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Evidence from Covered California

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Author

Masse, Estelle

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The Effect of Geographic Cost-of-Living Differences on Health Insurance Subsidies: Evidence from Covered California

Estelle Masse

Abstract

This analysis seeks to answer the following research question: Do counties with higher cost-of-living pressures exhibit greater average reported difficulty affording insurance? More specifically, do counties that demonstrate a larger share of residents with a rent burden greater than 30% of their income exhibit greater average difficulty affording health insurance under Covered California, controlling for subsidy eligibility composition and age? To answer this question, I used a standard OLS regression to compare the share of residents with rent burdens greater than 30% in each county with its respective average reported difficulty score. I then controlled for subsidy eligibility (the current metric for assigning Affordable Care Act (ACA) subsidies) and age, which accounts for age-rated premium variation in the market. I find that local housing affordability pressures meaningfully shape perceptions of ACA marketplace affordability. A greater share of housing-cost-burdened residents is positively correlated with difficulty finding affordable health insurance through Covered California. This finding was statistically significant ($p = 0.04$), which is especially important for healthcare policy following the expiration of federal enhanced premium tax credits in 2025, leaving many individuals with a stark increase in health insurance costs. If California seeks to mitigate this effect through its own enhanced health insurance subsidies, it may need to better account for geographic differences in the cost of living.

Introduction

Health insurance affordability in the United States is influenced not only by income, but by the broader financial pressures households face. Under the Affordable Care Act (ACA), premium subsidies are indexed to income relative to the Federal Poverty Level (FPL), a structure that assumes purchasing power is roughly uniform across geography. Yet in a state as economically diverse as California, this assumption may not hold. Using 2024 county-level data from the UCLA Center for Health Policy Research's California Health Interview Survey (CHIS) and the U.S. Census Bureau's American Community Survey (ACS), this analysis asks whether counties with higher cost-of-living pressures exhibit greater average reported difficulty affording health insurance. More specifically, do counties that demonstrate a larger share of residents with a rent burden greater than 30% of their income exhibit greater average difficulty affording health insurance under Covered California, controlling for subsidy eligibility composition and age? Using an OLS regression framework, I find evidence that local housing affordability pressures statistically significantly shape perceptions of ACA marketplace affordability ($p = 0.04$), after accounting for subsidy eligibility and age. This finding is especially relevant following the expiration of federal enhanced premium tax credits at the end of 2025, which produced a statewide premium increase of more than 10% and left 160,000 Californians without subsidy eligibility (McConville & Mustala, 2026). If California seeks to mitigate this effect through its own enhanced subsidies, it may need to better account for geographic differences in the cost of living.

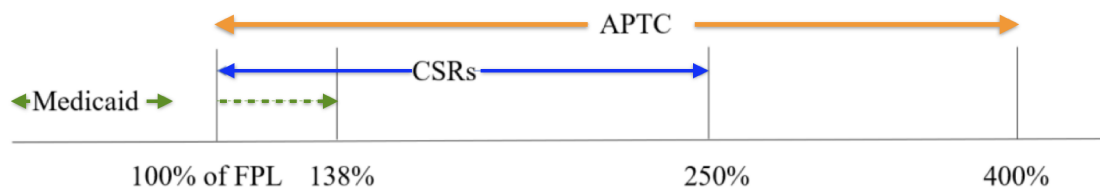
Context & Significance

As structured under the Affordable Care Act (ACA), individuals and families below 400% of the Federal Poverty Level (FPL) are eligible for health insurance exchange

(Marketplace) subsidies to offset the cost of health insurance premiums. This coverage is the sum of the ACA's two main components: The first, Medicaid expansion in 2014, broadened Medicaid eligibility to include individuals below 138% of the FPL for some states (including California) (See Figure 1; Liu & Geng, 2023). The second component is the Advanced Premium Tax Credit (APTC), which effectively limits a household's net premium for a silver plan to between 2% and 10% of annual income (LAO, 2022) for households between 100% and 400% of the FPL (LAO, 2022). Silver plans pay, on average, about 70% of medical costs (Covered California, 2026). They are the only plans eligible for cost-sharing reductions: subsidies that reduce households' out-of-pocket costs, such as copays, deductibles, and annual out-of-pocket maximums (LAO, 2022).

