

# Methodology for Estimating Effects of Enhanced Premium Tax Credit Expiration on Health Insurance Enrollment and Premiums in Congressional Districts

This document describes the methodology used to estimate the effects of enhanced premium tax credit expiration on health insurance enrollment and premiums in congressional districts. The analysis projects the enrollment and premium changes resulting from the expiration of the American Rescue Plan Act (ARP) and Inflation Reduction Act (IRA) enhanced premium tax credits (EPTCs) at the end of 2025, which reinstated the higher premium contribution limits established by the Affordable Care Act (ACA).<sup>1</sup> These estimates are based on finalized 2026 premiums as of November 2, 2025.

The methodology draws on information and data from the Department of Health and Human Services (HHS), the Census Bureau's American Community Survey (ACS), the Internal Revenue Service, KFF, ACASignups.net, and the Missouri Census Data Center, as well as data published by state agencies in California, Minnesota, New York, and Oregon.

## 2025 Marketplace Enrollment

This analysis estimates the number of marketplace enrollees for each congressional district. It uses two methods for estimating enrollment: one for districts in states using the federal marketplace (HealthCare.gov) and another for the states operating their own marketplaces. An adjustment is made for the three states with a Basic Health Program (BHP).

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<sup>1</sup> The premium tax credits (PTCs) established by the ACA reduce the cost of marketplace coverage for individuals and households with incomes between 100% and 400% of the federal poverty level (FPL) and who have no other source of comprehensive and affordable health insurance. The ARP expanded PTC eligibility to individuals and households with incomes at or above 400% FPL and lowered the required premium contributions for those with incomes below 400% FPL. Individuals and households with incomes between 100% and 250% FPL are also eligible for additional subsidies that limit their out-of-pocket medical expenses, and these additional subsidies are not affected by the expiration of the enhanced premium tax credits (EPTCs). See Congressional Research Service, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* (February 19, 2025) (<https://www.congress.gov/crs-product/R44425>).

**Federal Marketplace States:** Thirty-one states use the federal marketplace.<sup>2</sup> For these states, HHS publishes ZIP code-level data that includes the number of individuals who selected marketplace coverage during the 2025 open enrollment period.<sup>3</sup>

To estimate enrollment in each congressional district, this analysis maps ZIP code-level information to congressional districts using the Missouri Census Data Center’s ZIP code-to-district crosswalk.<sup>4</sup> When a ZIP code spans multiple congressional districts, its enrollment is proportionally allocated to each district based on the share of the ZIP code’s population living in each district. The sum of these allocations is the estimated number of marketplace enrollees for a district.

HHS suppresses enrollment data for ZIP codes with small numbers of marketplace enrollees, leaving a fraction of statewide enrollment unassigned. To account for this, the remaining state-level enrollment is allocated to districts based on each district’s share of the state’s total enrollment in direct-purchase (non-group) health insurance, as estimated from the American Community Survey (ACS).<sup>5</sup>

**States with State-Based Marketplaces, except California and New York:** For the District of Columbia and other states that operate their own marketplaces, total marketplace enrollment is available only at the state level. For these states, district-level enrollment estimates are constructed in three steps.

First, this analysis proportionally distributes state-level marketplace enrollment for enrollees who received an EPTC to districts based on each district’s share of tax units who claimed a premium tax credit in 2022.<sup>6</sup>

Second, the analysis estimates how many marketplace enrollees in each district do not qualify for an EPTC. Using the ACS, this analysis calculates the ratio of total direct-purchase coverage (which includes both subsidized and unsubsidized enrollees) to subsidized coverage.<sup>7</sup> This ratio

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<sup>2</sup> Twenty-eight states fully rely on the federal marketplace to perform all of the functions of their state’s insurance marketplace. Three more states – Arkansas, Illinois, and Oregon – use a hybrid “State-based Marketplace-Federal Platform” exchange. Under this arrangement, each of these states administers most of the functions of its insurance marketplace but uses the federal marketplace to make eligibility determinations and enroll eligible individuals. See KFF, *State Health Insurance Marketplace Types, 2025* (<https://www.kff.org/affordable-care-act/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>).

<sup>3</sup> U.S. Department of Health and Human Services, *2025 Marketplace Open Enrollment Period Public Use Files* (<https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>) (ZIP code-level public use file files).

<sup>4</sup> Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (October 2022). (<https://mcdc.missouri.edu/applications/geocorr2022.html>).

<sup>5</sup> U.S. Census Bureau, *American Community Survey, 2021-2023 American Community Survey Estimates*.

<sup>6</sup> Internal Revenue Service, *SOI Tax Stats – Data by ZIP Code 2022* (January 17, 2025) (<https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-statistics-2022-zip-code-data-soi>).

