia (along with two individuals) sued the federal government, alleging that the 2019 NBPP would harm enrollees and that the Trump administration was working to undercut the exchanges.[39] The court sided with the plaintiffs and effectively gutted income verification requirements for low-income exchange enrollees. This court decision—combined with no subsidy recapture for enrollees below 100 percent FPL and incentives facing brokers and insurers—set the stage for substantial improper spending.

This means that people have incentives to enroll even if they receive very low benefit from the plan. Worse, given automatic re-enrollment, many people might be enrolled for a second year when they already have other coverage, have moved out of state, or have passed away. For re-enrollees in all states, 32.8 percent were automatically re-enrolled in coverage in 2024.[40] All this leads to large payments to health insurers on behalf of many people who are likely receiving low value or no value from the coverage.

Importantly, the insurers are held harmless when people are enrolled receiving larger subsidies than what they were entitled to. Even though the payment goes directly from the U.S. Treasury to the insurer, the payment is effectively a PTC for the enrollee. So, the liability, which is limited for most enrollees who underestimate income (and nonexistent for enrollees with less than 100 percent FPL), is on the enrollees when they reconcile their taxes (assuming that they file their taxes). Insurers have significant financial upside from improper enrollment aimed at maximizing subsidies.

Some private brokers are likely making the problem of fraudulent enrollment worse. These entities have contracts with insurers, and these contracts require the insurers pay them a commission for each enrollee. Some brokers have come under increased scrutiny the past few months for changing the agent of record to capture other agents' commissions, enrolling people without their knowledge, and canceling exchange enrollee coverage and re-enrolling people in different plans to earn higher commissions.[41]

Unscrupulous broker behavior is also made easier in federal exchange states. Julie Appleby's reporting for KFF on unauthorized plan switching highlighted that brokers need very little information to access individuals' accounts.[42] If the broker is registered on HealthCare.gov, all they need is a name, date of birth, and state of residence to enroll an individual into coverage. Additionally, HealthCare.gov lacks basic consumer protections, such as two-factor authentication, and it does not notify enrollees when changes occur to their accounts. Furthermore, any broker or agent can get access to the account of any enrollee for whom the name, date of birth and state enrolled is available regardless of the enrollment platform used, including HealthCare.gov and direct enrollment platforms. On direct enrollment platforms, the user is redirected to HealthCare.gov. However, on enhanced direct enrollment platforms, an enrollment entity hosts a version of HealthCare.gov's eligibility application and integrates directly

On May 20, 2024, the Chairman of the Senate Finance Committee Ron Wyden sent a letter to the CMS Administrator Chiquita Brooks-LaSure expressing his "outrage with reports that agents and brokers are submitting plan changes and enrollments in the Federal marketplace without the consent of the people who rely on these plans."[44] Chairman Wyden criticized enhanced web-broker platforms, alleging that "bad actors with access to a consumer's eligibility information through web-broker platforms can make plan and agent-of-record changes while keeping people and their legitimate brokers in the dark."[45]

An additional example of unscrupulous behavior by brokers and agents includes fraudulently signing up homeless people.[46] Law-abiding brokers are harmed by unscrupulous broker behavior and recently filed a complaint against brokers they allege to be stealing their commissions.[47] The fraudsters are likely a small percentage of brokers, but they could still be having a large impact given the plethora of fully taxpayer-subsidized plans where enrollees have little, if any, incentive to pay attention to coverage changes.

According to a CMS presentation to brokers, agents and brokers assisted over 6.8 million enrollments during the 2023 open enrollment period. Direct enrollment and enhanced direct enrollment accounted for 81 percent of all active agent-and broker-assisted plan selections, or 5.5 million plan selections. CMS highlighted that data matching issues were over twice as likely to occur under agent-and broker-assisted enrollments. In fact, 16 percent of those who worked with agents or brokers submitted exchange applications that did not include Social Security Numbers versus less than one percent of consumers who self-enrolled.[48]

Heath care "navigators," who work at nonprofit entities, may also be complicit in encouraging misestimates of income, with some likely seeing it as consistent with their purpose and ideological aims to enroll as many people as possible in coverage, knowing that estimating income to maximize subsidies has little downside for people. In 2013, the House Committee on Oversight and Government Reform issued a scathing report on navigators, including a concerning section related to lax protocols to prevent tax fraud.[49]

RECOMMENDATIONS

switching, ensure that coverage provides at least a modicum of value to enrollees, and protect taxpayers is to let the enhanced PTCs expire after 2025.

Second, Congress should raise the subsidy recapture limits so that there are not large incentives for people to misestimate their income, and Congress should put a portion of the liability on entities that gain from improper enrollment — insurers and brokers — for repaying ill-gotten PTCs. As Senator Wyden recently recommended, brokers who are knowingly working with people to manipulate information to maximize subsidies should also be held criminally liable. And states should suspend their licenses.

Third, Congress or the next administration should limit automatic re-enrollment into exchange plans from one year to the next and end it for people moving from or into fully taxpayer-subsidized plans. Fourth, as outlined by Merkel and Blase, Congress should appropriate cost-sharing reduction payments and prohibit silver-loading, which has significantly increased PTC amounts.[51] Doing so would reduce the benchmark plan premium and PTCs, returning to a more sensible structure for the overall ACA subsidy structure.

Fifth, Congress should conduct aggressive oversight of both the Biden administration's management of HealthCare.gov, enhanced direct enrollment, and insurer and broker actions. Congress should ask the Joint Committee on Taxation and Treasury what percentage of people overestimate their income, what percentage of people underestimate their income, and how much PTC is improperly expended by year. Congress should require CMS to provide more information on navigators, particularly with respect to the information navigators are providing related to the large subsidies available for people with income between 100 percent and 150 percent FPL. Congress should also require CMS to provide information on data matching issues by platform.

Sixth, Congress or the next administration should reverse policies of the Biden administration that enabled such widespread fraudulent enrollment, particularly the continuous open-enrollment period for people who report they have income below 150 percent FPL.

APPENDIX

may not wish to exaggerate their income to such a large degree to report it under 150 percent FPL may be amenable to reporting it under 200 percent FPL to get both large subsidies for the premium and qualify for the CSR program, which significantly reduces deductibles and copayments to hit an 87 percent actuarial value.

Appendix Tables 1 and 2 continue to show severe fraudulent enrollment problems, again concentrated largely in Sunbelt states along with Utah. The fraudulent enrollment problem appears concentrated in states that did not adopt Medicaid expansion as well as states using the HealthCare.gov platform.

California	SBE	Adopted	717,031	1,625,750	44.1%
Colorado	SBE	Adopted	51,200	252,280	20.3%
Connecticut	SBE	Adopted	34,783	109,099	31.9%
Delaware	HC.gov	Adopted	17,541	37,630	46.6%
Florida	HC.gov	Not Adopted	3,322,479	1,538,613	215.9%
Georgia	HC.gov	Not Adopted	1,029,624	775,744	132.7%
Hawaii	HC.gov	Adopted	7,501	63,185	11.9%
Idaho	SBE	Adopted	32,244	124,126	26.0%
Illinois	HC.gov	Adopted	194,237	548,965	35.4%
Indiana	HC.gov	Adopted	175,041	354,519	49.4%
Iowa	HC.gov	Adopted	45,930	142,404	32.3%
Kansas	HC.gov	Not Adopted	110,544	195,669	56.5%
Kentucky	SBE	Adopted	27,107	212,396	12.8%
Louisiana	HC.gov	Adopted	142,313	238,496	59.7%
Maine	SBE	Adopted	15,358	59,355	25.9%
Maryland	SBE	Adopted	64,343	226,305	28.4%
Massachusetts	SBE	Adopted	90,454	174,445	51.9%
Michigan	HC.gov	Adopted	206,518	445,267	46.4%
Mississippi	HC.gov	Not Adopted	255,396	235,938	108.2%
Missouri	HC.gov	Adopted	239,119	385,638	62.0%
Montana	HC.gov	Adopted	21,240	61,983	34.3%
Nebraska	HC.gov	Adopted	45,298	117,491	38.6%
Nevada	SBE	Adopted	44,723	199,137	22.5%
New Hampshire	HC.gov	Adopted	19,616	40,937	47.9%
New Jersey	SBE	Adopted	154,391	341,533	45.2%
New Mexico	SBE	Adopted	17,670	105,841	16.7%
North Carolina	HC.gov	Adopted	671,971	701,467	95.8%
North Dakota	HC.gov	Adopted	12,021	40,112	30.0%
Ohio	HC.gov	Adopted	266,876	528,940	50.5%
Oklahoma	HC.gov	Adopted	185,990	299,447	62.1%
Oregon	HC.gov	Adopted	34,211	189,439	18.1%
Pennsylvania	SBE	Adopted	174,885	495,748	35.3%
Rhode Island	SBE	Adopted	14,617	35,624	41.0%
South Carolina	HC.gov	Not Adopted	386,973	349,974	110.6%
South Dakota	HC.gov	Adopted	18,429	57,492	32.1%
Tennessee	HC.gov	Not Adopted	397,837	481,722	82.6%
Texas	HC.gov	Not Adopted	2,620,488	2,407,750	108.8%
Utah	HC.gov	Adopted	196,804	201,827	97.5%
Vermont	SBE	Adopted	8,223	17,204	47.8%
Virginia	SBE	Adopted	187,426	370,053	50.6%
Washington	SBE	Adopted	77,930	292,879	26.6%
West Virginia	HC.gov	Adopted	28,835	88,182	32.7%
Wisconsin	HC.gov	Not Adopted	105,983	266,700	39.7%
Wyoming	HC.gov	Not Adopted	14,416	38,451	37.5%
TOTAL			13,067,488	16,464,434	79.4%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

California	SBE	Adopted	717,031	3,134,648	22.9%
Colorado	SBE	Adopted	51,200	402,109	12.7%
Connecticut	SBE	Adopted	34,783	223,522	15.6%
Delaware	HC.gov	Adopted	17,541	63,856	27.5%
Florida	HC.gov	Not Adopted	3,322,479	2,015,717	164.8%
Georgia	HC.gov	Not Adopted	1,029,624	973,526	105.8%
Hawaii	HC.gov	Adopted	7,501	97,742	7.7%
Idaho	SBE	Adopted	32,244	187,283	17.2%
Illinois	HC.gov	Adopted	194,237	905,757	21.4%
Indiana	HC.gov	Adopted	175,041	570,590	30.7%
Iowa	HC.gov	Adopted	45,930	239,033	19.2%
Kansas	HC.gov	Not Adopted	110,544	236,748	46.7%
Kentucky	SBE	Adopted	27,107	414,762	6.5%
Louisiana	HC.gov	Adopted	142,313	467,247	30.5%
Maine	SBE	Adopted	15,358	105,913	14.5%
Maryland	SBE	Adopted	64,343	375,718	17.1%
Massachusetts	SBE	Adopted	90,454	409,553	22.1%
Michigan	HC.gov	Adopted	206,518	814,776	25.3%
Mississippi	HC.gov	Not Adopted	255,396	309,883	82.4%
Missouri	HC.gov	Adopted	239,119	522,761	45.7%
Montana	HC.gov	Adopted	21,240	104,053	20.4%
Nebraska	HC.gov	Adopted	45,298	160,605	28.2%
Nevada	SBE	Adopted	44,723	295,567	15.1%
New Hampshire	HC.gov	Adopted	19,616	70,630	27.8%
New Jersey	SBE	Adopted	154,391	555,446	27.8%
New Mexico	SBE	Adopted	17,670	205,929	8.6%
North Carolina	HC.gov	Adopted	671,971	946,754	71.0%
North Dakota	HC.gov	Adopted	12,021	54,807	21.9%
Ohio	HC.gov	Adopted	266,876	927,552	28.8%
Oklahoma	HC.gov	Adopted	185,990	411,818	45.2%
Oregon	HC.gov	Adopted	34,211	343,876	9.9%
Pennsylvania	SBE	Adopted	174,885	879,693	19.9%
Rhode Island	SBE	Adopted	14,617	67,232	21.7%
South Carolina	HC.gov	Not Adopted	386,973	472,516	81.9%
South Dakota	HC.gov	Adopted	18,429	69,076	26.7%
Tennessee	HC.gov	Not Adopted	397,837	663,105	60.0%
Texas	HC.gov	Not Adopted	2,620,488	2,893,779	90.6%
Utah	HC.gov	Adopted	196,804	251,364	78.3%
Vermont	SBE	Adopted	8,223	39,829	20.6%
Virginia	SBE	Adopted	187,426	572,620	32.7%
Washington	SBE	Adopted	77,930	491,832	15.8%
West Virginia	HC.gov	Adopted	28,835	171,353	16.8%
Wisconsin	HC.gov	Not Adopted	105,983	423,367	25.0%
Wyoming	HC.gov	Not Adopted	14,416	46,997	30.7%
TOTAL			13,067,488	25,083,628	52.1%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

FOOTNOTES

1↑ A silver plan has an actuarial value of 70 percent, which means that the plan pays for about 70 percent of the typical enrollee's medical expenses covered by the plan.

2↑ ARPA enhanced subsidies applied for 2021 and 2022, while IRA enhanced subsidies applied for 2023-2025. American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 (2021). Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818 (2022).

3↑ In 2024, 100 percent FPL for a single person is $15,050. For a household of two, this amount is $20,440. For a four-person household, 100 percent FPL is $31,200.

4↑ Refundable means that they not only reduce tax liability but are direct payments to qualifying individuals. Most people who claim PTCs do not owe income taxes and receive

6↑ Brian Blase, "Fourteen Reasons to Let the Expanded Obamacare Subsidies Expire," Forbes, May 26, 2022, https://www.forbes.com/sites/theapothecary/2022/05/26/fourteen-reasons-to-let-the-expanded-obamacare-subsidies-expire/?sh=32c98a3b6cba; Brian Blase, "Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality," Galen Institute, June 2021, https://galen.org/assets/Expanded-ACA-Subsidies-Exacerbating-Health-Inflation-and-Income-Inequality.pdf.

7↑ IRS, Revenue Procedure 2023-34, https://www.irs.gov/pub/irs-drop/rp-23-34.pdf. These amounts are indexed to inflation. The amounts are also double for married persons filing jointly.

8↑ KFF, "Health Insurance Marketplace Calculator," https://www.kff.org/interactive/subsidy-calculator/

9↑ Since most silver plan enrollees report income that qualifies them for the CSR program, the average actuarial value for a silver plan is 88 percent. In order to approximate the added marginal benefit of the CSR program for enrollees who report income between 100 to 150 percent FPL, we multiplied the benchmark premium by 94/88.

10↑ IRS, 2023 Instructions for Form 8962, https://www.irs.gov/pub/irs-pdf/i8962.pdf

11↑ KFF, "Marketplace Average Benchmark Premiums: 2024," https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

12↑ KFF, "Marketplace Average Benchmark Premiums: 2024." We apply age rating tables from CMS. "State Specific Age Curve Variations" https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/downloads/statespecagecrv053117.pdf

13↑ Ben Hopkins, Jessica Banthin, and Alexandra Minicozzi, "How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender?," American Journal of Health Economics 10, no. 2 (Spring 2024), https://www.journals.uchicago.edu/doi/epdf/10.1086/727785

14↑ U.S. Department of the Treasury, "Treasury's Baseline Estimates of Health Coverage, FY 2020," September 11, 2019, https://home.treasury.gov/system/files/131/Treasurys-Baseline-Estimates-of-Health-Coverage-FY-2020.pdf. Total subsidies were $43.89 billion according to Treasury in 2020.

