United States Congress
Joint Economic Committee
Est. 1946

ISSUE BRIEF

Long Overdue: Enhanced Premium Tax Credits Should Expire

November 6, 2025

Executive summary

- **Enhanced premium tax credits (PTCs) have outlived their temporary purpose and are fiscally unsustainable.** Congress enacted a temporary enhancement of PTCs for Affordable Care Act Marketplace plans during the COVID-19 emergency. Since this short-term measure was implemented, total PTC spending has doubled. The growth far exceeds official budget projections made when they were enhanced.

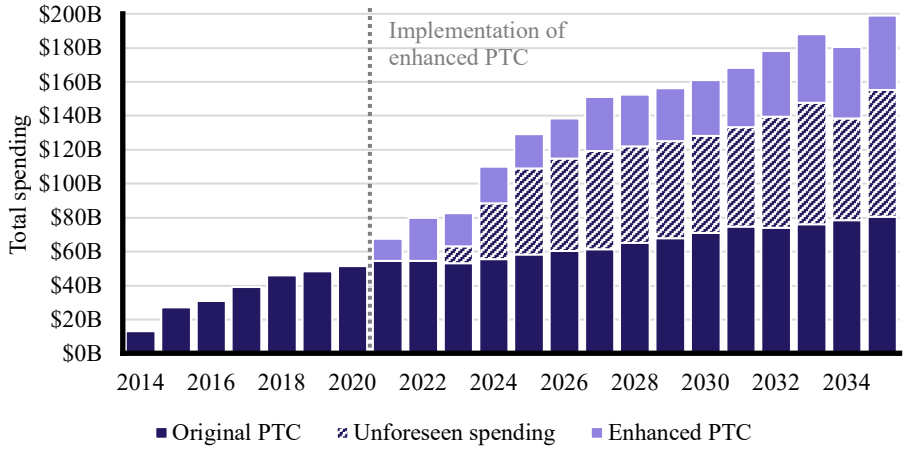
- **Reduced price competition benefits insurers and leads to economic deadweight loss.** The inherent inefficiency of the PTCs drives their increased costs: only one dollar benefits consumers for every two that either benefit insurers and intermediaries or are wasted. As the share of consumers paying little to nothing in premiums has increased to 42 percent, pressure to compete on price has weakened, and insurers have capitalized by hiding hikes in gross premiums. The enhanced subsidies result in a larger share of each subsidy dollar benefiting insurers or being wasted, instead of reducing premiums for consumers.

- **Zero-claim enrollees subsidize insurers.** Since the implementation of enhanced PTCs, the number of enrollees who file no claims has nearly quadrupled, and these individuals now constitute 35 percent of all enrollees. These cases impose fiscal costs and accrue gains to insurers without delivering health benefits, demonstrating that PTCs subsidize idle coverage rather than medical care.

- **Permanent extension entrenches market distortions and shirks fiscal responsibility.** The enhanced PTCs distort market incentives, erode competition, and direct taxpayer dollars to insurers and intermediaries. Even if left to expire, more federal dollars than ever will be subsidizing ACA Marketplace plans.

Intended to address the COVID-19 health emergency, the *American Rescue Plan Act* of 2021 (ARPA) and the *Inflation Reduction Act* of 2022 (IRA) temporarily provided enhanced advance premium tax credits (PTCs) for health insurance purchased through the Affordable Care Act Exchanges.[1] As shown in Figure 1, total federal PTC spending has risen substantially during the period in which the enhanced subsidies have been in effect; even if the enhanced PTCs expire at the end of this year, projections indicate that spending in 2026 will remain more than twice the level expected prior to their implementation.

Figure 1: Impact of Temporary ACA Marketplace Subsidy Enhancements on Government Spending



Source: Congressional Budget Office;[2] U.S. Department of the Treasury;[3] JEC calculations[4]

[1] Section 9661 of the ARPA established a "temporary rule for 2021 and 2022" that removed the income eligibility cap, previously set at 400 percent of the federal poverty level—$128,600 per year for a family of four in 2025. Section 12001 of the IRA extended this temporary rule to the end of 2025.

