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State Marketplace Subsidies to Support Health Insurance Affordability

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Jason Levitis, Claire O'Brien, Caitlin Rowley Gallamore, and Rachael Totz, the Urban Institute

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INTRODUCTION

The Affordable Care Act (ACA) has led to historic coverage gains, especially following passage of the enhanced premium tax credits (PTCs) in 2021. In 2025, 24 million people enrolled through the Marketplace, and uninsurance reached an all-time low. But the past year has brought several changes to reduce Marketplace affordability. Congress failed to extend the PTC enhancements at the end of 2025, resulting in both reduced PTCs and also higher gross premiums—those paid by people ineligible for PTCs. Congress also eliminated PTC eligibility for many lawfully present immigrants and imposed new administrative requirements that will decrease enrollment, especially among healthier people. Regulatory changes further increased administrative burdens and reduced PTC amounts for those still eligible.

Taken together, more than 20 million Americans saw large increases in their health insurance premiums for Marketplace coverage in 2026, and millions face additional large increases in 2027 and beyond. Average net premiums more than doubled, with increases at every income level. Gross premiums increased 26% on average due to insurers' expectations that healthier people would drop out amid the PTC reductions and new administrative requirements, as well as general uncertainty and other factors. While effectuated enrollment figures for 2026 are not yet available, Marketplace enrollment is projected to fall by 7.3 million this year due to the expiration of enhanced PTCs and could drop by half overall. Some consumers are responding by switching to lower-premium plans with higher deductibles and other cost-sharing. Others—especially those with preexisting conditions—are making painful choices to afford premium increases. People of color and other historically disadvantaged groups will be especially hard hit. And these trends are likely to continue in 2027, with additional cuts taking effect and the 2026 changes being felt more fully over time.

Fortunately, states have tools to mitigate these harms. Chief among them, states can provide their own Marketplace subsidies to supplement federal policies. With the recent changes, interest in state subsidies is more acute than ever. Already, more than a dozen states have enacted them.

State Marketplace subsidies can meet numerous state goals. They can address affordability gaps by reducing out-of-pocket premiums and cost-sharing, protecting against medical debt, which disproportionately affects people of color. They can expand health coverage, which improves state residents' health and productivity. They can draw healthier people into the risk pool, reducing gross premiums across the board. They can increase take-up of federally subsidized coverage, drawing federal dollars into the state. They can support a state's healthcare providers, who face significant revenue losses due to recent federal policy changes.

Subsidies are a flexible tool for meeting state goals. They can wrap around federal subsidies. They can fill gaps in PTC and cost-sharing reductions (CSR) eligibility, such as for immigrant populations and middle-income families. They can be targeted to help young adults or people facing small premiums or by geographic area. They can be dialed up or down depending on state budget conditions. Enacting legislation can be drafted so that subsidy parameters are adjustable year to year without further legislative action.

Offering a state subsidy generally requires a State-Based Marketplace. Beyond that, implementation is straightforward, with systems that have been vetted over many years. Often a state's biggest challenge is figuring out how to pay for it—an especially acute concern in the current environment.

Recent years have seen swift expansion of these subsidies. Until 2019, just two states—Massachusetts and Vermont—had them. Today, 10 states—California, Colorado, Connecticut, Maryland, Massachusetts, New Jersey, New Mexico, New York, Vermont, and Washington—have subsidies for premiums and/or cost-sharing for the general population. Three states subsidize individual market health insurance for immigrants who do not qualify for PTC. Several states also have narrower subsidies for specific populations or circumstances. And still others have programs under consideration, including legislation proposed in Minnesota and Rhode Island. These policies represent a wide range of design choices in terms of eligibility, generosity, subsidy structure, and other parameters.

This issue brief explores reasons states consider subsidies, design options, and state action to date. It is meant as a resource for state policymakers, consumers, and stakeholders considering whether to create a subsidy and how to structure it.

BACKGROUND ON ACA SUBSIDIES

The ACA provides two subsidies to help people afford Marketplace coverage: PTCs to help with premiums, and CSRs to help with deductibles and other cost-sharing.

The PTC. The PTC is an advanceable, refundable tax credit for people with Marketplace coverage. It is by statute available to people with incomes between the federal poverty level [(FPL), which is $15,650 for an individual for 2026 coverage] and 400% FPL. However, people eligible for other health coverage are generally ineligible for PTC, so PTC eligibility begins at 138% FPL or higher in states that have expanded Medicaid and at even higher levels for children and in states that have implemented a Basic Health Program (BHP). The PTC is paid out monthly as advance PTC (APTC) to reduce the consumer's premium payment based on their projected income, as determined by the Marketplace. The consumer must then reconcile APTC on the tax return based on their actual income for the year.

The PTC amount is calculated to limit consumers' premium contribution for a benchmark plan—the second-lowest-cost silver plan available—to a certain percentage of income, referred to as the "applicable percentage." If the consumer chooses a more or less expensive plan, they bear the cost difference. Applicable percentages increase with income. With the PTC's original structure back in place, applicable percentages in 2026 range from 2.10% FPL to 9.96% between 300% and 400% FPL (see Table 1 below). The applicable percentages are indexed over time.