Figure 1

Eligibility Requirements for Medicaid, CSRs, and APTC



Note: The green dotted line represents the eligibility requirements for Medicaid in Medicaid expansion states

Figure Source: Liu & Geng, 2023

However, after Congress failed to renew federal enhanced subsidies at the end of 2025, Affordable Care Act (ACA) premiums increased nationally by more than 20% on average in 2026, and by more than 10% in California (Holahan & O'Brien, 2026). Increases in healthcare system consolidation, wages, and utilization of certain treatments (such as new weight-loss drugs) have already led to general increases in employer-sponsored plans. These increases, along

with the expiration of enhanced federal tax credits, have also reduced the number of ACA marketplace enrollees. This phenomenon fosters insurers' belief that they face greater risk, causing them to either drop out of the ACA marketplace or continue participating with higher premiums (Holahan & O'Brien, 2026).

The American Rescue Plan Act of 2021 (ARPA) established these federal enhanced subsidies to buffer economic shocks during the COVID-19 pandemic (Fung et al., 2023, 1017). Before its implementation, enrollees at the median level of healthcare spending spent about 7–15% of their income on premiums and out-of-pocket costs (Fung et al., 2023, 1011). Under ARPA, premium subsidies increased for everyone, including those with incomes above 400% of the federal poverty level, who had previously not been eligible for subsidies (Fung et al., 2023, 1011). As part of the Inflation Reduction Act of 2022, these increased subsidies were extended until 2025. In addition, people who received or were approved to receive unemployment compensation at any time during 2021 were eligible for zero- or near-zero-premium Marketplace silver plans (Fung et al., 2023, 1011). As a result, Marketplace enrollment increased from 11.4 million in 2020 to 14.5 million in 2022 and around 16 million in 2023 (Fung et al., 2023, 1012).

While this expiration may seem to be a return to the status quo, the market has changed. Rising health insurance costs are a growing concern, particularly because the average employee contribution for an employer-sponsored family plan increased by 22% since 2017 (Fung et al., 2023, 1). California also faces unique obstacles due to the high cost of living. To put into perspective, in 2024, California's estimated rent prices were more than 53% higher than the US overall (Zakharenko, 2026). The San Francisco metropolitan area had the highest overall cost of living in the country, with prices nearly 16% higher than the national average (Zakharenko, 2026). In addition, premiums vary considerably across California regions due to differences in

health care markets (McConville & Mustala, 2026). Costs are much lower in large Southern California counties such as Los Angeles, San Diego, and Riverside compared to other areas, especially rural counties in the state's northern region and parts of the Central Coast (McConville & Mustala, 2026). Increases also vary across the state, from about 7.4% in the Sacramento region to nearly 13% in Fresno. This context is relevant when discussing "affordability," which can be explained using the household budget approach: "At each level of income, are sufficient funds available to pay for healthcare after accounting for spending on other essentials like housing, food, transportation, and childcare?" (Lucia & Jacobs, 2018).

While California's statewide increase in Covered California premiums is lower than the national increase of 26% for 2026, it is still the largest increase in recent years (a little over 10%) (McConville & Mustala, 2026). About 90% of Covered California enrollees received federal subsidies that increase with premiums, providing some buffer against higher costs (McConville & Mustala, 2026). However, without these enhanced tax credits, many Californians will pay more this year. This will be especially relevant for middle-income families, who face the largest absolute increases (McConville & Mustala, 2026). As of January 2026, 160,000 Californians who purchased insurance through Covered California in 2025 lost their eligibility for federal subsidies (McConville & Mustala, 2026). This is in part due to an affordability gap: individuals across California earn too much to qualify for Medi-Cal with no premiums or cost sharing, but do not earn enough to afford Covered California insurance even with subsidies. The upper income limit for premium subsidies under the ACA (four times the FPL, or 400%) is equivalent to five times that level in California (500%) and six times that level in San Francisco (600%) (Lucia & Jacobs, 2018). More specifically, 50-year-olds or older and those with an individual family income between \$48,240 and \$72,360 do not qualify for premium subsidies, yet

premiums rise significantly with age (Lucia & Jacobs, 2018). In many cases, this means many Californians who need it the most will be left without access to affordable health insurance.

