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How Well-Targeted Are the American Rescue Plan Act's Premium Tax Credits?

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Introduction

A major question facing Congress is whether to extend the American Rescue Plan Act (ARPA) premium tax credits (PTCs). Some have raised concerns about providing these benefits to people with incomes above 400 percent of the federal poverty level (FPL). The ARPA made subsidies more generous at each income level and newly extended subsidies to people with incomes above 400 percent of FPL by limiting the amount people at this income level would pay for Marketplace coverage to 8.5 percent of income; before the ARPA, people with incomes above 400 percent of FPL were ineligible for any PTC, regardless of the premium they faced in the Marketplace. Some argue that this unnecessarily extends subsidies to people with high incomes and does not target federal dollars to those in the lowest-income groups. In this brief, we show that the ARPA enhanced PTCs largely increase benefits for people with incomes at or below 400 percent of FPL, but they also provide important benefits for people at somewhat higher income levels who face very high premiums. The beneficiaries of this provision tend to be older adults, to live in regions with high premiums, or to have large families. This brief adds additional detail to earlier published results exploring expected health insurance coverage and spending outcomes if the ARPA subsidies are allowed to expire as they are slated to under current law (Buettgens, Banthin, and Green 2022).

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation’s and Urban Institute Health Policy Center’s websites.

Methods

We produce our estimates using the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

We updated the model using state-level Marketplace enrollment from the 2022 open enrollment period snapshot released by the Centers for Medicare & Medicaid Services.¹ By comparing those enrollment estimates with estimated Marketplace enrollment before the ARPA enhanced PTCs, we measured how the demand for Marketplace coverage increased in each state because of the enhanced PTCs. We found substantial variation across states that has important implications for our results.

We estimated the increase in Marketplace coverage as a result of losses of Medicaid enrollment after the public health emergency expires using our recently updated estimates of Medicaid enrollment in 2022 and 2023 (Buettgens and Green 2022). We describe the details of our methodology in a separate paper (Buettgens and Banthin 2022). For this brief, it is important to note that HIPSM calibrates Marketplace enrollment to the most recent available enrollment data from the Marketplace, Medicaid, and other sources. The model thus reflects the increased enrollment among people with incomes both above and at or below the 400 percent of FPL threshold due to the ARPA subsidies.

Results

Table 1 shows the distribution of subsidized nongroup coverage in 2023 if the ARPA enhanced PTCs expire at the end of 2022 and PTCs revert to the pre-ARPA level in place under the Affordable Care Act

and if the enhanced ARPA subsidies are extended. The table shows that 3.2 million more people with incomes at or below 400 percent of FPL would have subsidized nongroup coverage if the ARPA subsidies were extended. In addition, 1.8 million people with incomes above 400 percent of FPL (about 36 percent of the increase in subsidized coverage under the ARPA) would benefit from the ARPA percentage-of-income cap on premiums.² Of these, most would have incomes between 400 and 600 percent of FPL, although 625,000 would have incomes above 600 percent of FPL.

Table 1 also shows the age distribution of subsidized coverage for people with incomes above 400 percent of FPL. Older people, who face higher premiums in the Marketplace, are more likely to lose subsidized coverage if the ARPA subsidies expire; almost 45 percent of those losing subsidies would be ages 55 to 64. Given how Marketplace subsidies are determined, people with incomes above 400 percent of FPL must face very high premiums to qualify for PTCs. Specifically, their benchmark premium must exceed 8.5 percent of their income. For this reason, extending subsidies to people with incomes beyond 400 percent of FPL primarily helps older people, large families, and residents of high-premium states.

TABLE 1
Subsidized Nongroup Insurance in the ACA Marketplace for the Nonelderly Population, 2023

Income (% of FPL)	Enhanced PTCs Expire		Enhanced PTCs Are Extended		Change	
	Subsidized nongroup insured (1,000s of people)	Share of subsidized nongroup insured (%)	Subsidized nongroup insured (1,000s of people)	Share of subsidized nongroup insured (%)	Change in subsidized nongroup insured (1,000s of people)	Share of change in subsidized nongroup coverage (%)
At or below 400%	9,457	100.0	12,688	87.5	3,231	64.0
Above 400%, by income						
400–500%	0	0.0	750	5.2	749	14.8
500–600%	0	0.0	443	3.1	443	8.8
Above 600%	0	0.0	625	4.3	625	12.4
Total	9,457	100.0	14,506	100.0	5,049	100.0
At or below 400%	9,457	100.0	12,688	87.5	3,231	64.0
Above 400%, by age						
Younger than 20	0	0.0	297	2.0	297	5.9
20–44	0	0.0	302	2.1	302	6.0
45–54	0	0.0	408	2.8	408	8.1
55–64	0	0.0	811	5.6	811	16.1
Total	9,457	100.0	14,506	100.0	5,049	100.0

Source: Health Insurance Policy Simulation Model, 2022

Notes: ACA = Affordable Care Act; PTCs = premium tax credits; FPL = federal poverty level.