Table 1. PTC Applicable Percentages at Selected Incomes, 2026

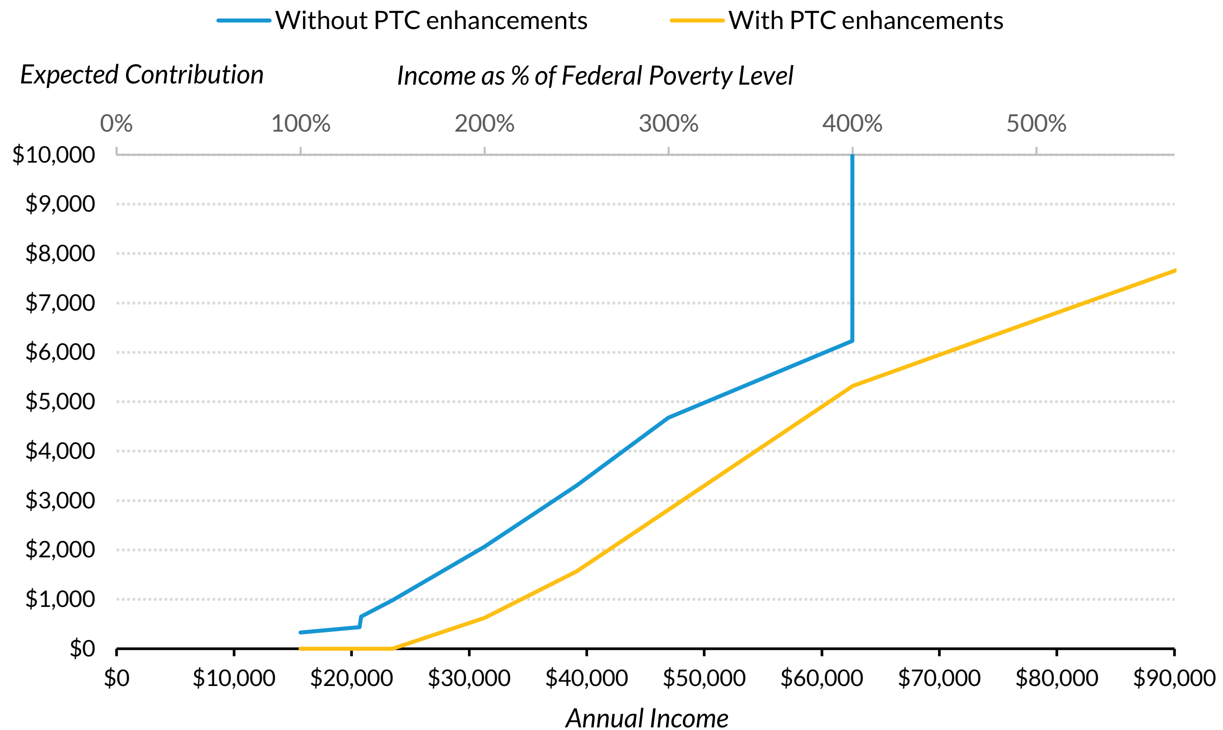
Income as % of FPL	Income for Individual ($)	Income for Family of Four ($)	Applicable Percentage
Up to 133%	Up to $20,814	Up to $42,760	2.10%
133%	$20,815	to $48,225	3.14%
150%	$23,47	$48,226	4.19%
200%	$31,300	$64,301	6.60%
250%	$39,126	$80,376	8.44%
300% to 400%	$46,951 to $62,600	$96,451 to $128,600	9.96%
Above 400%	Above $62,600	Above $128,600	No PTC available

***Sources**:* Rev. Proc. 2025-25, HealthCare.gov information on the Federal Poverty Level, and authors' analysis.
***Notes**:* Between the values shown, the applicable percentage increases linearly with income. Eligibility is tied to the most recently released FPL values at the time of enrollment, so 2026 eligibility is generally tied to 2025 FPL values,

and those are shown here. The FPL values used here and throughout this paper are the ones for the 48 contiguous states.

PTC eligibility ends in a cliff when income exceeds 400% FPL, or $62,600 for an individual in 2026. The PTC enhancements eliminated the cliff—replacing it with a gradual phase-out—and also increased the PTC amount for everyone who is eligible. See Figure 1 below.

Figure 1. Expected Contribution With PTC to Purchase Individual Benchmark Coverage, With and Without the PTC Enhancements, 2026



Sources: Authors' calculations using "Rev. Proc. 2024-35," "Rev. Proc. 2025-25," and the Federal Poverty Level.
Notes*:* Income is for an individual tax filer.

CSRs. CSRs reduce consumers' out-of-pocket costs for deductibles, co-payments, and coinsurance. They do this by requiring insurers to provide eligible people with coverage with a higher actuarial value (AV)—a measure of plan generosity that captures the share of covered healthcare costs paid for the plan.[1] Plans with a higher AV generally have lower deductibles, lower caps on consumers' out-of-pocket expenses, and smaller co-payments and co-insurance. See Table 2 below.

[1] An AV of 80% means the plan pays 80% of the cost of covered services for the average enrollee, leaving the enrollee responsible for approximately 20% through deductibles and co-payments.

Table 2. Silver Variant, Out-of-Pocket Maximum, and Average Deductible by Income with CSRs, 2026

Income as % of FPL	CSR Silver Plan Variant	Out-of-pocket maximum		Average Individual Silver Deductible
		Individual	Family	
Up to 150%	94% AV	$3,500	$7,000	$80
151% to 200%	87% AV	$3,500	$7,000	$790
201% to 250%	73% AV	$8,450	$16,900	$3,727
Above 250%	None, so Silver has 70% AV	$10,600	$21,200	$5,304

Sources*:* Marketplace Integrity and Affordability rule, ACA section 1402, Beyond the Basics' yearly guidelines and thresholds, KFF's Deductibles in ACA Marketplace Plans, 2014-2026, and HealthCare.gov information on the Federal Poverty Level.
Notes*:* To receive CSRs, the consumer must enroll in a silver plan.

Until 2017, the federal government paid for CSRs by reimbursing insurers for their actual cost for reducing cost-sharing. In 2017, the Center for Medicare and Medicaid Services (CMS) stopped making these payments. Under the supervision of state insurance regulators, insurers generally responded by increasing silver premiums to cover this cost. Because the PTC is tied to silver premiums, this "silver loading" increased PTC amounts, which generally insulated silver plan enrollees from the effects of the premium increases.

Other federal subsidies. Beyond the Marketplaces, virtually every American with health insurance receives a federal subsidy to help pay for it. The 160 million people with employer-sponsored coverage receive a subsidy through the tax exclusion for employer plans—the largest tax benefit in the Internal Revenue Code. Every Medicare and Medicaid enrollee also receives federal help.

WHY STATE POLICYMAKERS MAY CONSIDER A SUBSIDY

State subsidies are a flexible tool that can address several policy goals, including some that are difficult to achieve with other state policy options. They can address multiple affordability gaps, target specific populations, expand health coverage, improve the risk pool, and bring federal dollars to the state.

Addresses Affordability Gaps, Including for Specific Populations

PTCs and CSRs have helped millions of Americans afford healthcare, but they are not enough to make coverage affordable for everyone, especially following recent federal policy changes. The income caps leave out millions of middle-class Americans. They provide too little help for many who are eligible. They are unavailable to many categories of lawfully present immigrants. They leave people facing high cost-sharing, which can lead to medical debt and delay of needed care, both of which disproportionately impact people of color. And they provide no tailored assistance in scenarios where additional help may be warranted.

PTC Insufficiency. The newly reduced PTC leaves many consumers paying amounts that are unaffordable. For example, in 2026 a 40-year-old with an income of $47,000 (300% FPL) who qualifies for the PTC still owes $4,681 for a benchmark silver plan on average, the average deductible for which is about $5,300. This high premium contribution could also lead consumers to buy down to a bronze plan, which have average deductibles of $7,476. Regardless of the coverage choice, the costs are significant for families that are balancing other expenses like housing, food, transportation, and other necessities.

