CITIZENS RESEARCH COUNCIL OF MICHIGAN

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Upcoming Changes to the Affordable Care Act Tax Credits Will Also Disrupt Michigan's Health Care System

In a Nutshell

- Recent federal action and inaction are likely to lead to higher out-of-pocket premiums for people who obtain health insurance through the private Affordable Care Act marketplaces.
- Higher premiums on policies available in the marketplaces are likely to result in people opting out of obtaining coverage, which will not only impact those individuals, but will also likely have negative consequences for those who have private health insurance, the health care system, and the state.
- Michigan has limited options to respond to the federal changes, especially given the tight budget environment, but should be evaluating what can be done to limit the potential impact.

In July, major federal legislation known as the "One Big Beautiful Bill Act" (OBBBA) was enacted to extend significant portions of the 2017 Tax Cuts and Jobs Act. Congress paired these tax cuts with reductions in other federal spending to allow the bill to be passed without the possibility of a filibuster. A major source of these reductions came in the form of changes to Medicaid, which the Research Council covered in detail.

As we outlined, the cuts to Medicaid spending will have a large impact on Michigan for individuals who currently receive health care coverage through Medicaid, the health care system at large, and the state budget. However, Medicaid is not the only aspect of health insurance impacted by recent federal action (and inaction). Changes to the Affordable Care Act's (ACA) private marketplaces are also likely to lead to fewer people with health insurance and higher premiums for those covered by insurance.

As Michigan prepares to respond to the changes to Medicaid, it must also consider how changes to the ACA marketplaces will impact the state.

Affordable Care Act Marketplaces

The ACA, which was enacted in 2010, originally required individuals to obtain health insurance, either through an employer, public assistance program, or the private market. If people did not obtain coverage, they would face fines (The fine was later repealed).

One way in which the ACA helped facilitate compliance with this requirement was the creation of

"health insurance exchanges," also known as marketplaces, in which individuals and small businesses can shop for and purchase private health insurance or be connected to a public health insurance program if they are eligible. The law permitted states to establish their own exchanges – essentially online portals – or to make use of the federal exchange. Michigan, like 28 other states, uses the federal exchange.

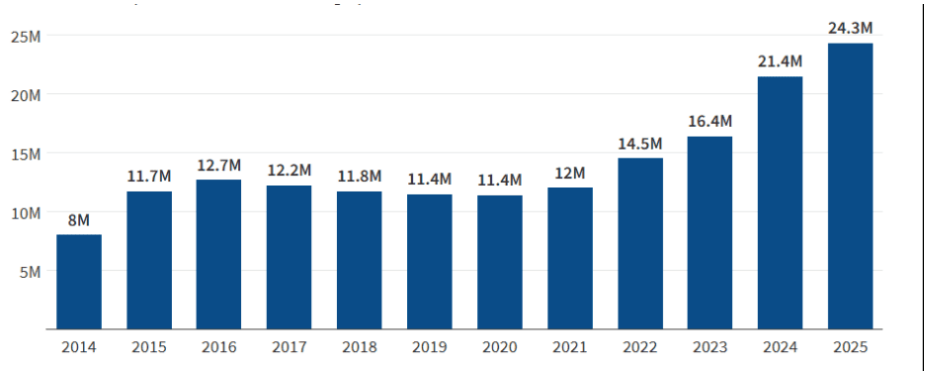
The purpose of the marketplaces is to facilitate enrollment, giving individuals the tools to compare coverage options, determine eligibility, learn what assistance they qualify for, and, ultimately, purchase coverage. Plans sold on the marketplaces are required to be a qualified health plan, meaning they must meet certain coverage requirements. A standard open enrollment period exists each year, with enrollment possible at other times based on life events. Plans sold on the marketplaces have the normal features of health insurance, such as premiums, deductibles, co-pays, and out-of-pocket maximums.

Roughly 25 million people nationwide purchased health insurance on an exchange last year, including 530,000 Michigan residents. Generally, people who shop on the marketplaces for health insurance have incomes too high to qualify for Medicaid but do not have a job that provides health insurance. Some of the primary users are self-employed or gig workers.