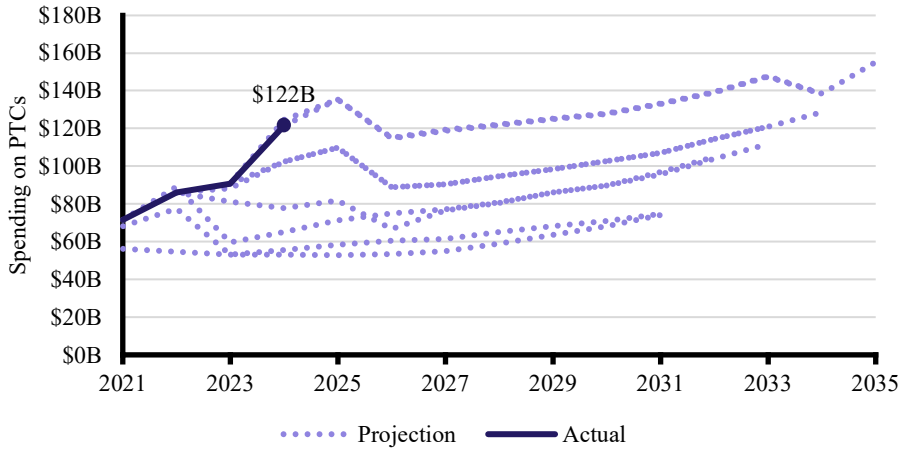
[2] Congressional Budget Office, "The Budget and Economic Outlook: 2021 to 2031" (February 2021), https://www.cbo.gov/publication/56970; Congressional Budget Office, "An Update to the Budget and Economic Outlook: 2021 to 2031" (July 2021), https://www.cbo.gov/publication/57218; Congressional Budget Office, "The Budget and Economic Outlook: 2025 to 2035" (January 2025), https://www.cbo.gov/publication/60870; Congressional Budget Office, "Estimated Budgetary Effects of H.R. 1319, American Rescue Plan Act of 2021" (As Passed by the Senate on March 6, 2021), https://www.cbo.gov/publication/57056; Congressional Budget Office, "Estimated Budgetary Effects of H.R. 5376, the Inflation Reduction Act of 2022" (August 2022), https://www.cbo.gov/publication/58366; Congressional Budget Office, "The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance," https://www.cbo.gov/publication/61734.

[3] U.S. Department of the Treasury, *Monthly Treasury Statement*, https://fiscaldata.treasury.gov/datasets/monthly-treasury-statement/summary-of-receipts-outlays-and-the-deficit-surplus-of-the-u-s-government.

[4] Original PTC values between 2021 and 2022 are derived from CBO's February 2021 10-year projections, which were used to score the ARPA. Original PTC values after 2022 are derived from CBO's July 2021 10-year projections, which were used to score the IRA. Original PTC values after 2031 are estimated using a linear forecast of data from 2021. "Unforeseen spending" values between 2023 and 2025 are derived from the difference between a year's total cost of enhanced PTCs in excess of the referenced July 2021 baseline using data from Monthly Treasury Statements and CBO projections. Unforeseen spending values after 2025 are derived from the difference between CBO's January 2025 10-year projections by budget account and the original PTC values. CBO overpredicted PTC costs between 2021 and 2022. Treasury data indicates they were $2.8B lower (2021) and $0.6B lower (2022). The overestimation is assumed to be equally distributed between the enhanced PTC and the original PTC amounts. Enhanced PTC values between 2021 to 2022 were derived from CBO's estimated budgetary effects of the ARPA, as passed by the Senate, in its detailed tables. Enhanced PTC values after 2022 were derived from CBO's estimated budgetary effects of the IRA. Enhanced PTC values after 2025 were derived from CBO's "The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance."

While the estimated incremental cost of extending the enhanced subsidies appears modest relative to current law, recent realized outlays have far exceeded what earlier projections and contemporaneous scoring of the enhancements predicted. This indicates that the fiscal savings from allowing the enhanced PTCs to expire as provided under current law would plausibly be larger than the current incremental scores suggest.[5]

Figure 2: Changes in Projected Spending on PTCs Compared to Actual Spending



Source: Congressional Budget Office;[6] U.S. Department of the Treasury[7]

With the public health emergency years in the rearview mirror, policymakers must consider whether the benefits produced by enhanced PTCs are worth the escalating cost to taxpayers. Analysis by the Joint Economic Committee finds that enhanced PTCs have not only outlived their intended *temporary* purpose, but that both economic theory and accumulating empirical evidence indicate that their design, focused on maximizing coverage regardless of cost, materially weakens the role of price signals and thereby reduces pressure on insurers to contain costs. As a result, enhanced PTCs perform poorly as permanent policy. They do more to improve the financial outcomes of large health insurers than to reduce healthcare costs for Americans. Indeed, for every dollar that benefits consumers through lower premiums, roughly two dollars are captured by insurers, brokers, and intermediaries or are lost entirely as economic deadweight loss.[8]