States have few options to help this PTC-eligible group. They have many options to reduce *gross* premiums, including reinsurance programs, lower-cost public options, individual mandates, and curbing sub-standard plans. But these options generally don't help PTC recipients, since the PTC adjusts dollar-for-dollar with the gross premium. Some states have lowered net premiums for bronze and gold plans through "premium alignment"—the practice of ensuring that the cost of CSRs is fully accounted for in silver premiums, which in turn increases the PTC. But this generally doesn't help silver plan enrollees, including low-income enrollees receiving cost-sharing reductions. And CMS' recent proposed Marketplace rule suggested that CMS may move to limit premium alignment. Other states have improved affordability for the PTC-eligible population using a BHP, but BHP eligibility is capped at 200% FPL.[2]

By contrast, a state subsidy can wrap around the PTC to further increase affordability for any group of PTC recipients. Many state subsidies take this approach today, including ones in California, Colorado, Maryland, Massachusetts, New Mexico, Vermont, and Washington (see Table 3 for more information about these programs).

PTC Cliff. With the enhancements gone, the PTC is unavailable to many middle-income people, even if they owe large premiums. An individual with income of $63,000—just over 400% FPL—would face the full premium. For a 40-year-old buying a benchmark plan with the national average premium, this is $7,494, or about 12% of income. But the price is far higher for some, especially older people and those in high-premium areas. A 60-year-old with this income in Cheyenne, Wyoming, faces a premium of $26,180—42% of income. (By contrast, there is no income cap on eligibility for the tax exclusion for employer-sponsored coverage.)

State premium subsidies can address this gap. Like APTC, they are generally paid monthly to reduce consumers' out-of-pocket premiums. For example, New Jersey's subsidy provides help up to 600% FPL, and Connecticut's recently announced subsidy includes enrollees with incomes between 400% and 500% FPL (Table 3). A state subsidy also helps those ineligible for the subsidy, since subsidies improve the risk pool and reduce gross premiums, as discussed below.

Cost-Sharing. Federal CSRs provide substantial help only at quite low incomes—up to 200% FPL ($31,300 for an individual). Beyond that, the subsidy quickly disappears, leaving cost-sharing high enough to be unaffordable for many families. Specifically, enrollees with incomes up to 150% FPL qualify for plans with a 94% AV, with average individual deductibles of $80. Enrollees with incomes between 150% and 200% FPL qualify for plans with an 87% AV, with average individual deductibles of $790. But enrollees with incomes between 200% and 250% FPL qualify for only a 73% AV plan, with deductibles averaging $3,727. And individuals with incomes above 250% are ineligible; if they purchase a 70% AV silver plan, the average individual deductible is $5,304. If they buy down to bronze, the average individual deductible is $7,476. Deductibles for family plans are frequently twice as high. In all of these latter categories, deductibles are so high that consumers may forgo needed care and end up with large medical debt.

To address this gap, six states have enacted cost-sharing subsidies that wrap around federal CSRs. They generally take the same approach as federal CSRs, providing higher-AV plans. For example, Vermont

[2] Establishing a BHP doesn't necessarily increase affordability for the eligible population. Doing so generally requires some combination of committing state funds and the BHP paying providers lower reimbursement rates than they would receive with Marketplace coverage.

increases the AV of a silver plan from 73% to 77% for those with incomes between 200% and 250% FPL, and from 70% to 73% of a silver plan for those with incomes between 250% and 300% FPL (Table 3).

Immigration Status. Perhaps the largest gap in federal health coverage policy is for immigrants. Immigrants have faced significant barriers to health coverage and safety net programs due to eligibility exclusions, complex rules and processes, language access challenges, and "public charge" rules that can jeopardize immigration status for those accessing services or programs. The ACA significantly improved access to affordable healthcare for immigrants by making lawfully present immigrants eligible for PTC and CSRs, generally on the same terms as citizens, helping to lower the uninsurance rate and improving access to care. Including these populations in the individual market also generally improved the risk pool, lowering costs for all. But H.R.1 included two provisions that eliminated PTC and CSR eligibility for many lawfully present immigrants. First, effective in 2026, H.R.1 eliminated the special rule that extended PTC and CSR eligibility to lawfully present immigrants with incomes below 100% FPL who were denied Medicaid due to immigration status (generally because of the "five-year bar" on Medicaid enrollment for lawfully present immigrants). Second, effective in 2027, H.R.1 narrowed eligibility for lawfully present immigrants to "eligible aliens," which are defined to include just three groups: lawful permanent residents (green card holders), Cuban/Haitian Entrants, and citizens of Compact of Free Association (COFA) states (Micronesia, Palau, Marshall Islands). This eliminates eligibility for refugees, asylees, victims of human trafficking, temporary workers, student exchange visitors, and other lawfully present groups. The Congressional Budget Office (CBO) has estimated that these changes will lead to 1.2 million additional people going uninsured. H.R.1 also generally narrowed Medicare and Medicaid eligibility among lawfully present immigrants to these same "eligible aliens." In addition, undocumented immigrants have been ineligible for Marketplace subsidies (and Marketplace coverage generally) since the ACA was enacted and also are ineligible for Medicare and Medicaid.

Taking all of this together, millions of people are or soon will be ineligible for any federal help purchasing health insurance. State subsidies can address these coverage gaps.

Three states—Colorado, New Mexico, and Washington—currently provide subsidies for individual market health insurance to immigrants who do not qualify for federal health programs (Table 4). In addition to replacing PTCs and CSRs, these subsidies can help people with incomes that would not normally make them PTC-eligible. For example, both New Mexico and Washington subsidize Marketplace coverage for lawfully present immigrants with incomes below the poverty line, which helps to address coverage gaps created by H.R.1.

Specific Circumstances, Especially Where Assistance Has a Large Impact. Some states find that specific circumstances warrant additional help. For example, the PTC is calculated so that enrollees of all ages generally make the same contribution, even though the ACA permits gross premiums to be age-rated. Young adults—who are disproportionately uninsured and helpful to the risk pool—may need more help to find enrollment worthwhile. Since 2022, Maryland has provided a subsidy targeted to young adults (Table 3). Other states, responding to research showing that even a very small premium can substantially reduce take-up, provide subsidies to cover very small premium shares not covered by PTC, such as a portion attributable to non-essential health benefits or abortion coverage.

Expands Health Coverage

Reducing consumers' premiums increases enrollment. That's why the expiration of enhanced PTCs (ePTCs) is estimated to reduce Marketplace enrollment by 7.3 million, and why other proposals to

increase subsidies are also projected to increase enrollment. Research from Massachusetts found that insurance take-up falls rapidly as subsidies decline, dropping about 25% for each $40 increase in monthly enrollee premiums. As noted above, even small premium amounts can substantially reduce enrollment. The experience of states with long-standing subsidies bears out these benefits—Massachusetts and Vermont have consistently had among the nation's lowest uninsured rates. And there is compelling evidence that health insurance reduces mortality, improves health, increases use of high-value preventive care, and reduces financial hardship. Expanding coverage may also draw additional insurers into the market, resulting in greater competition and market stability.