Table 2 shows that if the enhanced PTCs were extended, the new federal spending in 2023 would be heavily targeted to people with incomes at or below 400 percent of FPL. About 75 percent of the increased federal spending on subsidies—\$21 billion—would go to people with incomes at or below 400

percent of FPL. Another \$7.1 billion would go to people with higher incomes. Thus, though most new PTC dollars would go to lower-income groups, the remainder would go to people who face significant financial burdens despite their higher incomes.

TABLE 2
Federal Marketplace PTC Spending, 2023

Income (% of FPL)	Enhanced PTCs Expire		Enhanced PTCs Are Extended		Change	
	Federal PTCs (\$billions)	Share of federal PTCs (%)	Federal PTCs (\$billions)	Share of federal PTCs (%)	Change in federal PTCs (\$billions)	Share of new PTC spending (%)
At or below 400%	64.8	100.0	85.8	92.3	21.0	74.6
400–500%	0.0	0.0	3.3	3.6	3.3	11.8
500–600%	0.0	0.0	1.7	1.9	1.7	6.2
Above 600%	0.0	0.0	2.1	2.2	2.1	7.4
Total	64.8	100.0	92.9	100.0	28.1	100.0

Source: Health Insurance Policy Simulation Model, 2022

Notes: PTCs = premium tax credits; FPL = federal poverty level.

Table 3 shows that most of the reduction in uninsurance that would result from extending the ARPA enhanced PTCs would occur among people with incomes at or below 400 percent of FPL. Most people with incomes above 400 percent of FPL who would receive ARPA subsidies if they were extended would be insured without the extension but would pay premiums that would be high relative to their incomes. Nonetheless, a small number, about 267,000, would be newly insured.

TABLE 3
Uninsurance in the Nonelderly Population, 2023

Income (% of FPL)	Enhanced PTCs Expire		Enhanced PTCs Are Extended		Change in the Uninsured Population	
	Uninsured (1,000s of people)	Uninsurance rate (%)	Uninsured (1,000s of people)	Uninsurance rate (%)	1,000s of people	%
At or below 400%	25,038	13.6	22,179	12.0	-2,859	-11.4
400–500%	1,454	5.4	1,339	5.0	-115	-7.9
500–600%	803	4.3	747	4.0	-56	-6.9
Above 600%	1,791	3.7	1,694	3.5	-97	-5.4
Total	29,086	10.4	25,960	9.3	-3,126	-10.7

Source: Health Insurance Policy Simulation Model, 2022

Notes: PTCs = premium tax credits; FPL = federal poverty level.

Table 4 shows the considerable variation across states in the 2022 benchmark plan premium, which we present for hypothetical 30-year-old and 60-year-old singles with incomes of 500 percent of FPL. These are the costs such people would have paid in 2022 for a benchmark plan without the extension of PTCs to people with incomes above 400 percent of FPL under the ARPA. Premiums can be much lower

with the ARPA PTC extension; Marketplace enrollees pay no more than 8.5 percent of their incomes for a benchmark plan. For a person with income equal to 500 percent of FPL, this amount is the same across all states except Alaska and Hawaii.³ Because the PTC is the difference between the benchmark premium and 8.5 percent of income for people with incomes above 400 percent of FPL (if the premium exceeds the 8.5 percent cap), the value of the PTC is greater for people with higher premiums.⁴ For example, a 60-year-old in a state with low premiums still receives PTCs, but PTCs are much larger in states with high premiums. If the ARPA enhanced PTCs were not extended, premium differences by state would be even greater for families (not shown), because family premiums are the sum of each family member’s age-specific premium. States with competitive insurer and hospital markets tend to have lower premiums, but rural states and rural regions within larger states often end up with less competitive markets and, therefore, residents face higher premiums.

