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# Changes in Health Care Spending and Uncompensated Care under Enhanced Tax Credit Expiration for Marketplace Coverage

## Updated 2026 State and National Estimates

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## Introduction

**Enhanced premium tax credits (PTCs), which aim to expand and stabilize health insurance coverage, have been in place in the Marketplaces since 2021, but are set to expire after this year.[1] The enhanced PTCs substantially lowered the premiums people needed to pay for insurance in the Marketplace by reducing net premiums to zero for some people with low incomes and making subsidies available to people with higher incomes for the first time. Since the enhancements took effect in 2021, Marketplace enrollment has more than doubled.[2] After omitting the PTC enhancements from the recently adopted One Big Beautiful Bill Act (OBBBA), Congress is continuing to debate whether to allow them to expire, extend them, or make them permanent.**

Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), Buettgens et al. (2025) projected that without enhanced PTCs, net premiums in the Marketplace would significantly increase and 7.3 million fewer people would receive subsidized coverage, resulting in 4.8 million more adults becoming uninsured in 2026. The Congressional Budget Office also projected a similar increase in the number of uninsured, albeit over a longer ramp-up period, as it assumes individuals are slower to respond to premium increases.[3] These increases in the number of uninsured would significantly impact health care providers, as studies have shown that uninsured people use less medical care than they would if they had health insurance (Card, Dobkin, and Maestas 2008; Lau et al. 2014; McWilliams et al. 2007; Spillman 1992; Zhou et al. 2017). Moreover, uninsured people often need to seek uncompensated care from providers when they use medical services (Coughlin, Samuel-Jakubos, and Garfield 2021).

Building on Buettgens et al. (2025) and updating estimates from Blavin et al. (2024), this brief examines the implications of projected coverage losses on providers through reductions in health care spending and increases in uncompensated care. We estimate how the reductions in health care spending and increases in uncompensated care would be distributed across hospital care, office-based physician care, prescription drugs, and other services. We also provide in-depth estimates on how the decline in overall health care spending and spending on hospital care would vary across states.

The declines in insurance coverage and health care spending, as well as the increases in uncompensated care demand, are larger in this brief compared with Blavin et al. (2024), because enrollment in the 2025 open enrollment period was substantially higher than in 2024. The estimates presented here compare a baseline with enhanced PTCs that incorporates policies expected to be in effect in 2026, including the major provisions of the OBBBA and provisions of the Marketplace Integrity and Affordability rule released by the Center for Medicare and Medicaid Services (CMS),[4] except for provisions stayed by a Maryland District Court on August 22, to a projection with those policies, but in which enhanced PTCs expire at the end of 2025 (referred to as "standard PTCs").[5] Additional details on the provisions incorporated in the model can be found in Buettgens et al. (2025).

# Results

Buettgens et al. (2025) found that the reduced financial assistance available to lower- and moderate-income adults would lower Marketplace enrollment of people receiving premium tax credits (PTCs) by 7.3 million in 2026 (repeated in table 1). By making coverage less affordable, standard PTCs will shrink the subsidized Marketplace to cover 11.7 million people in 2026, compared with 19.0 million people if enhanced PTCs stay in effect, a decrease of 7.3 million, or 38 percent. The nongroup market overall, which includes subsidized and unsubsidized Marketplace coverage, state Basic Health Programs (BHP), and other nongroup coverage purchased outside the Marketplace that complies with federal standards, will cover 19.2 million people under standard PTCs, compared with 26.9 million people if enhanced PTCs stay in effect, a reduction of 7.7 million (29 percent).

Overall, if the enhanced PTCs were to expire and fewer people were attracted to the Marketplace, the number of uninsured nonelderly adults would increase by 4.8 million in 2026, from 23.2 million to 27.9 million. This 4.8 million increase in the number of uninsured is larger than the 4.0 million increase projected by both the Urban Institute and Congressional Budget Office last year (Banthin et al. 2024).

However, not everyone who drops Marketplace coverage becomes uninsured. For example, some adults who previously declined employer-sponsored health insurance offers for enhanced PTCs would switch back to employer-sponsored insurance under standard PTCs. We project that 3.2 million more people would choose employer-sponsored insurance—which typically has higher reimbursement rates for providers compared with Marketplace plans—under standard PTCs than under enhanced PTCs, an increase of about 2 percent.

