CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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CCIIO DATA BRIEF SERIES

Data Brief on State Innovation Waivers: Section 1332 Waivers

April 2024

BACKGROUND

Section 1332 of the Affordable Care Act (ACA) permits states to apply for waivers from certain ACA requirements to pursue innovative and individualized state strategies that provide their residents with access to affordable, quality health care, subject to approval by the Department of Health and Human Services (HHS) and the Department of the Treasury (together with HHS, the Departments). In order for a section 1332 waiver to be approved, the Departments must determine that the waiver: will provide coverage that is at least as comprehensive as the coverage provided without the waiver; will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver; will provide coverage to at least a comparable number of residents as without the waiver; and will not increase the federal deficit. States were first able to apply for section 1332 waivers beginning on January 1, 2017. To date, the Departments have approved section 1332 waivers for 20 states.

Of these 20 states, 18 states are implementing their approved section 1332 waivers during the 2023 plan year (PY).[1,2] Specifically, 17 states operate state-based reinsurance programs by waiving the single risk pool requirement under section 1312(c)(1) of the ACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate.[3] States with section 1332 state-based reinsurance programs have designed and implemented different reinsurance models, most of which are a claims cost-based model, where qualifying insurers are reimbursed for a percentage ("coinsurance rate") of an enrollee's claims costs exceeding a specified threshold ("attachment point") and up to a specified ceiling ("reinsurance cap"); these states are Colorado, Delaware, Georgia, Maryland, Maine (for PY 2022 onwards), Minnesota, Montana, North Dakota, New Hampshire, New Jersey, Oregon, Pennsylvania, Rhode Island, Virginia, and Wisconsin. Alternatively, Alaska uses a conditions-based model, where insurers are reimbursed for all medical and prescription drug costs of enrollees with one or more of pre-determined high-cost conditions. Idaho (and previously Maine from PYs 2019-2021) uses a hybrid conditions and claims cost-based model for its section 1332 state-based reinsurance program.

Additionally, 3 states are implementing other types of programs under their approved section 1332 waivers, some of which are in addition to state-based reinsurance programs. For example, Hawaii is waiving the Small Business Health Options Program (SHOP) to allow the state to continue with its Prepaid Health Care Act (Prepaid Act) and associated requirements for employers. Colorado's waiver allows for full implementation of a state-based reinsurance program and an innovative model for health insurance known as the Colorado Option. The Colorado Option promotes competition and health equity by combining several key components: standardized benefit plans; required premium reduction

[1] While Washington and New York are included in the total count of approved section 1332 waivers, details on their waivers are not included in this Data Brief as implementation of these waivers does not begin until PY 2024.

[2] For the most up-to-date information on section 1332 waivers, including waiver activity since the start of PY 2024, please visit: https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers.

[3] Section 1332 state-based reinsurance programs are distinct from the temporary federal reinsurance program that was effective for the 2014 through 2016 benefit years, the latter having been established via section 1341 of the ACA. The goal of the ACA's temporary reinsurance program was to stabilize individual market premiums during the early years of the federal market reforms that took effect beginning in 2014.

targets; regulatory and programmatic mechanisms as a backstop to ensure providers, hospitals, and issuers meet those targets; and state subsidies to lower out-of-pocket costs for individuals and families enrolling in coverage through the state's Exchange and for those not currently eligible for federal subsidies under the ACA. Maine has extended its reinsurance program to a newly merged individual and small group market (also referred to as a pooled market), as well as quarterly adjustments for small group plans that do not renew on a calendar year basis, to lower consumers costs and increase enrollment in the pooled market.

The data presented below provide an overview of approved section 1332 waivers that have been implemented through PY 2023, including relevant information about premiums, issuer participation, and enrollment.

The Departments remain committed to working with state partners to advance health care coverage goals. Through the review and approval of section 1332 waivers, the Departments aim to assist states with developing health insurance markets that expand coverage, lower costs, and ensure that affordable health coverage is available for their residents.