Improves the Risk Pool and Lowers Premiums Across the Board

A state subsidy program generally pulls healthier consumers into the health insurance market, which expands the risk pool and lowers gross premiums throughout the market. Consumers who expect to consume less healthcare are willing to pay less for the same coverage, so reducing net premiums increases enrollment of healthier people especially. This improves the risk pool, resulting in lower gross premiums. CBO estimates that extending the enhancements would reduce gross premiums by 9% in 2028.

Reducing gross premiums has several benefits. It lowers out-of-pocket costs for consumers ineligible for subsidies, including those with incomes above 400% FPL ($62,600 for an individual) and those ineligible due to immigration status. It reduces the cost of both the state and federal subsidies. And it reduces the cost of employer-sponsored coverage for employers and employees who rely on individual coverage health reimbursement arrangements (ICHRAs).

Brings Federal Dollars to the State and Supports Healthcare Providers

State subsidies cost states money. But state subsidies for PTC-eligible people also increase take-up of federally subsidized coverage. This brings federal dollars into the state, supporting the state economy and tax base. CBO estimates that PTC recipients will receive an average federal subsidy of $6,710 in 2026.

By expanding health coverage, a subsidy can also provide crucial support to hospitals and other providers in the state. The combination of H.R.1 and the expiration of ePTCs is projected to reduce provider revenue by $1 trillion and increase uncompensated care by $278 billion over the next 10 years, both in large part due to millions of people becoming uninsured. These cuts disproportionately harm rural providers. Premium subsidies can help mitigate this damage by reducing coverage losses. Cost-sharing subsidies can also help providers, since patients with higher cost-sharing have more trouble paying providers what they owe.

Is a Flexible Tool for Meeting State Goals

State subsidies are a highly flexible and targetable policy tool. Measures like changing insurance rules or enforcement and reinsurance programs affect the market overall. But subsidies can be targeted to specific populations and scenarios. They can target assistance based on income, age, geographic area, immigration status, health condition, or other characteristics. They can encourage enrollment in specific health plans, such as silver plans to maximize federal subsidies, or plans that meet other state goals like public options (as in Colorado) and standard plans (as in Washington). They can address specific scenarios, like smoothing coverage transitions from Medicaid into the Marketplace. Their cost can be dialed up or down depending on state budget conditions.

DESIGN OPTIONS

States have used many varieties of individual market subsidies to meet specific goals.[3] The key parameters are the type of subsidy (premium, cost-sharing, or both), the eligible population (PTC-eligible individuals vs. others, income requirements, or other criteria), and how the subsidy is structured and calculated. All options generally require a State-Based Marketplace. See Tables 3 and 4 for detail on the variety of state subsidies to date.

A key consideration for all of these decisions is the amount of funding available. Budget constraints require difficult choices. Providing a meaningful subsidy often means leaving out some people who would benefit from assistance. State subsidy amounts may need to be smaller than would be optimal. Economic modeling can help to estimate the impact of different options on coverage, premiums, and provider revenues.

Subsidy Type: Premiums Versus Cost-Sharing

A threshold decision for a state subsidy is whether to help pay for premiums, cost-sharing (deductibles, co-payments, and cost-sharing), or both. Each type has important benefits. Premium subsidies generally have a larger impact on enrollment and so are often prioritized.[4] Cost-sharing subsidies can address the strikingly large deductibles some Marketplace enrollees must pay, though premium subsidies can also help consumers enroll in a lower-deductible plan. Both types have proven straightforward to implement, though a State-Based Marketplace is needed, and cost-sharing subsidies require somewhat more involvement from insurance regulators.

The two original state Marketplace subsidies, in Massachusetts and Vermont, helped with both premium and cost-sharing subsidies. Several other states have followed this model, including Connecticut (effective mid-2021) and New Mexico (effective 2023). Other states focused on premiums, including Minnesota's one-year subsidy in 2017, California's subsidy in 2020 and 2021, New Jersey's subsidy that took effect in 2021, and Washington's subsidy that took effect in 2023. After the PTC enhancements were enacted, some states shifted their focus to cost-sharing. Colorado became the first state with a subsidy for cost-sharing but not premiums in 2022, followed by California in 2024 and New York (under its section 1332 state innovation waiver) in 2025. Most recently, with the PTC enhancements expiring, focus has shifted back to premium subsidies. For 2026, Connecticut, and Maryland added new premium subsidies, while California and Colorado replaced their cost-sharing subsidy with a premium subsidy. Design considerations for the two types of subsidies are discussed below. [5]

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[3] In addition to the individual market subsidies discussed in this piece, some states offer subsidies for employer coverage. For example, the District of Columbia provides free or low-cost Marketplace plans for employers who are licensed early childhood development centers and homes. New Mexico provides a premium subsidy for small businesses for the first half of 2026. Maine had a small business premium subsidy from 2021 to 2023. Indiana has an Individual Coverage Health Reimbursement Arrangement (ICHRA) subsidy.

[4] Hinde (2015) finds moderate evidence that PTC could be the driving incentive for consumers on the margin (i.e. consumers facing an enrollment decision), relative to CSRs.

[5] In 2025, California's CSR subsidy provided 95.07% AV for incomes 100% to 150% FPL; 88.86% AV for incomes 150% to 200% FPL; and 79.22% AV for incomes above 200% FPL. In 2025, Colorado's CSR subsidy provided 94% AV for incomes 150% to 200% FPL.

Eligible Population

State subsidies may be targeted by income, immigration status, age, and other factors, as described below. Most subsidies are also limited to people who meet other PTC eligibility requirements, such as being ineligible for Medicaid and employer coverage deemed affordable. And many state subsidies require recipients to claim whatever federal subsidies they are eligible for.

Income Eligibility. Virtually every state subsidy limits eligibility to certain incomes. Most states focus assistance on those with low to moderate incomes, since these groups have the greatest financial need and are most likely to be uninsured. Research suggests targeting these groups has the greatest impact on coverage. For example, California's premium subsidy is limited to individuals with income of 165% FPL, while Washington's premium subsidy is at 250% FPL and Vermont's premium and cost-sharing subsidies are at 300% FPL (Table 3).

But some states extend eligibility to higher incomes. New Jersey's premium subsidy extends eligibility to those with incomes up to 600% FPL. Connecticut's new premium subsidy in 2026 covers individuals with incomes between 400% and 500% FPL, in addition to those with incomes up to 200%. And Colorado's new premium subsidy extends to 400% FPL. In 2025, California's cost-sharing subsidy was available to all Marketplace enrollees. Massachusetts extended its premium subsidy to 500% FPL for 2025 but, because eligibility was tied to PTC eligibility, this cap fell to 400% with the expiration of the PTC enhancements. These higher-income groups are generally less likely to be uninsured than those in the lower APTC range, but they may be a priority since they receive no PTCs or CSRs and thus can face extremely high premiums. However, given the lack of federal support, state premium subsidies for this group can be expensive.