15↑ To be eligible for PTCs, individuals must not be eligible for public coverage including Medicaid, CHIP, Medicare, or military coverage (TRICARE). Section 5000A(f) of the ACA refers to these types of insurance as "Minimum Essential Coverage." Affordable Health Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

16↑ IRS, Publication 974 (2023), https://www.irs.gov/publications/p974

17↑ Our approach is simpler than Hopkins et al. Regarding potential exchange enrollment, Hopkins et al. classify this population as those between the ages of 20 and 64, excluding Medicare, Medicaid, CHIP, and TRICARE enrollees. Additionally, they

but using publicly available data. Hopkins et al. focuses on federal exchanges while this piece looks at all exchanges.

18↑ United States Census Bureau. "State Population Totals and Components of Change: 2020-2023" Vintage 2023. https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html#v2023. We apply the three-year trend to fully estimate state populations in 2024. This approach will not capture distributional changes that might be present.

19↑ This is partially due to eligibility for health coverage being defined differently than the FPL variables in ACS capture. These "tax unit" or "health insurance unit" designations tend to increase the number of people below 150 percent FPL.

20↑ For more discussion see Giovann Alarcon et al., "Defining Family for Studies of Health Insurance Coverage," State Health Access Data Assistance Center (SHADAC), August 2021, https://www.shadac.org/sites/default/files/publications/2021%20HIU%20Defining%20families%2(and Ithai Lurie and James Pierce, "The Effects of ACA on Income Eligibility for Medicaid and Subsidized Private Insurance Coverage: Income Definitions and Thresholds Across CPS and Administrative Data," U.S. Department of Treasury, Office of Tax Analysis. In SHADAC's methodology, this undercount is substantial, but the majority of the adjustment occurs below 100 percent FPL. In some states, fewer people are estimated in the 100 percent to 150 percent FPL category. Using Tresury's estimates suggests that 50 percent additional people could be between 100 percent and 150 percent of poverty ages 0-64. Treasury estimates 31.9 million versus 21 million in the ACS. Treasury estimates there are 9.3 million people aged 0-64 who have income between 100 percent to 150 percent FPL after excluding those with government and employer coverage. Our primary estimate of potential enrollees, which excludes children, seniors and people with Medicaid or Medicare, totals 7.0 million without New York, Minnesota, and the District of Columbia. Our expansive estimate, which includes those in this income range who report Medicare or Medicaid is 12.0 million.

21↑ Dong Ding, Benjamin D. Sommers, and Sherry A. Glied, "Unwinding and the Medicaid Undercount: Millions Enrolled in Medicaid During the Pandemic Thought They Were Uninsured," Health Affairs 43, no. 5 (May 2024), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01069

22↑ The $1,000 is a rough average of the improper benefit for people with income between 150 percent and 400 percent FPL who underestimate their income to between 100 percent and 150 percent FPL.

23↑ North Carolina Office of the Governor, "NC Medicaid Expansion Hits 450,000 Enrollees in Just Five Months," press release, May 9, 2024, https://governor.nc.gov/news/press-releases/2024/05/09/nc-medicaid-expansion-hits-450000-enrollees-just-five-months

24↑ CMS, 2024 Open Enrollment Public Use File, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files. Note: Even adjusting the population under 100 percent FPL according to SHADAC methodology still implies that the entire population

26↑ NC Medicaid Division of Health Benefits, "Questions and Answers about Medicaid Expansion," April 11, 2024, https://medicaid.ncdhhs.gov/questions-and-answers-about-medicaid-expansion

27↑ Research shows that there are more false positives for Medicaid—people with private coverage reporting Medicaid—in the ACS than in other surveys. "Among those for whom public coverage was reported, over-reporting in the ACS was higher than in the CPS—8.6% and 2.1%, respectively." See Joanne Pascale, Angela Fertig, and Kathleen Call, "Validation of Two Federal Health Insurance Survey Modules After Affordable Care Act Implementation," Journal of Official Statistics 35, no. 2 (June 2019), https://sciendo.com/article/10.2478/jos-2019-0019

28↑ Daniel Cruz and Greg Fann, "The Shortcomings of the ACA Exchanges: Far Less Enrollment at a Much Higher Cost," Paragon Health Institute, September 2023, https://paragoninstitute.org/wp-content/uploads/2023/11/Shortcomings-of-the-ACA-Cruz-Fann.pdf

29↑ New Jersey and Virginia are the two state-based exchange states that do not satisfy this criteria.

30↑ Tara Straw, "Final 2024 Payment Rule, Part 3: Exchange Operational Standards And APTC Policies," Health Affairs Forefront, April 21, 2023, https://www.healthaffairs.org/content/forefront/final-2024-payment-rule-part-3-exchange-operational-standards-and-aptc-policies

31↑ U.S. Government Accountability Office, State Health-Insurance Marketplaces: Three States Used Varied Data Sources for Eligibility and Had Few Indications of Potentially Improper Enrollments, GAO-17-694, September 2017, https://www.gao.gov/assets/gao-17-694.pdf

32↑ Drew Gonshorowski, Brian Blase, and Niklas Kleinworth, "The Cost of Good Intentions: The Harm of Delaying the Disenrollment of Medicaid Ineligibles," Paragon Health Institute, July 2023, https://paragoninstitute.org/wp-content/uploads/2023/07/the-cost-of-good-intentions.pdf

33↑ President Joe Biden, "Continuation of the National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic," 88 Fed. Reg. 9385 (February 10, 2023), https://www.federalregister.gov/d/2023-03218

34↑ Matthew Buettgens and Andrew Green, "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," Urban Institute, December 5, 2022, https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage

35↑ CMS, "HHS Notice of Benefit and Payment Parameters for 2025 Final Rule," April 2, 2024, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule

36↑ CMS, "2024 Notice of Benefit and Payment Parameters," https://www.cms.gov/files/document/cms-9899-f-patient-protection-final.pdf; CMS, "Streamlining Medicaid and CHIP, Final Rule, Fact Sheet," September 18, 2023, https://www.cms.gov/newsroom/fact-sheets/streamlining-medicaid-and-chip-final-rule-fact-sheet.

24,216. https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver

39↑ City of Columbus, et. al. v. Norris Cochran, in his official capacity as Acting Secretary of the Department of HHS, et al., https://democracyforward.org/wp-content/uploads/2021/03/Columbus-et-al.-v.-Trump.pdf

40↑ CMS, "2024 OEP State, Metal Level, and Enrollment Status Public Use File," https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files

41↑ Julie Appleby, "Rising Complaints of Unauthorized Obamacare Plan-Switching and Sign-Ups Trigger Concern," KFF Health News, April 8, 2024, https://kffhealthnews.org/news/article/aca-unauthorized-obamacare-plan-switching-concern/

42↑ Appleby, "Rising Complaints."

43↑ CMS, "Direct Enrollment and Enhanced Direct Enrollment," https://www.cms.gov/marketplace/agents-brokers/direct-enrollment-partners

44↑ United States Senator Ron Wyden, "Wyden Letter to CMS on Brokers" May 20, 2024, https://www.finance.senate.gov/imo/media/doc/wyden_letter_to_cms_on_brokerspdf.pdf

45↑ Ibid.

46↑ Daniel Chang, "Florida Homeless People Duped into Affordable Care Act Plans They Can't Afford," Tampa Bay Times, June 12, 2023, https://www.tampabay.com/news/florida-politics/2023/06/12/florida-homeless-people-duped-into-affordable-care-act-plans-they-cant-afford/

47↑ Appleby, "Rising Complaints."

48↑ CMS, "Welcome to the 2023 Agent and Broker Summit," May 24, 2023, https://www.cms.gov/files/document/ab-summit-2023-welcome-slides.pdf

49↑ U.S. Congress, House Committee on Oversight and Government Reform, Risks of Fraud and Misinformation with ObamaCare Outreach Campaign: How Navigator and Assister Program Mismanagement Endangers Consumers, majority staff report, December 16, 2013, https://oversight.house.gov/wp-content/uploads/2013/12/Navigator-Report-Number-Two-12-13-13.pdf

50↑ Theo Merkel and Brian Blase, "Follow the Money: How Tax Policy Shapes Health Care," Paragon Health Institute, May 2024, https://paragoninstitute.org/private-health/follow-the-money-how-tax-policy-shapes-health-care/

51↑ Silver-loading is the practice of loading the cost of CSRs onto the silver plans when the Trump administration complied with a federal court ruling that there was no valid congressional appropriation for the CSR payments.

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The Great Obamacare Enrollment Fraud

Brian Blase, PhD Drew Gonshorowski

PARAGON HEALTH INSTITUTE

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The authors are grateful to Doug Badger, Jonathan Ingram, Theo Merkel, and Peter Nelson for exceptional review and comments, and to Emma Gallutia for exceptional research assistance and work in review of the paper.

PARAGON HEALTH INSTITUTE
(703) 527-2734
paragoninstitute.org

ABOUT THE AUTHORS

Brian C. Blase, PhD, is the president of Paragon Health Institute. He is also a visiting fellow at the Foundation of Government Accountability. From 2017 through 2019, he was a special assistant to the president for economic policy at the White House's National Economic Council. Brian guided the House Committee on Oversight and Government Reform's health care and entitlement program oversight and investigation efforts from 2011 to 2014, and then served as the Senate Republican Policy Committee's health policy analyst from 2014 to 2015. He has held research positions at the Mercatus Center at George Mason University and at The Heritage Foundation. He has a PhD in economics from George Mason University and publishes regularly in outlets such as *The Wall Street Journal*, *New York Post*, *The Hill*, *Health Affairs*, and *Forbes*. He lives in northern Florida with his wife and five children.

Drew Gonshorowski is a Senior Research Fellow at Paragon Health Institute. Prior to joining Paragon, Drew worked in The Center for Data Analysis (CDA) at The Heritage Foundation. At Paragon, Drew provides quantitative analysis on a wide range of health policy topics including Medicaid financing, microsimulation, and premium analysis. Drew has testified on Medicaid policies in many states including Michigan, Ohio, Pennsylvania, Utah, and Virginia. His work has appeared in several publications including *The Wall Street Journal*, *Health Affairs*, and *The Hill*. Drew lives in Falls Church, Virginia and spends his free time bikepacking, hiking, and making music.

EXECUTIVE SUMMARY

What This Paper Covers

The Affordable Care Act (ACA) provided large subsidies for lower-income people to buy coverage in the exchanges. President Biden signed legislation that increased these subsidies through 2025, making plans fully-subsidized for enrollees with income between 100 percent and 150 percent of the federal poverty line (FPL). Enrollees in this income range also qualify for a cost-sharing reduction program that raises plan actuarial value to 94 percent with minimal deductibles and cost-sharing requirements. The Biden administration has also pursued administrative actions which have made this coverage more accessible for lower-income households and loosened eligibility reviews.

This paper describes the incentives for people to misestimate income to qualify for larger subsidies. By state, this paper shows the number of people claiming income between 100 percent to 150 percent FPL who sign-up for coverage with the likely number of people who are eligible for this coverage within that income grouping. Then, this paper discusses the problematic incentives facing brokers and insurers for improper enrollment. The paper concludes with a set of recommendations to minimize improper and fraudulent enrollment and spending.

What We Found & Why It Matters

Nearly half of exchange sign-ups during the 2024 open enrollment period reported income between 100 percent and 150 percent FPL, qualifying for fully-subsidized, 94 percent actuarial value plans. The percentage of people signing up who report income in this range has increased substantially since the enhanced subsidies took effect.

In nine states (Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah), the number of sign-ups reporting income between 100 percent and 150 percent FPL exceed the number of potential enrollees. The problem is particularly acute in Florida, where we estimate there are four times as many enrollees reporting income in that range as meet legal requirements.

The problem of fraudulent exchange enrollment is much more severe in states that have not adopted the ACA's Medicaid expansion as well as in states that use the federal exchange (HealthCare.gov). In states that use HealthCare.gov, 8.7 million sign-ups reported enrollment between 100 percent and 150 percent FPL compared to only 5.1 million people likely eligible for such coverage, or 1.7 sign-ups for every eligible person.

Overall, fraudulent exchange enrollment appears to be a significant problem in nearly half of states. We estimate that fraudulent enrollment at 100 percent to 150 percent FPL is likely upwards of four to five million people in 2024. We estimate, conservatively, that this cost will likely be upwards of $15 to $20 billion this year.

In all states, there is an incentive for people who have income between 200 and 400 percent of the FPL to report income between 100 and 150 percent of the FPL. They qualify for a larger advanced subsidy and a plan with much lower cost-sharing, and the Internal Revenue Service only recaptures a portion of the excess subsidy when they file their taxes.

In non-Medicaid-expansion states, there is a large incentive for people, particularly older people, to overestimate their income. These individuals do not need to repay any of the subsidy to which they were not entitled.

Controlling for Medicaid expansion demonstrates the problems with HealthCare.gov as the percent of people who report income between 100 percent to 150 percent of FPL as those who are potentially eligible is more than twice as high in states using HealthCare.gov as using a state-based exchange. Evidence suggests that part of the issue is that state-based exchanges have done a more thorough job of re-evaluating people for exchange coverage who were no longer eligible for Medicaid after the public health emergency unwinding than states that use HealthCare.gov.

Unscrupulous brokers are certainly contributing to fraudulent enrollment and the enhanced direct enrollment feature of HealthCare.gov appears to be a problem. Brokers just need a person's name, date of birth, and address to enroll them in coverage, and reports indicate that many people have been recently removed from their plan and enrolled in another plan by brokers who earn commissions by doing so.

Health insurers are a primary beneficiary of the surge in improper enrollment from people misestimating income. The larger subsidies mean that consumers are less sensitive to prices of plans and are more likely to enroll, and it's much easier for insurers to collect subsidies from the U.S. Treasury than customers.

What We Recommend

We recommend six steps to reduce fraudulent exchange enrollment:

1. Congress should permit the enhanced subsidies to expire after 2025;
2. Congress should raise subsidy recapture limits to reduce incentives for people to misestimate their income;
3. Congress or the next administration should limit automatic re-enrollment into exchange plans and end it for people moving from or into fully-taxpayer subsidized plans;
4. Congress should appropriate cost-sharing reduction payments and prohibit silver-loading;
5. Congress should conduct aggressive oversight of the Biden administration's management of HealthCare.gov, enhanced direct enrollment, and insurer and broker actions to take advantage of misestimating income;
6. Congress or the next administration should reverse policies of the Biden administration that enabled such widespread fraudulent enrollment, particularly the continuous open-enrollment period for people who report they have income below 150 percent FPL.

BACKGROUND

An analysis of Affordable Care Act (ACA) enrollment data, Census data, and U.S. Treasury data shows a widespread problem of people misestimating their income to maximize subsidies for exchange plans. We estimate upwards of four to five million fraudulently enrolled exchange sign-ups who will cost taxpayers north of $15 to $20 billion this year. We find that the issue is more severe in states that did not adopt the ACA's Medicaid expansion (as there is a large incentive to overestimate income in those states) and states that are using the federal exchange platform for enrollment, HealthCare.gov.

Enrollment in the exchanges has grown substantially over the past few years, driven by increased subsidies. The subsidies, structured as premium tax credits (PTCs), reduce the percentage and amount of income that a person must pay for a benchmark plan — the second-lowest-cost silver plan[1] available to them.