Giving people one place to go to find all of their health insurance options was the key motivation for the marketplace, but the marketplaces also serve to simplify the implementation of federal subsidies for purchasing coverage. One tool the federal government has used to increase enrollment for those above the Medicaid income threshold who do not have coverage through an employer is to subsidize the cost of private coverage through tax incentives that are claimed directly through marketplace enrollment.

The credits essentially create a cap on the cost of a health insurance plan for individuals and families based on their income, with the federal government covering the rest of the cost. Premium tax credits have existed since the original enactment of the ACA, but they were significantly expanded under the American Rescue Plan in 2021, both in terms of the size of the credit and who is eligible. As a result of the tax credit enhancement, premiums for plans sold on the marketplace have been much cheaper for many enrollees compared to 2020 and earlier. Since the enhanced tax credits went into effect, nationwide coverage through the marketplaces has roughly doubled (see chart), demonstrating how influential the marginal cost decrease has been at incentivizing people to enroll.

Total ACA Marketplace Plan Enrollments During Open Enrollment, 2014-2025



Source: KFF. April 2, 2025. https://www.kff.org/affordable-care-act/enrollment-growth-in-the-aca-marketplaces/

Upcoming Changes to the Marketplaces

While the OBBBA made a number of changes that impact the ACA, two categories will have the most impact. First, changes were made to the enrollment and eligibility verification process for ACA marketplace plan enrollment. Previously, enrollees were deemed conditionally eligible for subsidies and tax credits in cases where the information on their application did not match something in a federal database, offering them 90 days to submit documentation that resolves the discrepancy. The new law now withholds those subsidies and tax credits until that information is verified, potentially jeopardizing tax credits even for people who will still be eligible if the enhanced credits expire. Also, under the prior version of the law, returning enrollees essentially had their coverage auto-renewed each year. The new law ends that practice, requiring people to fully re-enroll each year.

The second category of change is that Congress did not extend the enhanced ACA tax credits as part of the OBBBA, leaving them set to expire at the end of 2025.

Allowing the enhanced tax credits to expire would lead to premiums increasing for a large number of potential enrollees, likely leading many to decline to renew their coverage. In 2025, the enhanced tax credits reduced premiums for individuals nationwide by $705 per year on average, although the amount was much larger for some enrollees. Over 350,000 residents in Michigan are covered by a tax credit supported plan purchased on the marketplace, accounting for over $300 million in annual federal support. Estimates suggest premium would increase in Michigan by about 70 percent on the marketplace, or over $800 per year, if the credits expire.

The Impact of Expiring ACA Tax Credits in Michigan

Broadly, the changes to the ACA in the OBBBA and the absence of the tax credit extension are expected to lead to about eight million fewer people with health insurance over the next decade nationwide, including roughly 200,000 people in Michigan. About half of these coverage losses are related directly to the enhanced tax credit expiration and about half are related to the other provisions (such as eligibility verification changes, enrollment procedures, and coverage changes for immigrants). This is on top of the coverage losses related to Medicaid.

The impact of people not buying private insurance through the marketplace will likely have cascading effects across the state, much in the same way that the Medicaid cuts are expected to.

The people who can no longer afford their existing coverage because they cannot afford a plan without the tax credit or because of changes to the enrollment process will face all of the personal impacts of not having coverage, or in some cases, lesser coverage. These impacts may include worse health outcomes and financial hardship.

The impact will likely not be limited to the people who no longer have coverage for a variety of reasons. First, given the way that insurance pools spread risk across the population of people who have it, the fact that people may decline to purchase coverage due to the loss of the tax credit would drive up the price of plan premiums even further. This would happen because, on average, people who are healthier will be more likely to not purchase coverage, making the average cost per enrollee to the insurance company higher. Insurance companies have already begun to release rates for next year based on the assumption that these healthier people will be the ones to decline coverage, including those in Michigan. If this occurs, it would impact private plans on the marketplaces, but it is likely to also impact employer-sponsored coverage as well, given that most insurers operate in both arenas.

Second, people who decline to purchase coverage as a result of these changes will continue showing up in emergency rooms to receive care and hospitals will remain obligated, by law, to serve them. This will drive up the amount of uncompensated care, either leading to hospital closures or an increase in prices elsewhere to offset the losses, which would also likely lead insurers to raise premiums.