Literature Review

ACA Marketplace & Affordability

This paper expands on existing literature surrounding the ACA Marketplace and health insurance affordability. A 2025 analysis conducted by Kohn et al. examined the total cost of coverage for members in California's marketplace as a percentage of household income in 2019 and 2022. They found that in 2022, the average total cost of coverage for households below 400% of the federal poverty line was 6.6% of household income compared with 8.7% in 2019 (Kohn et al., 2025, 1). Decreases in net premiums drove the overall decrease in cost, since out-of-pocket costs remained relatively unchanged (Kohn et al., 2025,1). They also found that the total cost of coverage as a percentage of household income is progressively distributed and varies substantially by plan metal tier. This implied that income-adjusted affordability measures established under the ACA reduced financial burdens for many consumers (Kohn et al., 2025,4).

Broader theoretical work on consumer insurance behavior offers a useful lens for understanding these perceptions of affordability. Research on insurance repurchase intention suggests that perceived costs, rather than absolute cost levels, more strongly shape individual financial decision-making (Eftekhari et al., 2015, 10). Consumers evaluate value by subjectively weighing perceived gains against perceived disadvantages, not merely through objective price, meaning that two individuals facing identical premiums may reach entirely different conclusions about affordability based on their broader financial circumstances (Eftekhari et al., 2015, 10). When perceived costs are high, both the functional and emotional value of insurance diminish, reducing the likelihood of enrollment or renewal (Eftekhari et al., 2015, 18). Applied to health

insurance, this framework suggests that enrollment decisions hinge on whether individuals believe premium costs, compounded by out-of-pocket expenses and competing financial obligations, are justified by expected coverage benefits.

Housing Burden

This paper builds on these frameworks by determining whether geographic cost-of-living differences play a role in affordability in addition to income. Housing burden was specifically targeted for several reasons: First, high housing costs may limit financial resources available for other essential expenses, such as routine doctor visits, general healthcare, or prescribed medication (Mehdipanah, 2023, 419; Meltzer & Schwartz, 2016). Second, low-income households often live in substandard housing, exposing them to environmental hazards (overcrowding, inadequate heating and cooling, and poor air and water quality) that can negatively impact their health (Mehdipanah, 2023, 420). Finally, severe rent burden can lead to increased housing instability and evictions, which can disrupt medical care continuity and escalate psychological distress (Mehdipanah, 2023, 421–422).

Housing burden and insurance expenditures were previously studied in a 2025 paper by Melanie M. Lytell, which demonstrated that even small increases in housing burden meaningfully shift insurance choices. More specifically, a one-percentage-point rise in housing burden is linked to a 0.5% decrease in health insurance (Lytell, 2025). In addition, renters, cash-rent households, and student housing residents spend less than owners, consistent with lower income and limited access to employer-sponsored insurance. The insights garnered from this paper highlight that families and individuals face tradeoffs. When housing affordability pressures impact household budgets, spending in other areas, such as health insurance, is crowded out (Lytell, 2025).

The use of the 30% cutoff is based on the conventional standard for housing rental affordability used since 1981, and applied in another recent study by Cao et al. In this study, they examined the impact of the ACA on health insurance coverage among rent-burdened households (those spending more than 30% of their income on rent) and non-rent-burdened households (Cao et al., 2024, 415). In 2019, nearly half of renter households in the United States were rent-burdened, spending more than 30% of their income on rent; about a quarter were severely rent-burdened, spending over 50% (Cao et al., 2024, 415). Using data from the American Community Survey (ACS), they found that households with incomes below 100% of the FPL allocate approximately 49.8% of their earnings to rent (Cao et al., 2024, 417). Among these households, 75% were considered rent-burdened, and 45.4% were severely rent-burdened, spending more than 50% of their income on rent (Cao et al., 2024, 417). For households earning between 100% and 138% FPL, the average rent expenditure was 42.5% of their income, with 70% classified as rent-burdened and 30.1% as severely rent-burdened (Cao et al., 2024, 417). Their analysis of the association between housing burden and health insurance using ACS data showed that the Medicaid take-up rate increased 8.88% among rent-burdened households and 7.54% among non-rent-burdened households in expansion states (Cao et al., 2024, 415). They also discovered that, conditional on household income and demographic characteristics, rent-burdened households exhibit a 1.5% higher likelihood of Medicaid enrollment, with an additional decline of 0.7% in employer-sponsored insurance and 1% in directly purchased insurance enrollment (Cao et al., 2024, 415). These findings were more pronounced among individuals in states without state-run exchanges and those older than 26 (Cao et al., 2024, 425). These findings further demonstrate that for low-income renters, the high and inflexible cost of