President Biden signed the American Rescue Plan Act of 2021 (ARPA) in March 2021 and the Inflation Reduction Act of 2022 (IRA) in August 2022, which increased the subsidies through 2025.[2] As a result, people who claim that their income is between 100 percent and 150 percent[3] of the federal poverty level (FPL) now pay $0 for benchmark plans, meaning that their coverage is fully paid by taxpayers. The ACA limited the PTCs to enrollees in households with income below 400 percent FPL, but the legislation signed by President Biden lifted that cap, extending the subsidies to households in the top two quintiles. Figure 1 shows the percentage of income that households at a given percentage of the FPL had to pay for benchmark plans under the original ACA and from 2021 to 2025 under the increased subsidies.

The ACA subsidies are generally payments directly from the U.S. Treasury to health insurers on behalf of enrollees who select plans in the exchanges. In official terminology, the subsidies are advance PTCs (APTCs), as they are credited to individuals based on their estimated household income and then sent to insurers. The PTCs are refundable[4] and larger for lower-income enrollees, as they phase down as enrollee income increases. People with income below 200 percent FPL also qualify for a cost-sharing reduction (CSR) program that

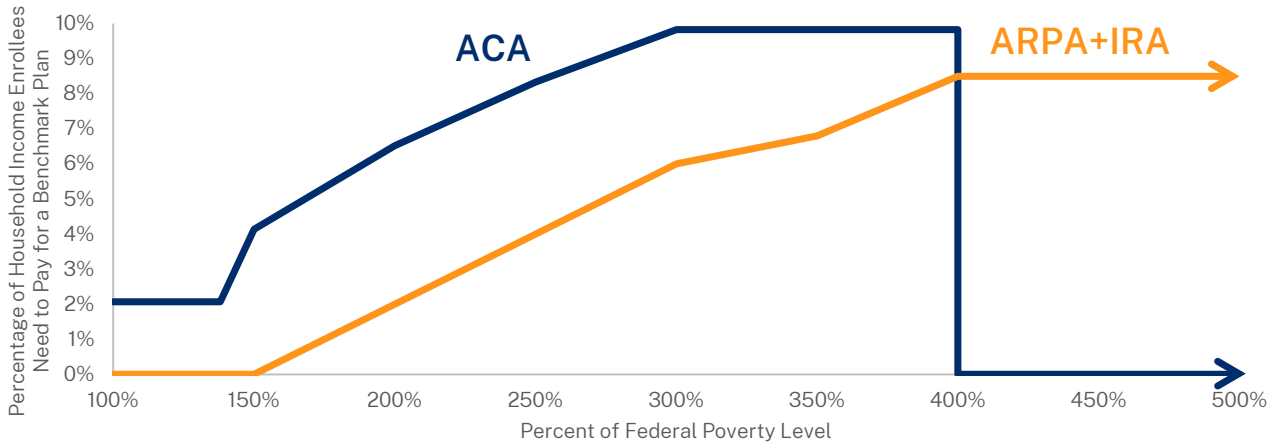
1 A silver plan has an actuarial value of 70 percent, which means that the plan pays for about 70 percent of the typical enrollee's medical expenses covered by the plan.

2 ARPA enhanced subsidies applied for 2021 and 2022, while IRA enhanced subsidies applied for 2023-2025. American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 (2021). Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818 (2022).

3 In 2024, 100 percent FPL for a single person is $15,050. For a household of two, this amount is $20,440. For a four-person household, 100 percent FPL is $31,200.

4 Refundable means that they not only reduce tax liability but are direct payments to qualifying individuals. Most people who claim PTCs do not owe income taxes and receive money back from the federal government through the income tax code after the PTC.

Figure 1: Legislation Signed by President Biden Significantly Increased ACA Subsidies by Lowering Enrollee Premium Share



SOURCES: CMS, *Plan Year 2023 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces*, October 26, 2022, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2023QHPPremiumsChoiceReport.pdf.

NOTE: ARPA is the American Rescue Plan Act and IRA is Inflation Reduction Act.

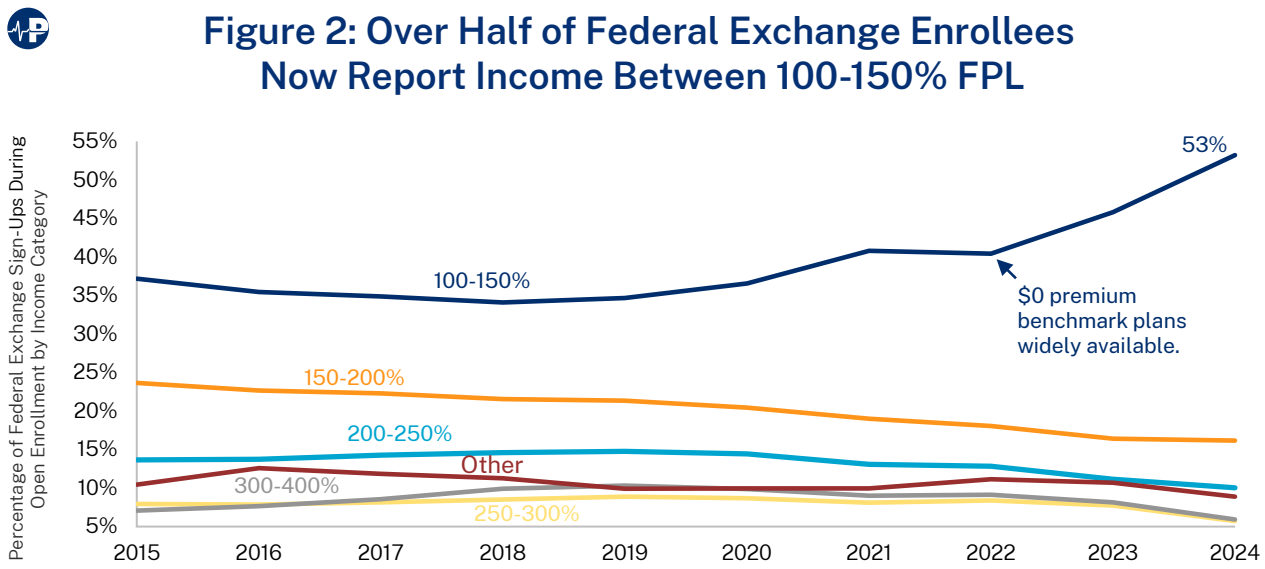
significantly reduces deductibles, cost-sharing amounts, and out-of-pocket limits.[5] For someone with income between 100 percent and 150 percent FPL who selects a silver plan, the CSR program raises plan actuarial value — the average percentage of expenses paid by the plan — to 94 percent. For silver plan enrollees with income between 150 percent and 200 percent FPL, the CSR program raises the actuarial value to 87 percent.

The PTC structure, particularly after the enhancement, creates numerous problems, which we have explored in other papers.[6] The focus of this piece, however, is to present data on how the PTC structure — particularly after President Biden signed legislation increasing the subsidies and making fully subsidized plans with very limited cost-sharing available to enrollees with income between 100 percent and 150 percent FPL — has led to far more people enrolling in the lowest income category than are eligible.

Figure 2 demonstrates the shift in overall enrollment to the lowest-income category in the states that use HealthCare.gov. In 2022, the fully subsidized plans were first readily available during that year's open enrollment period. In 2024, 53 percent of people who signed up for coverage during open enrollment reported that their income was between 100 percent and

5 People with income between 200 percent and 250 percent FPL also qualify for the CSR program, but for them the effect is much more limited as the actuarial value of the plan increases to only 73 percent, just a 3 percentage point increase from the standard silver plan without CSR subsidies.

6 Brian Blase, "Fourteen Reasons to Let the Expanded Obamacare Subsidies Expire," *Forbes*, May 26, 2022, https://www.forbes.com/sites/theapothecary/2022/05/26/fourteen-reasons-to-let-the-expanded-obamacare-subsidies-expire/?sh=32c98a3b6cba; Brian Blase, "Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality," Galen Institute, June 2021, https://galen.org/assets/Expanded-ACA-Subsidies-Exacerbating-Health-Inflation-and-Income-Inequality.pdf.



SOURCE: Compiled from CMS Marketplace Open Enrollment Period Public Use Files.

NOTE: The lines represent percentages of the federal poverty level (FPL). The other category includes people with income below 100 percent of FPL, those above 400 percent of FPL, and those with uncertain income.

150 percent FPL. This figure shows only the federal exchange sign-ups, because not all states with state-based exchanges reported sign-ups by income grouping prior to 2022.

Overall, when including states with their own exchanges, 47 percent of people who selected plans during open enrollment reported income between 100 percent and 150 percent FPL in 2024. The reason for the decline when including states that established their own exchanges is that all those states expanded Medicaid under the ACA. In those states, the ACA requires that people with income between 100 percent and 138 percent FPL enroll in Medicaid and not in exchange-based plans.

A Massive Incentive to Misestimate Income

During open enrollment (typically in November and December preceding the coverage year), enrollees sign up for exchange plans. During this period, they, likely with the assistance of brokers or navigators working with them on their applications, estimate their household income for the following year.

The APTC is a function of this estimated income, so people generally qualify for larger subsidies if they underestimate their income, although there is an incentive for some people in states that have not expanded Medicaid to overestimate income (see discussion below). When a person files his or her subsequent tax return (generally in April of the year after the coverage), the APTC amount gets reconciled with the amount of the PTC that person was entitled because of actual income. People who received excessive subsidies would owe the

excess back when they file their taxes, subject to limits discussed below. Those who received subsidies that were too small would receive additional credit against their taxes when they file.

In Medicaid expansion states, able-bodied, working-age adults with income below 138 percent FPL are eligible for Medicaid. Therefore, in expansion states, only enrollees who estimate their income between 138 percent and 150 percent FPL are eligible for fully subsidized benchmark plans.

In states that have not expanded their Medicaid programs, enrollees with income between 100 percent and 150 percent FPL are eligible for fully subsidized benchmark plans, as able-bodied, working-age enrollees are generally not eligible for Medicaid in those states. If their income is below 100 percent FPL, they also are ineligible for PTCs. This creates an incentive for able-bodied adults with income below the poverty line to overestimate their earnings. By estimating that their earnings are between 100 percent and 150 percent FPL, such an individual can claim a PTC that now covers the entire premium for a benchmark plan that would also have a very low deductible, cost-sharing amounts, and out-of-pocket limit because of the CSR program. By misstating their income, these individuals get generous coverage at zero cost to them — instead of being ineligible for any subsidies at all.

The incentives to misstate income are magnified because the law limits the amount that people need to repay when they file their taxes. For 2024, the amount that single filers must pay back to the Internal Revenue Service (IRS) is capped at $375 for individuals between 100 percent and 200 percent FPL, $950 for those between 200 percent and 300 percent FPL, and $1,575 for those between 300 percent and 400 percent FPL.[7] People with income above 400 percent FPL would need to fully reconcile the APTC amounts with the PTC amounts to which they were entitled.

Because of these relatively low recapture limits, many enrollees have an incentive to underestimate their income. For example, for a 40-year-old enrollee at 290 percent FPL, the incentive for estimating income at just under 150 percent FPL is $1,438 on average in the United States. He would receive an APTC of $5,723 to cover the full premium of insurance coverage with an actuarial value of 94 percent. At 290 percent FPL, he was eligible for a PTC of $3,355 — receiving $2,368 of excessive subsidy for much less generous coverage (70 percent actuarial value). He would need to repay $950, which would leave him better off by $1,418 in premium subsidies due to underestimating his income and the added benefit of having coverage with much less cost-sharing.

7 IRS, Revenue Procedure 2023-34, https://www.irs.gov/pub/irs-drop/rp-23-34.pdf. These amounts are indexed to inflation. The amounts are also double for married persons filing jointly.

The incentives to overestimate income in non-expansion states are much larger for older enrollees, as the PTC structure limits premium payment to a certain percentage of household income, regardless of the premium amount. Because premiums are three times more for enrollees near 65 than for enrollees in their 20s, the subsidies are also much larger. Nationally, the average PTC for a 21-year-old is $4,478 and the average PTC for a 64-year old is $13,434.[8] Older enrollees demand more medical services all else equal, and some may be looking to retire before the age of 65. These factors contribute to a larger incentive for them to overestimate income to earn a PTC.

Given how the subsidy structure works, there is not much differential incentive for older people to underestimate their income to gain a higher subsidy. In fact, the only differential occurs because the value of the cost-sharing reduction subsidy, which we explain below, is greater for older enrollees than younger enrollees.

Figure 3 demonstrates the age dynamic. The incentive to underestimate income is minimal for enrollees with income below 200 percent FPL, so the figure starts showing the benefit of underestimating income at 200 percent FPL. The benefit gradually increases as household income increases until the benefit ceases at 400 percent FPL. Figure 3 includes an estimate of the taxpayer cost for enrollees who underestimate their income to qualify for the CSR program and a 94 percent actuarial value plan.[9]

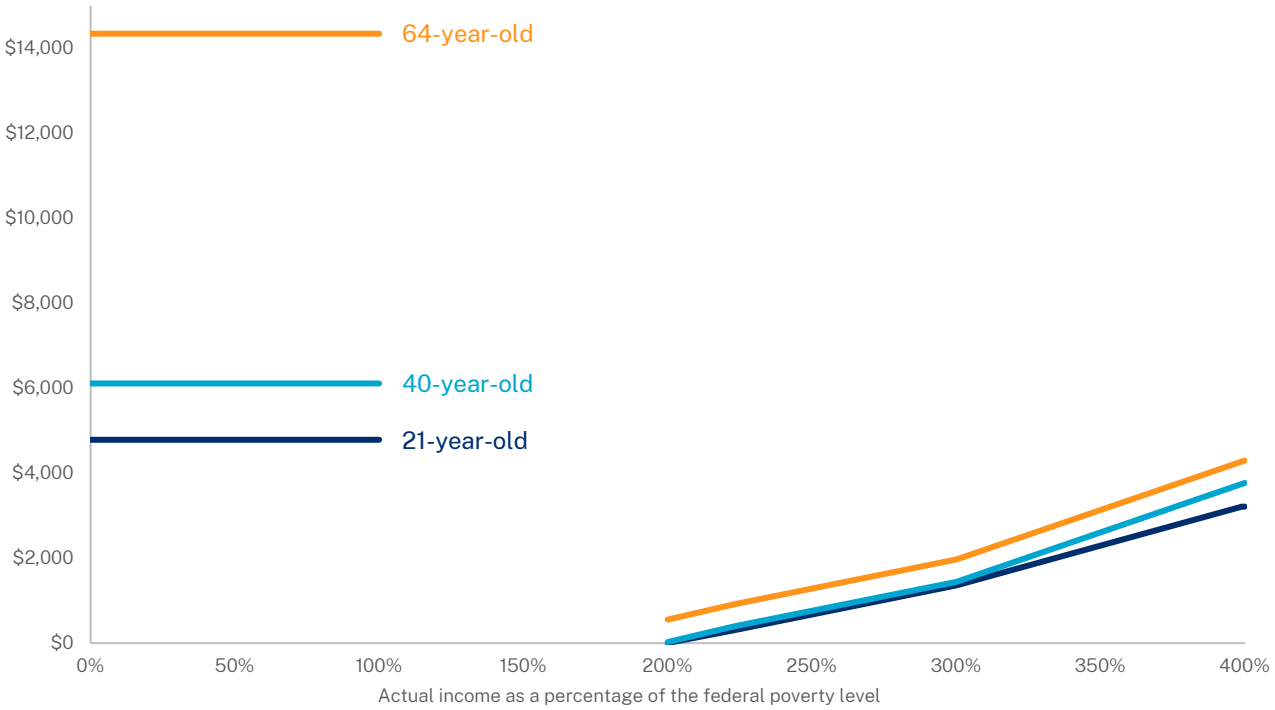
People who estimate their income to be at least 100 percent FPL at the time of enrollment but end up earning less than 100 percent FPL do not have to pay any of the APTC back. In that circumstance, the IRS considers the person to be qualified for the PTC so long as the income estimate was not made "with intentional or reckless disregard for the facts."[10] Therefore, people with income below 100 percent FPL in non-Medicaid expansion states have an even more significant incentive to overestimate their income to qualify for a large PTC, as they would not need to pay any of it back. Such enrollees who overestimate their income to an amount greater than 100 percent FPL receive a full subsidy. In other words, they pay zero premium for plans with actuarial values of 94 percent.