Similarly, older adults generally receive much larger PTCs because the Affordable Care Act permits nongroup premiums paid by the oldest adults to be up to three times higher than the premiums paid by the youngest adults.⁵ Indeed, a single 30-year-old earning 500 percent of FPL would have an unsubsidized premium only 42 percent as high as that for a single 60-year-old in most states.⁶ Younger people with similar income but lower premium costs would often receive no PTC, because their premiums are less than 8.5 percent of their incomes. They would be eligible for a subsidy only in the states with high overall premiums (Alabama, Alaska, Connecticut, DC, Nebraska, South Dakota, Utah, West Virginia, and Wyoming) and in states with no variation in premiums by age (New York and Vermont).

TABLE 4

State Average Benchmark Premium versus the ARPA 8.5 Percent of Income Cap, 2022

Dollars per year

State	30-Year-Old with Income of 500% of FPL			60-Year-Old with Income of 500% of FPL		
	Average unsubsidized benchmark premium	Premium cap under ARPA (8.5% of income)	ARPA PTC	Average unsubsidized benchmark premium	Premium cap under ARPA (8.5% of income)	ARPA PTC
AL	6,293	5,474	819	15,048	5,474	9,574
AK	7,638	6,838	800	18,264	6,838	11,426
AZ	4,073	5,474	0	9,740	5,474	4,266
AR	4,123	5,474	0	9,859	5,474	4,385
CA	4,443	5,474	0	10,623	5,474	5,149
CO	3,741	5,474	0	8,946	5,474	3,472
CT	6,149	5,474	675	14,703	5,474	9,229
DE	2,830	5,474	0	9,994	5,474	4,520
DC	5,842	5,474	368	13,970	5,474	8,496
FL	4,876	5,474	0	11,659	5,474	6,185
GA	4,105	5,474	0	9,817	5,474	4,343
HI	5,186	6,299	0	12,401	6,299	6,102
ID	4,841	5,474	0	11,575	5,474	6,101
IL	4,430	5,474	0	10,593	5,474	5,119
IN	4,255	5,474	0	10,174	5,474	4,700
IA	4,848	5,474	0	11,591	5,474	6,117
KS	4,825	5,474	0	11,538	5,474	6,064

State	30-Year-Old with Income of 500% of FPL			60-Year-Old with Income of 500% of FPL		
	Average unsubsidized benchmark premium	Premium cap under ARPA (8.5% of income)	ARPA PTC	Average unsubsidized benchmark premium	Premium cap under ARPA (8.5% of income)	ARPA PTC
KY	4,316	5,474	0	10,321	5,474	4,847
LA	5,453	5,474	0	13,039	5,474	7,565
ME	4,547	5,474	0	10,872	5,474	5,398
MD	3,474	5,474	0	8,307	5,474	2,833
MA	4,835	5,474	0	8,152	5,474	2,678
MI	3,551	5,474	0	8,491	5,474	3,017
MN	3,405	5,474	0	8,142	5,474	2,668
MS	4,787	5,474	0	11,447	5,474	5,973
MO	4,767	5,474	0	11,400	5,474	5,926
MT	5,105	5,474	0	12,208	5,474	6,734
NE	6,151	5,474	677	14,707	5,474	9,233
NV	4,105	5,474	0	9,817	5,474	4,343
NH	3,289	5,474	0	7,863	5,474	2,389
NJ	4,498	5,474	0	10,755	5,474	5,281
NM	4,182	5,474	0	10,000	5,474	4,526
NY	7,248	5,474	1,774	7,248	5,474	1,774
NC	5,263	5,474	0	12,585	5,474	7,111
ND	4,654	5,474	0	11,129	5,474	5,655
OH	3,965	5,474	0	9,480	5,474	4,006
OK	4,814	5,474	0	11,512	5,474	6,038
OR	4,690	5,474	0	11,215	5,474	5,741
PA	4,728	5,474	0	11,305	5,474	5,831
RI	3,837	5,474	0	9,174	5,474	3,700
SC	4,748	5,474	0	11,354	5,474	5,880
SD	6,082	5,474	608	14,543	5,474	9,069
TN	4,732	5,474	0	11,315	5,474	5,841
TX	4,452	5,474	0	10,646	5,474	5,172
UT	5,901	5,474	427	11,006	5,474	5,532
VT	8,991	5,474	3,517	8,991	5,474	3,517
VA	4,801	5,474	0	11,480	5,474	6,006
WA	4,142	5,474	0	9,904	5,474	4,430
WV	8,165	5,474	2,691	19,524	5,474	14,050
WI	4,439	5,474	0	10,615	5,474	5,141
WY	8,095	5,474	2,621	19,356	5,474	13,882