rent consumes a large share of the household budget, creating financial constraints that limit spending on other essentials, such as healthcare.

Theory & Hypothesis

Based on these studies, I suspect that counties with a larger share of residents paying more than 30% of their income on rent will have a higher average difficulty score than counties with a smaller share of respondents paying more than 30% of their income on rent, controlling for subsidy eligibility and age. In other words, in 2024, counties with higher cost-of-living pressures will report greater difficulty affording health insurance than counties with similar incomes and subsidy-eligible residents living in lower-cost counties.

This theory is based on the theoretical concepts and findings of previous studies. While subsidies are indexed to income, they are not necessarily adjusted for local factors, such as geographic cost-of-living differences. These differences, along with rising costs in California, exacerbate affordability gaps present across California counties, where some individuals earn too much to qualify for Medi-Cal with no premiums or cost-sharing, but do not earn enough to afford Covered California insurance even with subsidies (Lucia & Jacobs, 2018). As a result, those living in high-cost counties may face tighter budget constraints, leaving less disposable income to cover premiums and out-of-pocket health care costs (Cao et al., 2024, 417). When facing such difficult tradeoffs, they may perceive greater difficulties with health insurance costs (Eftekhari et al., 2015, 10) despite having incomes that are high relative to the rest of the country (Lucia & Jacobs, 2018) or other California counties with lower housing burdens.

Research Design

The independent variable is cost-of-living pressure measured by the percentage of households spending greater than 30% of their income on rent. These data were gathered from

the United States Census Bureau's 2024 housing characteristics dataset. Rent was chosen as a cost-of-living proxy because it is typically an inflexible cost that cannot be easily adjusted without incurring additional upfront costs, making it a distinct financial burden. In addition, the data shows that the median annual household income needed to qualify for a mortgage on a mid-tier California home in September 2024 was about \$102,000, but has more than doubled in 2025 to \$221,000 (Walters, 2025). Therefore, California has the second-lowest home-ownership rate in the nation, with 55.3% of Californians living in homes they or their families own, leaving many who rent instead (Walters, 2025).

The dependent variable is difficulty finding affordable health insurance, measured on a 1–4 scale based on county-level reported difficulty (1 = “Not at all difficult”, 2 = “Not too difficult”, 3 = “Somewhat difficult”, 4 = “Very difficult”). These data were collected from the “Difficulty of finding affordable plan through Covered California” dataset from the UCLA Center for Health Policy Research (CHIS). A weighted average of these responses was calculated to create a difficulty index for each county, as represented in equation 1.

$$\bar{D} = \frac{\sum_{i=1}^4 i * w_{ci}}{\sum_{i=1}^4 w_{ci}} \quad (1)$$

where $\bar{D}_c$ is the weighted average difficulty score for county c ; i is the difficulty response category (1–4); and w_{ci} is the survey weight of respondents in county c reporting difficulty level i .

The control variables are subsidy eligibility and age. Subsidy eligibility was calculated by aggregating the share of individuals in each county between 100% and 300% of the Federal Poverty Level (FPL) from the 2024 CHIS data. ACA premiums are currently indexed using this variable, so it needs to be isolated to determine the true differences in cost burden across counties. To account for age-rated premium variation in the ACA individual market, ages 55–64

are controlled for. This age range typically faces the most expensive premiums. These data were also pulled from CHIS for 2024 in California.