In 2024, a 40-year-old enrollee reporting income between 100 percent to 150 percent FPL would receive an average subsidy of $5,869 in Florida, $5,556 in Georgia, and $5,700 in

8 KFF, "Health Insurance Marketplace Calculator," https://www.kff.org/interactive/subsidy-calculator/.

9 Since most silver plan enrollees report income that qualifies them for the CSR program, the average actuarial value for a silver plan is 88 percent. In order to approximate the added marginal benefit of the CSR program for enrollees who report income between 100 to 150 percent FPL, we multiplied the benchmark premium by 94/88.

10 IRS, 2023 Instructions for Form 8962, https://www.irs.gov/pub/irs-pdf/i8962.pdf.



SOURCES: KFF Marketplace Subsidy Calculator and IRS.

NOTE: For those under 100 percent FPL, incentives for older populations increase, because the cost of a benchmark plan increases by age. Those between 100 and 150 percent of FPL are correctly reporting income and so gain no benefit. There are minimal effects for people 150 percent to 200 percent FPL. Enrollees over 200 percent FPL have an incentive to underestimate income and the differences in the lines account for a greater benefit that older enrollees receive from the 94 percent actuarial value plan through the CSR program.

Texas.[11] For a 60-year-old enrollee, the amounts in these states would be $12,464, $11,799, and $12,104.[12] And their cost-sharing would be far more generous than what all but a few Americans get through their employer-sponsored insurance. These estimates of the benefit of misestimating their income are conservative, because they do not factor in the additional value of the CSR program that benefits them. However, Figure 3 accounts for the extra benefits of the CSR program and the 94 percent actuarial value plan to which enrollees who report income between 100 percent and 150 percent FPL are entitled.

Analysis Confirms People Are Misestimating Income

New research shows that people have been misestimating their income — with a particularly high concentration in Florida — since the ACA's key provisions took effect. In a 2024 piece using 2015-2017 federal exchange data, three authors — all of whom are past or present

11 KFF, "Marketplace Average Benchmark Premiums: 2024," https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

12 KFF, "Marketplace Average Benchmark Premiums: 2024." We apply age rating tables from CMS. "State Specific Age Curve Variations" https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/downloads/statespecagecrv053117.pdf

Congressional Budget Office experts — find "evidence suggesting that many people in the coverage gap in non-expansion states obtain subsidies by reporting income just above the Federal Poverty Line at the time of enrollment, especially in Florida."[13] The "coverage gap" refers to people in non-expansion states with incomes below 100 percent FPL.

The authors continued, "The precise incomes reported by marketplace enrollees suggests that they were aware of the cutoff for PTC eligibility at the FPL. Consider single-person households in non-expansion states in 2015, for whom the lower bound for eligibility for the PTCs was $11,670.... [S]o many enrollees reported income between $11,670 and $12,500 to Healthcare.gov that actual marketplace enrollment was 136% of estimated potential enrollment in that range. Furthermore, many of these enrollees reported [modified adjusted gross income] precisely equal to $11,670, $11,700, or $12,000, suggesting that they were aware of the cutoff for PTC eligibility and reported just enough income to exceed it. Other spikes correspond to round values, like $15,000, or inflation-adjusted round values from 2014." Such precision on a widespread scale suggests significant counseling of income manipulation by outside entities aware of the program rules.

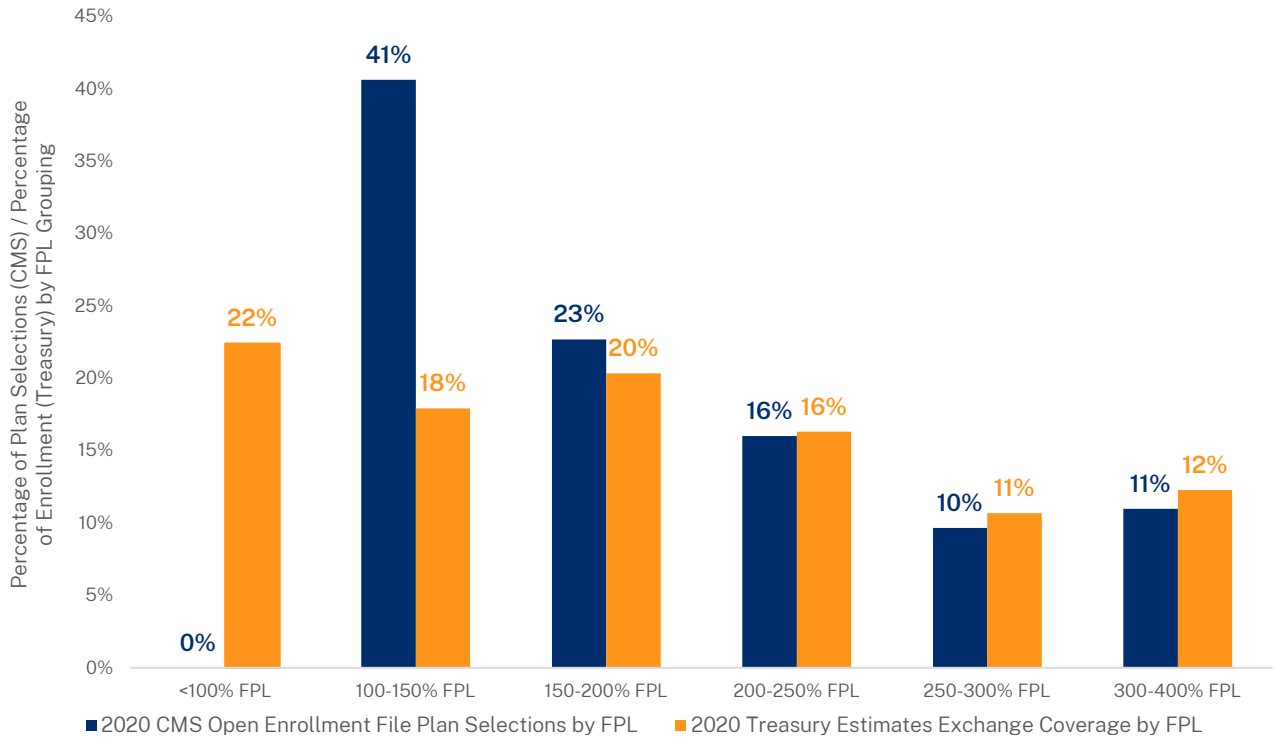
The authors conclude: "Taken together, these facts suggest that many people who eventually earned less than 100% FPL reported that they expected to earn more than this amount when enrolling in marketplace insurance and were able to receive PTCs. This implies that many people who earned less than the FPL (or, in the ACS [American Community Survey], reported earning less) were effectively eligible for PTCs."

In 2019 (the most recent year Treasury published this analysis), the Treasury Department estimated that over one-fourth of all PTCs — an amount equal to $11.32 billion — would be paid to insurers on behalf of households with income below 100 percent FPL in 2020.[14] Treasury estimates that roughly 1.70 million tax filers receiving PTCs would have income under 100 percent FPL, and 1.38 million who would receive PTCs would have income between 100 percent and 150 percent FPL. This data shows that the reported income data that the Centers for Medicare and Medicaid Services (CMS) uses has major problems, as CMS enrollment data did not include any enrollment for people with income below 100 percent FPL. Figure 4 highlights the discrepancy between Treasury estimates and CMS plan selection data. This data shows that misestimating income for people with income below 100 percent FPL was a problem before the enhanced subsidies. That problem was made worse given the access to

13 Ben Hopkins, Jessica Banthin, and Alexandra Minicozzi, "How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender?," *American Journal of Health Economics* 10, no. 2 (Spring 2024), https://www.journals.uchicago.edu/doi/epdf/10.1086/727785.

14 U.S. Department of the Treasury, "Treasury's Baseline Estimates of Health Coverage, FY 2020," September 11, 2019, https://home.treasury.gov/system/files/131/Treasurys-Baseline-Estimates-of-Health-Coverage-FY-2020.pdf. Total subsidies were $43.89 billion according to Treasury in 2020.

Figure 4: More than One-Fifth of Exchange Enrollees Had Income Below 100% FPL in 2020, Despite None Being Reported by CMS



SOURCES: 2020 CMS Open Enrollment Public Use File and 2020 Treasury Department Baseline Estimates of Health Coverage.

fully subsidized plans, while the problem with people above 150 percent FPL underestimating income was made more severe.

It is worth noting that people also have incentives to report lower income in order to enroll in Medicaid in expansion states. Medicaid has extremely low (if any) cost-sharing, and the plans are similar to exchange plans in terms of providers accepting the coverage. Our analysis, which focuses on exchange enrollment, excludes this dynamic and thus makes expansion states look better than non-expansion states on these fraudulent enrollment statistics.

The Data and Methodology

We contrast sign-ups during open enrollment by state for people claiming income across FPL categories with estimates of the number of people who would be eligible for exchange plans and PTCs in each FPL category. The first set of tables is for the lowest-income category: 100-150 percent FPL. We show the number of 100-150 percent FPL sign-ups and the number of state residents between 19 and 64 years of age who report income between 100 percent and 150 percent FPL and who also do not report having Medicare or Medicaid. We exclude those ages 19-64 in this income category who reported coverage in Medicaid or Medicare,

because they are likely on federal disability programs with that coverage (and thus precluded from eligibility for PTCs in the exchange) or live in expansion states and are on Medicaid.[15] We exclude children age 18 and under because they are eligible for Medicaid or the Children's Health Insurance Program (CHIP) if their incomes are in this range and are thus precluded from exchange coverage and PTC eligibility.[16] We exclude seniors, because they are almost certainly enrolled in Medicare and are precluded from exchange coverage. People who have either Medicare or Medicaid are also precluded from exchange coverage.[17]

The data set we use is the 2022 ACS 1-Year Public Use Microdata Sample file. This survey is a nationally representative survey from the U.S. Census Bureau that produces information about the U.S. population, including demographic and economic data. For our analysis, we use this data to estimate the number of people by state who would potentially enroll in exchange coverage within income groupings. We adjust this data by population growth trends by state from 2020 to 2023 in order to approximate the number of people in income groupings in 2024.[18] We compare this estimate to the number of plan selections on the exchanges in 2024 by FPL from the CMS Marketplace Open Enrollment Public Use File. We exclude New York and Minnesota from the analysis due to their Basic Health Programs (BHP), which provide coverage for this lower-income exchange population. We exclude the District of Columbia, as most of its reporting in the open enrollment file does not report income.

For our analysis, we have attempted to be overly inclusive of the population with income between 100 percent and 150 percent FPL eligible for exchange coverage with APTCs. We do not exclude individuals who report employer coverage. Excluding these people would further reduce the number of people potentially eligible for exchange coverage. ACS data generally undercounts people in lower income brackets,[19] but we make other assumptions that include people as potential enrollees between 100 percent and 150 percent FPL who would not be eligible for an exchange plan with a PTC. Much of our analysis is on the fraudulent enrollment comparisons across states, which means that our findings of differences across states should

15 To be eligible for PTCs, individuals must not be eligible for public coverage including Medicaid, CHIP, Medicare, or military coverage (TRICARE). Section 5000A(f) of the ACA refers to these types of insurance as "Minimum Essential Coverage." Affordable Health Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

16 IRS, Publication 974 (2023), https://www.irs.gov/publications/p974.

17 Our approach is simpler than Hopkins et al. Regarding potential exchange enrollment, Hopkins et al. classify this population as those between the ages of 20 and 64, excluding Medicare, Medicaid, CHIP, and TRICARE enrollees. Additionally, they exclude individuals who would be eligible for Medicaid or CHIP based on age and imputed income, as well as through pregnancy pathways. They also use different income assumptions for potential eligibility between expansion and non-expansion states. For expansion states, they apply a lower bound reflective of current law: 100 percent FPL. In non-expansion states, they apply a lower bound of 80 percent FPL, because their "analysis strongly suggests that many people with income below 100 percent FPL in non-expansion states obtain advanced PTCs." Our work is illustrative of this specific finding in Hopkins et al.'s research for individuals below 100 percent FPL using CMS exchange data but using publicly available data. Hopkins et al. focuses on federal exchanges while this piece looks at all exchanges.

18 United States Census Bureau. "State Population Totals and Components of Change: 2020-2023" Vintage 2023. https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html#v2023. We apply the three-year trend to fully estimate state populations in 2024. This approach will not capture distributional changes that might be present.

19 This is partially due to eligibility for health coverage being defined differently than the FPL variables in ACS capture. These "tax unit" or "health insurance unit" designations tend to increase the number of people below 150 percent FPL.

be largely unaffected by the ACS undercount — assuming that there is not large variation in the undercount across states.[20]

We are unable to exclude unauthorized immigrants, people who receive veterans' health care, and anyone who might have an offer of affordable coverage from an employer. Additionally, this analysis does not account for individuals who are unaware that they have Medicaid coverage, which represented nearly 30 percent of Medicaid enrollees in 2022.[21] Accounting for these limitations would result in an even smaller number of exchange-eligible people, which are additional reasons why our estimates are overly inclusive.

LARGE-SCALE EXCHANGE ENROLLMENT FRAUD

Table 1 compares the number of people ages 19-64 who sign up for exchange plans and report income between 100 percent and 150 percent FPL with the projected maximum number of people who would be eligible for such coverage.

In nine states, more people signed up for coverage than would be eligible, meaning that the number of people who enrolled in a plan with zero premium and very low cost-sharing plans exceeded the number of eligible adults in that income range. Seven of these nine states did not expand their Medicaid programs — an indication that a large part of the issue is people in non-Medicaid expansion states overestimating their income in order to qualify for fully subsidized, low cost-sharing plans. This outcome is expected considering people with incomes between 100 percent and 138 percent FPL in the 100 percent to 150 percent FPL range do not legally qualify for APTCs in expansion states. Florida is a clear outlier, enrolling more than four times as many people in this income category as we estimate are eligible. Georgia, Mississippi, and South Carolina enrolled more than twice as many people in this income category as estimated eligible. Texas enrolled nearly twice as many people in this income category as estimated eligible.

20 For more discussion see Giovann Alarcon et al., "Defining Family for Studies of Health Insurance Coverage," State Health Access Data Assistance Center (SHADAC), August 2021, https://www.shadac.org/sites/default/files/publications/2021%20HIU%20Defining%20families%20brief.pdf; and Ithai Lurie and James Pierce, "The Effects of ACA on Income Eligibility for Medicaid and Subsidized Private Insurance Coverage: Income Definitions and Thresholds Across CPS and Administrative Data," U.S. Department of Treasury, Office of Tax Analysis. In SHADAC's methodology, this undercount is substantial, but the majority of the adjustment occurs below 100 percent FPL. In some states, fewer people are estimated in the 100 percent to 150 percent FPL category. Using Tresury's estimates suggests that 50 percent additional people could be between 100 percent and 150 percent of poverty ages 0-64. Treasury estimates 31.9 million versus 21 million in the ACS. Treasury estimates there are 9.3 million people aged 0-64 who have income between 100 percent to 150 percent FPL after excluding those with government and employer coverage. Our primary estimate of potential enrollees, which excludes children, seniors and people with Medicaid or Medicare, totals 7.0 million without New York, Minnesota, and the District of Columbia. Our expansive estimate, which includes those in this income range who report Medicare or Medicaid is 12.0 million.