TABLE 1

**Health Insurance Coverage of the Nonelderly under Enhanced and Standard Marketplace PTCs, 2026**

*Millions of people*

| | Enhanced PTCs | | Standard PTCs | | Difference |
|---|---|---|---|---|---|
| **Insured (MEC)** | 256.0 | 91.0% | 251.1 | 89.2% | -4.9 |
| Employer | 147.1 | 52.3% | 150.3 | 53.4% | 3.2 |
| Basic Health Program | 1.8 | 0.7% | 1.8 | 0.6% | 0.0 |
| Nongroup Marketplace with PTC | 19.0 | 6.8% | 11.7 | 4.2% | -7.3 |
| Nongroup unsubsidized | 6.1 | 2.2% | 5.7 | 2.0% | -0.4 |
| Medicaid/CHIP | 73.2 | 26.0% | 72.8 | 25.9% | -0.4 |
| Other public | 8.8 | 3.1% | 8.8 | 3.1% | 0.0 |
| **Noncompliant nongroup (without MEC)** | 2.3 | 0.8% | 2.4 | 0.9% | 0.1 |
| **Uninsured** | 23.2 | 8.2% | 27.9 | 9.9% | 4.8 |
| **Total** | **281.4** | **100.0%** | **281.4** | **100.0%** | **0.0** |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

**Notes:** PTC = premium tax credit; CHIP = Children's Health Insurance Program; MEC = minimum essential coverage.

Total spending on health care services would decrease by $32.1 billion in 2026—approximately 1.3 percent of current total spending for the nonelderly—because of these coverage changes (table 2). Around $14.2 billion less would be spent on services provided by hospitals (44 percent of the total decline in spending), $5.1 billion less on services provided by office-based physicians, $6.9 billion less on other health care services,[6] and $5.8 billion less on prescription drugs. These declines in insurer (public and private) and household spending on health care are mainly driven by decreases in payments by private insurers for health care claims incurred by Marketplace enrollees and households' direct out-of-pocket spending on services.

TABLE 2

**Health Care Spending for the Nonelderly by Insurers (public and private) and Households under Enhanced and Standard Marketplace PTCs, 2026**

*Billions of dollars*

| | Total health care spending | Hospitals | Physician practices | Other services | Prescription drugs |
|---|---|---|---|---|---|
| Enhanced PTCs | 2432.2 | 860.1 | 390.9 | 643.7 | 537.5 |
| Standard PTCs | 2400.1 | 845.9 | 385.8 | 636.7 | 531.7 |
| Difference | -32.1 | -14.2 | -5.1 | -6.9 | -5.8 |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.

**Notes:** PTC = premium tax credit. Other services include services delivered by providers other than hospitals and office-based physicians, and additional services such as dental care, home health care, and other medical equipment.

Coverage losses from the expiration of the enhanced PTCs would also increase the amount of uncompensated care sought by the uninsured (table 3).[7] We estimate that total uncompensated care demand would increase by $7.7 billion (11.6 percent relative to the $66.7 billion baseline) if PTCs reverted to standard levels. The burden of the additional $7.7 billion in uncompensated care would fall

on all provider types: about $2.2 billion on hospitals, $1.0 billion on physician offices, $3.1 billion on other services, and $1.5 billion on prescription drugs.

TABLE 3

**Uncompensated Care Demand under Enhanced and Standard Marketplace PTCs, 2026**

*Billions of dollars*

| | Total uncompensated | Hospitals | Physician practices | Other services | Prescription drugs |
|---|---|---|---|---|---|
| Enhanced PTCs | 66.7 | 19.0 | 8.7 | 25.4 | 13.5 |
| Standard PTCs | 74.4 | 21.2 | 9.6 | 28.5 | 15.0 |
| Difference | 7.7 | 2.2 | 1.0 | 3.1 | 1.5 |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.
**Notes:** PTC = premium tax credit. Other services include services delivered by providers other than hospitals and office-based physicians, and additional services such as dental care, home health care, and other medical equipment.