The sample population was restricted to adults. My benchmark analysis focuses specifically on those aged 18–64, to capture the full view of the working population. However, to isolate the significant increase in insurance premiums from my primary independent variable, I controlled for ages 55–64. The target population was low-to medium-income renters because they face greater housing constraints with less flexibility (Cao et al., 2024, 417)

This study uses a cross-sectional, large-N observational design. I used an Ordinary Least Squares (OLS) regression model to analyze the relationship between the variables. Equation 2 represents the initial bivariate regression analysis using housing burden and difficulty finding affordable health insurance. Equation 3 represents the regression model after adding subsidy eligibility and age controls to check for robustness.

$$\bar{D}_c = \beta_0 + \beta_1 \text{Rent Burden}_c + \varepsilon_c \quad (2)$$

where β_0 is the intercept, β_1 captures the association between rent burden and reported difficulty, and ε_c is the error term.

$$\bar{D}_c = \beta_0 + \beta_1 \text{Rent Burden}_c + \beta_2 \text{Subsidy Elig}_c + \beta_3 \text{Age } 55 - 64_c + \varepsilon_c \quad (3)$$

where $\bar{D}_c$ = average difficulty score for county c; Rent Burden_c = share of residents spending >30% of income on rent; Subsidy Elig_c = share of residents with income between 100–300% FPL; $\text{Age } 55 - 64_c$ = share of residents aged 55–64; ε_c = error term.

Of the 58 California counties, seven (Imperial, Kings, Yolo, Marin, Solano, Lake, and Butte) were excluded due to statistical instability. Tuolumne, Calaveras, Amador, Inyo,

Mariposa, Mono, and Alpine were grouped due to their reduced size and the lack of available data from each county. Del Norte, Siskiyou, Lassen, Trinity, Modoc, Plumas, and Sierra counties were also grouped, along with Tehama, Glenn, and Colusa. The unit of analysis is county-level demographic and cost-of-living measures linked to individual respondents in each county. All variables are restricted to 2024 to examine the pre-expiration state of the marketplace.

Results

Descriptive statistics

The primary descriptive results for 2024 are listed in Table 1. An important value to note, however, is that the mean weighted difficulty score was 2.468. This implies that even before enhanced federal tax credits expired, California counties found it “somewhat difficult” on average to find affordable health insurance under Covered California (Table 1). The median is similar at 2.618 (Table 1).

Table 1

Summary Statistics: County-Level Difficulty Finding Affordable Health Insurance

Statistic	<i>Difficulty Score</i>
Mean	2.468
Median	2.618
Standard Deviation	0.700
Minimum	0.814
Maximum	3.544
Skewness	−0.722
Kurtosis	0.131
Observations	37

Notes: Unit of observation is the county. Difficulty score is a county-level index of self-reported difficulty finding affordable health insurance under Covered California (2024)

Benchmark Results

This analysis examined predictors of reported difficulty finding an affordable plan through Covered California. An initial OLS regression analysis was performed between the proportion of residents with a housing burden greater than 30% and the average difficulty score. I found that a 1 percentage point increase in the share of renters spending 30% or more of their income on housing is associated with a 0.047-point increase in reported difficulty finding an affordable plan (Table 2). This finding was nearly statistically significant with $p = 0.052$.

Table 2

OLS Regression Results: Effect of Housing Burden and Demographics on County-Level Average Difficulty Finding Affordable Health Insurance

	<i>Difficulty Score</i>
Intercept	−0.063 (1.263)
Renter 30%+ Burden (%)	0.047* (0.023)
Observations	37
R ²	0.104
Adjusted R ²	0.078
F-statistic	4.046*

Notes: OLS estimates. Standard errors in parentheses.

* $p < 0.10$. All regressors are measured as percentages.

Robustness Checks

As a robustness check, I included variables such as the proportion of individuals eligible for traditional ACA subsidies (not Medicaid)—an aggregate of the share of individuals in each county between 100% and 300% of the FPL—and the proportion of individuals in each county between the ages of 55–64. Results show that a 1 percentage point increase in the share of renters

spending 30% or more of their income on housing is associated with a 0.052–point increase in reported difficulty finding an affordable plan (Figure 2, Table 3). In context, if 10% more renters had a housing burden greater than 30%, then that county’s difficulty index would increase by 0.52 on the 1–4 difficulty scale. While the overall model is not statistically significant ($F = 0.17$), this relationship is statistically significant ($p = 0.04$). These findings suggest that local housing affordability pressures meaningfully shape perceptions of ACA marketplace affordability. In contrast, subsidy eligibility rates and age structure are not statistically significant predictors once the renter housing burden is included.