21 Dong Ding, Benjamin D. Sommers, and Sherry A. Glied, "Unwinding and the Medicaid Undercount: Millions Enrolled in Medicaid During the Pandemic Thought They Were Uninsured," *Health Affairs* 43, no. 5 (May 2024), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01069.

Table 1: Exchange Sign-Ups Reporting Income 100-150% FPL Compared to Total Potential Enrollees

State	Platform	Expansion Status	Exchange Sign-Ups (1)	Total Potential Enrollees (2)	Percentage (1)/(2)
Alabama	HC.gov	Not Adopted	228,883	160,429	142.7%
Alaska	HC.gov	Adopted	2,317	11,671	19.9%
Arizona	HC.gov	Adopted	114,197	175,174	65.2%
Arkansas	HC.gov	Adopted	56,640	79,825	71.0%
California	SBE	Adopted	278,204	676,577	41.1%
Colorado	SBE	Adopted	14,786	105,073	14.1%
Connecticut	SBE	Adopted	12,991	45,615	28.5%
Delaware	HC.gov	Adopted	8,374	16,292	51.4%
Florida	HC.gov	Not Adopted	2,718,501	676,297	402.0%
Georgia	HC.gov	Not Adopted	834,058	338,044	246.7%
Hawaii	HC.gov	Adopted	3,006	27,349	11.0%
Idaho	SBE	Adopted	8,193	55,863	14.7%
Illinois	HC.gov	Adopted	111,131	232,030	47.9%
Indiana	HC.gov	Adopted	112,127	140,930	79.6%
Iowa	HC.gov	Adopted	23,908	54,344	44.0%
Kansas	HC.gov	Not Adopted	82,256	83,391	98.6%
Kentucky	SBE	Adopted	8,534	82,820	10.3%
Louisiana	HC.gov	Adopted	93,833	107,669	87.1%
Maine	SBE	Adopted	4,581	19,696	23.3%
Maryland	SBE	Adopted	21,599	92,608	23.3%
Massachusetts	SBE	Adopted	30,595	78,527	39.0%
Michigan	HC.gov	Adopted	122,597	179,256	68.4%
Mississippi	HC.gov	Not Adopted	210,749	104,613	201.5%
Missouri	HC.gov	Adopted	154,459	170,544	90.6%
Montana	HC.gov	Adopted	8,522	25,591	33.3%
Nebraska	HC.gov	Adopted	25,158	53,877	46.7%
Nevada	SBE	Adopted	22,471	85,772	26.2%
New Hampshire	HC.gov	Adopted	8,484	15,449	54.9%
New Jersey	SBE	Adopted	69,867	134,985	51.8%
New Mexico	SBE	Adopted	6,747	44,995	15.0%
North Carolina	HC.gov	Adopted	507,098	304,295	166.6%
North Dakota	HC.gov	Adopted	3,770	16,468	22.9%
Ohio	HC.gov	Adopted	166,814	209,037	79.8%
Oklahoma	HC.gov	Adopted	120,013	130,807	91.7%
Oregon	HC.gov	Adopted	11,190	81,209	13.8%
Pennsylvania	SBE	Adopted	81,714	206,033	39.7%
Rhode Island	SBE	Adopted	6,117	14,238	43.0%
South Carolina	HC.gov	Not Adopted	301,553	147,569	204.3%
South Dakota	HC.gov	Adopted	8,821	23,677	37.3%
Tennessee	HC.gov	Not Adopted	310,781	207,288	149.9%
Texas	HC.gov	Not Adopted	2,133,460	1,097,793	194.3%
Utah	HC.gov	Adopted	133,065	79,712	166.9%
Vermont	SBE	Adopted	2,227	6,979	31.9%
Virginia	SBE	Adopted	110,912	152,173	72.9%
Washington	SBE	Adopted	21,588	126,253	17.1%
West Virginia	HC.gov	Adopted	17,243	38,859	44.4%
Wisconsin	HC.gov	Not Adopted	64,398	112,084	57.5%
Wyoming	HC.gov	Not Adopted	8,054	15,952	50.5%
TOTAL			9,406,586	7,045,733	133.5%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

Conservative Estimates of Enrollment Fraud: Upwards of 4-5 Million People and $15-$20 Billion in 2024

We estimate four to five million people improperly enrolled for subsidized health coverage on the exchanges in 2024 and that the cost of improper enrollment is likely upward of $15-$20 billion this year.

We estimate improper enrollment separately for Medicaid expansion and non-Medicaid expansion states. In non-Medicaid expansion states, we count improper enrollment as any enrollment above the total potential enrollees (i.e., the number of 19-64-year-olds with income in that category as reported by the ACS). In expansion states, we count improper enrollment as any enrollment above half the number of potential enrollees. As a reminder, only those with income between 138 percent to 150 percent FPL would be eligible for exchange coverage in this income category. We believe both estimates are conservative.

This method yields 4.84 million fraudulently enrolled people at 100 percent to 150 percent FPL, but only in 21 states as the other states, which include New York and Minnesota that rely on the BHP for coverage for this population, do not meet the above criteria. Since there is some degree of improper enrollment in every state, and our methodology is designed to yield a conservative estimate, the number of improperly enrolled people at 100 to 150 percent FPL is likely higher than this four to five million people range.

Taking a conservative estimate of five million people improperly enrolled in fully subsidized plans, we estimate that 60 percent of enrollees have income below 100 percent of the FPL and are receiving $6,000 worth of subsidy to which they are not entitled. Of the remaining 40 percent of enrollees who have underestimated their income, we estimate they have received an excess subsidy of $1,000.[22] Putting these together yields about $20 billion of improper PTCs for 2024.

The main reason these estimates are conservative is because we use a $6,000 average subsidy, which is the subsidy for a 40-year-old. The average age of an exchange enrollee is older than 40 and, as Figure 3 shows, the PTC is much larger for older enrollees. If the average PTC for improperly enrolled people is $8,000 (which may be more realistic), then the estimated cost of improper enrollment would be $26 billion in 2024.

An additional reason the $20 billion is a conservative estimate is that the number of people who have overestimated their income in non-expansion states who are receiving fully

22 The $1,000 is a rough average of the improper benefit for people with income between 150 percent and 400 percent FPL who underestimate their income to between 100 percent and 150 percent FPL.

subsidized PTCs to which they are not entitled (by far the biggest contributor to improper spending) almost certainly exceeds 3.0 million people. In seven non-expansion states, there are 4.0 million more 100 percent to 150 percent sign-ups than ACS data indicate are eligible in that income category. Our back-of-the-envelope estimate does not consider any improper enrollment in the other three non-expansion states — Kansas (sign-ups are 98.7 percent of potential enrollees), Wisconsin, and Wyoming.

Using a similar methodology for the more expansive set of potential enrollees for the 100 percent to 150 percent FPL group, consistent with Table 3 below, produces estimates of roughly 4 million improper enrollees in this category at a cost of about $15 billion in 2024. We believe that this estimate is a lower bound of total fraudulent enrollment in the 100 percent to 150 percent group and the associated cost.

Fraudulent Enrollment in North Carolina

North Carolina expanded Medicaid on December 1, 2023, and was the only state to adopt the ACA's expansion of the program during the 2024 ACA open enrollment period, which started on November 1, 2023.

As of May 5, 2024, 451,194 people enrolled under North Carolina's Medicaid expansion.[23] While enrollment in Medicaid expansion has been substantial, at the same time significantly more North Carolinians reporting income between 100 percent and 150 percent FPL enrolled in exchange plans in the 2024 open enrollment period (507,098) than selected plans in 2023 (347,551).

Combining 2024 exchange plan selections in open enrollment with the number of Medicaid expansion enrollees totals 958,292 individuals. This is 28.2 percent higher than the 2023 ACS estimate for the number of people in North Carolina under 150 percent FPL ages 19-64 who did not report having Medicaid or Medicare — which is an upper bound on the number of individuals potentially eligible for the exchanges or Medicaid expansion.[24]

23 North Carolina Office of the Governor, "NC Medicaid Expansion Hits 450,000 Enrollees in Just Five Months," press release, May 9, 2024, https://governor.nc.gov/news/press-releases/2024/05/09/nc-medicaid-expansion-hits-450000-enrollees-just-five-months.

24 CMS, 2024 Open Enrollment Public Use File, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files. Note: Even adjusting the population under 100 percent FPL according to SHADAC methodology still implies that the entire population under 150 percent FPL has health coverage. We attempt to provide this estimate for the project expansion population by excluding enrollment in traditional Medicaid.

The data indicates that many North Carolinians were (and likely still are) simultaneously enrolled in Medicaid and the exchanges. Because North Carolina transitioned its Medicaid program to managed care in 2021,[25] this suggests that insurers are potentially reaping windfall profits from dual enrollment. It also suggests that enrollees in North Carolina are at substantial risk of financial penalties, as the state put out the following guidance: "If you qualify for full Medicaid, you will not be able to get financial help with the cost of your Marketplace plan. Therefore, you probably will not want to keep your Marketplace coverage because it will cost more than coverage through NC Medicaid."[26]

25 NC Medicaid, "Fact Sheet NC Medicaid Managed Care," April 2021, https://medicaid.ncdhhs.gov/ncmt-fact-sheet-managedcarepopulations-04292021/download?attachment.

26 NC Medicaid Division of Health Benefits, "Questions and Answers about Medicaid Expansion," April 11, 2024, https://medicaid.ncdhhs.gov/questions-and-answers-about-medicaid-expansion.

Table 2: North Carolina Medicaid Expansion Enrollment and 100-150% FPL Exchange Enrollment Exceeds Eligible Population

Plan Selections 2024	507,098
Medicaid Expansion Enrollment	451,194
Current Total	958,292
Population Ages 19-64, Under 150 percent of FPL, Excluding Medicaid and Medicare	747,554

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 and 2023 Open Enrollment File and North Carolina Office of the Governor, "NC Medicaid Expansion Hits 450,000 Enrollees in Just Five Months," press release, May 9, 2024, https://governor.nc.gov/news/press-releases/2024/05/09/nc-medicaid-expansion-hits-450000-enrollees-just-five-months.

Table 3 shows the same results as Table 1, except it compares the number of people who signed up for coverage during open enrollment reporting income between 100 percent and 150 percent FPL with all potential enrollees who are residents ages 19-64 by state. The difference with Table 1 is that we include people who report either Medicaid or Medicare in this income category as potential exchange enrollees with PTCs. We do this because it is possible that people are confusing exchange plans with Medicaid plans.[27] In many states, exchange plans are very similar to Medicaid plans, and many of these enrollees use little if any

27 Research shows that there are more false positives for Medicaid — people with private coverage reporting Medicaid — in the ACS than in other surveys. "Among those for whom public coverage was reported, over-reporting in the ACS was higher than in the CPS — 8.6% and 2.1%, respectively." See Joanne Pascale, Angela Fertig, and Kathleen Call, "Validation of Two Federal Health Insurance Survey Modules After Affordable Care Act Implementation," *Journal of Official Statistics* 35, no. 2 (June 2019), https://sciendo.com/article/10.2478/jos-2019-0019.

Table 3: Exchange Sign-Ups Reporting Income 100-150% FPL Compared to Total Potential Enrollees (Expansive Assumptions)

State	Platform	Expansion Status	Exchange Sign-Ups (1)	Total Potential Enrollees (Expansive Assumptions (2)	Percentage (1)/(2)
Alabama	HC.gov	Not Adopted	228,883	241,825	94.6%
Alaska	HC.gov	Adopted	2,317	24,709	9.4%
Arizona	HC.gov	Adopted	114,197	294,562	38.8%
Arkansas	HC.gov	Adopted	56,640	154,595	36.6%
California	SBE	Adopted	278,204	1,501,964	18.5%
Colorado	SBE	Adopted	14,786	183,259	8.1%
Connecticut	SBE	Adopted	12,991	111,731	11.6%
Delaware	HC.gov	Adopted	8,374	28,953	28.9%
Florida	HC.gov	Not Adopted	2,718,501	952,666	285.4%
Georgia	HC.gov	Not Adopted	834,058	453,044	184.1%
Hawaii	HC.gov	Adopted	3,006	47,574	6.3%
Idaho	SBE	Adopted	8,193	89,492	9.2%
Illinois	HC.gov	Adopted	111,131	447,001	24.9%
Indiana	HC.gov	Adopted	112,127	261,413	42.9%
Iowa	HC.gov	Adopted	23,908	115,741	20.7%
Kansas	HC.gov	Not Adopted	82,256	109,945	74.8%
Kentucky	SBE	Adopted	8,534	200,601	4.3%
Louisiana	HC.gov	Adopted	93,833	246,452	38.1%
Maine	SBE	Adopted	4,581	46,939	9.8%
Maryland	SBE	Adopted	21,599	170,883	12.6%
Massachusetts	SBE	Adopted	30,595	203,664	15.0%
Michigan	HC.gov	Adopted	122,597	393,876	31.1%
Mississippi	HC.gov	Not Adopted	210,749	150,673	139.9%
Missouri	HC.gov	Adopted	154,459	251,022	61.5%
Montana	HC.gov	Adopted	8,522	46,007	18.5%
Nebraska	HC.gov	Adopted	25,158	82,415	30.5%
Nevada	SBE	Adopted	22,471	138,250	16.3%
New Hampshire	HC.gov	Adopted	8,484	32,356	26.2%
New Jersey	SBE	Adopted	69,867	250,657	27.9%
New Mexico	SBE	Adopted	6,747	106,051	6.4%
North Carolina	HC.gov	Adopted	507,098	444,838	114.0%
North Dakota	HC.gov	Adopted	3,770	25,512	14.8%
Ohio	HC.gov	Adopted	166,814	446,496	37.4%
Oklahoma	HC.gov	Adopted	120,013	199,569	60.1%
Oregon	HC.gov	Adopted	11,190	169,456	6.6%
Pennsylvania	SBE	Adopted	81,714	439,826	18.6%
Rhode Island	SBE	Adopted	6,117	32,294	18.9%
South Carolina	HC.gov	Not Adopted	301,553	217,740	138.5%
South Dakota	HC.gov	Adopted	8,821	31,161	28.3%
Tennessee	HC.gov	Not Adopted	310,781	313,721	99.1%
Texas	HC.gov	Not Adopted	2,133,460	1,371,752	155.5%
Utah	HC.gov	Adopted	133,065	106,353	125.1%
Vermont	SBE	Adopted	2,227	18,527	12.0%
Virginia	SBE	Adopted	110,912	270,980	40.9%
Washington	SBE	Adopted	21,588	237,173	9.1%
West Virginia	HC.gov	Adopted	17,243	89,695	19.2%
Wisconsin	HC.gov	Not Adopted	64,398	204,105	31.6%
Wyoming	HC.gov	Not Adopted	8,054	20,769	38.8%
TOTAL			9,406,586	11,978,289	78.5%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

health care and are not highly engaged or knowledgeable about their coverage.[28] So Table 3 provides conservative estimates on the extent of the fraudulent enrollment problem and likely represents a lower bound on the degree of improper enrollment in the income category of 100 percent to 150 percent FPL.