Subsidizing coverage for individuals with somewhat higher incomes can also raise additional issues. First, in the absence of the PTC enhancements, extending a substantial subsidy over the eligibility cliff raises the prospect of potential windfalls for consumers whose income crosses the cliff. For example, suppose a consumer enrolls with projected income at 410% FPL and so receives a substantial state subsidy, but ends the year with income at 390% FPL. The consumer can now claim the PTC on their federal tax return. If the state subsidy is not repaid, this individual effectively receives a double benefit. To address this concern, California previously implemented a premium subsidy as an advanceable tax credit with back-end reconciliation, much like the PTC itself, rather than as a front-end-only premium subsidy like the ones in other states. This added operational cost and complexity for state agencies and consumers, as evidenced by the extensive regulations, tax forms, instructions, and publications that the Internal Revenue Service (IRS) and California have published to implement their tax credits. Second, there are questions about whether a state subsidy at this higher income range might be included in income for federal income tax purposes, which would add additional complexity and potentially affect federal tax liability and eligibility for benefits like the earned income tax credit.[6]

Regardless of the income range(s) chosen, states should consider phasing subsidies in and out gradually to avoid cliffs.

[6] Many state programs–including the long-standing Marketplace subsidies in Massachusetts and Vermont–are excluded from federal income under the "general welfare doctrine." Qualifying for the general welfare doctrine generally requires that eligibility for a program be based on need. There are no clear standards for what constitutes need.

Targeting by Age. Since 2022, Maryland has offered a "young adult" subsidy to help attract a group that is difficult to reach and could improve the risk pool. A young adult subsidy could also help to rationalize premium variation overall given that unsubsidized premiums can currently vary 3:1 by age while the PTC is set to generally hold individual contributions constant regardless of age.

Helping Immigrants. As discussed above, many immigrants—including those who are lawfully present—are, or soon will be, ineligible for PTCs and CSRs, as well as other federally subsidized healthcare programs. State subsidies can help these groups. For lawfully present immigrants, who are eligible to enroll through the Marketplace, states can create subsidies for Marketplace coverage that operate alongside PTCs and CSRs. For undocumented immigrants, state subsidies can help pay for off-Marketplace ACA-compliant coverage. (Off-Marketplace coverage could also be subsidized for lawfully present immigrants, if desired.) While these programs can be undertaken as part of a section 1332 waiver, doing so is not generally necessary and may be infeasible in the current environment.

Several states have created such subsidies. New Mexico recently created a subsidy program for lawfully present non-citizens who are ineligible for APTC and have incomes below 100% FPL. Washington has a subsidy for individuals who do not qualify for federal subsidies, including immigrants. And Colorado sets aside funds for people with incomes up to 150% FPL who do not qualify for the PTC, for example undocumented immigrants.

Health Condition. State subsidies can target help to individuals with specific health conditions. For example, as part of its 1332 waiver, New York implemented a program to cover cost-sharing for most diabetes, pregnancy, and postpartum services. This helps pay for high-impact services, which in turn can reduce avoidable hospitalizations. And Florida has a premium subsidy for people with HIV, though eligibility was recently narrowed due to budget constraints.

Qualifying Coverage. Subsidy eligibility can also be tied to a specific type of coverage. Subsidies for APTC-eligible people often require CSR-eligible people to enroll in a silver plan and all enrollees to receive any federal subsidies for which they are eligible. Washington requires subsidy recipients to enroll in a silver or gold plan. States can also tie subsidy eligibility to enrolling in a state public option or standard plan designed to meet state goals, such as reducing premiums or providing a specific benefit package. Colorado and Washington both take this approach.

Transitioning from Medicaid to Marketplace coverage. During the unwinding of the Medicaid continuous coverage requirement, New Mexico and Rhode Island established subsidies to pay the first month's net premium after APTC for those transitioning from Medicaid to the Marketplace. This addressed both the cost for those newly facing a premium and also the administrative burden of the transition. New Mexico has continued this subsidy for individuals switching from Medicaid to Marketplace coverage.

Table 3. Parameters of State Health Insurance Subsidies for APTC-Eligible Populations (and Those With Higher Incomes), 2026

STATE	EFFECTIVE DATE	SUBSIDY TYPE	ELIGIBLE POPULATION	SUBSIDY STRUCTURE	NOTES	SOURCES
California	2026	Premium	APTC-eligible enrollees with income below 165% FPL	Provides 0% applicable percentage for incomes 100% to 150% FPL and between 3.19% and 3.91% for enrollees with incomes 150% to 165% FPL	Parameters are set annually by CoveredCA with adoption by the advisory board, contingent on state budget approval.	Covered California April 2025 and July 2025 Board Meetings; and Covered California Guidance for 2026
Colorado	2026	Premium	APTC-eligible enrollees with incomes below 400% FPL	For the first household enrollee, provides the lesser of $80 per month or the net premium after APTC; For each additional household member, provides the lesser of $29 per month or the net premium after APTC	Parameters are set annually by the insurance department in consultation with the Health Insurance Affordability Enterprise. From 2023 to 2025, Colorado provided a CSR subsidy.	Colorado Department of Regulatory Agencies Presentation; and Amended Regulation 4-2-78
Connecticut	July 2021 (Covered CT)	Premium and Cost-Sharing	APTC-eligible silver plan enrollees ages 19 to 64 with incomes up to 175% FPL	Covers 100% of net premium after APTC and 100% of cost-sharing after CSR	Parameters are set by statute. In July 2022, expanded to include dental and non-emergency medical transportation costs.	Access Health CT; Governor Lamont Press Release; SB 1202, Section 16; and Access Health CT Press Release
	2026 (New subsidy)	Premium	APTC-eligible enrollees with incomes 100% to 200% FPL and 400% to 500% FPL	Fully replaces the expired ePTCs for consumers with incomes 100% to 200% FPL and who are not enrolled in CoveredCT; Replaces 50% of the expired ePTCs for those	Set by the governor using one-time fund for H.R.1 mitigations..	