States Implementing Section 1332 Waivers through PY 2023

TABLE 1
Types of Section 1332 State Waiver Programs Implemented

State	Type of Waiver Program	Provisions Waived
Alaska, Colorado,[4] Delaware, Georgia,[5] Idaho, Maine,[6] Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, Wisconsin	Individual market reinsurance program	ACA section 1312(c)(1)
Hawaii	SHOP waiver to implement the Hawaii Prepaid Health Care Act and associated requirements for employers in the small group market	ACA sections 1311(b)(1)(B), 1312(c)(1), 1312(a)(2), 1312(f)(2)(A), 1304(b)(4)(D)(i) and (ii), 1301(a)(1)(C)(ii), 1301(a)(2)[7]
Colorado	State-based standard health benefit plan for the individual and small group markets that requires premium reduction targets and is subject to regulatory and programmatic mechanisms	ACA sections 1312(c)(1) and 1312(c)(2)
Maine	Merged individual and small group markets with reinsurance applied to the newly pooled market; allows for quarterly adjustments for small group plans that do not renew on a calendar year basis	ACA sections 1312(c)(1)-1312(c)(3)

[4] For PYs 2020-2021.
[5] Part I of Georgia's section 1332 approved waiver plan.
[6] For PYs 2019-2021.
[7] The Departments' regulations, policy statements, and guidance implementing these provisions with respect to SHOPs and small employers are also waived.

Program Design Elements and Funding Sources

Tables 2, 3, and 4 summarize programmatic elements and state funding sources for currently operating section 1332 waivers. States are presented in chronological order from earliest to most recent approval.

TABLE 2
Program Design Elements of Section 1332 Waivers

State	Program Parameters[8]
Hawaii	**SHOP Waiver:** In lieu of operating a SHOP, Hawaii carries out the state's Prepaid Health Care Act (Prepaid Act) through its section 1332 waiver. The Prepaid Act requires employers with one or more employees to provide health insurance coverage to employees who are working 20 or more hours per week. Prepaid-compliant plans are either "platinum" or "gold" plans and have out-of-pocket limits of no more than $3,000 per individual and $9,000 per family, therefore capping cost-sharing associated with the coverage. Prepaid prohibits employers from recouping more than 1.5% of an employee's gross wages to pay for employee-only insurance premiums.
Alaska	**Reinsurance Program Model: Conditions-based** **Total Amount of Reinsurance Payments:[9]** **Planned*/ Paid** $60M* / $60M (2018) $64.1M* / $64.1M (2019) $69M* / $64.4 (2020) $80M* / $80M (2021) $100M* / $100M (2022) $120M* (2023) **Eligibility:** For 2018 and 2019, Alaska covered all the costs of claims for one or more of 33 conditions specified in state regulation. Since 2020, Alaska has covered all claims costs for residents diagnosed with one or more of 34 covered conditions identified in regulation,[10] including severe COVID-19 cases. **Cap:** None, but for claims above $1M the program pays net of amounts covered by the federal risk adjustment program high-cost risk pool (2018-2023).

[8] Parameters for PY 2021 reflect the American Rescue Plan Act of 2021 (ARP), as the ARP's enhanced premium tax credits (PTC) increased states' final 2021 pass-through determinations, leading some states to update their PY 2021 parameters since submitting rate filings for PY 2021.

[9] In *Table 2* for Total Amount of Reinsurance Payments, values marked with one asterisk (*) indicate the total planned cost of the reinsurance payments for eligible claims, which is the state's estimated total reinsurance reimbursements for a given reporting year for eligible claims expected to be incurred in the individual market. This value is also reflected in states' pass-through reporting for the applicable PY. However, planned or estimated reinsurance payment amounts for a given year will vary, depending on the point in time. States may update these estimates each year, based on premium rates, enrollment, and other factors that change from year to year.

Values without any asterisks indicate the total actual amount paid out by the state for reinsurance payments in the individual market for a given reporting year where known. The final total amount paid out by the state for a given reporting year is typically available in the following PY. Furthermore, the total actual amount does not include the expected operational costs associated with running the section 1332 state-based reinsurance program.