Table 3 illustrates that fraudulent enrollment is so acute in several states that there are more people signing up for exchange plans than could possibly be eligible, even under expansive assumptions that raise the number of potential enrollees. These states include Florida, Georgia, Texas, South Carolina, Mississippi, Utah, and North Carolina, but fraudulent enrollment is certainly occurring to a significant degree in many other states as well. The states with the most severe problems are all states that use HealthCare.gov, and most are states that did not expand Medicaid. Of the 20 states that have fewer than 20 percent of the 19-64 year old, 100 percent to 150 percent of the FPL population enrolling in exchange plans during open enrollment (from Table 3's calculation), 14 are states with state-based exchanges. For context, there are only 16 state-based exchange states in our analysis, as we have excluded Minnesota, New York, and the District of Columbia.[29]

Fraudulent Enrollment Much Greater in Non-Expansion States and HealthCare.gov *States*

Table 4 shows the enrollment estimates broken down by expansion states and non-expansion states and states using the federal exchange (HealthCare.gov) and those states that established their own exchanges. The data clearly indicates that fraudulent enrollment is much more severe in states that did not expand Medicaid as well as in states that use the HealthCare.gov platform. As expected, the number of people misestimating their income is much greater in non-expansion states, as there is both an incentive for people above 200 percent FPL to report lower income and an incentive for people with income below 100 percent FPL to report higher income.

More surprising is that fraud is much greater in HealthCare.gov states. In states that used HealthCare.gov, 8.7 million sign-ups reported enrollment between 100 percent and 150 percent FPL compared to only 5.1 million people likely eligible for such coverage, or 1.7 sign-ups for every eligible person.

Unique deficiencies with HealthCare.gov are shown when controlling for whether states expanded Medicaid. All states with state-based exchanges did expand Medicaid, but many expansion states also used HealthCare.gov. Isolating the analysis to expansion states

28 Daniel Cruz and Greg Fann, "The Shortcomings of the ACA Exchanges: Far Less Enrollment at a Much Higher Cost," Paragon Health Institute, September 2023, https://paragoninstitute.org/wp-content/uploads/2023/11/Shortcomings-of-the-ACA-Cruz-Fann.pdf.

29 New Jersey and Virginia are the two state-based exchange states that do not satisfy this criteria.

Table 4: Fraudulent Exchange Enrollment More Severe in Non-Medicaid-Expansion States and States Using HealthCare.gov

State	Exchange Sign-Ups (1)	Total Potential Enrollees (2)	Percentage (1)/(2)	Total Potential Enrollees (Expansive Assumptions) (3)	Percentage (1)/(3)
HC.gov	8,705,460	5,117,524	170.1%	7,975,997	109.1%
Expansion and HC.gov	1,812,767	2,174,064	83.4%	3,939,756	46.0%
Non-expansion and HC.gov	6,892,693	2,943,461	234.2%	4,036,240	170.8%
SBE	701,126	1,928,208	36.4%	4,002,293	17.5%
Medicaid Expansion	2,513,893	4,102,272	61.3%	7,942,049	31.7%
Expansion and SBE	701,126	1,928,208	36.4%	4,002,293	17.5%
Expansion and HC.gov	1,812,767	2,174,064	83.4%	3,939,756	46.0%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

excludes the states where fraudulent enrollment is severe. The percentage of open enrollment sign-ups reporting income between 100 percent and 150 percent FPL relative to all those ages 19-64 eligible for such coverage is more than twice as high in expansion states with HealthCare.gov than in expansion states with state-based exchanges.

Some state-based exchanges verify income using alternative data sources, such as state tax data.[30] In 2017, the Government Accountability Office reviewed processes in three states — Idaho, Maryland, and Rhode Island — to verify eligibility for APTCs and found "few indications of potentially improper enrollments."[31] States using alternative data or state-specific data to verify eligibility could contribute to observed differences in fraudulent enrollment between the federal and state-based exchanges.

Some of the differences appear to be in how states have handled the removal of Medicaid enrollees (the "unwinding" process) who were no longer eligible for that program after the conclusion of the public health emergency. For the duration of the public health emergency,

30 Tara Straw, "Final 2024 Payment Rule, Part 3: Exchange Operational Standards And APTC Policies," *Health Affairs Forefront*, April 21, 2023, https://www.healthaffairs.org/content/forefront/final-2024-payment-rule-part-3-exchange-operational-standards-and-aptc-policies.

31 U.S. Government Accountability Office, *State Health-Insurance Marketplaces: Three States Used Varied Data Sources for Eligibility and Had Few Indications of Potentially Improper Enrollments*, GAO-17-694, September 2017, https://www.gao.gov/assets/gao-17-694.pdf.

Table 5: Ex-Medicaid Enrollees Far More Likely to Move to Exchange Plans in HealthCare.gov states (as of January 2024)

Category	Federal Exchange		State-Based Exchange	
		% of Removed from Medicaid/CHIP		% of Removed from Medicaid/CHIP
All States				
Removed from Medicaid/CHIP	4,788,553		2,936,872	
Determined exchange eligible	4,236,031	88%	2,192,908	75%
Determined eligible for APTC	3,759,747	79%	1,282,878	44%
Consumers with a plan selection	3,341,758	70%	482,231	16%
Expansion States				
Removed from Medicaid/CHIP	2,084,714		2,936,872	
Determined exchange eligible	1,795,737	86%	2,192,908	75%
Determined eligible for APTC	1,577,138	76%	1,282,878	44%
Consumers with a plan selection	1,417,478	68%	482,231	16%

SOURCES: CMS Unwinding Monthly Update Files. Most recent data is available for January 2024.

NOTES: Excludes DC, MN, and NY, and VA. VA is excluded because of data issues due to converting to SBE within the year. At the state level, SBE results widely vary, but are particularly driven by CA.

which lasted for more than three years, states did not remove enrollees from Medicaid regardless of whether they gained other coverage or earned income making them ineligible.[32]

As detailed in Table 5, according to CMS, 70 percent of individuals enrolled in Medicaid and CHIP at the start of the unwinding process were enrolled in an exchange plan when removed from Medicaid in HealthCare.gov states. In expansion states, this percentage was 68 percent — demonstrating that there was not a difference in this percentage overall based on whether states adopted Medicaid expansion or not. In contrast, in states with state-based exchanges, only 16 percent of people who lost Medicaid or CHIP during the unwinding were enrolled in an exchange plan. In states with state-based exchanges, a far lower percentage of enrollees was deemed eligible for PTCs and a far lower percentage of enrollees deemed eligible for PTCs enrolled in coverage. This data strongly suggests that HealthCare.gov eased the flow of people from Medicaid to the exchanges, potentially without proper verification, including through more fraudulent claims of income between 100 percent and 150 percent FPL.

32 Drew Gonshorowski, Brian Blase, and Niklas Kleinworth, "The Cost of Good Intentions: The Harm of Delaying the Disenrollment of Medicaid Ineligibles," Paragon Health Institute, July 2023, https://paragoninstitute.org/wp-content/uploads/2023/07/the-cost-of-good-intentions.pdf.

Examining the Population Between 138 Percent and 150 Percent FPL

While the majority of this analysis focuses on incentives that occur for populations under 100 percent FPL, there is an incentive for people in expansion states to report income between 138 percent and 150 percent FPL in order to gain fully subsidized exchange plans. Table 6 presents similar findings to previous tables, focusing on people reporting income between 138 percent and 150 percent FPL. Plan sign-ups are calculated from the 2024 open enrollment files, and this table focuses on working-age adults (19-64) who do not report Medicaid or Medicare enrollment (and so corresponds to Table 1).

Regardless of expansion status, many states have more exchange sign-ups reporting income between 138 percent and 150 percent FPL than potentially eligible individuals in this income range. Utah is an outlier at more than four times as many people reporting income in this category than would be eligible. Twenty-two states have more people signing up who report income between 138 percent and 150 percent FPL than are potentially eligible.

Again, there is a drastic difference between federal exchange states and state-based exchange states in fraudulent enrollment rates — as noted in Table 7. In federal exchange states, sign-ups reporting income between 138 percent and 150 percent FPL are 155 percent of the eligible population. In states with state-based exchanges, sign-ups are 76 percent of the eligible population. In expansion states using HealthCare.gov, sign-ups who report income between 138 percent and 150 percent FPL are 177 percent of the eligible population. This implies that the misreporting of income is also a severe issue in expansion states, with the biggest fraud in those using HealthCare.gov.

Big Money for Insurers and Brokers

The Biden administration has made a political decision to prioritize enrollment in public programs and neglect program integrity issues. For example, the administration extended the COVID public health emergency into the spring of 2023 to delay Medicaid redeterminations and removals.[33] This led to approximately 18 million ineligible Medicaid enrollees in March 2023.[34] The administration has created a continuous open enrollment period for the exchanges for people below 150 percent FPL.[35] As should be apparent from the analysis above, because half of exchange enrollees are claiming income below 150 percent FPL, this

33 President Joe Biden, "Continuation of the National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic," 88 Fed. Reg. 9385 (February 10, 2023), https://www.federalregister.gov/d/2023-03218.

34 Matthew Buettgens and Andrew Green, "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," Urban Institute, December 5, 2022, https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage.

35 CMS, "HHS Notice of Benefit and Payment Parameters for 2025 Final Rule," April 2, 2024, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule.

Table 6: Exchange Sign-Ups Reporting Income 138-150% FPL Compared to Total Potential Enrollees

State	Platform	Expansion Status	Exchange Sign-Ups (1)	Total Potential Enrollees (2)	Percentage (1)/(2)
Alabama	HC.gov	Not Adopted	35,892	45,380	79.1%
Alaska	HC.gov	Adopted	1,214	2,595	46.8%
Arizona	HC.gov	Adopted	85,621	52,861	162.0%
Arkansas	HC.gov	Adopted	40,727	25,106	162.2%
California	SBE	Adopted	191,029	179,304	106.5%
Colorado	SBE	Adopted	10,754	29,431	36.5%
Connecticut	SBE	Adopted	4,196	10,691	39.2%
Delaware	HC.gov	Adopted	5,465	6,160	88.7%
Florida	HC.gov	Not Adopted	462,458	175,008	264.2%
Georgia	HC.gov	Not Adopted	124,074	89,563	138.5%
Hawaii	HC.gov	Adopted	1,888	10,525	17.9%
Idaho	SBE	Adopted	5,362	16,655	32.2%
Illinois	HC.gov	Adopted	75,082	63,636	118.0%
Indiana	HC.gov	Adopted	79,886	40,403	197.7%
Iowa	HC.gov	Adopted	18,114	15,702	115.4%
Kansas	HC.gov	Not Adopted	16,614	20,181	82.3%
Kentucky	SBE	Adopted	5,710	26,170	21.8%
Louisiana	HC.gov	Adopted	68,566	31,425	218.2%
Maine	SBE	Adopted	2,832	5,762	49.1%
Maryland	SBE	Adopted	11,895	25,591	46.5%
Massachusetts	SBE	Adopted	14,134	21,937	64.4%
Michigan	HC.gov	Adopted	90,585	43,078	210.3%
Mississippi	HC.gov	Not Adopted	28,905	25,822	111.9%
Missouri	HC.gov	Adopted	106,913	49,044	218.0%
Montana	HC.gov	Adopted	5,792	7,574	76.5%
Nebraska	HC.gov	Adopted	17,479	20,148	86.8%
Nevada	SBE	Adopted	11,732	25,180	46.6%
New Hampshire	HC.gov	Adopted	5,994	4,764	125.8%
New Jersey	SBE	Adopted	32,762	33,289	98.4%
New Mexico	SBE	Adopted	2,807	9,422	29.8%
North Carolina	HC.gov	Adopted	168,594	79,020	213.4%
North Dakota	HC.gov	Adopted	2,426	3,073	78.9%
Ohio	HC.gov	Adopted	117,548	55,245	212.8%
Oklahoma	HC.gov	Adopted	77,306	38,379	201.4%
Oregon	HC.gov	Adopted	8,160	21,420	38.1%
Pennsylvania	SBE	Adopted	37,821	65,519	57.7%
Rhode Island	SBE	Adopted	2,148	3,935	54.6%
South Carolina	HC.gov	Not Adopted	48,395	41,080	117.8%
South Dakota	HC.gov	Adopted	4,313	6,071	71.0%
Tennessee	HC.gov	Not Adopted	49,375	55,420	89.1%
Texas	HC.gov	Not Adopted	281,332	289,384	97.2%
Utah	HC.gov	Adopted	81,644	19,748	413.4%
Vermont	SBE	Adopted	1,387	592	234.4%
Virginia	SBE	Adopted	54,018	40,812	132.4%
Washington	SBE	Adopted	16,396	37,046	44.3%
West Virginia	HC.gov	Adopted	12,529	10,409	120.4%
Wisconsin	HC.gov	Not Adopted	17,827	32,866	54.2%
Wyoming	HC.gov	Not Adopted	1,715	4,556	37.6%
TOTAL			2,547,416	1,916,982	132.9%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

Table 7: Exchange Enrollment Fraud of 138-150% FPL Enrollees More Severe in States Using HealthCare.gov

State	Exchange Sign-Ups (1)	Total Potential Enrollees (2)	Percentage (1)/(2)
HC.gov	2,142,433	1,385,646	154.6%
Expansion and HC.gov	1,075,846	606,387	177.4%
Non-expansion and HC.gov	1,066,587	779,260	136.9%
SBE	404,983	531,335	76.2%
Medicaid Expansion	1,480,829	1,137,722	130.2%
Expansion and SBE	404,983	531,335	76.2%
Expansion and HC.gov	1,075,846	606,387	177.4%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

open enrollment period is almost certainly subject to widespread abuse. The administration has also been sympathetic to self-attestation rather than verification of information.[36]

In 2021, a federal district court stopped four provisions of the 2019 Notice of Benefit and Payment Parameters (NBPP),[37] which would have required people to submit additional information to verify their income if they reported income above the FPL and administrative data suggests that their income is below that level.[38] In *City of Columbus, et al. v. Norris Cochran*, the cities of Columbus, Baltimore, Cincinnati, Chicago, and Philadelphia (along with two individuals) sued the federal government, alleging that the 2019 NBPP would harm enrollees and that the Trump administration was working to undercut the exchanges.[39] The court sided with the plaintiffs and effectively gutted income verification requirements for low-income exchange enrollees. This court decision — combined with no subsidy recapture for enrollees below 100 percent FPL and incentives facing brokers and insurers — set the stage for substantial improper spending.

36 CMS, "2024 Notice of Benefit and Payment Parameters," https://www.cms.gov/files/document/cms-9899-f-patient-protection-final.pdf; CMS, "Streamlining Medicaid and CHIP, Final Rule, Fact Sheet," September 18, 2023, https://www.cms.gov/newsroom/fact-sheets/streamlining-medicaid-and-chip-final-rule-fact-sheet.

37 The four provisions vacated by the decision in *City of Columbus, et al. v. Norris Cochran* included "Federal Review of Network Adequacy," "Income Verification," "Standardized Options," and "Medical Loss Ratio."

38 CMS, HHS; Monetary Offices, Department of the Treasury. "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond." 86 FedReg 24,216. https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver.

39 City of Columbus, et. al. v. Norris Cochran, in his official capacity as Acting Secretary of the Department of HHS, et al., https://democracyforward.org/wp-content/uploads/2021/03/Columbus-et-al.-v.-Trump.pdf.

A primary beneficiary of the surge in improper enrollment from people misestimating their income are health insurers. The larger subsidies mean that consumers are less sensitive to prices of plans, so more of them enroll. It is also much easier to collect subsidies from the U.S. Treasury than premiums from customers. Because roughly half of enrollees have fully subsidized plans, the cost to enrollees is only the paperwork burden. This means that people have incentives to enroll even if they receive very low benefit from the plan. Worse, given automatic re-enrollment, many people might be enrolled for a second year when they already have other coverage, have moved out of state, or have passed away. For re-enrollees in all states, 32.8 percent were automatically re-enrolled in coverage in 2024.[40] All this leads to large payments to health insurers on behalf of many people who are likely receiving low value or no value from the coverage.