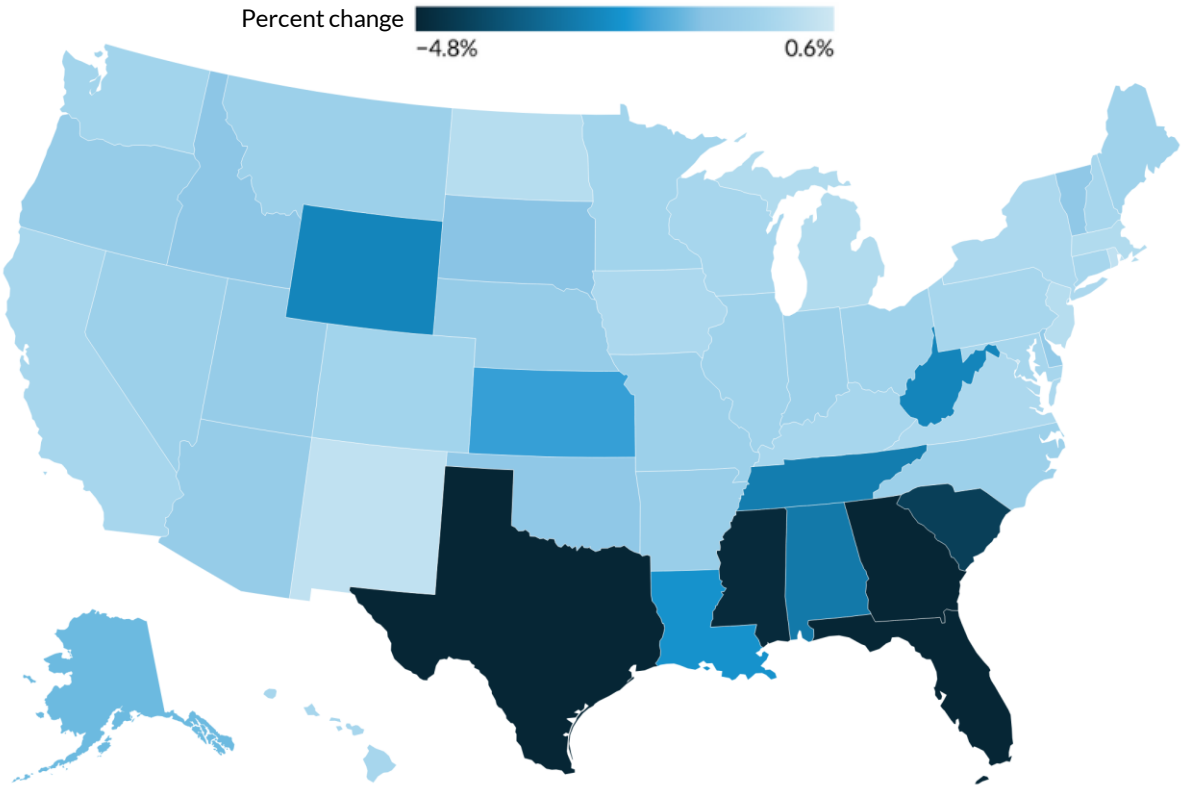
Uncompensated care is financed in different ways: some is financed by the federal government (e.g., Medicare and Medicaid disproportionate share hospital programs), some is financed by state and local governments (e.g., uncompensated care pools, Medicaid disproportionate share hospital programs, funding for public hospitals), and some is delivered as free or reduced-price care by providers (e.g., hospitals, physicians, pharmaceutical companies). In general, uncompensated care funding (e.g., from federal, state, and local governments or health care providers) does not increase automatically with the number of uninsured people. Whether funding from federal, state, and local governments would increase to meet the larger amount of uncompensated care expected to be sought by the newly uninsured remains unclear.

As a result, we estimate the amount of uncompensated care the newly uninsured would demand, not the value of the uncompensated care they would receive. Our estimates indicate that slightly more than half of the increase in uncompensated care would be financed by providers, 30 percent by the federal government, and 19 percent by state and local governments (data not shown). If government uncompensated care funding is less than we estimate, providers would be responsible for more uncompensated care, and the uninsured would forgo additional health care.

Driven in part by the relative share of the population currently enrolled in Marketplace coverage, we see substantial variation in the percent change in total spending on health care services by state (figure 1 and appendix table A.1). For example, 14 states would have declines of 1 percent or more of total spending, with the largest declines occurring in Florida (4.8 percent or $6.7 billion), Georgia (4.8 percent or 3.7 billion), Texas (4.8 percent or $10.2 billion), Mississippi (4.7 percent or $1.0 billion), and South Carolina (4.2 percent or $1.5 billion). The remaining states and the District of Columbia would experience spending declines of less than 1 percent, with 10 states having declines as small as 0.1 percent or even small increases, including DC, Iowa, Massachusetts, Michigan, New Jersey, New Mexico, New York, North Dakota, Rhode Island, and Virginia.

FIGURE 1

**Percent Decline in Total Health Care Spending for the Nonelderly Associated with Expiration of Enhanced PTCs, by State, 2026**




URBAN INSTITUTE

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.
**Notes:** PTC = premium tax credit.

Ten of the 11 states that would experience the largest percent declines in total health care spending if the enhanced PTCs were to expire are all nonexpansion states, which are concentrated in the South and generally have a larger share of the population that lives in rural areas. The larger declines in health care spending among the states that have not expanded Medicaid are mainly because individuals between 100 and 138 percent of the federal poverty level (FPL) are eligible for Marketplace PTCs in nonexpansion states, whereas those in this same income band in expansion states are generally eligible for Medicaid.