STATE	EFFECTIVE DATE	SUBSIDY TYPE	ELIGIBLE POPULATION	SUBSIDY STRUCTURE	NOTES	SOURCES
				with income over 400% FPL and up to 500% FPL		
Maryland	2022 (Young adult subsidy)	Premium	Young adults ages 18 to 37 with incomes up to 400% FPL.	Reduces expected contribution to premium by 0.5% to 2.5% (younger individuals benefit more)	Legislation enacted in June 2025 for plan years 2026 and 2027; Parameters are established by the Exchange in consultation with the insurance commissioner.	Maryland Health Benefit Exchange report and briefing; Maryland Insurance Administration Press Release; and HB 1082
	2026 (Subsidy for general population)		APTC-eligible enrollees with incomes up to 400% FPL	Replaces 100% of ePTC for incomes up to 200% FPL, phases out down to 50% of ePTC at 250% FPL, then stays at 50% at 250% to 400% FPL		
Massachusetts	2007	Premium	APTC-eligible enrollees with incomes 100% to 400% FPL	Graduated premium schedule coordinated with state individual mandate affordability standards	Subsidy levels are set annually by the Health Connector, subject to available funds. Under statute, subsidy extends to 500% FPL but is tied to PTC eligibility which is currently capped at 400%.	Health Connector Board of Directors Meeting; Massachusetts Health Connector; and Final Award of the 2024 Seal of Approval
		Cost-Sharing		Provides 94% to 96% AV silver variants		Direct communication with Massachusetts Health Connector staff
New Jersey	2021	Premium	Individuals eligible for ePTC with incomes up to 600% FPL	A series of flat amounts that vary across FPL thresholds, capped for consumers with little or no expected contribution	Parameters are set annually by the commissioner of banking and insurance, the departments where the Exchange sits.	Department of Banking and Insurance Press Release; Get Covered NJ and P.L. 2020, CHAPTER 61

STATE	EFFECTIVE DATE	SUBSIDY TYPE	ELIGIBLE POPULATION	SUBSIDY STRUCTURE	NOTES	SOURCES
New Mexico	2023	Premium	Individuals eligible for ePTC	$0 premium for incomes up to 200% FPL; Applicable percentage reduced on sliding scale at 200% to 400% FPL; For 400% FPL and beyond, applicable percentage set at 8.5%	Subsidy parameters are set annually by the insurance department.	New Mexico Health Care Authority Press Release; HB1; HB2; and New Mexico Health Care Authority
	2023	Premium for Native Americans	Native Americans eligible for ePTC	$0 up to 300% FPL, then applicable percentage increases on a sliding scale from 1% to 1.85% for incomes between 300% and 400% FPL; Beyond 400%, applicable percentage is set at 8.5%		
	2023	Cost-sharing	APTC-eligible enrollees with income up to 400% FPL	Provides 90%, 95% or 99% AV depending on income; Must select Turquoise Plan, which, depending on income, is a silver (up to 200% FPL) or gold (200% to 400% FPL) variant		
New York	2025	Cost-sharing	APTC-eligible enrollees with incomes 250% to 400% FPL	Provides 87% AV plan for incomes 250% to 350% FPL and 73% AV plans at 350% and 400% FPL; Additional subsidy eliminates cost-sharing for most diabetes, pregnancy, and postpartum services	Subject to change since the 1332 waiver, which was the funding source, will likely end in 2026 due to H.R.1 cuts. Under the waiver, enrollees with incomes up to 250% FPL	New York State of Health

STATE	EFFECTIVE DATE	SUBSIDY TYPE	ELIGIBLE POPULATION	SUBSIDY STRUCTURE	NOTES	SOURCES
					get Essential Plan with no premium and 100% AV.	
Vermont	2014	Premium	APTC-eligible enrollees with income up to 300% FPL	Reduces PTC applicable percentages by 1.5 percentage points.	Premium and cost-sharing subsidy parameters are set by statute.	Vermont Statutes Title 33, Ch. 018; and Vermont Health Connect
		Cost-Sharing		Provides 73% AV for 250% to 300% FPL; 77% AV for 201% to 250% FPL		
Washington	2023	Premium	APTC recipients with income up to 250% FPL enrolled in Cascade Care (standard plan) silver or gold plan	Provide $55 flat amount per member per month, capped at net premium after APTC for the lowest-cost Cascade Care silver plan	Marketplace determines amounts annually based on statutory guidelines and available funding.	Washington Health Benefit Exchange; and Engrossed Second Substitute SB 5377.

Notes: Eligible population and structure shown are for 2026 and may have differed in earlier years. Some subsidies are permanent under current law, some enacted only for a single year, and others are somewhere in between, where new funding or other action is required each year.

Table 4. Parameters of State Individual Health Insurance Subsidies for APTC-Ineligible Consumers, 2026

STATE	EFFECTIVE DATE	SUBSIDY TYPE	ELIGIBLE POPULATION	SUBSIDY STRUCTURE	NOTES	SOURCES
Colorado	2023	Premium and Cost-Sharing	OmniSalud enrollees who are ineligible for APTC and other affordability programs with income below 150% FPL can enter lottery for subsidy. New in 2026, must be 2025 subsidy recipient to enter lottery.	Provides Silver Enhanced 73% Plan with $0 Premium; Relies on off-Marketplace individual market coverage sold through Marketplace-like portal	Parameters are set annually by the insurance department with the advisory board in consultation with the Health Insurance Affordability Enterprise. Due to reduced funding, approximately 6,700 individuals will receive Silver Enhanced Savings in 2026, a 44% decrease from 2025.	Connect for Health Colorado
New Mexico	November 2025	Premium and Cost-Sharing	Lawfully present non-citizens who are QHP-eligible, APTC-ineligible, and have income up to 100% FPL	Premium subsidy is set to have applicable percentage of 0%, can be used to purchase a plan of any metal tier other than catastrophic Cost-sharing subsidy provides turquoise plans (silver variants) with 99% AV	Parameters set by the New Mexico Health Care Authority with funds from the Health Care Affordability Fund, which was established in 2023; Created in response to federal changes in H.R.1.	New Mexico Health Care Authority
Washington	2024	Premium	QHP-eligible, APTC-ineligible enrollees with income below 250% FPL	Flat amount of $250 per member per month, capped at consumer premium	Marketplace determines amounts annually based on statutory guidelines and available funding.	Washington Health Benefit Exchange and 1332 Waiver Approval

Notes: Eligible population and structure shown are for 2026 and may have differed in earlier years. Abbreviations used: QHP=Qualified health plan

Premium Subsidy Design Considerations

A state premium subsidy's amount can be calculated in several ways. As with the PTC, the subsidy calculation is generally invisible to the consumer—based on their income, they will be presented with coverage options with different premiums. And every subsidy is capped at the consumer's net premium after APTC, so consumers can't "turn a profit."