Importantly, the insurers are held harmless when people are enrolled receiving larger subsidies than what they were entitled to. Even though the payment goes directly from the U.S. Treasury to the insurer, the payment is effectively a PTC for the enrollee. So, the liability, which is limited for most enrollees who underestimate income (and nonexistent for enrollees with less than 100 percent FPL), is on the enrollees when they reconcile their taxes (assuming that they file their taxes). Insurers have significant financial upside from improper enrollment aimed at maximizing subsidies.

Some private brokers are likely making the problem of fraudulent enrollment worse. These entities have contracts with insurers, and these contracts require the insurers pay them a commission for each enrollee. Some brokers have come under increased scrutiny the past few months for changing the agent of record to capture other agents' commissions, enrolling people without their knowledge, and canceling exchange enrollee coverage and re-enrolling people in different plans to earn higher commissions.[41]

Unscrupulous broker behavior is also made easier in federal exchange states. Julie Appleby's reporting for KFF on unauthorized plan switching highlighted that brokers need very little information to access individuals' accounts.[42] If the broker is registered on HealthCare.gov, all they need is a name, date of birth, and state of residence to enroll an individual into coverage. Additionally, HealthCare.gov lacks basic consumer protections, such as two-factor authentication, and it does not notify enrollees when changes occur to their accounts. Furthermore, any broker or agent can get access to the account of any enrollee for whom the name, date of birth and state enrolled is available regardless of the enrollment platform used,

40 CMS, "2024 OEP State, Metal Level, and Enrollment Status Public Use File," https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.

41 Julie Appleby, "Rising Complaints of Unauthorized Obamacare Plan-Switching and Sign-Ups Trigger Concern," *KFF Health News*, April 8, 2024, https://kffhealthnews.org/news/article/aca-unauthorized-obamacare-plan-switching-concern/.

42 Appleby, "Rising Complaints."

including HealthCare.gov and direct enrollment platforms. On direct enrollment platforms, the user is redirected to HealthCare.gov. However, on enhanced direct enrollment platforms, an enrollment entity hosts a version of HealthCare.gov's eligibility application and integrates directly with the back-end suite of federal exchange interfaces.[43] The coupling of these improper safeguards with fully subsidized plans means that enrollees can be signed up or have their coverage switched without their knowledge. Prior to fully subsidized plans, the vast majority of enrollees paid some premium each month and would have had a much greater opportunity to know if they were switched.

On May 20, 2024, the Chairman of the Senate Finance Committee Ron Wyden sent a letter to the CMS Administrator Chiquita Brooks-LaSure expressing his "outrage with reports that agents and brokers are submitting plan changes and enrollments in the Federal marketplace without the consent of the people who rely on these plans."[44] Chairman Wyden criticized enhanced web-broker platforms, alleging that "bad actors with access to a consumer's eligibility information through web-broker platforms can make plan and agent-of-record changes while keeping people and their legitimate brokers in the dark."[45]

An additional example of unscrupulous behavior by brokers and agents includes fraudulently signing up homeless people.[46] Law-abiding brokers are harmed by unscrupulous broker behavior and recently filed a complaint against brokers they allege to be stealing their commissions.[47] The fraudsters are likely a small percentage of brokers, but they could still be having a large impact given the plethora of fully taxpayer-subsidized plans where enrollees have little, if any, incentive to pay attention to coverage changes.

According to a CMS presentation to brokers, agents and brokers assisted over 6.8 million enrollments during the 2023 open enrollment period. Direct enrollment and enhanced direct enrollment accounted for 81 percent of all active agent-and broker-assisted plan selections, or 5.5 million plan selections. CMS highlighted that data matching issues were over twice as likely to occur under agent-and broker-assisted enrollments. In fact, 16 percent of those who worked with agents or brokers submitted exchange applications that did not include Social Security Numbers versus less than one percent of consumers who self-enrolled.[48]

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43 CMS, "Direct Enrollment and Enhanced Direct Enrollment," https://www.cms.gov/marketplace/agents-brokers/direct-enrollment-partners.

44 United States Senator Ron Wyden, "Wyden Letter to CMS on Brokers" May 20, 2024, https://www.finance.senate.gov/imo/media/doc/wyden_letter_to_cms_on_brokerspdf.pdf.

45 Ibid.

46 Daniel Chang, "Florida Homeless People Duped into Affordable Care Act Plans They Can't Afford," *Tampa Bay Times*, June 12, 2023, https://www.tampabay.com/news/florida-politics/2023/06/12/florida-homeless-people-duped-into-affordable-care-act-plans-they-cant-afford/.

47 Appleby, "Rising Complaints."

48 CMS, "Welcome to the 2023 Agent and Broker Summit," May 24, 2023, https://www.cms.gov/files/document/ab-summit-2023-welcome-slides.pdf.

Heath care "navigators," who work at nonprofit entities, may also be complicit in encouraging misestimates of income, with some likely seeing it as consistent with their purpose and ideological aims to enroll as many people as possible in coverage, knowing that estimating income to maximize subsidies has little downside for people. In 2013, the House Committee on Oversight and Government Reform issued a scathing report on navigators, including a concerning section related to lax protocols to prevent tax fraud.[49]

RECOMMENDATIONS

As discussed by Theo Merkel and Brian Blase in *Follow the Money: How Tax Policy Shapes Health Care*, enormous problems result from the widespread availability of fully subsidized plans, and this data analysis provides more evidence for the magnitude of resulting waste, fraud, and abuse.[50] The most important way that Congress can mitigate this problem, protect enrollees from unauthorized plan enrollment and switching, ensure that coverage provides at least a modicum of value to enrollees, and protect taxpayers is to let the enhanced PTCs expire after 2025.

Second, Congress should raise the subsidy recapture limits so that there are not large incentives for people to misestimate their income, and Congress should put a portion of the liability on entities that gain from improper enrollment — insurers and brokers — for repaying ill-gotten PTCs. As Senator Wyden recently recommended, brokers who are knowingly working with people to manipulate information to maximize subsidies should also be held criminally liable. And states should suspend their licenses.

Third, Congress or the next administration should limit automatic re-enrollment into exchange plans from one year to the next and end it for people moving from or into fully taxpayer-subsidized plans.

Fourth, as outlined by Merkel and Blase, Congress should appropriate cost-sharing reduction payments and prohibit silver-loading, which has significantly increased PTC amounts.[51] Doing so would reduce the benchmark plan premium and PTCs, returning to a more sensible structure for the overall ACA subsidy structure.

49 U.S. Congress, House Committee on Oversight and Government Reform, *Risks of Fraud and Misinformation with ObamaCare Outreach Campaign: How Navigator and Assister Program Mismanagement Endangers Consumers*, majority staff report, December 16, 2013, https://oversight.house.gov/wp-content/uploads/2013/12/Navigator-Report-Number-Two-12-13-13.pdf.

50 Theo Merkel and Brian Blase, "Follow the Money: How Tax Policy Shapes Health Care," Paragon Health Institute, May 2024, https://paragoninstitute.org/private-health/follow-the-money-how-tax-policy-shapes-health-care/.

51 Silver-loading is the practice of loading the cost of CSRs onto the silver plans when the Trump administration complied with a federal court ruling that there was no valid congressional appropriation for the CSR payments.

Fifth, Congress should conduct aggressive oversight of both the Biden administration's management of HealthCare.gov, enhanced direct enrollment, and insurer and broker actions. Congress should ask the Joint Committee on Taxation and Treasury what percentage of people overestimate their income, what percentage of people underestimate their income, and how much PTC is improperly expended by year. Congress should require CMS to provide more information on navigators, particularly with respect to the information navigators are providing related to the large subsidies available for people with income between 100 percent and 150 percent FPL. Congress should also require CMS to provide information on data matching issues by platform.

Sixth, Congress or the next administration should reverse policies of the Biden administration that enabled such widespread fraudulent enrollment, particularly the continuous open-enrollment period for people who report they have income below 150 percent FPL.

APPENDIX

Appendix Tables 1 and 2 correspond to Tables 1 and 3 but display the information for sign-ups reporting income between 100 percent and 200 percent FPL. There is not as significant an incentive for people to report income between 150 percent and 200 percent FPL, because those enrollees are not eligible for fully subsidized benchmark plans. However, some people who expect income well above 200 percent FPL and who may not wish to exaggerate their income to such a large degree to report it under 150 percent FPL may be amenable to reporting it under 200 percent FPL to get both large subsidies for the premium and qualify for the CSR program, which significantly reduces deductibles and copayments to hit an 87 percent actuarial value.

Appendix Tables 1 and 2 continue to show severe fraudulent enrollment problems, again concentrated largely in Sunbelt states along with Utah. The fraudulent enrollment problem appears concentrated in states that did not adopt Medicaid expansion as well as states using the HealthCare.gov platform.

Appendix Table 1: Exchange Sign-Ups Reporting Income 100-200% FPL Compared to Total Potential Enrollees

State	Platform	Expansion Status	Exchange Sign-Ups (1)	Total Potential Enrollees (2)	Percentage (1)/(2)
Alabama	HC.gov	Not Adopted	292,425	360,379	81.1%
Alaska	HC.gov	Adopted	6,640	26,638	24.9%
Arizona	HC.gov	Adopted	188,459	412,970	45.6%
Arkansas	HC.gov	Adopted	94,348	188,691	50.0%
California	SBE	Adopted	717,031	1,625,750	44.1%
Colorado	SBE	Adopted	51,200	252,280	20.3%
Connecticut	SBE	Adopted	34,783	109,099	31.9%
Delaware	HC.gov	Adopted	17,541	37,630	46.6%
Florida	HC.gov	Not Adopted	3,322,479	1,538,613	215.9%
Georgia	HC.gov	Not Adopted	1,029,624	775,744	132.7%
Hawaii	HC.gov	Adopted	7,501	63,185	11.9%
Idaho	SBE	Adopted	32,244	124,126	26.0%
Illinois	HC.gov	Adopted	194,237	548,965	35.4%
Indiana	HC.gov	Adopted	175,041	354,519	49.4%
Iowa	HC.gov	Adopted	45,930	142,404	32.3%
Kansas	HC.gov	Not Adopted	110,544	195,669	56.5%
Kentucky	SBE	Adopted	27,107	212,396	12.8%
Louisiana	HC.gov	Adopted	142,313	238,496	59.7%
Maine	SBE	Adopted	15,358	59,355	25.9%
Maryland	SBE	Adopted	64,343	226,305	28.4%
Massachusetts	SBE	Adopted	90,454	174,445	51.9%
Michigan	HC.gov	Adopted	206,518	445,267	46.4%
Mississippi	HC.gov	Not Adopted	255,396	235,938	108.2%
Missouri	HC.gov	Adopted	239,119	385,638	62.0%
Montana	HC.gov	Adopted	21,240	61,983	34.3%
Nebraska	HC.gov	Adopted	45,298	117,491	38.6%
Nevada	SBE	Adopted	44,723	199,137	22.5%
New Hampshire	HC.gov	Adopted	19,616	40,937	47.9%
New Jersey	SBE	Adopted	154,391	341,533	45.2%
New Mexico	SBE	Adopted	17,670	105,841	16.7%
North Carolina	HC.gov	Adopted	671,971	701,467	95.8%
North Dakota	HC.gov	Adopted	12,021	40,112	30.0%
Ohio	HC.gov	Adopted	266,876	528,940	50.5%
Oklahoma	HC.gov	Adopted	185,990	299,447	62.1%
Oregon	HC.gov	Adopted	34,211	189,439	18.1%
Pennsylvania	SBE	Adopted	174,885	495,748	35.3%
Rhode Island	SBE	Adopted	14,617	35,624	41.0%
South Carolina	HC.gov	Not Adopted	386,973	349,974	110.6%
South Dakota	HC.gov	Adopted	18,429	57,492	32.1%
Tennessee	HC.gov	Not Adopted	397,837	481,722	82.6%
Texas	HC.gov	Not Adopted	2,620,488	2,407,750	108.8%
Utah	HC.gov	Adopted	196,804	201,827	97.5%
Vermont	SBE	Adopted	8,223	17,204	47.8%
Virginia	SBE	Adopted	187,426	370,053	50.6%
Washington	SBE	Adopted	77,930	292,879	26.6%
West Virginia	HC.gov	Adopted	28,835	88,182	32.7%
Wisconsin	HC.gov	Not Adopted	105,983	266,700	39.7%
Wyoming	HC.gov	Not Adopted	14,416	38,451	37.5%
TOTAL			13,067,488	16,464,434	79.4%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

Appendix Table 2: Exchange Sign-Ups Reporting Income 100-200% FPL Compared to Total Potential Enrollees (Expansive Assumptions)

State	Platform	Expansion Status	Exchange Sign-Ups (1)	Total Potential Enrollees (Expansive Assumptions) (2)	Percentage (1)/(2)
Alabama	HC.gov	Not Adopted	292,425	487,293	60.0%
Alaska	HC.gov	Adopted	6,640	51,644	12.9%
Arizona	HC.gov	Adopted	188,459	632,395	29.8%
Arkansas	HC.gov	Adopted	94,348	321,353	29.4%
California	SBE	Adopted	717,031	3,134,648	22.9%
Colorado	SBE	Adopted	51,200	402,109	12.7%
Connecticut	SBE	Adopted	34,783	223,522	15.6%
Delaware	HC.gov	Adopted	17,541	63,856	27.5%
Florida	HC.gov	Not Adopted	3,322,479	2,015,717	164.8%
Georgia	HC.gov	Not Adopted	1,029,624	973,526	105.8%
Hawaii	HC.gov	Adopted	7,501	97,742	7.7%
Idaho	SBE	Adopted	32,244	187,283	17.2%
Illinois	HC.gov	Adopted	194,237	905,757	21.4%
Indiana	HC.gov	Adopted	175,041	570,590	30.7%
Iowa	HC.gov	Adopted	45,930	239,033	19.2%
Kansas	HC.gov	Not Adopted	110,544	236,748	46.7%
Kentucky	SBE	Adopted	27,107	414,762	6.5%
Louisiana	HC.gov	Adopted	142,313	467,247	30.5%
Maine	SBE	Adopted	15,358	105,913	14.5%
Maryland	SBE	Adopted	64,343	375,718	17.1%
Massachusetts	SBE	Adopted	90,454	409,553	22.1%
Michigan	HC.gov	Adopted	206,518	814,776	25.3%
Mississippi	HC.gov	Not Adopted	255,396	309,883	82.4%
Missouri	HC.gov	Adopted	239,119	522,761	45.7%
Montana	HC.gov	Adopted	21,240	104,053	20.4%
Nebraska	HC.gov	Adopted	45,298	160,605	28.2%
Nevada	SBE	Adopted	44,723	295,567	15.1%
New Hampshire	HC.gov	Adopted	19,616	70,630	27.8%
New Jersey	SBE	Adopted	154,391	555,446	27.8%
New Mexico	SBE	Adopted	17,670	205,929	8.6%
North Carolina	HC.gov	Adopted	671,971	946,754	71.0%
North Dakota	HC.gov	Adopted	12,021	54,807	21.9%
Ohio	HC.gov	Adopted	266,876	927,552	28.8%
Oklahoma	HC.gov	Adopted	185,990	411,818	45.2%
Oregon	HC.gov	Adopted	34,211	343,876	9.9%
Pennsylvania	SBE	Adopted	174,885	879,693	19.9%
Rhode Island	SBE	Adopted	14,617	67,232	21.7%
South Carolina	HC.gov	Not Adopted	386,973	472,516	81.9%
South Dakota	HC.gov	Adopted	18,429	69,076	26.7%
Tennessee	HC.gov	Not Adopted	397,837	663,105	60.0%
Texas	HC.gov	Not Adopted	2,620,488	2,893,779	90.6%
Utah	HC.gov	Adopted	196,804	251,364	78.3%
Vermont	SBE	Adopted	8,223	39,829	20.6%
Virginia	SBE	Adopted	187,426	572,620	32.7%
Washington	SBE	Adopted	77,930	491,832	15.8%
West Virginia	HC.gov	Adopted	28,835	171,353	16.8%
Wisconsin	HC.gov	Not Adopted	105,983	423,367	25.0%
Wyoming	HC.gov	Not Adopted	14,416	46,997	30.7%
TOTAL			13,067,488	25,083,628	52.1%

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

May 7, 2025

Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Re: Estimates for Medicaid Policy Options and State Responses

Dear Ranking Member Wyden and Ranking Member Pallone:

This letter provides the Congressional Budget Office's estimates you requested for five policy options concerning Medicaid and explains how the agency projects that states would respond to those policies. Under the first four policy options, federal contributions to the Medicaid program would be smaller, reducing federal budget deficits. CBO anticipates that states would respond in four ways:

- Spend more themselves on Medicaid, mainly using a mix of revenue increases and reduced spending on other programs for financing,
- Reduce payment rates to health care providers,
- Limit the scope or amount of optional benefits, and
- Reduce enrollment in Medicaid.