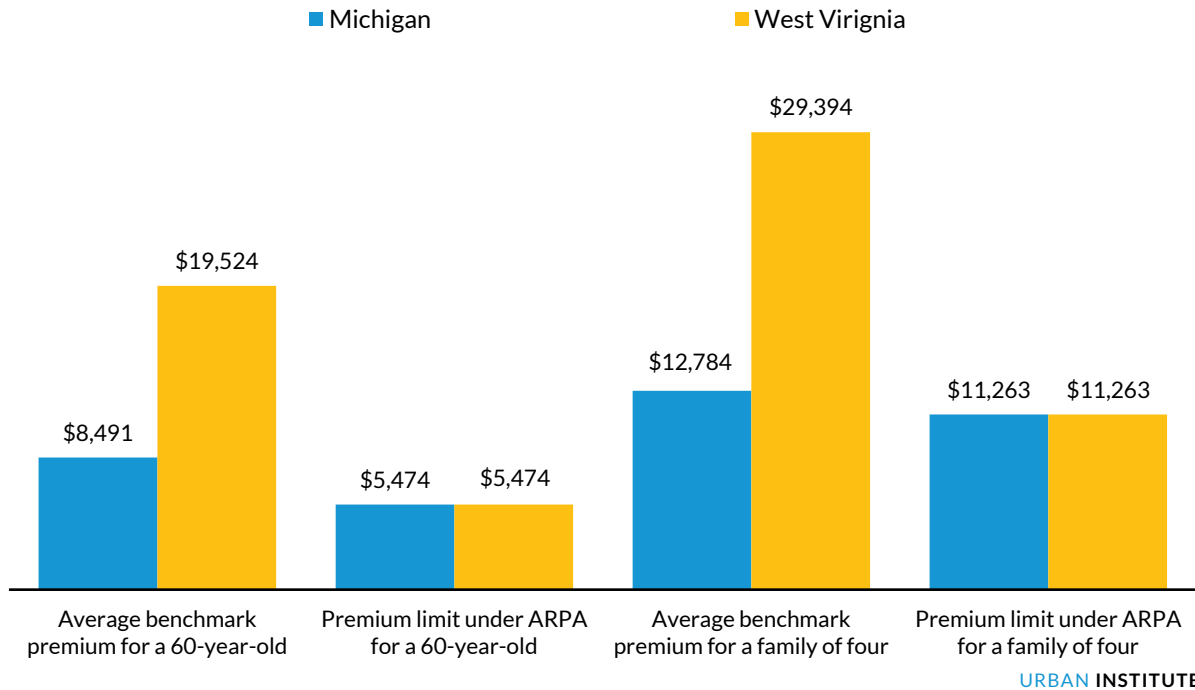
Sources: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and authors' analysis of data from Healthcare.gov and relevant state-based Marketplace websites.

Notes: ARPA = American Rescue Plan Act; PTC = premium tax credit; FPL = federal poverty level. The FPL is higher in Alaska and Hawaii than in the 48 contiguous states and the District of Columbia.

Figure 1 shows that in a low-premium state like Michigan, premium subsidies for people with incomes above 400 percent of FPL are relatively small under the ARPA. But in a state like West Virginia with high premiums in the nongroup market, the protection provided by the 8.5 percent of income cap under the ARPA is quite substantial.

FIGURE 1

Annual Premium Costs for the State Average Benchmark Plan for a Person or Family with Income of 500 Percent of FPL in Michigan (Low Premiums) and West Virginia (High Premiums) under the American Rescue Plan Act, 2022



Sources: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and authors' analysis of data from Healthcare.gov.

Notes: FPL = federal poverty level; ARPA = American Rescue Plan Act. Example family of four is two 40-year-olds and two children under age 14.

Discussion

If the ARPA PTCs are not extended, eligibility for PTCs will be capped at 400 percent of FPL (\$54,400 for a single adult or \$92,100 for a family of three). Under the ARPA, PTCs are available to people in this higher-income group who face Marketplace premiums that exceed 8.5 percent of their family incomes. The people who benefit the most from this ARPA provision include 50-to-64-year-olds and those living in areas with higher premiums, such as certain rural communities and areas with fewer insurers competing in the Marketplace. We estimate that if the ARPA PTCs expire, people losing PTCs will see annual average silver premiums climb by more than 40 percent, from \$4,928 to \$6,931 per person.⁷

Most people who will benefit from extension of the ARPA PTCs will have incomes at or below 400 percent of FPL. Similarly, most new spending under an extension of the ARPA PTCs would go to people with incomes at or below 400 percent of FPL. People with incomes above 400 percent of FPL who receive subsidies under the ARPA face high premium costs because of their age, family size, or residence in an area with high nongroup premiums; these high-premium areas typically are rural, have a high

concentration of providers, or have little choice in nongroup insurers. Thus, though most new federal spending under an extension of the enhanced PTCs would go to people with lower incomes, spending on those with incomes above 400 percent of FPL would also be well targeted. Further, given that premiums for employer-sponsored insurance are generally excluded from taxation for people at all income levels, a precedent for subsidizing health insurance for people with incomes above 400 percent of FPL already exists.