<sup>7</sup> The number of subsidized enrollees in this calculation is based on the number of ACS respondents who report enrolling in direct-purchase insurance and claiming a premium tax credit. U.S. Census Bureau, *American Community Survey, 2021-2023 American Community Survey Estimates*.

estimates how much larger total marketplace enrollment is likely to be compared with subsidized enrollment.<sup>8</sup>

Third, this analysis multiplies each district's number of subsidized enrollment (from step one) by the ratio of total-to-subsidized coverage (from step two). This produces a preliminary estimate of total enrollment for each district. These preliminary district totals are proportionally adjusted so they sum to the state-level enrollment reported by HHS. These adjusted totals are the final district-level enrollment estimates.

**California and New York:** For districts in California and New York, the number of marketplace enrollees eligible for an enhanced premium tax credit is taken from district-level estimates published by California and New York's health insurance marketplaces.<sup>9</sup>

**Adjustment for Basic Health Program (BHP) States:** For districts in New York, district-level enrollment is taken from fact sheets published by New York's health insurance marketplace.<sup>10</sup> For districts in Minnesota and Oregon, the number of BHP enrollees is estimated using enrollment information published by each state.<sup>11</sup> For districts in Minnesota, county enrollment data for 2025 is mapped to congressional districts using the Missouri Census Data Center's county-to-congressional district crosswalk.<sup>12</sup> When a county spans multiple congressional districts, the county's enrollment totals are proportionally allocated to each district based on the share of the county's population in each district. Oregon reports a single enrollment figure for each district that combines BHP enrollees with enrollees in a state-funded Medicaid program. To estimate BHP enrollment alone, the statewide BHP total from HHS's 2025 open enrollment data is allocated to districts in proportion to Oregon's reported district-level enrollment.<sup>13</sup>

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<sup>8</sup> U.S. Census Bureau, *American Community Survey, 2021-2023 American Community Survey Estimates*.

<sup>9</sup> Covered California, *Estimated 2026 Premium Increases by Congressional District for Covered California Members if Enhanced Premium Tax Credits Expire: All Subsidized Members* (as of July 2025) ([https://hbex.coveredca.com/data-research/library/California Congressional District Data Enhanced Premium Tax Credit Expiration.pdf](https://hbex.coveredca.com/data-research/library/California%20Congressional%20District%20Data%20Enhanced%20Premium%20Tax%20Credit%20Expiration.pdf)); NY State of Health, *Congressional District Fact Sheets* (as of January 2025)

([https://info.nystateofhealth.ny.gov/sites/default/files/Congressional District Fact Sheet 2025.pdf](https://info.nystateofhealth.ny.gov/sites/default/files/Congressional%20District%20Fact%20Sheet%202025.pdf)),

<sup>10</sup> NY State of Health, *Congressional District Fact Sheets* (as of January 2025)

([https://info.nystateofhealth.ny.gov/sites/default/files/Congressional District Fact Sheet 2025.pdf](https://info.nystateofhealth.ny.gov/sites/default/files/Congressional%20District%20Fact%20Sheet%202025.pdf)), New York is in the process of modifying its BHP program for 2026, which will include lowering the program's income eligibility.

See, New York Department of Health, *Following Devastating Federal Funding Cuts, New York State Takes New Action to Preserve Health Care for as Many New Yorkers as Possible* (September 10, 2025)

([https://www.health.ny.gov/press/releases/2025/2025-09-10\\_federal\\_funding\\_cuts.htm](https://www.health.ny.gov/press/releases/2025/2025-09-10_federal_funding_cuts.htm)).

<sup>11</sup> The BHP was established by the ACA, and it provides states with the option of creating a separate health benefits program for individuals with incomes up to 200% FPL that is distinct from the coverage options available through a state's marketplace or Medicaid program (New York has expanded eligibility up to 250% FPL in 2024). See Department of Health and Human Services, *Basic Health Program* (<https://www.medicaid.gov/basic-health-program/index.html>).

<sup>12</sup> Minnesota Department of Human Services, *Managed Care Enrollment Figures, August 2025*

([https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16\\_141529](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_141529)); Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (October 2022) (<https://mcdc.missouri.edu/applications/geocorr2022.html>).

<sup>13</sup> Oregon Health Authority, *Oregon Health Plan (OHP) Enrollment Quick Facts* (March 2025)

(<https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/OHP-Enrollment-Congressional-Districts.pdf>)

Total marketplace enrollment estimates for each district are rounded to the nearest 1,000 people. In New York and California, the number of enrollees eligible for enhanced premium tax credits is unrounded. BHP enrollment in Minnesota and Oregon is rounded to the nearest 1,000 enrollees, and to the nearest 100 enrollees in New York.