[5] This is not an artifact of the higher than usual inflation during this period; the increase is 125 percent after adjusting for medical care inflation over the same period. U.S. Bureau of Labor Statistics, "Consumer Price Index for All Urban Consumers: Medical Care in U.S. City Average," https://fred.stlouisfed.org/series/CPIMEDNS; JEC calculations.
[6] Congressional Budget Office, "The Budget and Economic Outlook: 2021 to 2031" (February 2021), https://www.cbo.gov/publication/56970; Congressional Budget Office, "Additional Information About the Budget Outlook: 2021 to 2031" (March 2021), https://www.cbo.gov/publication/56996; Congressional Budget Office, "An Update to the Budget and Economic Outlook: 2021 to 2031" (July 2021), https://www.cbo.gov/publication/57218; Congressional Budget Office, "The Budget and Economic Outlook: 2022 to 2032" (May 2022), https://www.cbo.gov/publication/57950; Congressional Budget Office, "The Budget and Economic Outlook: 2023 to 2033" (February 2023), https://www.cbo.gov/publication/58848; Congressional Budget Office, "An Update to the Budget Outlook: 2023 to 2033" (May 2023), https://www.cbo.gov/publication/59096; Congressional Budget Office, "The Budget and Economic Outlook: 2024 to 2034" (February 2024), https://www.cbo.gov/publication/59710; Congressional Budget Office, "An Update to the Budget and Economic Outlook: 2024 to 2034" (June 2024), https://www.cbo.gov/publication/60039; Congressional Budget Office, "The Budget and Economic Outlook: 2025 to 2035" (January 2025), https://www.cbo.gov/publication/60870.
[7] U.S. Department of the Treasury, *supra* note 3.
[8] Deadweight loss refers to the portion of spending that does not generate offsetting gains in consumer or producer welfare.

Enhanced PTCs reduce the role of price competition and allow insurers to capture more of the subsidy

While the statutory incidence of PTCs falls on insurers (the subsidy is remitted to plans on behalf of enrollees), the *economic* incidence depends on how premiums respond. In other words, it depends on the degree to which the subsidies are passed through to consumers as lower net premiums versus captured by insurers through higher gross premiums and increased administrative margins. In general, economic theory predicts that the incidence will depend on the relative elasticities of supply and demand, that is, the extent to which the quantity demanded by consumers varies with price and the degree of competition among insurers. Greater consumer price elasticity and more competitive insurance markets result in a larger share of the subsidy benefiting consumers.

In the context of the ACA and similar marketplaces, there is a well-developed empirical literature on the incidence of premium subsidies, with the best available evidence being a study by Polyakova and Ryan (2021). The authors study the pre-enhancement subsidies in the ACA Marketplace in 2017 and compare it to a modeled counterfactual without subsidies. The authors find that for every additional dollar of federal spending on PTCs, consumers gain about 34 cents through lower net premiums, while insurers capture roughly 38 cents.[9]

This is due to a combination of the subsidy reducing consumers' price elasticity and many Marketplace rating areas being served by only a small number of insurers. As a result, insurers respond by raising gross premiums. The remaining 28 cents does not accrue to either consumers or insurers.[10] Higher premiums reduce enrollment at the margin, thereby creating deadweight loss. This led the authors to conclude that, in the ACA setting, subsidizing premiums generates negative economic value, even without considering the cost of raising public funds.[11] The authors note that once the cost of raising public funds from taxpayers is accounted for, the deadweight loss more than doubles.[12]

As discussed, Polyakova and Ryan estimate the incidence of the original PTCs in 2017, not the enhanced PTCs. However, theory and empirical findings provide two strong reasons to consider their pre-enhancement PTC findings to be a theoretical best-case scenario for the economic incidence of enhanced PTC subsidies.