While Michigan's ACA marketplace enrollment population is much smaller than the general Medicaid population, a similar issue is likely to unfold where providers who are accustomed to treating people with marketplace plans will see less business and potentially reduce operations or close. As is the case with the Medicaid population, the data suggests that rural areas will likely be hit hardest.

Unlike Medicaid, the state will not see the same direct budgetary impact from the ACA changes because the federal money does not flow through the state for the marketplace tax credits. But the state will likely have to grapple with the downstream impacts of fewer people having health insurance, higher insurance premiums, and more uncompensated care for hospitals.

Michigan's Options to Respond to Marketplace Changes

Time still exists for the federal government to extend the expiring ACA tax credits, so it is possible a significant portion of the impacts discussed here could be mooted over the next few months. At the moment, while some in Congress are pushing for an extension, no significant movement has been publicized that another extension is forthcoming, so the state should prepare for the impact as it looks ahead. Similar to the Medicaid changes, no good options exist for the state, as any solutions are likely to require an increase in spending in an already tight budget environment.

The state could have more room to maneuver on the ACA front, however, than it does on the direct Medicaid cuts. Given that the difference between enrolling or not enrolling through the marketplace for many will likely come down to out-of-pocket costs, the state could create tax credits of its own to incentivize people to enroll even after the federal incentives expire. The state probably cannot find the full $300 million in lost federal support without cuts to other programs or raising additional revenue, but it is likely that some people would continue to purchase coverage even with a smaller subsidy amount than what exists under current federal law. Since the subsidy would only be available to those who purchase coverage, the state could make it small enough to fit whatever money it wants to allocate for this purpose. Additionally, if it turns out that the incentive is too small to move the needle on enrollment, the money would not be lost beyond the administrative cost of the program, keeping the risk relatively low.

Failing that, and similar to the Medicaid population, the state should look for options to subsidize low-cost preventive care, medications, and/or immunizations in the hopes of avoiding an increase in emergency room visits and uncompensated care for hospitals. This is especially relevant given recent changes to federal vaccination policies.

Again, similar to the Medicaid impact, it is easy to imagine the ACA changes further imperiling local hospitals and other sorts of providers, particularly in rural areas. Finding a way to finance grants or loans to affected providers may be necessary, as the state has an interest in ensuring the survival of a robust network of healthcare providers across the state. This effort does not require a Medicaid or ACA specific solution, but layering the ACA changes on top of the Medicaid cuts will make the need more pressing.

From an overall budget perspective, all of the changes in health care policy are going to feed into one another. Fewer people with coverage will drive prices up for those who do have coverage and it

will strain providers. Individuals who do not have coverage as a result may need more services, but individuals who retain coverage will have less disposable income. The exact way this unfolds remains uncertain, but the human and economic impact will be significant.

Conclusion

Upcoming changes to the private ACA marketplaces are likely to lead to fewer people with health insurance and higher premiums for those who do, on top of the changes that are already coming with respect to Medicaid.

People whose incomes are too high for Medicaid but who do not have employer-sponsored health care are going to see a direct increase in their premiums, and those increases are likely to spur further increases across the health insurance landscape. The impact of higher premiums and fewer people with coverage will likely strain the health care provider network, particularly rural hospitals which already operate on thin margins.

Michigan's options all involve spending more general fund dollars to offset the loss of federal support. None of these options are appealing in a tight budget environment, but policymakers should be considering the options and potential consequences now before the effects start to unfold. They should consider what the costs may be if they standby and accept the effects of these federal policy changes.

ABOUT THE AUTHOR

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Karley Abramson joined the Research Council in 2022 as a Research Associate focusing on health policy. Previously, Karley was a nonpartisan Research Analyst at the Michigan Legislative Service Bureau where she specialized in the policy areas of public health, human services, education, civil rights, and family law. Karley has worked as a research fellow for various state and national organizations, including the National Institutes of Health and the ACLU of Michigan. She is a three-time Wolverine with a bachelor's degree in sociology, a master's of public health, and a juris doctor from the University of Michigan.

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