Table 3

Robustness Checks: OLS Regression with Additional Controls

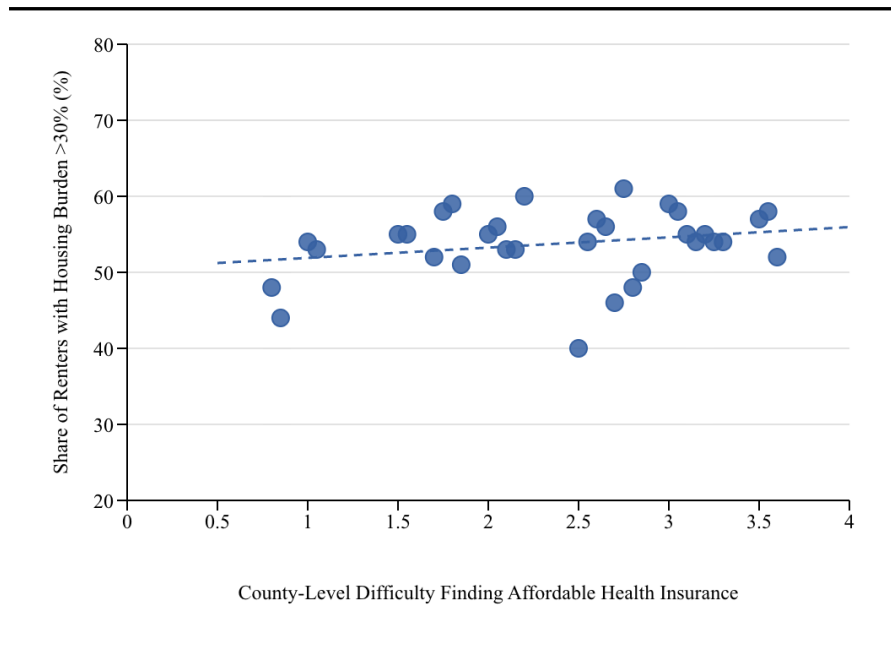
	<i>Average Difficulty Finding Affordable Health Insurance</i>
Intercept	0.664 (1.456)
Renter 30%+ Burden (%)	0.052** (0.024)
Subsidy Eligible (%)	−0.010 (0.010)
Age 55–64 (%)	−0.045 (0.045)
Observations	37
R ²	0.138
Adjusted R ²	0.060
F-statistic	1.764

Notes: OLS estimates. Standard errors in parentheses.

** $p < 0.05$. All regressors are measured as percentages.

Figure 2

County-Level Housing Burden and Difficulty Finding Affordable Health Insurance (2024)



Notes: Each observation represents a county or county group. Dashed line shows OLS linear fit. Housing burden defined as spending more than 30% of income on rent. Difficulty finding affordable health insurance is a county-level index. N=37

Discussion & Research Implications

These findings suggest that the current ACA subsidy framework, which indexes subsidies to income relative to the Federal Poverty Level, does not fully account for geographic variation in purchasing power across California counties. Even after controlling for subsidy eligibility and age, counties with larger shares of rent-burdened households reported meaningfully higher difficulty affording Covered California plans. Two households with identical incomes and subsidy eligibility may face substantially different financial realities depending on where in the state they live.

This result is consistent with prior literature on the household budget approach to affordability. As Lucia & Jacobs (2018) describe using the household budget approach to affordability, the income thresholds used to determine subsidy eligibility do not scale with local

costs of living, meaning that residents of high-cost counties can simultaneously earn too much to qualify for Medi-Cal and too little to afford Covered California plans even with subsidies. At each income level, what matters is whether sufficient funds remain after paying for other essentials such as housing. Their observation that the 400% FPL subsidy cap is equivalent to 500% FPL in California and 600% FPL in San Francisco reflects the same geographic disparity this analysis captures at the county level. The result also aligns with Lytell (2025), who found that even small increases in housing burden shift insurance-related spending, and with Cao et al. (2024), who documented lower rates of directly purchased insurance enrollment among rent-burdened households. This paper extends those findings to the county level, suggesting that the crowding-out effect of housing costs is detectable even in aggregate data.