The average premium reduction rates in the with-waiver scenario compared to the without-waiver scenario for a given PY (as seen in Table 5) reflect the total planned cost of the reinsurance payments for eligible claims. States may update their program budgets and payment parameters as more claims and enrollment data are received.

[10] Alaska Admin Code (AAC) 31.540 was signed into law in January 2017. Available online at http://www.akleg.gov/basis/aac.asp#3.31.540

State	Program Parameters[8]
Minnesota	**Reinsurance Program Model: Claims cost-based** **Total Amount of Reinsurance Payments:** **Planned* / Paid** Up to $271M* / $136.1M (2018) — Up to $271M* / $149.7M (2019) $165.8M* / $160.2M (2020) — $194.7M* / $189.3M (2021) $180.7M* / $146.9M (2022) — $236.5M* (2023) **Attachment Point:** $50,000 (2018/2019/2020/2021/2022/2023) **Coinsurance Rate:** 80% (2018/2019/2020/2021) 60% (2022) 80% (2023) **Cap:** $250,000 (2018/2019/2020/2021/2022/2023)
Oregon	**Reinsurance Program Model: Claims cost-based** **Total Amount of Reinsurance Payments:** **Planned* / Paid** $90M* / $90M (2018) — $95.4M* / $94.5M (2019) $101.8M* / $87.3M (2020) — $104.3M* / $97.1M (2021) $107.9M* / $107.8M (2022) — $113.3M* (2023) **Attachment Point:** $95,000 (2018) — $90,000 (2019/2020) $83,000 (2021) — $92,000 (2022) $95,000 (2023) **Coinsurance Rate:** **Target* / Actual** 59.2% (2018) — 50% (2019/2020/2021) 50%* / 48.1% (2022) — 50%* (2023) **Cap:** $1M (2018/2019/2020/2021/2022/2023)

State	Program Parameters[8]
Maine	**Reinsurance Program Model: Hybrid of attachment point and conditions-based (2019/2020/2021); claims cost-based (2022/2023).** **Waiver Amendment:** Merged individual and small group markets with claims cost-based reinsurance program applied to both markets and allow for quarterly adjustments for small group plans that do not renew on a calendar year basis (2023). **Total Amount of Reinsurance Payments:** **Planned* / Paid** $89.7M* / $90.5M (2019) $81.8M* / $69M (2020) $86M* / $73.5M (2021) $63M* / $87M (2022) $110.5M* (2023) **Eligibility:** Under the former hybrid model, there were two types of ceding to the Maine Guaranteed Access Reinsurance Association (MGARA) for reinsurance benefits: 1) all policies covering individuals with one of eight listed high-risk health conditions are required to be ceded, and 2) any other policies may be ceded at the carrier's discretion (2019/2020/2021). **Attachment Point:** $47,000 (2019) $65,000 (2020) $65,000 (2021) $76,000 (2022) $90,000 (2023) **Coinsurance Rate:** • 90% for $47,000-$77,000 in 2019 and for $65,000-$95,000 in 2020 and 2021. • 100% for >$77,000 in 2019 and for >$95,000 in 2020 and 2021; and a percentage of claims above $1M, which are not partially covered by the high-cost risk pool under the federal risk adjustment program (2019/2020/2021). • 100% (2022/2023) **Cap:** None, but for claims above $1M the program pays net of amounts covered by the federal risk adjustment program high-cost risk pool (2019/2020/2021). $250,000 (2022) $275,000 (2023)