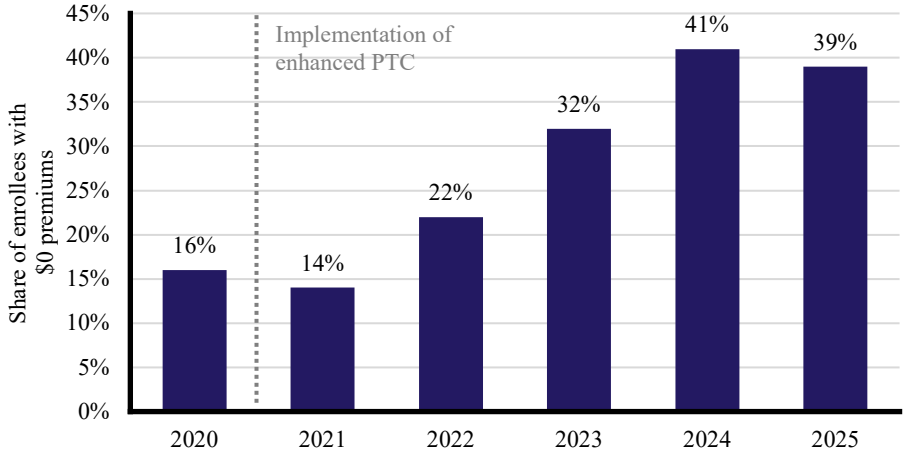
First, Polyakova and Ryan studied the states that facilitate ACA enrollment through the HealthCare.gov Marketplace, which accounts for around 70 percent of ACA enrollment. The remaining enrollment is through states that operate separate State-Based Exchanges (SBEs). Crucially, SBE states tend to be less competitive, with an average of 1.6 large participating insurers compared to 2.1 in the HC.gov states examined in the study.[13]

Second, the enhanced PTCs have substantially reduced the price elasticity of demand among consumers. By eliminating or reducing the required out-of-pocket contributions for consumers, the number of plans

[9] Maria Polyakova and Stephen P. Ryan, "Subsidy Targeting with Market Power," NBER working paper no. 26367 (October 2019), 3, 29–31, https://doi.org/10.3386/w26367; JEC calculations.
[10] *Ibid.*
[11] *Ibid.*
[12] *Ibid.*
[13] Kaiser Family Foundation, "Individual Insurance Market Competition" (2021), https://www.kff.org/state-health-policy-data/state-indicator/individual-insurance-market-competition/; Centers for Medicare and Medicaid Services, "2021 Marketplace Open Enrollment Period State-Level Public Use Files," https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files; JEC calculations.

available to them at $0 per month dramatically increased. The result has been record-breaking increases in enrollment in plans that charge consumers $0 or only nominal monthly premiums. The JEC finds that, following the implementation of enhanced PTCs, the share of enrollees that pay $0 or less than $10 in monthly premiums rose sharply to 42 percent, while the share on HealthCare.gov paying exactly $0 in monthly premiums has more than doubled to 39 percent.[14]

Figure 3: Surge in Share of Enrollees on HealthCare.gov with $0 Premiums After Enhanced PTC Implementation



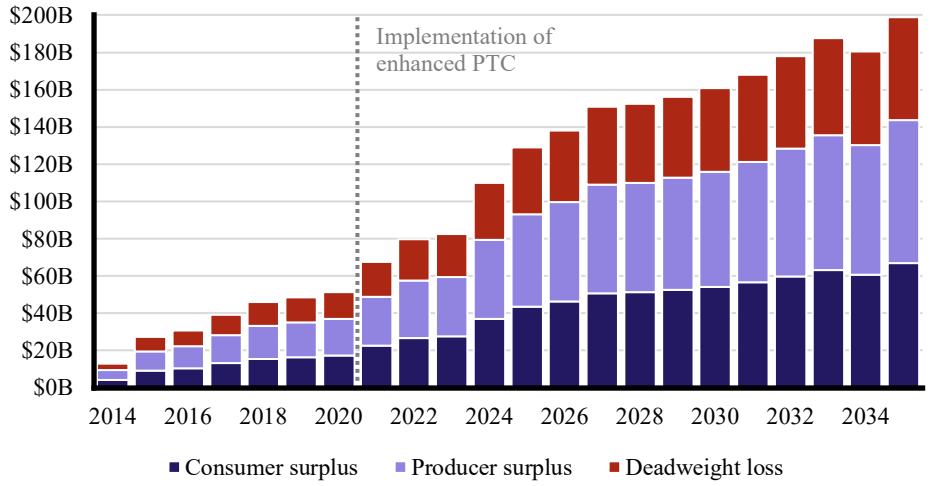
Source: Centers for Medicare and Medicaid Services;[15] JEC calculations

Together, a greater overall market concentration and lower consumer price elasticity unambiguously shift the economic incidence of the subsidy away from consumers and toward insurers and deadweight loss. As a result, the 34/38/28 welfare decomposition from Polyakova and Ryan represents a theoretical lower bound on the efficiency cost of enhanced PTCs and an upper bound on the share of subsidy dollars passed through to consumers. While the model is not linear and therefore cannot be directly extrapolated to the enhanced PTCs, the relatively concentrated market structure and the large reductions in consumer price elasticity in SBE states suggest that the resulting shift in incidence is likely to be material rather than marginal.