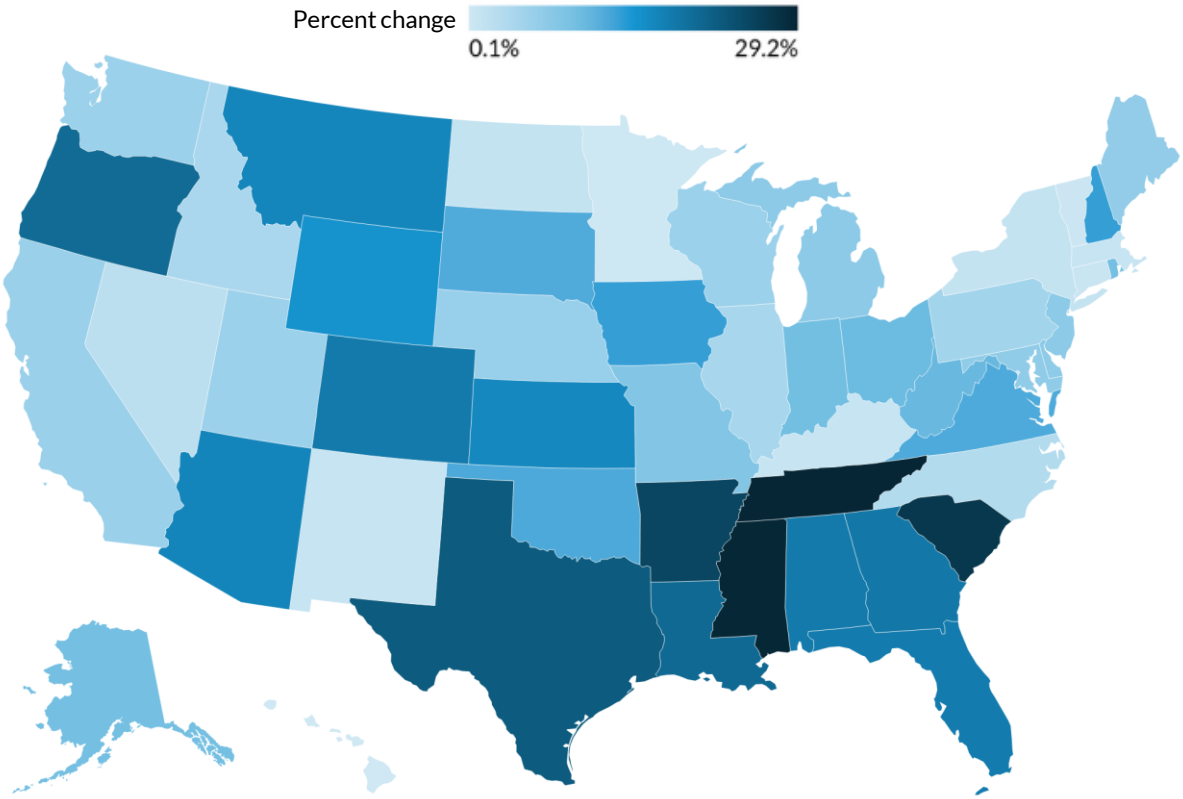
Appendix table A.1 includes the state-specific data for both total health care spending and hospital health care spending. The patterns for hospital spending changes mirror those observed for total health care spending changes.

We also see substantial variation in the percent change in uncompensated care sought by the uninsured by state (figure 2 and appendix table A.2). Consistent with the changes in health care

spending, the percent increases in uncompensated care sought by the nonelderly uninsured are generally largest in nonexpansion states; nine of the most impacted 15 states have not expanded Medicaid. Demand for uncompensated care would increase by 27 percent or more in Mississippi (29.1 percent or $251 million), South Carolina (26.9 percent or $265 million), and Tennessee (29.2 percent or $378 million). In contrast, uncompensated care demand would increase by 5 percent or less in 15 states, and less than one percent in Connecticut, the District of Columbia, Hawaii, Minnesota, and Vermont.

FIGURE 2

**Percent Increase in Uncompensated Care Spending for the Nonelderly Associated with Expiration of Enhanced PTCs**




URBAN INSTITUTE

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2025.
**Notes:** PTC = premium tax credit

# Conclusion

Since the enhanced PTCs were first adopted in 2021, they have led to record-high enrollment in the Marketplaces at all income levels. If Congress doesn't extend enhanced PTCs after 2025, 4.8 million people would become uninsured, resulting in health care spending declines of $14.2 billion on hospital services, $5.1 billion on office-based physician services, $6.9 billion on other health care services, and

$5.8 billion on prescription drugs. Declines in health care spending would be more pronounced in states that have not expanded Medicaid, communities in the South, and rural communities. The expiration of the enhanced PTCs would also result in a $7.7 billion increase in uncompensated care sought by the uninsured.

Because lower spending on health care services means lower revenue for health care providers and fewer services rendered, the resulting decline in revenue could have adverse consequences, particularly for already financially at-risk hospitals and the communities they serve. This loss of health insurance coverage could have significant negative consequences for individuals, as health care use declines and unmet health care needs increase when people become uninsured (Ayanian et al. 2000; Card, Dobkin, and Maestas 2008; McWilliams et al. 2007; Spillman 1992; Zhou et al. 2017).

The size and stability of the Marketplace, and the implications for providers, could be even more important after 2026, when the OBBBA provisions, such as further restrictions on PTC eligibility for lawfully present immigrants and the elimination of automatic enrollment with PTCs, will reduce Marketplace enrollment further, with or without enhanced PTCs. Also, if provisions of the 2026 Marketplace Integrity rule that have been stayed by the court take effect in later years, there would be further reductions in enrollment. At the time of writing, it is unclear what would be in effect after 2026.

With the end of the enhanced subsidies on the horizon, federal, state, and local policymakers must consider the expiration's potential adverse effects on health care access and affordability, as well as revenue losses for providers of all types.

# Data and Methods

We used the Urban Institute's HIPSM to produce our analysis of the effects of PTC generosity on coverage, health care spending, and uncompensated care costs in 2026.[8] HIPSM 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 2026.