State	Program Parameters[8]	
Maryland	**Reinsurance Program Model: Claims cost-based**	
	Total Amount of Reinsurance Payments:	
	Planned* / Paid	
	$462M* / $352.8M (2019)	$400M* / $400.1M (2020)
	$416.8M* / $467.7M (2021)	$491.6M* / $484.9M (2022)
	$582M* (2023)	
	Attachment Point:	
	$20,000 (2019/2020/2021/2022)	
	$18,500 (2023)	
	Coinsurance Rate:	
	80% (2019/2020/2021/2022/2023)	
	Cap:	
	$250,000 (2019/2020/2021/2022/2023)	
	Dampening Factor (optional):[11]	
	0.800 (2019)	0.785 (2020)
	0.760 (2021)	0.805 (2022)
	0.840 (2023)	
New Jersey	**Reinsurance Program Model: Claims cost-based**	
	Total Amount of Reinsurance Payments:	
	Planned* / Paid	
	$295M* / $267.7M (2019)	$320M* / $294.7M (2020)
	$397.5M* / $376.3M (2021)	$454.5M* / $428.9M (2022)
	$521M* (2023)	
	Attachment Point:	
	$40,000 (2019/2020)	$35,000 (2021/2022/2023)
	Coinsurance Rate:	
	60% (2019/2020)	50% (2021/2022/2023)
	Cap:	
	$215,000 (2019/2020)	$245,000 (2021/2022/2023)

[11] In some states, the section 1332 state-based reinsurance program may interact with the high-cost risk pool component of the HHS-operated risk adjustment program, creating an overlap between the two programs for enrollees with the highest claims costs in which double payments could occur. To address this interaction, states may choose to apply a dampening factor to adjust payments made under the section 1332 state-based reinsurance program.

State	Program Parameters[8]	
Wisconsin	**Reinsurance Program Model: Claims cost-based**	
	Total Amount of Reinsurance Payments:	
	Planned* / Paid	
	$200M* / $174.3M (2019)	$200M* / $183.5M (2020)
	$200M* / $202.8M (2021)	$230M* / $230.7M[12] (2022)
	$230M* (2023)	
	Attachment Point:	
	$50,000 (2019)	$40,000 (2020/2021/2022)
	$45,000 (2023)	
	Coinsurance Rate:	
	50% (2019/2020)	48% (2021)
	50% (2022/2023)	
	Cap:	
	$250,000 (2019)	$175,000 (2020/2021/2022)
	$141,685 (2023)	

[12] This total exceeds the $230 million state statutory limit for annual reinsurance program expenditures by approximately 0.305%. Individual insurer payments were reduced by 0.305% to meet the $230 million spending limit.

State	Program Parameters[8]
Colorado	**Reinsurance Program Model: Claims cost-based with geographic tiers. Colorado's program specifies a three-tier structure for coinsurance rates, with targeted reduction in claim costs by rating area.** **Total Amount of Reinsurance Payments:** **Planned* / Paid** $250M* / $229.1M (2020) $262M* / $237.6M (2021) $267.7M* / $272.5M (2022) $308M* (2023) **Attachment point:** $30,000 (2020/2021/2022/2023) **Coinsurance rate:[13]** Average 60% (2020) Average 55% (2021) Average 55.3% (2022) Average 53.6% (2023) **Cap:** $400,000 (2020/2021/2022/2023) **Tiers:** • Tier 1 (Rating Areas 1, 2, 3 for Boulder, Colorado Springs, Denver): Claim costs are to be reduced by between 15% and 20%. • Tier 2 (Rating Areas 4, 6, 7, 8 for Fort Collins, Greeley, Pueblo, Eastern Plains, central southern part of state): Claim costs are to be reduced by between 20% and 25%. • Tier 3 (Rating Areas 5 and 9 for Grand Junction, Mountain Areas, Western Slope, western half of state): Claim costs are to be reduced by between 30% and 35%. **Waiver Amendment: Colorado Option (2023)** Beginning in PY 2023, the Colorado Option program created a standardized health benefit plan ("standardized plans" or "Colorado Option plans") to be offered in the individual and small group markets. All issuers are required to offer Colorado Option Standardized Plans at the bronze, silver, and gold metal levels in all counties where they operate and are required to reduce premiums on these standardized plans. Specifically, issuers must offer Colorado Option plans with a premium that is reduced by a specified percent relative to their PY 2021 premiums, after adjustments for medical inflation and other actuarial adjustments ("premium rate reductions"). These reductions are 5% in 2023, 10% in 2024, and 15% in 2025. After 2025, Colorado Option plan premiums are only permitted to grow at the rate of medical inflation.