Figure 4 illustrates the implications of these findings. It shows that, in 2025, the federal PTC spending that is wasted entirely or fails to benefit either enrollees or insurers will roughly equal the combined benefits to enrollees and insurers in 2020, the year before implementation of the enhanced PTCs.

[14] Centers for Medicare and Medicaid Services, "Marketplace Products," https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products; JEC calculations.
[15] *Ibid.*

Figure 4: Incidence of Subsidy for PTCs



Source: Congressional Budget Office;[16] JEC calculations[17]

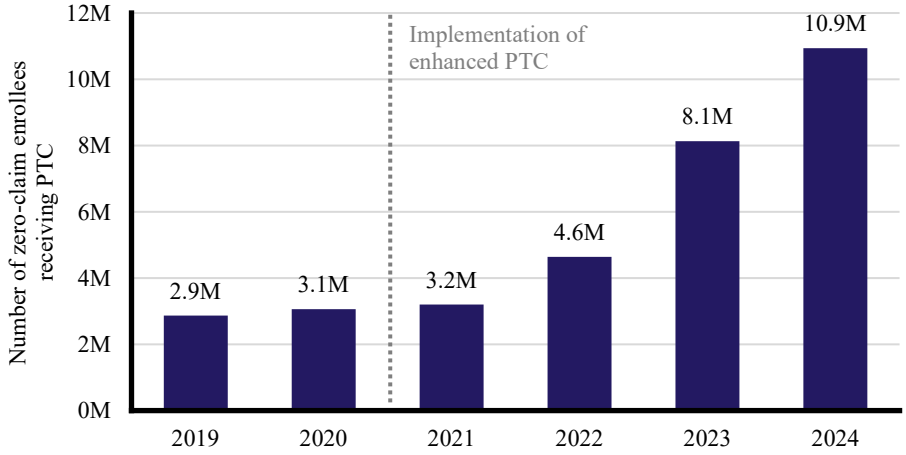
As the previous discussion has shown, a substantial portion of the increase in government spending on PTCs since the passage of the ARPA is likely accruing to producers and intermediaries. The JEC examines two main reasons for this: a concurrent rise in zero-claim enrollment and insurers' raising of gross premiums that are hidden from the consumer by the subsidy.

Surge in subsidized zero-claim enrollment

A zero-claim enrollee is an individual for whom the insurer receives a premium tax credit (PTC) remittance but who does not submit any medical claims during the year. A baseline level of zero-claim enrollment is expected, as some healthy individuals purchase coverage but do not use it. However, following the implementation of the enhanced PTCs in 2021, the number of subsidized enrollees filing no claims has nearly quadrupled. Because insurers receive the full PTC payment regardless of whether services are used, these enrollees are especially profitable.

[16] Congressional Budget Office, *supra* note 4.
[17] Maria Polyakova and Stephen P. Ryan, "Subsidy Targeting with Market Power."

Figure 5: Surge in Number of Subsidized Zero-Claim Enrollment After Enhanced PTC Implementation



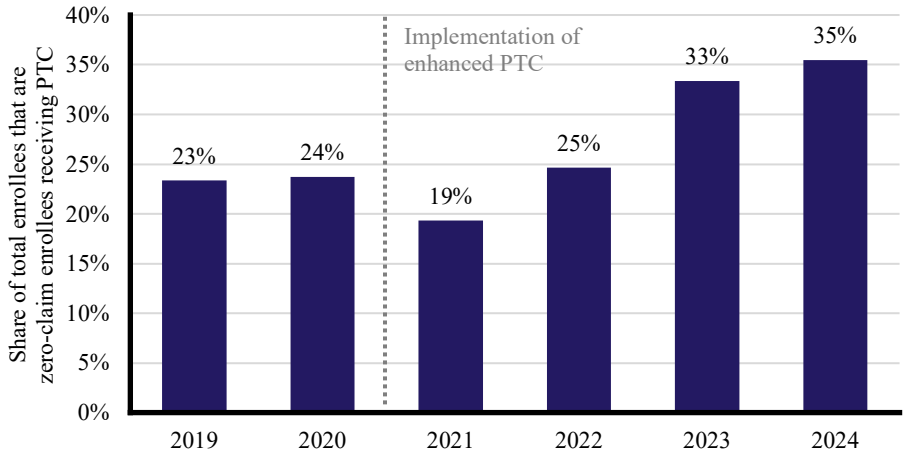
Source: Centers for Medicare and Medicaid Services;[18] JEC calculations[19]