- **Flat dollar amount**. A simple approach is for the credit to be a flat dollar amount per year or per month (often called a "per member per month" amount or PMPM). For example, Washington's subsidy in 2026 provides a flat $55 PMPM ($250 if ineligible for federal subsidies). Colorado's subsidy for APTC-eligible consumers provides up to $80 per month for the first household member and $29 per month for each additional household member. This approach is generally progressive, since a fixed amount is a larger percentage of a lower income. A fixed amount will generally cover a larger fraction of the premium owed by lower-income people.
- **Fixed reduction in applicable percentages**. A subsidy may reduce the consumer's expected premium contribution as a share of income by a fixed delta below the PTC applicable percentages. For example, Vermont's subsidy reduces the PTC applicable percentage for eligible people by 1.5 percentage points. However, this approach generally provides a larger subsidy at higher incomes, since a fixed percentage of a larger income is a larger amount.
- **Alternative schedule of applicable percentages**. A state subsidy can be set to reduce the PTC's applicable percentage schedule to a lower one. For example, it could match the schedule under enhanced PTCs. Maryland's and California's subsidies in 2026 both follow this approach, providing a subsidy sufficient to match the enhanced PTCs' applicable percentages for consumers with incomes up to 200% FPL and 150% FPL, respectively. California's subsidy also reduces the applicable percentage from about 4.5% to between 3.19% and 3.91% for enrollees with incomes between 150% and 165% FPL, while Maryland replaces 50% of the enhanced federal subsidies for those between 250% and 400% FPL. (Maryland further reduces the applicable percentages for young adult enrollees ages 18 to 37, as discussed below). New Mexico has its own reduced applicable percentage schedule and a further reduced schedule for Native Americans. This approach can be tailored to distribute assistance as desired.
- **Stepwise subsidy schedule.** Massachusetts' and New Jersey's subsidy change stepwise across income ranges, creating small cliffs between steps. Massachusetts' subsidy is set so that, combined with the PTC, individual contributions satisfy the affordability standard under the state's individual mandate. New Jersey's subsidy is a flat amount that varies across FPL thresholds, subject to caps.
- **Full premium.** Some subsidies pay the full premium for a specific benchmark plan, so consumers generally owe a premium only if they choose a more expensive plan. In addition to making coverage more affordable, this can expand coverage by alleviating administrative burden of paying even a small premium, which research shows can substantially reduce enrollment. Connecticut's subsidy program covers the full post-APTC silver premium for people with incomes up to 175% FPL. Colorado's subsidy for PTC-ineligible people pays the full premium for a 73% silver variant plan. Both Massachusetts' and California' subsidies are sufficient at very low incomes to zero out the premium contribution for a benchmark plan. And the subsidies in Rhode Island and New Mexico for those transitioning from Medicaid, mentioned above, were designed to pay the first month's net premium after APTC. A small

state subsidy can also cover the $1 per member per month of segregated cost for abortion coverage. For example, Colorado provides such a subsidy to ensure compliance with both the state law requiring insurers to cover abortion and the federal law prohibiting federal dollars from funding covering abortion. A state could also tie eligibility to owing a small premium, thereby potentially increasing coverage substantially with only a very small expenditure.

Cost-Sharing Subsidy Design Considerations

State cost-sharing subsidies all use the same general approach as the ACA CSRs: paying insurers the differential cost of a plan with a higher AV, which translates into lower deductibles and other cost-sharing. A cost-sharing subsidy raises several design issues:

- **New versus existing silver variants**. As with federal CSRs, most state subsidies rely on silver variants. States may either create new silver variants or reuse existing variants, extending them to higher incomes. For example, New Mexico's cost-sharing subsidy creates new 90%, 95%, and 99% variants, while Colorado's cost-sharing subsidy (which has since been replaced with a premium subsidy) extended the 94% variant to higher incomes. Creating new variants requires some additional work by insurers and insurance departments, but it also provides greater flexibility. A state could also use a combination of new and existing variants—the approach taken by Massachusetts and Vermont.
- **Metal level to build off**. While most state cost-sharing subsidies build on federal CSRs by increasing the generosity of silver variants, New Mexico's relies on silver plans between 100% and 200% FPL but gold plans between 200% and 400% FPL. New Mexico explains that this bifurcated approach reduces the cost of the state subsidy, since silver premiums are increased by silver loading, making it is less expensive to provide a high AV building on an 80% gold plan than a 70% or 73% silver plan.
- **Payment approach**: States pay for the higher-AV coverage in several ways. Most states use the approach taken by the federal government before CSR payments were discontinued in 2017, paying an estimated amount upfront and then reconciling based on the insurer's actual cost. California, Massachusetts, New Mexico, and Vermont take this approach. Some states, such as Colorado, pay insurers the estimated cost differential of the higher-AV plan. A state could also pay insurers the actual cost of the forgone deductibles and co-payments.[7]

Legislative Approach

States can use legislation to specify parameters or leave varying degrees of flexibility. For example, Vermont's statute specifies a premium subsidy that reduces enrollees' applicable percentages by 1.5% and specific AVs that vary by income level. Colorado's statute created the Health Insurance Affordability Board, leaving details to the administrative process, which sets subsidy parameters and makes decisions such as electing to target cost-sharing instead of premium subsidies. The more flexible approach may be helpful in permitting states to adjust to changed circumstances without seeking additional legislation.

PAYING FOR A STATE SUBSIDY

Often the biggest challenge in establishing a state subsidy is paying for it. The current budget environment may be especially challenging due to federal policy changes in H.R.1. Even as it created new affordability gaps that states may wish to fill, as discussed above, H.R.1 also shifted costs from the

[7] Direct communication with Health Insurance Affordability Enterprise staff.

federal government to states for benefit programs such as Medicaid and the Supplemental Nutrition Assistance Program. It also reduced expected tax revenues in the many states that tie their taxable income concepts to federal law. Because of these and other factors, funding is in doubt for several of the existing subsidies.

Fortunately, states have numerous funding options, several of which have been successfully deployed. Table 5 illustrates the funding sources leveraged by states.

Health Sector Fees and Other Taxes

Many states fund subsidies with sources connected to health coverage. For example, subsidies in Colorado, Maryland, New Jersey, and New Mexico are supported by health insurer fees, which generally replaced the ACA's federal health insurer fee after it was repealed in 2021. Subsidies in California, Massachusetts, and New Jersey are supported in part by payments from individuals who have access to affordable health insurance but choose not to enroll (individual mandates). Massachusetts also collects an employer contribution to support its subsidies and relies on taxes. Several states also rely on general fund revenue, and other sources could be used as well.

Revenue Opportunities Stemming From H.R.1

H.R.1 will greatly increase the financial burden on states through benefit cuts and cost shifts, as discussed above. But it also created two revenue opportunities for states. First, H.R.1 reduced states' expected tax revenues, since most states tie their taxable income concepts to federal law. Some state income taxes automatically update to reflect the latest federal law —an approach known as "rolling conformity." Other states generally enact periodic legislation to conform to some or all federal changes. States with rolling conformity can reverse H.R.1-imposed revenue cuts by "decoupling" from the new federal tax cuts. States that generally enact legislation to conform could refrain from adopting some of the new federal cuts.

Second, H.R.1 provided substantial tax cuts for the highest-income families and corporations. This includes both extending tax cuts due to expire after 2025 and also new tax cuts. CBO estimates that H.R.1 increases the resources of highest-income decile by $13,622 per household. States could maintain affordable coverage despite the federal reductions by soaking up some of this forgone federal revenue with state taxes to support a state Marketplace subsidy.