[13] Note the average coinsurance rates listed are not weighted by enrollment. According to Colorado, approximately 70% of enrollees are in Tier 1 (rating areas 1-3), while the remaining 30% are in Tiers 2 and 3 (rating areas 4-9). Because the Tier 1 coinsurance rate is lower than Tiers 2 and 3, if the average coinsurance rates were instead weighted by enrollment, the rates reported would be lower. For PY 2023, the coinsurance rates for Colorado's three geographic reinsurance tiers remain in line with prior years' rates.

State	Program Parameters[8]
Delaware	**Reinsurance Program Model: Claims cost-based** **Total Amount of Reinsurance Payments:** **Planned* / Paid** $26.9M* / $23.8M (2020) $39.3M* / $49.9M (2021) $52.1M* / $43.8M (2022) $59.7M* (2023) **Attachment Point:** $65,000 (2020/2021/2022/2023) **Coinsurance Rate:** 75% (2020) 80% (2021/2022) 75% (2023) **Cap:** $215,000 (2020) $335,000 (2021) $300,000 (2022) $340,000 (2023)
Montana	**Reinsurance Program Model: Claims cost-based** **Total Amount of Reinsurance Payments:** **Planned* / Paid** $32.9M* / $25.2M (2020) $39.1M* / $39.4M (2021) $45.6M* / $48.5M (2022) $39.6M* (2023) **Attachment Point:** $40,000 (2020/2021/2022/2023) **Coinsurance Rate:** 60% (2020/2021/2022/2023) **Cap:** $101,750 (2020/2021) $106,100 (2022) $80,800 (2023)
North Dakota	**Reinsurance Program Model: Claims cost-based** **Total Amount of Reinsurance Payments:** **Planned* / Paid** $47.3M* / $22.5M (2020) $24.7M* / $27.3M (2021) $27.5M* / $31.2M (2022) $31M* (2023) **Attachment Point:** $100,000 (2020/2021/2022/2023) **Coinsurance Rate:** 75% (2020/2021/2022/2023) **Cap:** $1M (2020/2021/2022/2023)

State	Program Parameters[8]	
Rhode Island	**Reinsurance Program Model: Claims cost-based**	
	Total Amount of Reinsurance Payments:	
	Planned* / Paid	
	$14.7M* / $10.8M (2020)	$19.3M* / $18.8M (2021)
	$13.6M* / $14.9M (2022)	$13.6M* (2023)
	Attachment Point:	
	$40,000 (2020)	$30,000 (2021/2022/2023)
	Coinsurance Rate:	
	Target* / Actual	
	50%* / 39.7% (2020)	50%* / 52.9% (2021)
	40%* / 44.6% (2022)	40%* (2023)
	Cap:	
	$97,000 (2020)	$72,000 (2021)
	$65,000 (2022)	$61,500 (2023)
Pennsylvania	**Reinsurance Program Model: Claims cost-based**	
	Total Amount of Reinsurance Payments:	
	Planned* / Paid	
	$133.9M* / $137.5M (2021)	$179.2M* / $154.9M (2022)
	$135.9M* (2023)	
	Attachment point:	
	$60,000 (2021/2022/2023)	
	Coinsurance Rate:	
	Target* / Actual	
	60% (2021)	40%* / 64% (2022)
	53%* (2023)	
	Cap:	
	$100,000 (2021/2022/2023)	
New Hampshire	**Reinsurance Program Model: Claims cost-based**	
	Total Amount of Reinsurance Payments:	
	Planned* / Paid	
	$45.5M* / $45M (2021)	$43.5M* / $39.79M (2022)
	$40.1M* (2023)	
	Attachment point:	
	$60,000 (2021/2022/2023)	
	Coinsurance rate:	
	Target* / Actual	
	74%* / 84.6% (2021)	70%* / 70.1% (2022)
	58%* 2023	
	Cap:	
	$400,000 (2021/2022/2023)	