The ACA Marketplace requires insurers to meet a Medical Loss Ratio (MLR) of at least 80 percent, meaning that at most 20 percent of premium revenue may be retained for administrative costs and profit.[20] If an insurer's MLR falls below 80 percent, it must remit rebates to enrollees.[21] In practice, the surge in zero-claim enrollment interacts with the MLR in two ways. For insurers whose MLR is not binding, the increase in zero-claim enrollees simply raises premium revenue without increasing medical spending, making these enrollees highly profitable. For insurers whose MLR is binding, meaning it is below 80 percent or risks falling below the threshold, the additional premium revenue pushes them closer to the rebate threshold and reduces the margin available before rebates are required. These insurers then face strong incentives not to reduce premiums or pass savings back to consumers, but instead to increase low-value medical spending to keep their MLR above 80 percent. From a competitive standpoint, spending on low-value claims can be more advantageous than issuing rebates, since rebates effectively lower the insurer's premium.

As a result, the increase in zero-claim enrollment produces two types of insurers in the Marketplace: those for whom the enhanced subsidies generate windfall profits,[22] and those for whom the subsidies are likely to induce increase marginal or low-value care to avoid triggering rebates. In both cases, the structure of the subsidy encourages higher federal spending without commensurate gains in health value for consumers.

[18] Centers for Medicare and Medicaid Services, "2019-2024 Enrollees Without Claims by State Market Metal Level," https://www.cms.gov/files/document/enrolleeswithoutclaims-2019-24.xlsx.
[19] CMS data indicates about 90 percent of all Marketplace enrollees receive the PTC, with the estimated share receiving the PTC differing slightly depending on the plan metal levels. JEC calculations assume the Silver plan has a 95 percent rate, Gold 90 percent, Bronze 90 percent, and Platinum 85 percent.
[20] Centers for Medicare and Medicaid Services, "Medical Loss Ratio," https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio.
[21] *Ibid.*
[22] Or near-windfall profits in the event the insurer incurs administrative costs, such as broker fees.

Figure 6: Surge in Share of Subsidized Zero-Claim Enrollment After Enhanced PTC Implementation



Source: Centers for Medicare and Medicaid Services;[23] JEC calculations

Around 35 percent of enrollees filed zero claims in 2024, which is nearly double the rate in 2021.[24] By contrast, small group plans have seen no such increase in zero-claim enrollment over that same period.[25] A large and sudden increase in such enrollment specifically in the ACA Marketplace, where enhanced PTCs were implemented, signals that at least part of the zero-claim enrollment illustrated in Figure 6 represents phantom enrollment, attributable to the enhanced PTCs.

As of this year, more than 6.4 million people may be improperly enrolled.[26] Recent research has found that "phantom" enrollees (those that have separate health coverage or, in some cases, have been enrolled without their knowledge) represent a growing subset of this group, a trend enabled in part by zero-premium enrollment.[27] The implementation of the enhanced PTCs has driven up the share of enrollees paying $0 monthly premiums from 16 percent to about 39 percent in 2025.[28] By eliminating the financial barrier that even a very small premium imposes, these $0 plans have made it easier for brokers and other intermediaries to enroll people fraudulently or use stolen identities, likely contributing to the observed increase in zero-claim enrollment.

Research indicates that a significant portion of potential coverage losses would come from consumers currently paying $0 per month.[29] An increase in the premiums on those plans made currently free by the enhanced PTC to just $1 could have a large marginal effect on enrollment by systematically disenrolling those phantom enrollees. A reduction in the number of $0 premium plans not only helps to disenroll any phantom enrollees, to the extent they exist, but also increases consumers' price elasticity across the health