Under a fifth policy option, which also would reduce the federal budget deficit, only Medicaid enrollment would be reduced as a result of the policy change. The options and CBO's estimates are explained below.

Policy Specifications

The first three estimates you asked for involve updates to policy options that

EXHIBIT 7

CBO has described previously.[1] You described the fourth and fifth options for which you seek estimates. CBO's analysis and estimates assume an enactment date of October 1, 2025, for all five options.

Option 1, Set the Federal Medicaid Matching Rate for the Expansion Population Equal to That for Other Enrollees. The federal government's share of costs for medical services is larger for enrollees who became eligible for Medicaid under the Affordable Care Act (ACA) than it is for other enrollees. That law allowed states to expand eligibility to all adults under age 65 (including parents and adults without dependent children) whose income is below 138 percent of the federal poverty guidelines. (Forty states and the District of Columbia have adopted the expansion.) The federal government's share of Medicaid costs, referred to as the federal medical assistance percentage (FMAP), is fixed at 90 percent for enrollees who gained eligibility under the ACA; that amount does not vary by state.

Under this policy option, the FMAP for enrollees who became eligible under the Medicaid expansion would be the same as the percentage that applies to all other enrollees in a particular state. The state formulas vary, and the federal government's share of Medicaid's cost varies as well, from 50 percent to 77 percent in 2025. The FMAP change would take effect in October 2026.

Option 2, Limit State Taxes on Health Care Providers. Virtually all states finance a portion of their Medicaid spending through taxes collected from health care providers.[2] Those amounts are returned to the providers in the form of higher Medicaid payments, thereby leaving providers at least no worse off (that is, held harmless). Federal law effectively allows states to use hold-harmless arrangements when the taxes they collect do not exceed 6 percent of a provider's net revenues from treating patients. The higher Medicaid payments increase the contributions from the federal government to states' Medicaid programs.

This policy option would eliminate the 6 percent threshold, and states would no longer be effectively allowed to collect revenues under hold-harmless arrangements.

Option 3, Establish Caps on Federal Spending for the Entire Medicaid Population. Under current law, almost all federal Medicaid funding is

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1. Congressional Budget Office, *Options for Reducing the Deficit: 2025 to 2034* (December 2024), www.cbo.gov/publication/60557.

2. Medicaid and CHIP Payment and Access Commission. *Issue Brief: Health Care-Related Taxes in Medicaid.* (May 2021), https://tinyurl.com/3acjh37m.

open-ended: If state spending increases because enrollments or costs per enrollee rise, larger federal payments are automatically generated.

This policy option would establish a per-enrollee cap on federal spending. As a result, each state's total federal funding would be limited to the product of the number of enrollees and the capped per-enrollee spending amount, which would vary for the different Medicaid eligibility groups in each state. For this estimate, CBO used 2024 as the base year for the per-enrollee amounts, with growth of the caps based on the consumer price index for all urban consumers. The caps would take effect in October 2028.

Option 4, Establish Caps on Federal Spending for the Medicaid Expansion Population. This policy option also would establish a per-enrollee cap on federal spending, but limited to Medicaid enrollees who gained eligibility under the ACA's expansion.

Option 5, Repeal Medicaid's Eligibility and Enrollment Rule. The Centers for Medicare & Medicaid Services issued two final rules, one each in 2023 and 2024, that together are referred to as the Eligibility and Enrollment final rule.[3] This policy option would repeal the Eligibility and Enrollment final rule.

The first rule, issued in September 2023, focuses on reducing barriers to enrollment in Medicare Savings Programs (MSPs), which help low-income Medicare beneficiaries pay their premiums and, in some cases, cover their cost-sharing requirements. This rule is aimed at increasing participation among people who are eligible for, but not currently enrolled in, MSPs. Among several other provisions, the rule establishes processes for states to facilitate MSP applications for people who are eligible for the low-income subsidy under Medicare Part D. The rule also requires states to automatically enroll some people in the Qualified Medicare Beneficiary Program, a type of MSP, eliminating the need for a separate application.

The second rule, issued in April 2024, focuses on simplifying and standardizing state processing of applications and renewals for coverage in Medicaid and the Children's Health Insurance Program (CHIP), aiming to reduce administrative burdens and barriers to enrollment. For example, it aligns application and renewal policies for people who qualify on the basis of

3. Centers for Medicare & Medicaid Services, "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," final rule, *88 Fed. Reg.* 65230 (September 21, 2023), https://tinyurl.com/2up3bvw4, and "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, and Renewal Processes," final rule, *89 Fed. Reg.* 22780 (April 2, 2024), https://tinyurl.com/y9ebx2pt.

age or disability with policies for people who have income-based eligibility. Among several other provisions, the 2024 rule also requires states to provide Medicaid enrollees with clear guidance and adequate time to confirm ongoing eligibility, and to take extra steps before terminating coverage because of returned mail.

Basis of CBO's Estimates

Options 1 through 4 would reduce the resources available to states to fund Medicaid programs, either in the form of smaller reimbursements or smaller tax revenues from providers. Given the reduced resources available to fund Medicaid, states would need to consider how to respond. Although states could maintain the same provider payment rates, benefits packages, and enrollment by raising taxes or reducing spending on other programs and spending those resources on Medicaid instead, CBO expects that such steps would prove challenging for many states.

States would vary concerning how they would replace the reduced funds—as well as the priorities they would place on maintaining current Medicaid benefits and enrollment. In CBO's view, different states would make different choices regarding how much of the reduced Medicaid funds to replace. Instead of modeling separate responses for each state, the agency estimated state responses in the aggregate, accounting for a range of possible outcomes. Overall, CBO expects that, on average, states would replace roughly half of the reduced funds with their own resources. Additionally, in response to the loss of the other half of the resources, states would modify their Medicaid programs and reduce Medicaid spending using three levers: reduce provider payment rates, reduce the scope or amount of optional services, and reduce Medicaid enrollment.

In considering the changes that states might make to enrollment, CBO first examined how policy changes would influence states' future decisions to expand Medicaid coverage under the ACA. In CBO's baseline budget projections, additional states are expected to expand coverage, generally consistent with the historical trend since 2015—with the share of potentially eligible adults living in states with expanded coverage rising from 72 percent in 2024 to 80 percent in 2035. Under Options 1 through 4, CBO projects, some states that would expand eligibility for Medicaid in the agency's baseline projections would no longer do so because expanding coverage would require states to provide more of their own funds when faced with smaller resources under the policy options. In addition to decisions about future expanded coverage for adults under the ACA, CBO expects that states would reduce enrollment by eliminating optional coverage categories and by

changing enrollment policies and procedures to make enrollment more challenging to navigate.

CBO considered the extent to which states would reduce provider payments, benefits, and enrollment under each option individually, taking into account the incentives created by each policy. For example, under Option 1, CBO projects that laws in some states would trigger the elimination of the Medicaid expansion because of the reduced matching rate, leading to a greater degree of enrollment reduction.

For Options 1 through 4, the state response to reduce the total costs of their Medicaid programs would add to the federal savings from each policy. For Options 1, 3, and 4, the lower federal matching rates and the new caps on federal reimbursement would generate savings to the federal government before any steps states would take to reduce spending on their programs. In response to those federal policy changes, CBO expects that states would reduce the total costs of their Medicaid programs. As a result, the federal government would provide reimbursement for a smaller amount of state spending. Because the per-enrollee caps specified in Options 3 and 4 would set a fixed amount of federal funding per beneficiary, the state reductions in provider payments or benefits would not result in additional federal savings, although any reduction in enrollment would.

For Option 2, the elimination of provider taxes would not directly generate federal savings because there would be no change to Medicaid itself. That option would reduce resources available to states. CBO expects that, in the aggregate and after accounting for decisions about expanded coverage, states would replace only 50 percent of the reduced provider revenues. Thus, state reductions to Medicaid would generate savings under Option 2 that would be similar to those under Options 1, 3, and 4: The federal government would provide reimbursement for a smaller amount of state spending.

Option 5, which would repeal the Eligibility and Enrollment final rule, would reduce enrollment but not affect the division of costs between the federal government and states, CBO estimates. Under the current rule, enrollment in Medicaid will increase because administrative barriers will be lower. Repealing that final rule would return enrollment to levels seen before the rule took effect as states return to earlier administrative practices. Moreover, people who, under the rule, receive Medicare premium and cost-sharing assistance through MSPs are more likely to use Medicare-covered services, resulting in higher Medicare spending. Repealing the rule would generate net savings to states and therefore would not lead to additional state spending, reductions in provider payment rates, or reductions in benefits. In general,

CBO does not consider that states would use the net savings generated from Option 5 or certain other options that reduce enrollment alone, such as imposing work requirements, to increase states' spending on Medicaid.

Estimated Effects

CBO estimates that under Option 1, which would set the FMAP for the expansion population equal to that for other enrollees, the deficit would be reduced by $710 billion over the 2025–2034 period (see Table 1). That estimate is the net of a gross decrease in Medicaid spending of $860 billion and an increase in costs of $150 billion from enrollment in federally subsidized health insurance obtained through employment or in the marketplaces established by the ACA.

The $860 billion gross decrease in federal Medicaid spending consists of initial savings of $516 billion from the FMAP reduction, $142 billion in savings attributable to states' reducing payment rates for providers and reducing benefits, and $202 billion in savings from lower enrollments. CBO estimates that, in 2034, 2.4 million of the 5.5 million people who would no longer be enrolled in Medicaid under this option would be without health insurance.

CBO expects that gross federal Medicaid spending also would decrease under Options 2 through 4 (which would impose limits on state tax collections from health care providers or establish caps on federal spending either for the entire Medicaid population or for the expansion population). States would respond to the loss of resources by increasing state spending on Medicaid, reducing payment rates for providers, limiting benefits, and reducing enrollment. Under each of those options, Medicaid enrollment would decrease and the number of people without health insurance would increase.

Under Option 5, which would repeal the Eligibility and Enrollment final rule, CBO estimates that the deficit would be reduced by $162 billion over the 2025–2034 period.

That estimate is the net of a gross decrease in Medicaid spending of $170 billion, a decrease in Medicare spending of $11 billion, a decrease in CHIP spending of $1 billion, and an increase of $20 billion attributable to increased enrollment in federally subsidized health insurance.

The decrease in federal Medicaid and CHIP spending would consist entirely of savings from reduced enrollment. CBO estimates that, in 2034, 2.3 million people would no longer be enrolled in Medicaid under this option. Roughly 60 percent of the people who would lose Medicaid coverage would be dual-

benefit enrollees who would retain their Medicare coverage. Medicare enrollees who were no longer receiving cost-sharing assistance would face increased out-of-pocket costs (for Medicare premiums and copayments, for example), leading to a reduction in use of Medicare's services and thus to lower Medicare spending, relative to amounts currently projected under the rule.

Table 1.

Medicaid Policy Options and Estimated Federal Effects From State Responses, 2025–2034

	Option 1. Reduce Expansion Population Matching Rate	Option 2. Limit State Taxes on Health Care Providers[a]	Cap on Spending per Enrollee[b]		Option 5. Repeal Eligibility and Enrollment Final Rule[c]
			Option 3. All Eligibility Groups	Option 4. Expansion Only	
Budgetary Effects (Billions of dollars)					
Reduction in the Federal Deficit[d]	710	668	682	225	162
Gross Reduction in Federal Medicaid Outlays	860	880	792	298	170
Federal Reduction Before State Response	516	0	534	146	0
Additional Federal Reduction From States' Reducing Benefits and Provider Payments	142	408	0	0	0
Additional Federal Reduction From States' Reducing Enrollment	202	472	258	152	170
Change in Coverage in 2034 (Millions of people)					
Reduction in Medicaid Coverage	5.5	8.6	5.8	3.3	2.3
Increase in Uninsured People	2.4	3.9	2.9	1.5	0.6

Source: Congressional Budget Office.

a. Limiting providers' state taxes would not directly generate federal savings. Medicaid itself would not change, but because states would reduce their spending, federal payments to states also would be reduced.

b. Because the per-enrollee cap specified in Options 3 and 4 would set a fixed amount of federal funding per beneficiary, CBO expects that states would reduce provider payments and benefits. Unlike reductions in enrollment that would reduce federal spending, those reductions would not result in additional federal savings.

c. A repeal of the final rule would reduce Medicaid enrollment, generating net savings to states. CBO does not expect that states would respond by reducing provider payment rates or benefits and thus does not estimate additional changes for those areas.

d. Includes offsetting costs from increased enrollment in subsidized health insurance obtained through employment or in the marketplaces established by the ACA.

Other Considerations

The estimates described above consider each policy option as though enacted separately. Where CBO estimated the effects of a set of policies involving Medicaid, the agency considered whether states would realize net savings or

net costs from the policies combined. In the agency's estimation, that effect would then inform states' responses to any particular policy. For example, states that realized net savings from the combined policies would not have an incentive to change their programs in response to any specific policy that increased their costs.

An area of ongoing analysis involves CBO's expectations of the states' responses to changes in federal Medicaid funding. State budget conditions and Medicaid programs are continuously changing. If you and your staff have data to share or know of stakeholders with whom you would like us to communicate, please let us know.

I hope this information is useful to you. Please contact me if you have further questions.

Sincerely,

Phillip L. Swagel
Director

cc: Honorable Mike Crapo
Chairman
Senate Committee on Finance

Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

AMERICAN ASSOCIATION OF ANCILLARY BENEFITS, et al., *Plaintiffs,* v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*, *Defendants*.	§	Case No. 24-CV-783 Judge Sean D. Jordan

[PROPOSED] ORDER FOR PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO EXTEND STAY

The court has considered Plaintiffs' Response in Opposition to Defendants' Motion for a 6-Month Stay or an Extension of Time. For the reasons stated on the record:

It is ORDERED that:

□ Defendants' Motion for a 6-Month Stay or an Extension of Time is GRANTED.

□ Defendants' Motion for a 6-Month Stay or an Extension of Time is DENIED.

_____ _____

DATE PRESIDING JUDGE