For this brief and in Buettgens et al. (2025), we updated HIPSM using 2025 Marketplace premiums and state-level Marketplace enrollment data from the 2025 Open Enrollment Period Report snapshot released by CMS.[9] We adjusted the Open Enrollment Period Report snapshot numbers downward to represent average monthly Marketplace enrollment more accurately for the entire year. These adjustments reflect the "effectuation" of plan choices and midyear attrition. We first calibrated the model to replicate 2025 enrollment with 2025 premiums and Marketplace rules. We then simulated 2026 enrollment and costs in two different ways: (1) assuming enhanced PTCs were extended and remained in effect; and (2) assuming enhanced PTCs expired at the end of 2025 and standard PTCs were back in place. Enrollment totals for the latter scenario are comparable to those before the enhanced PTCs and COVID-era Medicaid continuous coverage requirements were in effect, except for

states with recent policy changes, such as additional state-funded Marketplace subsidies. Under both the enhanced and standard PTC scenarios, our estimated effects reflect 2026 provisions of the OBBBA and the 2026 Marketplace Integrity rule not stayed by the court, as explained above. The two most significant OBBBA changes affecting enrollment are the loss of PTC eligibility for lawfully present immigrants with incomes below 100 percent of FPL and the loss of the special enrollment period for people with incomes below 150 percent of FPL. For this analysis, Medicaid baseline enrollment for 2026 does not reflect provisions in the OBBBA because the major provisions affecting Medicaid enrollment do not take effect until later years.

People in New York with incomes up to 250 percent of FPL and in Minnesota and Oregon with incomes up to 200 percent of FPL who would be eligible for Marketplace PTCs in other states would instead be covered by a BHP or state waiver that builds on BHP (as in New York). This coverage has both lower premiums and cost sharing than Marketplace coverage, even with enhanced PTCs. For example, New York offers comprehensive coverage with no premiums to eligible people with incomes up to 250 percent of FPL. The expiration of enhanced PTCs will not directly change BHP coverage, but it will reduce federal funding for BHP. States may need to raise BHP premiums and/or cost sharing if they cannot make up for the shortfall. Also, the OBBBA terminates eligibility for low-income lawfully present immigrants. Several hundred thousand such people reside in New York, and the federal funding for their coverage is a crucial part of the state's waiver. As a result, New York has announced that it plans to eliminate waiver coverage of people with incomes between 200 and 250 percent of FPL, while keeping BHP coverage for people with incomes up to 200 percent of FPL.[10] Our results do not assume changes in BHP or New York's waiver, as the announcement came after our results were finalized.

The estimation of health care costs for individuals with various types of insurance and the estimation of uncompensated care are basic features of HIPSM. Health care spending data used in HIPSM come from the Medical Expenditure Panel Survey-Household Component (MEPS-HC) as well as other sources. Details are available in the HIPSM methodology documentation (Buettgens and Banthin 2022). We estimate total health care spending for each person represented in HIPSM for each possible health insurance status; these estimates of spending control for a broad array of sociodemographic variables and health statuses. Using the MEPS-HC, we then compute the share of individual health expenditures attributable to each type of care (hospital, office-based physician, prescription drugs, other) by individual characteristics: health insurance coverage, age, gender, income, and health status. The percentage splits of spending across provider types are then imputed to the individuals represented in HIPSM.

We predict the amount of uncompensated care that each newly uninsured person would seek, controlling for age, gender, income, health status, and other sociodemographic characteristics. The prediction model is estimated using MEPS-HC data, where the dependent variable is the value of uncompensated care received by each uninsured person. We use this estimated equation to predict the value of uncompensated health care services that each insured individual would seek if he or she were to become uninsured. As explained in the results, current patterns of uncompensated care use may not persist if, for example, large increases in the number of uninsured are not met by commensurate

increases in government funding or in provider contributions of free or reduced-price care. As a result, we refer to the estimated amounts of care based on recent patterns of uncompensated care use as the value of the care the newly uninsured would demand, not the value of the uncompensated care they would actually receive. We assume that newly uninsured people would contribute to their care costs consistent with the spending patterns of uninsured people with similar characteristics and health needs in recent years.

# Appendix

APPENDIX TABLE A.1

**All Health Care Spending and Hospital Spending for the Nonelderly by Insurers (public and private) and Households under Enhanced and Standard Marketplace PTCs, by State, 2026**