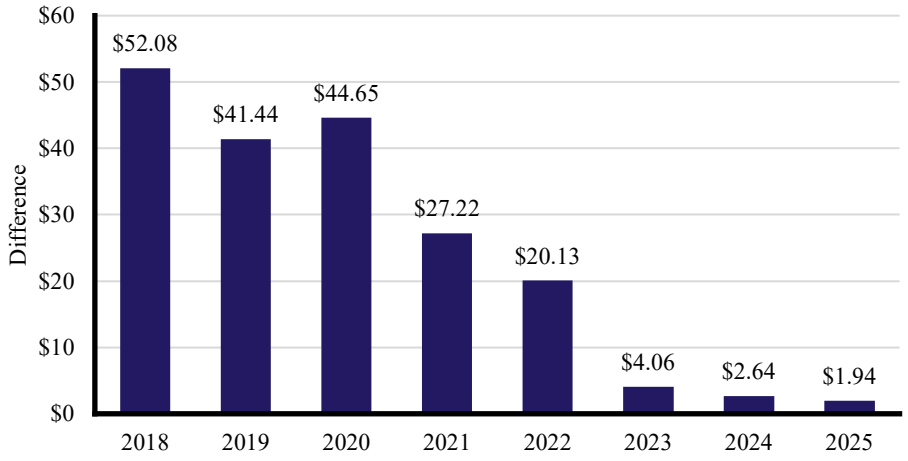
[23] Centers for Medicare and Medicaid Services, *supra* note 18.
[24] *Ibid.*
[25] *Ibid.*
[26] Centers for Medicare and Medicaid Services, *supra* note 18.
[27] Niklas Kleinworth, Liam Sigaud, and John R. Graham, "Ghostbusting ACA Fraud: Millions Who Don't Use Their Health Insurance Expose Abuse in the Program," https://paragoninstitute.org/private-health/ghostbusting-aca-fraud-millions-who-dont-use-their-health-insurance-expose-abuse-in-the-program/.
[28] *Ibid.*
[29] Matthew Fiedler, "How would eliminating $0 Marketplace premiums affect insurance coverage?" October 8, 2025, https://www.brookings.edu/articles/how-would-eliminating-0-marketplace-premiums-affect-insurance-coverage/.

insurance market. As a result, the incidence of the remaining federal subsidy would shift toward consumers who actively rely on health insurance and away from insurers.

Inflation of gross premiums

Government involvement in the health insurance market has caused the masking of cost increases that would otherwise be reflected in consumer-facing premiums. PTCs are calculated using the price of the second-lowest-cost Silver plan (SLCSP) in each area, known as the benchmark plan.[30] As a result, they directly link federal spending to premiums in the Marketplace.[31] In recent years, insurers have increasingly "silver loaded"—embedding, or "loading," higher costs into the price of their Silver plans to offset rising expenses.[32] This practice has moved the average premium of the SLCSP closer to the average premium of the lowest-cost Gold plans. In 2025, the average premium for the lowest-cost Gold plan was only $1.94 higher than the average premium for the SLCSP, down 96 percent from $52.08 in 2018.[33]

Figure 7: Difference between Average SLCSP and Average Lowest-Cost Gold Plan



Source: Centers for Medicare and Medicaid Services;[34] JEC calculations

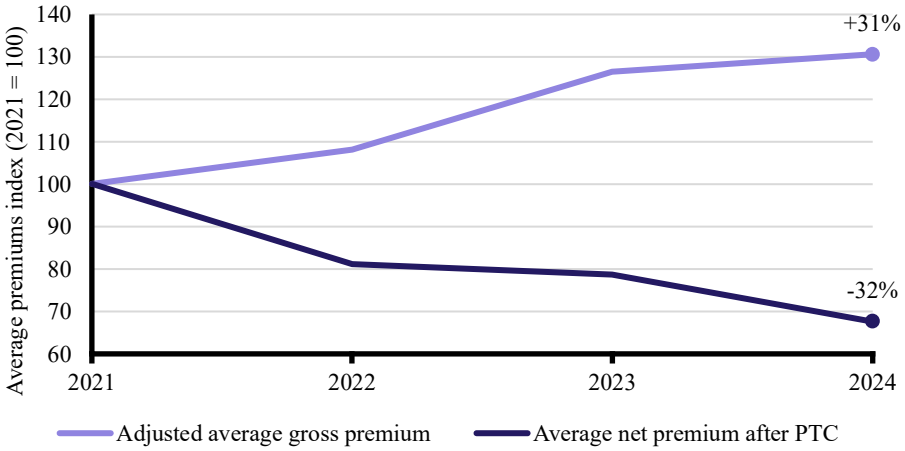
The increase in the average premiums of SLCSPs, along with the enhancements to PTCs in 2021, has dramatically increased the value of the PTCs subsidizing all insurance plans over the past few years.