Notes

- ¹ Centers for Medicare & Medicaid Services, “Marketplace 2022 Open Enrollment Period Report: Final National Snapshot,” news release, January 27, 2022, <https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot>.
- ² Our estimate is similar to the Congressional Budget Office’s estimate that 40 percent of the people who gained Marketplace coverage under the ARPA have incomes above 400 percent of FPL (CBO 2021)
- ³ Both table 4 and figure 1 show premiums, the 8.5 percent of income limit on premiums for a person or family earning 500 percent of FPL, and the available PTC applicable in 2022, the latest year for which we have compiled premiums. Both premiums and the level of the cap will increase with inflation; the distribution of states into high- and low-premium categories is relatively stable over time.
- ⁴ Though the ARPA is often described as eliminating the income cap for people with incomes above 400 percent of FPL, an income cap is still in place because of the operation of the PTC calculation. No one with income exceeding 11.8 (1/0.085) times the benchmark premium qualifies for a credit. For example, if the benchmark premium is \$8,500, no one with income above \$100,000 qualifies. If the benchmark premium is \$17,000, no one with income above \$200,000 qualifies.
- ⁵ The details of premium age rating can vary by state; see “State Specific Age Curve Variation,” Centers for Medicare & Medicaid Services, accessed July 5, 2022, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf>. Most states use a 3:1 ratio, but Massachusetts uses a 2:1 ratio, and premiums do not vary by age in New York and Vermont.
- ⁶ Under the Affordable Care Act, premiums for adults can vary by age up to a limit of 3 (for the highest premiums for the oldest people) to 1 (for the lowest premiums for young adults).
- ⁷ Jessica Banthin and Andrew Green, “Allowing the American Rescue Plan Premium Tax Credits to Expire Would Reverse Recent Progress in Reducing the Rate of Uninsured Americans,” *Urban Wire* (blog), Urban Institute, May 25, 2022, <https://www.urban.org/urban-wire/allowing-american-rescue-plan-premium-tax-credits-expire-would-reverse-recent-progress>.

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About the Authors

Michael Simpson is a principal research associate in the Health Policy Center at the Urban Institute with 25 years of experience developing economic models and using survey and administrative data. His current work focuses on using Urban’s Health Insurance Policy Simulation Model to project health insurance coverage and spending both in the baseline and under policy alternatives. Before joining Urban, Simpson developed the Congressional Budget Office’s long-term dynamic microsimulation model. He analyzed numerous policy reform proposals, investigated differences between various projections of Social Security finances and benefits, quantified the importance of Monte Carlo variation in model results, and created multiple methods to demonstrate uncertainty in projections.

John Holahan is an Institute fellow in the Health Policy Center, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impacts of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Jessica Banthin is a senior fellow in the Health Policy Center, where she studies the effects of health insurance reform policies on coverage and costs. Before joining the Urban Institute, she served more than 25 years in the federal government, most recently as deputy assistant director for health at the Congressional Budget Office. During her eight-year term at the Congressional Budget Office, Banthin directed the production of numerous major cost estimates of legislative proposals to modify the Affordable Care Act. Banthin has contributed to Congressional Budget Office reports and written about how reform proposals affect individuals’ and families’ incentives to enroll in coverage, influence employers’ decisions to offer coverage to their employees, and affect insurance market competitiveness. In her recent work, Banthin has written on competition in insurer markets and the accuracy of various data sources used in modeling health reforms.

Matthew Buettgens is a senior fellow in the Health Policy Center, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state by state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

Erik Wengle is a research analyst in the Health Policy Center using both quantitative and qualitative analyses in the monitoring of the Affordable Care Act Marketplaces and private health insurance. His research to date has focused primarily on the implementation of the Affordable Care Act and the future outlook of the health insurance Marketplaces and health reform at large. Additionally, Wengle has written extensively on the competition and market dynamics of the health insurance marketplaces and its interactions with private health insurance more broadly. He has analyzed various health reform proposals both actively under legislative construction and theoretical. Wengle graduated from the University of Maryland with a BS in environmental science and policy.

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