The behavioral framework offered by Eftekhari et al. (2015) is also relevant here. Their research finds that perceived costs, rather than absolute premium levels, more strongly shape individual financial decision-making. Counties with higher housing burdens may report greater difficulty, not simply because premiums are objectively higher, but because competing financial obligations make the same premium feel less manageable. This distinction matters: it suggests that measuring affordability through income-to-premium ratios alone, as the ACA subsidy structure does, may systematically underestimate financial strain in high-cost regions.

These results are especially relevant given that the federal enhanced premium tax credits expired at the end of 2025, producing a statewide premium increase of more than 10% and leaving 160,000 Californians without subsidy eligibility. The affordability pressures documented here are likely to intensify as a result. If California seeks to mitigate this through its own enhanced subsidies, a geographically adjusted structure that accounts for regional cost-of-living differences, similarly to how federal housing programs use area median income data, could better

align assistance with actual household budget constraints. Targeted outreach in high-burden counties may also help, since perceived unaffordability can itself discourage enrollment even among those who are technically eligible (Eftekhari et al., 2015).

It is also worth addressing one unexpected finding: subsidy eligibility and age did not reach statistical significance once rent burden was included in the model. Given the well-documented premium increases for older enrollees, the age result in particular is notable. One interpretation is that housing burden captures a broader dimension of financial strain that absorbs variation these controls might otherwise explain. It may also be due to the fact that the model used renter data, and older individuals may already own their homes. A simpler explanation, however, is that with only 37 county-level observations, the model lacks sufficient power to detect those relationships reliably.

Limitations & Future Research

While these findings are notable, several limitations temper these results. For one, this analysis relies on county-level aggregates, which may obscure individual-level financial strain. In addition, housing burden serves as a proxy for broader cost-of-living pressures and may not fully capture geographic variation in purchasing power. With only one year's worth of data for 51 counties (37 after grouping smaller counties), statistical power is also limited. Furthermore, when using subsidy eligibility as a control, the CHIS data categories for income relative to the FPL were 0–99%, 100–199%, 200–299%, and 300%+. Since ACA APTC subsidies are capped at 400%, the last category included individuals who would not be subsidy-eligible and were therefore excluded, limiting the scope of the analysis somewhat. It is also important to acknowledge that while this study focuses on rent burden, other household expenses, such as debt and childcare costs, also significantly impact household budgets. In addition, ACS data does

not contain a cost-of-living index that would allow for a broader understanding of the financial constraints counties face.

Future research using individual-level data or more comprehensive regional price indices would allow for a more precise test of whether federal subsidy formulas fully equalize purchasing power across high- and low-cost regions. In addition, using data that categorizes the proportion of individuals in each county with incomes relative to the FPL in bins similar to the current health insurance subsidy structure in California (0–138% for Medicaid, 100–250% for CSRs, and 100–400% for APTC) may produce more comprehensive and applicable results.

Affordability challenges may become more common after the expiration of the federal enhanced premium tax credits, and future research may reflect that shift. When this data becomes available, future analysis may benefit from employing a difference-in-difference (DID) approach to estimate and compare the pre- and post-coverage changes after the expiration.

Conclusion

This paper set out to determine whether counties with higher housing cost burdens report greater difficulty affording health insurance through Covered California, beyond what income and subsidy eligibility alone would predict. Using an OLS regression on 2024 county-level data from CHIS and the ACS, this analysis finds that a 1% increase in the share of rent-burdened households is associated with a statistically significant 0.052-point increase in the county-level difficulty index. This relationship holds even after controlling for subsidy eligibility and age structure. These results suggest that the income-based structure of ACA subsidies does not fully equalize affordability across California's varied cost landscape, and that geographic differences in housing costs represent an independent source of financial pressure for Covered California enrollees. While the cross-sectional design and aggregate unit of analysis limit this analysis to

correlations rather than causal inference, the findings offer a useful signal for policymakers: as California responds to the expiration of federal enhanced tax credits, subsidy designs that account for geographic cost-of-living differences may better reflect the actual budget constraints facing households across the state.

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