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ACA Subsidy Rollback: A Broader Credit Story for Public Finance - Kroll

KBRA expects an increase in uncompensated care across the health care ecosystem following the expiration of enhanced premium tax credits at the end of 2025, although the magnitude of the impact remains uncertain. This trend has negative credit implications for hospitals and creates knock-on pressures for states already facing budgetary constraints stemming from the One Big Beautiful Bill Act (OBBBA).

While there are proposals in Congress to address the expiration of the enhanced premium tax credits, none represent a long-term solution, and enactment remains uncertain. In KBRA's view, the risk of rising uncompensated care and mounting financial pressures at the state and local levels will remain ongoing credit concerns.

Key Takeaways

- Absent congressional action, enhanced premium tax credits will not be renewed, and current legislative proposals do not offer a long-term solution.
- Hospitals are likely to absorb the cost of increased uncompensated care, which will not be fully addressed by existing public programs designed to mitigate shortfalls.
- Policy changes in Washington are shifting greater responsibility for funding certain federal programs to state and local governments, with some states expanding subsidies to partially offset higher premiums.
- Given constrained governmental budgets and gloomy consumer sentiment,1 these dynamics amount to a zero-sum game and will continue to pressure the credit profiles of municipal issuers.

Background

An enhanced premium tax credit is a refundable credit that helps offset the cost of health insurance premiums for individuals purchasing coverage through the Affordable Care Act (ACA) marketplace. To qualify, a household must not be eligible for employer-sponsored insurance, Medicare, or Medicaid, and household income must not exceed 400% of the federal poverty level (FPL).

Premium tax credits were temporarily enhanced under the American Rescue Plan Act (ARPA) through removing the FPL income cap, increasing the value of the credit, and capping premiums as a percentage of income. These enhancements were subsequently extended through the Inflation Reduction Act (IRA). As of the end of 2025, the enhanced premium tax credits expired, effectively reverting eligibility and benefit levels to their pre-pandemic framework, including the reinstatement of the 400% FPL income cap. In KBRA's view, the absence of these enhancements is likely to result in a decline in the covered population and a meaningful increase in net premiums for those who maintain coverage, developments that could have negative credit implications across several sectors.

Various projections have outlined the possible effects of the expired enhanced premium tax credit on the insured population.2 , 3 For example, the Congressional Budget Office (CBO) estimated that

letting the enhanced premium tax credits expire at the end of 2025 would increase the number of uninsured Americans by about 4.2 million by 2034 relative to a permanent extension of the credits. KBRA notes that most projections to date have overstated actual enrollment declines. The Centers for Medicare and Medicaid Services (CMS) reports4 that for states using the HealthCare.gov platform and state-based exchanges, approximately 22.8 million individuals enrolled in or were automatically renewed for coverage during the 2026 open enrollment period, a decline of 830,000 from approximately 23.6 million people at the same time last year.

KFF notes that enrollment declines have been less pronounced than projected, partly because reported figures reflect early plan selections rather than confirmed, paid coverage; as a result, final enrollment data will be necessary to fully assess the true impact on the covered population.

What Is the Effect of Uncompensated Care on Hospitals?

Uncompensated care places direct financial pressure on hospitals, but its reverberations extend beyond the health care sector, increasingly shifting the burden of addressing coverage gaps to the public sector.

- Hospitals absorb the cost of uncompensated care without reimbursement, compressing margins. Rising levels of uncompensated care often result in higher accounts receivable and increased write-offs, negatively affecting cash flow.
- Federal and state disproportionate share hospital (DSH) payments only partially offset these costs. State-level federal DSH allotments may cap total payments regardless of the level of uncompensated care, while hospital-specific DSH limits may further constrain the amount any individual hospital can receive.
- Thin margins at safety-net and rural hospitals may be further strained. These providers disproportionately serve uninsured and Medicaid patients, who are more likely to generate uncompensated care. Lower patient volumes at rural hospitals amplify the impact, as fixed costs are spread across fewer reimbursable cases.
- Unprofitable services are at heightened risk of reduction or elimination, including in areas where access to care is already limited. Hospitals often cut unprofitable service lines to preserve overall cash flow, potentially requiring patients to travel longer distances for care and increasing the risk of delayed access to time-sensitive treatment.

How Is Uncompensated Care Addressed and How Are States Responding?

The burden of uncompensated care is expected to fall disproportionately on safety-net hospitals, providers in Medicaid non-expansion states, and rural hospitals. There is no single funding mechanism for uncompensated care; instead, costs are addressed through a patchwork of the following public programs and health care provider strategies:

- DSH payments from federal and state governments partially fund clinical care provided to low-income, underinsured, and uninsured patients.
- Additional support is provided by state and local governments through various supplemental programs funded by a mix of appropriations, tax revenues, intergovernmental transfers, and other state premium subsidies.
- As public funding becomes more constrained, some hospitals may seek to shift a portion of the cost burden to private insurers through higher rates paid by the insured population.
- Many hospitals and health systems are increasingly emphasizing population health initiatives that aim to shift the focus from reactive care to proactive wellness. Providers may pursue available federal and state grants to support population health-related investments.

Some states have expanded their health care subsidies to partially offset higher premiums. However, most states did not fully bridge the gap between insurance costs prior to the expiration of the enhanced premium tax credits and costs in the absence of those credits.

Cumulative Pressure on States: The Knock-on Effects

As outlined in KBRA's previous research on the OBBBA and the Federal Emergency Management Agency (FEMA) (see Related Publications section), policy changes in Washington are transferring greater responsibility for funding certain federal programs—particularly indigent care—to state and local governments. Given constrained governmental resources and current gloomy consumer sentiment, these shifts effectively represent a zero-sum game.

- A declining federal share of Medicaid and the Supplemental Nutrition Assistance Program (SNAP) would require states to absorb a greater portion of program costs, materially increasing their cost burden.
- As Medicaid eligibility standards tighten, volumes of uncompensated care are likely to rise, particularly at safety-net hospitals. Many of these providers already operate with minimal financial flexibility and may be forced to rely on additional state or local support or, in more severe cases, cease operations. Political pressure on state and local governments to support safety-net hospitals—especially in rural areas—could therefore intensify.
- Congressional and Trump Administration review of FEMA's role and responsibilities remains ongoing. If states and localities are required to assume a larger share of disaster recovery costs previously covered by FEMA, future federal funding may not be commensurate with current support levels, potentially constraining budgetary capacity to absorb higher costs associated with charity care.

Conclusion

KBRA has previously commented on the transfer of responsibility for certain federal programs to state and local governments. In an environment of constrained resources, these governments face difficult decisions around funding critical social welfare programs. KBRA will continue to monitor congressional legislative efforts related to the expired ACA enhanced premium tax credits, their implications for the nonprofit health care sector, and the broader set of countervailing pressures buffeting states.

Kroll Bond Rating Agency

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