State	Program Parameters[8]
Georgia	**Reinsurance Program Model: Claims cost-based with geographic tiers** **Total Amount of Reinsurance Payments:** **Planned* / Paid** $474.7M* / $471M (2022) $703.4M* (2023) **Attachment Point:** $20,000 (2022/2023) **Coinsurance Rate:**[14] Average 47% (2022/2023) **Cap:** $500,000 (2022/2023) **Tiers:** • Tier 1 (low-cost regions) includes rating areas 2, 3, 5, 8, 14: Claim costs are to be reduced by a coinsurance rate of 15%. • Tier 2 (mid-cost regions) includes rating areas 1, 7, 9, 12, 16: Claim costs are to be reduced by a coinsurance rate of 45%. • Tier 3 (high-cost regions) includes rating areas 4, 6, 10, 11, 13, 15: Claim costs are to be reduced by a coinsurance rate of 80%.
Virginia	**Reinsurance Program Model: Claims cost-based** **Total Amount of Reinsurance Payments:** **Planned* / Paid** $316.1M* (2023) **Attachment Point:** $40,000 (2023) **Coinsurance Rate:** 70% (2023) **Cap:** $155,000 (2023)
Idaho	**Reinsurance Program Model: Hybrid of attachment point and conditions-based** **Total Amount of Reinsurance Payments:** **Planned* / Paid** $95.1M* (2023) **Eligibility:** Idaho covers a portion of claims costs for residents diagnosed with one or more covered high-risk medical conditions identified by the High-Risk Reinsurance Pool Board.[15] **Attachment Point:** $50,000 (2023) **Coinsurance Rate:** 70% (2023) **Cap:** $665,000 (2023)

[14] Note the average coinsurance rate listed is not weighted by enrollment.
[15] High-risk medical conditions that are eligible for reinsurance ceding are published at: https://doi.idaho.gov.

Generally, the top 5% most expensive individuals to insure account for over half of the costs (55%) of the applicable total market.[16] Along with the reinsurance programs, states may also implement other measures to mitigate the costs associated with this population and lower overall health care spending. *Table 3* shows how several states with approved section 1332 waivers have included requirements or incentives for providers and issuers to continue managing health care costs and utilization for individuals with eligible reimbursements from their state reinsurance programs.

TABLE 3
Cost Containment and Care Management Strategies for Section 1332 State-Based Reinsurance Programs

State	Cost Containment and Care Management Strategies
Colorado	Since 2020, issuers participating in Colorado's reinsurance program are required to annually submit care management protocols detailing their strategies to manage high-cost claims and provide effective care management to enrollees whose claims are expected to fall within the payment parameters. Issuers must identify reinsurance-eligible individuals prospectively when possible and describe efforts to include social determinants of health in their member risk stratification models. Issuers must also implement and track care management strategies with contracted providers. Colorado has incorporated this reporting into issuers' annual rate filing requirements and uses a SERFF template to collect care management protocol information from issuers.[17]
Delaware	Since 2021, issuers participating in Delaware's reinsurance program are required to submit a report detailing the effectiveness or impact of their care management activities, e.g., information on the determination of cost savings to the reinsurance program associated with such programs.
Maine	Since its inception in 2012 and continuation under a section 1332 waiver in 2019, issuers participating in Maine's reinsurance program (Maine Guaranteed Access Reinsurance Association, or MGARA) are required to manage claims of reinsured and non-reinsured claims on an undifferentiated basis. Additionally, beginning in PY 2024, Maine is implementing the High-Priced Items and Services (HPIS) program on a pilot basis, which identifies certain high-cost items and services that may offer an opportunity for savings.[18] Payments to providers related to HPIS are identified in insurers' annual claims reporting identifying the HPIS, the provider, and the amount of related claims payment. Reinsurance for HPIS claims is limited to no greater than 200% of the allowed charge determined for the item or service under the original Medicare fee-for-service program under Part A and Part B of Title XVIII of the Social Security Act for the applicable year. Annually MGARA is required to compile and publish a list of (i) the name of each high-priced item or service for which its payment exceeded the 200% of Medicare limit, and (ii) the name of the provider that received this payment, as reported to MGARA by member insurers.[19]
Maryland	Since 2019, issuers participating in Maryland's reinsurance program are required to annually submit information on program accountability to document actions that manage costs and utilization of enrollees whose claims are reimbursable under the reinsurance program.[20] Maryland also focuses on collecting targeted information on diabetes, behavioral health, asthma, and pregnancy/childbirth.