## 2025 Gross Marketplace Premiums

**Federal marketplace states:** HHS reports the average 2025 marketplace premiums at the county level for these states.<sup>14</sup> These county premiums are mapped to congressional districts using the Missouri Census Data Center’s county-to-congressional district crosswalk.<sup>15</sup> When a county spans multiple districts, premiums are proportionally allocated to each district based on the share of the county’s population in each district.

**State-based marketplaces, excluding New York and California:** The 2025 statewide average premium is applied uniformly to all congressional districts.

## 2026 Gross Marketplace Premiums

To project 2026 gross premiums, the statewide premium change for all states except California and New York from ACASignups.net is applied uniformly to each district’s 2025 marketplace premiums.<sup>16</sup> This produces the 2026 unsubsidized benchmark premium for each district outside of California and New York.<sup>17</sup>

## Effect of Enhanced Premium Tax Credit Expiration on Average Net Marketplace Premiums

For districts in New York and California, 2026 net premium increases are taken from district-level information published by each state’s health insurance marketplace.<sup>18</sup>

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(enrollment totals include the Bridge Basic Health Plan and the state-funded Healthier Oregon Program).

<sup>14</sup> U.S. Department of Health and Human Services, *2025 Marketplace Open Enrollment Period Public Use Files* (<https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>) (county-level public use file files).

<sup>15</sup> Missouri Census Data Center, *Geocorr 2022: Geographic Correspondence Engine* (October 2022). (<https://mcdc.missouri.edu/applications/geocorr2022.html>).

<sup>16</sup> Charles Gaba, ACASignups.net, *2026 Rate Changes* (updated on November 2, 2025, accessed on November 3, 2025) (<https://acasignups.net/2026-rate-changes>). The statewide average gross premium changes are weighted by 2025 enrollment.

<sup>17</sup> These premium estimates do not include additional premium subsidies provided by state governments in 10 states. Healthinsurance.org, *Which States Offer Their Own Health Insurance Subsidies* (August 26, 2025) (<https://www.healthinsurance.org/faqs/which-states-offer-their-own-health-insurance-subsidies/>).

<sup>18</sup> Covered California, *Estimated 2026 Premium Increases by Congressional District for Covered California Members if Enhanced Premium Tax Credits Expire: All Subsidized Members* (as of July 2025) ([https://hbex.coveredca.com/data-research/library/California Congressional District Data Enhanced Premium Tax Credit Expiration.pdf](https://hbex.coveredca.com/data-research/library/California%20Congressional%20District%20Data%20Enhanced%20Premium%20Tax%20Credit%20Expiration.pdf)); NY State of Health, *Congressional District Fact Sheets* (as of January 2025) ([https://info.nystateofhealth.ny.gov/sites/default/files/Congressional District Fact Sheet 2025.pdf](https://info.nystateofhealth.ny.gov/sites/default/files/Congressional%20District%20Fact%20Sheet%202025.pdf)),

For each district outside of California and New York, 2026 net premiums are calculated under two scenarios.

**Baseline: Enhanced Premium Tax Credits (EPTCs) in Effect in 2025:** Net premiums are first calculated by income group using the ARP/IRA contribution schedule, including the 8.5% income cap for households above 400% FPL.<sup>19</sup> This household-level contribution is converted to a per-person amount by dividing it by an ACS-based estimate of the average number of people per household, which varies by state and income group. The income-group results are then weighted by the district’s 2025 enrollment mix across income ranges to produce the district’s average net marketplace premium with the EPTCs. For states using the federal marketplace, the income distribution is based on HHS’s county-level 2025 open enrollment data, which is allocated to congressional districts as described above. For states using their own marketplaces, the income distribution is estimated from ACS data showing the incomes of district residents who report purchasing individual health insurance.

**Current Law: Enhanced Subsidies Expired:** The method above is then repeated without EPTCs, using the original ACA contribution schedule under which households under 400% FPL face higher premium contribution limits and those above 400% FPL receive no premium tax credit.<sup>20</sup>

The percent change in net premiums is the difference between the net premiums with and without the EPTCs divided by the 2026 net premium with the EPTCs, using unrounded values. For presentation, dollar amounts are rounded to the nearest \$10. District averages refer to the “benchmark silver” plan.<sup>21</sup>

## Household Examples

The premium estimates for three representative households in each district are based on 2026 benchmark premiums from KFF’s premium subsidy calculator for a selected ZIP code.<sup>22</sup> These household examples are illustrative only and do not affect the district averages above.<sup>23</sup> The

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<sup>19</sup> Internal Revenue Code § 36B(b)(3)(A)(iii) ([https://uscode.house.gov/view.xhtml?req=\(title:26%20section:36B%20edition:prelim\)](https://uscode.house.gov/view.xhtml?req=(title:26%20section:36B%20edition:prelim))) (ARP/IRA expected-contribution parameters; 8.5% income cap above 400% FPL).