[30] Internal Revenue Service, "Publication 974 (2024), Premium Tax Credit (PTC)," March 10, 2025, https://www.irs.gov/pub/irs-pdf/p974.pdf.
[31] Looking beyond the current, flawed subsidy system, research has found cost-effective ways to reduce gross premium inflation while making premiums affordable. A 2020 study found that a flat, "voucher-like" subsidy system would have decreased monthly premiums by up to 6 percent in the Massachusetts individual marketplace if it replaced the ACA system of adjusting subsidies based on plan costs. A 2025 study built upon those findings and reported a 6 to 27 percent decrease in base ACA Marketplace premiums, depending on the number of insurers present in the Marketplace. Sonia Jaffe and Mark Shepard, "Price-Linked Subsidies and Imperfect Competition in Health Insurance," *American Economic Journal: Economic Policy* 12, no. 3 (August 2020): 279–311, https://doi.org/10.1257/pol.20180198; Pietro Tebaldi, "Estimating Equilibrium in Health Insurance Exchanges: Price Competition and Subsidy Design under the ACA," *The Review of Economic Studies* 92, no. 1 (January 2025): 586–620, https://doi.org/10.1093/restud/rdae020.
[32] Emma Wager and Cynthia Cox, "Explaining Cost-Sharing Reductions and Silver Loading in ACA Marketplaces," June 26, 2025, https://www.kff.org/affordable-care-act/explaining-cost-sharing-reductions-and-silver-loading-in-aca-marketplaces/.
[33] Centers for Medicare and Medicaid Services, "2025 QHP Choice and Premiums in HealthCare.gov States," accessed October 2025, https://www.cms.gov/files/document/2025-qhp-premiums-choice-appendix.xlsx.
[34] *Ibid.*

Because these subsidies have reduced consumers' price elasticity, insurers can raise gross premiums without substantially harming demand, creating upward pressure on average gross premiums. However, the large increase in zero-claim enrollment has simultaneously added millions of relatively healthy consumers to the insurance market, which has reduced average risk and exerted downward pressure on average gross premiums. This does not reflect the underlying health or risk of the existing enrollees, and it does not suggest this group saw a decrease in gross premiums. Rather, the downward pressure on the average results simply from the large influx of low-risk individuals into the consumer population.

These countervailing pressures have resulted in the average gross premium increasing by only about 6 percent over the past five years.[35] To isolate the change in the average gross premium absent this compositional effect, the JEC uses a risk level adjustment to normalize premiums to the share of zero-claim enrollees in a baseline year, 2019. After accounting for these composition effects, the adjusted average gross premium charged by insurers increased by 31 percent from 2021 to 2024, while the average net premium paid by consumers decreased by 32 percent. This suggests that the PTC has suppressed the net premiums paid by consumers and hidden the underlying increase in premiums charged by insurers.

Figure 8: Change in Average Gross and Average Net Premiums After Implementation of Enhanced PTCs



Source: Centers for Medicare and Medicaid Services;[36] JEC calculations

This subsidization continues to build a "subsidy bubble" for as long as it remains in place, meaning its removal and consequent sudden price reversion invariably creates sticker shock for the consumer. However, maintaining the subsidy bubble also has persistent negative consequences because it is supported by continuous increases in government spending.

Brokers and other intermediaries also capture some of the federal support intended to benefit consumers. Forthcoming JEC research will explore the extent of this benefit further, though preliminary estimates indicate that intermediaries received between $4 and $5 billion in federal support in 2024 through PTCs.

[35] Centers for Medicare and Medicaid Services, *supra* note 18; Centers for Medicare and Medicaid Services, *supra* note 13.
[36] Centers for Medicare and Medicaid Services, *supra* note 13.

Implications for Americans

The sharp rise in zero-claim enrollment and inflation of gross premiums provide empirical evidence for the economic theory that PTC subsidies do more to benefit insurers than consumers. Moreover, enhanced PTC spending has supported growth in coverage that is either not used or susceptible to misuse due to being completely subsidized, making it unclear whether their expiration would truly cause the adverse health outcomes predicted by their proponents.

What is clear, however, is that enhanced PTCs are fiscally unsustainable and cannot survive as a permanent policy: they both directly and indirectly drive massive increases in government spending, weaken market integrity, and redirect gains toward insurers and intermediaries rather than American households. Even after the long-scheduled expiration of the enhanced PTCs, the ACA Marketplace is still expected to receive more federal funding than ever seen before the pandemic. Maintaining an unsustainable subsidy bubble perpetuates a broken incentive system that deepens market distortions, burdens the American taxpayer, and converts precious federal dollars into economic deadweight loss.

Markus Bjoerkheim, *Senior Economist*
Matthew Cernicky, *Data Analyst*
Jaxson Dealy, *Policy Analyst*
Oliver Sibal, *Research Assistant*
Lauren Smith, *Research Assistant*