[16] Frederick (Fritz) Busch and Paul Houchens, 2017. "Reinsurance and high-risk pools: Past, present, and future role in the individual health insurance market." Milliman. https://us.milliman.com/en/insight/reinsurance-and-highrisk-pools-past-present-and-future-role-in-the-individual-health-i

[17] HB 19-1168 was signed into law on May 17, 2019. Available online at https://leg.colorado.gov/bills/hb19-1168. Section 10-16-1105(5), C.R.S., includes the statutory requirement for issuers to submit care management protocols. Also see Amended Regulation 4-2-71 "Concerning carrier care management protocols for the Colorado Reinsurance Program." Available online at https://drive.google.com/file/d/1xc2I6oftUNAIzQKAAgQJtsD8xcCRvkgq/view

[18] Title 24-A, Chapter 54-A: Maine Guaranteed Access Reinsurance Association Act. Available online at https://www.mainelegislature.org/legis/statutes/24-a/title24-Ach54-A.pdf

[19] MGARA Amended and Restated Plan of Operation: Merged Individual and Small Group Markets. Available online at https://mgara.org/wp-content/uploads/2023/08/Amended-Plan-of-Operation-with-Exhibits16369734.1.pdf

[20] COMAR 14.35.17.03(C). Available online at https://www.marylandhbe.com/wp-content/uploads/2018/09/14.35.17%20Regulatory%20Text%20(final).pdf

State	Cost Containment and Care Management Strategies
Montana	Since 2020, issuers participating in Montana's reinsurance program are required to file an annual report disclosing their utilization review plan and activities as part of cost containment measures. Issuers must apply all managed care, utilization review, case management, preferred provider arrangements, claims processing, and other methods of operation, as appropriate to each claim without regard to whether such claim is eligible for or may be paid by reinsurance.[21]
New Hampshire	Since 2021, issuers participating in New Hampshire's reinsurance program have been required to submit information to the state care management protocols.[22] Issuers identify resources and programs available to manage higher risk/cost members, including care transitions, disease management, specialty care programs, and approaches to identify or refer members for special care management (i.e., algorithms, provider referral, member self-referral). The purpose is to assure that each eligible carrier has programs available to help manage higher-cost members so that reinsurance payments are made to eligible carriers that are attempting to manage care coordination and cost incurrence.
Wisconsin	Since 2021, issuers participating in Wisconsin's reinsurance program are required to annually submit information to the state on care management, top health conditions covered, and prescription drug data.[23]

TABLE 4
State Funding Sources for Section 1332 Waivers

State	First Year of Operation Under a Waiver	State Funding Sources[24]
Hawaii	2017	Hawaii funds the state portion of its SHOP waiver through the Prepaid Health Care Premium Supplementation Fund, which is established by general fund appropriation and used to defray the cost of providing health care benefits for eligible small employers entitled to and covered under the Prepaid Act.[25]
Alaska	2018	Alaska funds the state portion of its section 1332 state-based reinsurance program through a separate fund called the Alaska Comprehensive Health Insurance Fund. This fund is established within Alaska's general fund and financed by the state's premium tax that applies to all lines of insurance (not just health insurers) in Alaska.[26] Premium tax rates vary from 0.75% to 6% depending on insurer type.
Minnesota	2018	Minnesota funds the state portion of its section 1332 state-based reinsurance program through its general fund and a portion of past accumulations of the state's 2% provider tax, which applies to hospitals and other providers.[27, 28]

[21] MCA §§ 33-22-1317 and 33-22-207. Available online at https://leg.mt.gov/bills/mca/title_0330/chapter_0220/part_0130/section_0170/0330-0220-0130-0170.html and https://leg.mt.gov/BILLS/mca/title_0330/chapter_0220/part_0020/section_0070/0330-0220-0020-0070.html.