Federal Waivers Under Sections 1332 and 1115

Some states have sought to fund subsidies with pass-through funding from section 1332 state innovation waivers, but this has proven challenging and may be even more so in the current environment. Section 1332 permits states to waive or modify certain ACA coverage provisions and—if the changes reduce PTC spending—receive the federal savings as "pass-through funding" to support the waiver. But paying for state subsidies with section 1332 waivers is impeded by strict statutory guardrails, procedural hurdles, and federal discretion and oversight.

A section 1332 waiver is generally not a good funding source for a premium subsidy for PTC-eligible people. That's because a premium subsidy generally increases enrollment, which adds to the federal cost and therefore—if funded through the waiver—reduces whatever pass-through funding might otherwise be available. Thus, if a state has pass-through funding available, it is better off using it for another purpose and paying for the subsidy with funds separate from the waiver. One possible exception is a subsidy targeted at PTC-eligible people whose enrollment improves the risk pool, like

young adults. But even there, available analysis suggests savings due to risk pool improvements could defray only a small fraction of the cost of such a subsidy.

Section 1332 is potentially more promising as a funding source for subsidies for populations that improve the risk pool and are ineligible for PTC, since increasing enrollment for these populations doesn't typically increase federal costs. However, experience suggests that this is also challenging due to difficulties of demonstrating savings to the satisfaction of federal agencies. For example, Washington's initial 1332 waiver application sought pass-through funding based on savings created from risk pool improvements due to subsidizing coverage for non-citizens. But this request was rejected in 2022, with the federal government explaining it did not see sufficient evidence about the effects on the risk pool.

A waiver may also create savings to support a subsidy by reducing provider payments and thus Marketplace premiums. But this approach also appears challenging. Colorado's waiver amendment taking this approach has resulted in relatively little pass-through funding due to the challenges of getting the federal government to recognize the savings. States should also consider that seeking and implementing such waivers is time-consuming and costly and requires intensive ongoing federal coordination and oversight, and that waiver approval is subject to the discretion of the federal government.

Finally, in the past CMS has approved section 1115 waivers to help support state subsidies. What we know about CMS' direction under the current administration suggests that additional waivers of this sort are unlikely for the next several years.

CONCLUSION

The ACA Marketplaces provide a strong chassis for providing affordable health coverage, with meaningful consumer protections, a convenient shopping platform, and substantial financial federal assistance. But federal subsidies are not sufficient to make coverage universally affordable, especially in the wake of recent federal policy changes. Fortunately, state subsidies can fill these affordability gaps. They can address premiums and cost-sharing, help populations denied federal assistance, and be targeted in any number of ways. For states with sufficient budget resources, state subsidies provide crucial flexibility to take control of the ACA affordability landscape.

Table 5. Funding Sources and Representative Cost Estimates for Select State Subsidies

STATE	SUBSIDY TYPE	FUNDING SOURCE(S)	STATE ESTIMATE OF COST	NOTES	SOURCES
California	Premium	State individual mandate	$175 million (New for PY26)	The 2026 premium subsidy will be funded with $190 million in funding from a reserve fund.	Covered California June 2021, April 2025, and July 2025 Board Meetings; Covered California Guidance for 2026; Covered California Presentation; and 2025-26 Budget Summary.
Colorado	Premium (APTC-eligible)	Fee assessed on insurers; general revenues; for 2026, revenues from the sale of tax credits against future fee liability	$75 million (PY26)	Additional one-year funding for both the APTC-eligible and ineligible subsidies was added during a special session in 2026.	Health Insurance Affordability Enterprise September 2025 and October 2025 Board Meetings; HB25B – 1006; and Colorado Department of Regulatory Agencies
	Premium and Cost-Sharing (APTC-ineligible)		$50 million (PY26)		
Connecticut	Premium and Cost-Sharing (Covered CT)	General revenues, other dedicated funds	$64.6 million (PY26)		Connecticut State Budget FY26-27; Access Health CT Press Release; and Letter from Secretary Wojcik
	Premium (New subsidy)	General revenues via a special fund to mitigate federal changes	$50.76 million (PY26)	During a November 2025 special session, $500 million was appropriated from the Budget Reserve Fund to the Office of Policy & Management for mitigation efforts relating to federal policy changes– $114.86 million is a draw down from these funds.	
Maryland	Premium	State health insurer fee	$132 million to $136 million (PY26)	2026 subsidy is administered using existing budgetary resources from a special fund.	House Bill 1082 Fiscal and Policy Note; and Maryland Health

STATE	SUBSIDY TYPE	FUNDING SOURCE(S)	STATE ESTIMATE OF COST	NOTES	SOURCES
					Benefit Exchange briefing and presentation
Massachusetts	Premium and Cost-Sharing	Cigarette taxes, individual mandate penalties, employer assessments, other dedicated funds	**Premium:** $325 million (PY26) **CSR:** $282 million (PY26)	An additional $250 million from a trust fund is being invested in the ConnectorCare program for 2026.	Direct communication with Massachusetts Health Connector staff; and Massachusetts Health Connector Press Release and Report
New Jersey	Premium	The Health Insurance Affordability Fund, which is made up of insurer assessments and general fund appropriations	$215 million (PY26)		Department of Banking and Insurance Press Release; Department of Banking and Insurance Legislative Q&A; and P.L. 2020, CHAPTER 61
New Mexico	Premium and Cost-Sharing	**APTC-eligible:** The Health Care Affordability Fund (HCAF), which is made up of insurer assessments and general fund appropriations	$72.3 million to $117.1 million (PY26)	Funding for the continuation of premium and cost-sharing subsidies in light of the expiration of ePTCs was approved in the FY26 state budget ($210 million); Additional funds were approved in an October 2025 special legislative session ($17.3 million).	Direct communication with New Mexico Health Care Authority staff; Department of Finance and Administration Budget Recommendation; HB1; HB2; New Mexico Legislative Finance Committee Program Evaluation; and New Mexico Health Care Authority
		APTC-ineligible: HCAF	Estimated $12.6 million (FY27)		
Vermont	Premium	General revenues, other dedicated funds	$ 5.4 million (FY25)		Vermont Health Access Report to the Vermont Legislature; and Vermont Medicaid Reports to the Vermont Legislature
	Cost-Sharing	General revenues	$1.68 million (FY24)		

STATE	SUBSIDY TYPE	FUNDING SOURCE(S)	STATE ESTIMATE OF COST	NOTES	SOURCES
Washington	Premium	**APTC-eligible:** General revenues	$28.7 million (PY26)	2026 subsidy is administered using existing budgetary resources from a special account.	Washington Health Benefit Exchange; 2025-27 Biennial Budget; and Senate Bill 5377
		APTC-ineligible: General revenues	$24.3 million (PY26)		

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