*Millions of dollars*

| | All Health Spending for the Nonelderly | | | | Hospital Spending for the Nonelderly | | | |
|---|---|---|---|---|---|---|---|---|
| State | Enhanced PTCs | Standard PTCs | Difference | Percent difference | Enhanced PTCs | Standard PTCs | Difference | Percent difference |
| All States | 2,432,220 | 2,400,129 | -32,091 | -1.3% | 860,110 | 845,880 | -14,230 | -1.7% |
| AL | 33,167 | 32,228 | -939 | -2.8% | 11,854 | 11,443 | -411 | -3.5% |
| AK | 6,611 | 6,524 | -87 | -1.3% | 2,348 | 2,310 | -38 | -1.6% |
| AZ | 54,190 | 53,806 | -383 | -0.7% | 19,222 | 19,026 | -196 | -1.0% |
| AR | 22,533 | 22,389 | -144 | -0.6% | 8,075 | 7,992 | -83 | -1.0% |
| CA | 286,885 | 286,388 | -497 | -0.2% | 100,385 | 100,026 | -359 | -0.4% |
| CO | 43,141 | 42,996 | -145 | -0.3% | 14,904 | 14,825 | -79 | -0.5% |
| CT | 29,230 | 29,185 | -45 | -0.2% | 10,024 | 10,002 | -22 | -0.2% |
| DE | 7,693 | 7,635 | -58 | -0.8% | 2,721 | 2,698 | -23 | -0.8% |
| DC | 5,955 | 5,987 | 33 | 0.6% | 2,172 | 2,182 | 9 | 0.4% |
| FL | 139,226 | 132,484 | -6,742 | -4.8% | 49,243 | 46,253 | -2,991 | -6.1% |
| GA | 76,298 | 72,641 | -3,657 | -4.8% | 27,077 | 25,441 | -1,636 | -6.0% |
| HI | 9,435 | 9,412 | -23 | -0.2% | 3,388 | 3,381 | -7 | -0.2% |
| ID | 13,546 | 13,416 | -130 | -1.0% | 4,830 | 4,781 | -49 | -1.0% |
| IL | 90,262 | 89,891 | -372 | -0.4% | 31,366 | 31,206 | -161 | -0.5% |
| IN | 52,251 | 51,986 | -264 | -0.5% | 18,668 | 18,546 | -123 | -0.7% |
| IA | 24,154 | 24,127 | -27 | -0.1% | 8,474 | 8,458 | -16 | -0.2% |
| KS | 21,988 | 21,570 | -418 | -1.9% | 7,798 | 7,598 | -201 | -2.6% |
| KY | 32,593 | 32,537 | -56 | -0.2% | 11,641 | 11,612 | -29 | -0.2% |
| LA | 32,504 | 31,799 | -705 | -2.2% | 11,694 | 11,432 | -261 | -2.2% |
| ME | 10,150 | 10,112 | -38 | -0.4% | 3,572 | 3,560 | -12 | -0.3% |
| MD | 45,983 | 45,870 | -113 | -0.2% | 16,019 | 15,991 | -28 | -0.2% |
| MA | 51,187 | 51,193 | 6 | 0.0% | 18,141 | 18,120 | -21 | -0.1% |
| MI | 66,384 | 66,416 | 32 | 0.0% | 23,431 | 23,433 | 3 | 0.0% |
| MN | 49,791 | 49,663 | -128 | -0.3% | 17,433 | 17,383 | -50 | -0.3% |
| MS | 20,660 | 19,679 | -981 | -4.7% | 7,607 | 7,129 | -477 | -6.3% |
| MO | 49,238 | 48,991 | -247 | -0.5% | 17,668 | 17,570 | -98 | -0.6% |

| State | All Health Spending for the Nonelderly | | | | Hospital Spending for the Nonelderly | | | |
|---|---|---|---|---|---|---|---|---|
| | Enhanced PTCs | Standard PTCs | Difference | Percent difference | Enhanced PTCs | Standard PTCs | Difference | Percent difference |
| MT | 7,676 | 7,638 | -38 | -0.5% | 2,709 | 2,696 | -14 | -0.5% |
| NE | 15,293 | 15,180 | -113 | -0.7% | 5,374 | 5,329 | -45 | -0.8% |
| NV | 23,925 | 23,814 | -110 | -0.5% | 8,483 | 8,435 | -48 | -0.6% |
| NH | 10,259 | 10,240 | -19 | -0.2% | 3,499 | 3,486 | -13 | -0.4% |
| NJ | 69,276 | 69,339 | 63 | 0.1% | 23,813 | 23,853 | 40 | 0.2% |
| NM | 15,467 | 15,506 | 39 | 0.3% | 5,631 | 5,642 | 11 | 0.2% |
| NY | 144,492 | 144,279 | -213 | -0.1% | 52,765 | 52,696 | -70 | -0.1% |
| NC | 84,846 | 84,409 | -437 | -0.5% | 30,120 | 29,975 | -146 | -0.5% |
| ND | 5,625 | 5,629 | 4 | 0.1% | 1,974 | 1,984 | 10 | 0.5% |
| OH | 88,441 | 88,078 | -363 | -0.4% | 31,433 | 31,274 | -159 | -0.5% |
| OK | 29,518 | 29,253 | -265 | -0.9% | 10,543 | 10,436 | -107 | -1.0% |
| OR | 35,428 | 35,191 | -237 | -0.7% | 12,524 | 12,441 | -83 | -0.7% |
| PA | 100,229 | 99,999 | -229 | -0.2% | 35,371 | 35,281 | -90 | -0.3% |
| RI | 7,465 | 7,485 | 21 | 0.3% | 2,628 | 2,636 | 8 | 0.3% |
| SC | 35,416 | 33,915 | -1,501 | -4.2% | 12,736 | 12,085 | -651 | -5.1% |
| SD | 6,377 | 6,309 | -68 | -1.1% | 2,239 | 2,214 | -25 | -1.1% |
| TN | 47,664 | 46,381 | -1,283 | -2.7% | 16,899 | 16,322 | -577 | -3.4% |
| TX | 213,277 | 203,077 | -10,200 | -4.8% | 75,991 | 71,524 | -4,466 | -5.9% |
| UT | 27,000 | 26,808 | -192 | -0.7% | 9,454 | 9,379 | -74 | -0.8% |
| VT | 5,192 | 5,145 | -47 | -0.9% | 1,853 | 1,835 | -18 | -0.9% |
| VA | 63,283 | 63,191 | -92 | -0.1% | 22,138 | 22,066 | -73 | -0.3% |
| WA | 58,728 | 58,568 | -160 | -0.3% | 20,409 | 20,332 | -77 | -0.4% |
| WV | 12,737 | 12,425 | -312 | -2.5% | 4,574 | 4,445 | -128 | -2.8% |
| WI | 44,825 | 44,735 | -90 | -0.2% | 15,545 | 15,523 | -22 | -0.1% |
| WY | 4,729 | 4,610 | -119 | -2.5% | 1,650 | 1,593 | -57 | -3.4% |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM). 2025.