<sup>20</sup> IRS, *Revenue Procedure 2025-25* (<https://www.irs.gov/pub/irs-drop/rp-25-25.pdf>) (ACA 2026 expected-contribution percentages; no APTC above 400% FPL).

<sup>21</sup> Marketplace plans are grouped into four “metal levels,” based on how much of total health care costs the insurer pays on average. Silver plans cover about 70% of costs. The “benchmark” is the second-lowest-cost silver plan in each area, and it is used to set the amount of premium tax credits. Enrollees can then apply those credits to any marketplace plan. See Congressional Research Service, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions* (February 19, 2025) (<https://www.congress.gov/crs-product/R44425>).

<sup>22</sup> KFF, *Calculator: ACA Enhanced Premium Tax Credit* (accessed on November 3, 2025) (<https://www.kff.org/interactive/how-much-more-would-people-pay-in-premiums-if-the-acas-enhanced-subsidies-expired/>).

<sup>23</sup> KFF, *Calculator: ACA Enhanced Premium Tax Credit* (accessed on November 3, 2025) (<https://www.kff.org/interactive/how-much-more-would-people-pay-in-premiums-if-the-acas-enhanced-subsidies-expired/>).

single-parent household is not applicable for districts in Minnesota, New York, and Oregon because the household is eligible for BHP coverage.

Two additional households with incomes at 250% FPL are shown for New York districts. In 2025, these households were eligible for the Essential Plan, the state's BHP program, which did not charge a premium.<sup>24</sup> New York announced in September 2025 that it had begun the process of lowering the Essential Plan's income threshold from 250% FPL to 200% FPL, pending federal approval. If this transition is approved and implemented as scheduled, households with incomes at 250% FPL will no longer have access to Essential Plan coverage. These examples show the difference between their 2025 Essential Plan premium (\$0) and their 2026 marketplace premiums without the EPTCs. Marketplace premiums in New York do not vary by age.

All examples assume no tobacco use, household ages, incomes, and FPL percentages as shown in the district-level spreadsheet. For presentation in the summary document, households' incomes were rounded to the nearest \$1,000 and premium amounts were rounded to the nearest \$10.

## Increase in the Uninsured and Loss of Essential Plan Coverage

The projected increase in uninsured marketplace enrollees is based on KFF's state-level estimates, which draw on the Congressional Budget Office's projected 2034 marketplace enrollment changes due to the 2025 budget reconciliation law, Trump Administration regulations, and EPTC expiration.<sup>25</sup> For district-level impacts, each state's projected increase in uninsured marketplace enrollees is allocated to districts in proportion to their share of 2025 marketplace enrollment. For each district, the percentage is the allocated increase in the uninsured divided by 2025 marketplace enrollment, rounded to the nearest percentage point.

For New York districts, the number of individuals losing eligibility for Essential Plan coverage was estimated using county-level Essential Plan enrollment information by enrollees' incomes.<sup>26</sup> Enrollees with incomes between 200% and 250% FPL were assumed to lose Essential

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<sup>24</sup> NY State of Health, *Essential Plan Information* (<https://info.nystateofhealth.ny.gov/EssentialPlan>). From 2014 through 2024, Essential Plan coverage was operated as a BHP. In 2024, New York began administering Essential Plan coverage through a 1332 waiver program and expanded the program's income eligibility from 200% FPL to 250% FPL. In September 2025, New York announced that it would begin the process of ending its 1332 waiver program and return to operating Essential Plan coverage through a BHP, which the state expects to complete by July 1, 2026, pending federal approval. See, NY State of Health, *NY State of Health 1332 Waiver Information Page*, (October 20, 2025) (<https://info.nystateofhealth.ny.gov/1332>).

<sup>25</sup> KFF, *How Will the 2025 Reconciliation Law Affect the Uninsured in Each State?* (August 20, 2025) (<https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/>). On August 22, 2025, a federal district court issued a national stay of several provisions of the Centers for Medicare and Medicaid Services' Marketplace Integrity and Affordability Rule. The litigation is ongoing. See, O'Neill Institute, *City of Columbus et al. v. Kennedy et al.* (updated February 9, 2026) (<https://litigationtracker.law.georgetown.edu/litigation/city-of-columbus-et-al-v-kennedy-et-al-2/>). The coverage estimates presented here partially account for the Rule, as KFF's analysis is based on CBO projections that incorporated half of the Rule's expected effect on enrollment.

Plan coverage and were proportionally allocated to congressional districts using the Missouri Census Data Center's county-to-congressional district crosswalk.<sup>27</sup>