**Notes:** PTC = premium tax credit.

APPENDIX TABLE A.2

**All Uncompensated Care Demand and Hospital Uncompensated Care Demand for the Nonelderly under Enhanced PTCs and Standard Marketplace PTCs, by State, 2026**

*Millions of dollars*

| | All Uncompensated Care Demand for the Nonelderly | | | | Hospital Uncompensated Care Demand for the Nonelderly | | | |
|---|---|---|---|---|---|---|---|---|
| State | Enhanced PTCs | Standard PTCs | Difference | Percent difference | Enhanced PTCs | Standard PTCs | Difference | Percent difference |
| All States | 66,661 | 74,407 | 7,746 | 11.6% | 19,045 | 21,218 | 2,173 | 11.4% |
| AL | 998 | 1,180 | 183 | 18.3% | 299 | 355 | 56 | 18.8% |
| AK | 285 | 312 | 28 | 9.7% | 78 | 84 | 6 | 7.4% |
| AZ | 1,830 | 2,139 | 309 | 16.9% | 501 | 581 | 80 | 15.9% |
| AR | 706 | 883 | 177 | 25.1% | 199 | 241 | 42 | 21.0% |
| CA | 7,039 | 7,448 | 409 | 5.8% | 1,941 | 2,033 | 93 | 4.8% |
| CO | 1,360 | 1,608 | 249 | 18.3% | 337 | 392 | 55 | 16.3% |
| CT | 616 | 621 | 5 | 0.8% | 167 | 168 | 1 | 0.7% |
| DE | 144 | 154 | 10 | 7.1% | 40 | 43 | 3 | 6.9% |
| DC | 133 | 133 | 1 | 0.4% | 40 | 40 | 0 | 0.3% |
| FL | 5,541 | 6,547 | 1,006 | 18.1% | 1,558 | 1,860 | 302 | 19.4% |
| GA | 2,389 | 2,831 | 441 | 18.5% | 666 | 805 | 139 | 20.8% |
| HI | 275 | 275 | 0 | 0.1% | 77 | 77 | 0 | -0.1% |
| ID | 560 | 583 | 23 | 4.1% | 145 | 150 | 5 | 3.8% |
| IL | 2,905 | 3,034 | 129 | 4.4% | 892 | 927 | 35 | 4.0% |
| IN | 1,315 | 1,444 | 128 | 9.8% | 438 | 473 | 35 | 7.9% |
| IA | 365 | 415 | 50 | 13.7% | 105 | 119 | 14 | 13.5% |
| KS | 823 | 959 | 135 | 16.4% | 292 | 342 | 50 | 16.9% |
| KY | 937 | 948 | 11 | 1.1% | 261 | 264 | 3 | 1.0% |
| LA | 974 | 1,174 | 200 | 20.5% | 294 | 350 | 56 | 19.2% |
| ME | 200 | 213 | 13 | 6.7% | 58 | 63 | 4 | 7.5% |
| MD | 960 | 1,026 | 66 | 6.9% | 276 | 294 | 17 | 6.3% |
| MA | 926 | 937 | 10 | 1.1% | 285 | 288 | 3 | 1.0% |
| MI | 1,810 | 1,942 | 132 | 7.3% | 526 | 562 | 36 | 6.8% |
| MN | 1,577 | 1,582 | 5 | 0.3% | 418 | 420 | 2 | 0.4% |
| MS | 863 | 1,115 | 251 | 29.1% | 258 | 335 | 77 | 29.9% |
| MO | 1,702 | 1,843 | 140 | 8.3% | 467 | 503 | 36 | 7.6% |
| MT | 314 | 366 | 52 | 16.7% | 88 | 100 | 12 | 13.9% |
| NE | 358 | 379 | 21 | 6.0% | 93 | 99 | 6 | 6.1% |
| NV | 1,016 | 1,038 | 22 | 2.2% | 276 | 281 | 5 | 1.8% |

| State | All Uncompensated Care Demand for the Nonelderly | | | | Hospital Uncompensated Care Demand for the Nonelderly | | | |
|---|---|---|---|---|---|---|---|---|
| | Enhanced PTCs | Standard PTCs | Difference | Percent difference | Enhanced PTCs | Standard PTCs | Difference | Percent difference |
| NH | 212 | 241 | 29 | 13.7% | 56 | 64 | 8 | 14.5% |
| NJ | 1,541 | 1,653 | 112 | 7.3% | 438 | 471 | 33 | 7.5% |
| NM | 499 | 504 | 5 | 1.1% | 142 | 143 | 1 | 1.0% |
| NY | 1,866 | 1,890 | 24 | 1.3% | 564 | 573 | 9 | 1.5% |
| NC | 2,188 | 2,262 | 73 | 3.3% | 644 | 663 | 19 | 3.0% |
| ND | 225 | 228 | 3 | 1.3% | 65 | 65 | 1 | 1.1% |
| OH | 1,581 | 1,744 | 163 | 10.3% | 471 | 513 | 42 | 8.9% |
| OK | 1,287 | 1,446 | 159 | 12.4% | 388 | 430 | 43 | 11.0% |
| OR | 869 | 1,046 | 177 | 20.3% | 249 | 296 | 47 | 19.0% |
| PA | 1,747 | 1,835 | 88 | 5.0% | 516 | 540 | 24 | 4.7% |
| RI | 103 | 113 | 10 | 9.7% | 26 | 29 | 2 | 8.8% |
| SC | 988 | 1,253 | 265 | 26.9% | 286 | 371 | 86 | 30.0% |
| SD | 169 | 190 | 21 | 12.2% | 50 | 55 | 5 | 9.8% |
| TN | 1,295 | 1,673 | 378 | 29.2% | 383 | 489 | 106 | 27.8% |
| TX | 6,798 | 8,319 | 1,521 | 22.4% | 1,982 | 2,442 | 460 | 23.2% |
| UT | 772 | 816 | 43 | 5.6% | 208 | 215 | 8 | 3.8% |
| VT | 133 | 133 | 1 | 0.5% | 35 | 35 | 0 | 0.5% |
| VA | 1,727 | 1,939 | 213 | 12.3% | 450 | 494 | 43 | 9.7% |
| WA | 1,810 | 1,912 | 102 | 5.6% | 472 | 496 | 24 | 5.1% |
| WV | 415 | 458 | 44 | 10.6% | 112 | 123 | 11 | 10.1% |
| WI | 1,289 | 1,362 | 73 | 5.6% | 363 | 382 | 19 | 5.4% |
| WY | 228 | 262 | 34 | 15.1% | 69 | 77 | 8 | 11.6% |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM). 2025.

**Notes:** PTC = premium tax credit.

# Notes

[1] The enhanced PTCs were adopted in the American Rescue Plan Act of 2021 and were extended by the Inflation Reduction Act of 2022.

[2] Marketplace Open Enrollment Period Public Use Files for 2021–25, see "Marketplace Products," CMS.gov, accessed September 12, 2025, https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products.

[3] John Thune, William Cassidy, Lindsey Graham, and Mike Crapo, "Re: The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance," September 18, 2025.

[4] "2025 Marketplace Integrity and Affordability Final Rule," CMS.gov, June 20, 2025, https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-final-rule.

[5] See *City of Columbus v. Robert F. Kennedy, Jr.* The parts of the rule stayed by the Maryland District Court include the following provisions:

- permit coverage denials for past-due premiums
- require additional documentation to verify income
- require additional documents to verify eligibility for special enrollment periods through the federal Marketplace
- deny advance PTC payments more quickly for failure to satisfy tax filing requirements
- require a minimum $5 premium from consumers who are automatically re-enrolled in the federal Marketplace
- expand the de minimis ranges for Marketplace plans' actuarial values

For all but the last of these provisions, the Department of Justice has not asked for emergency relief, so they will not take effect for the coming open enrollment period. For the provision expanding the de minimis ranges for Marketplace plan actuarial values, the Department of Justice has asked for an immediate reversal, though that provision remains stayed as of this writing.

[6] Other health care services include services delivered by providers other than hospitals and office-based physicians, and additional services such as dental care, home health care, and other medical equipment.

[7] In this analysis, health care delivered to the uninsured that the uninsured people themselves do not pay for is referred to as uncompensated care.

[8] 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.

[9] "Marketplace 2024 Open Enrollment Period Report: National Snapshot," CMS.gov, January 10, 2024, https://www.cms.gov/newsroom/fact-sheets/marketplace-2024-open-enrollment-period-report-national-snapshot-0.

[10] "Following Devastating Federal Funding Cuts, New York State Takes New Action to Preserve Health Care for as Many New Yorkers as Possible," New York State Department of Health, September 10, 2025, https://www.health.ny.gov/press/releases/2025/2025-09-10_federal_funding_cuts.htm.

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