[22] Second Amendment to Amended and Restated Plan of Operation and Termination of New Hampshire Health Plan. Available online at https://nhhp.org/wp-content/uploads/2022/03/NHHP_Restated_Plan_of_Operation_Second_Amendment_04-27-2020-Signed.pdf

[23] Wisconsin Healthcare Stability Plan. Available online at https://docs.legis.wisconsin.gov/code/admin_code/ins/19

[24] Unless otherwise indicated, the state funding sources presented reflect all active years to date of a given state's waiver.

[25] SB 2775 was signed into law on April 25, 2016. Available online at https://www.capitol.hawaii.gov/sessions/session2016/bills/SB2775_.HTM

[26] SB 165 was signed into law on June 29, 2018 (Chapter 46 SLA 18). Available online at http://www.akleg.gov/basis/Bill/Detail/30?-Root=SB%20165

[27] HF No. 5 was signed into law on April 3, 2017. Available online at https://www.revisor.mn.gov/bills/text.php?number=HF5&version=0&-session=ls90&session_year=2017&session_number=0&type=ccr&format=pdf

[28] SF 3472 was signed into law on April 1, 2022. Available online at https://www.revisor.mn.gov/bills/text.php?number=SF3472&type=c-cr&session=ls92&version=0

State	First Year of Operation Under a Waiver	State Funding Sources[24]
Oregon	2018	For PYs 2018 through 2019, Oregon funded the state portion of its section 1332 state-based reinsurance program through a phased-in 1.5% state premium assessment levied on major medical premiums and, for PY 2018 only, Oregon also used excess fund balances held in two state programs, the Oregon Health Insurance Marketplace (OHIM) fund and the Oregon Medical Insurance Pool (OMIP) account.[29] Starting in PY 2020, Oregon made two changes to the assessments: 1) increased the premium assessment to 2%, and 2) expanded the assessment to apply to premiums derived from "insurance described in ORS 742.065" (stop loss insurance).[30, 31]
Maine	2019	Maine funds the state portion of its section 1332 state-based reinsurance program through a market-wide (fully-insured and self-funded commercial health insurance markets) assessment of $4 per member per month. Previously under the hybrid model (PYs 2019-2021), the state also collected a ceding premium equal to 90% of premiums received from consumers for all policies ceded, whether on a mandatory or discretionary basis.[32]
Maryland	2019	In PY 2019, Maryland funded the state portion of its section 1332 state-based reinsurance program through a 2.75% state assessment on certain health insurance carriers.[33] The assessment equals the amount carriers otherwise would have been subject to under the now-repealed federal Health Insurance Providers Fee of Section 9010 of the ACA. Maryland extended and reduced the assessment to 1% for PYs 2020-2023 and again extended it through PY 2028.[34, 35]
New Jersey	2019	New Jersey funds the state portion of its section 1332 state-based reinsurance program from revenue raised by shared responsibility payments per the state individual mandate,[36] and if necessary, the state general fund.
Wisconsin	2019	Wisconsin funds the state portion of its section 1332 state-based reinsurance program through state general purpose revenue (GPR), which consists of general taxes, miscellaneous receipts, and revenues collected by the state. The state is able to appropriate GPR for the Wisconsin Healthcare Stability Plan (WIHSP) through a sum sufficient appropriation.[37]

[29] HB 2391 was signed into law on July 5, 2017. Available online at https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/HB2391

[30] Oregon Revised Statutes, 743B.800 (2019). Available online at https://www.oregonlegislature.gov/bills_laws/ors/ors743b.html

[31] HB 2010 was signed into law on March 13, 2019. Available online at https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/HB2010/Enrolled

[32] SP 221 LD 659 was signed into law on June 2, 2017. Available online at https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0221&item=3&snum=128

[33] SB 387 was signed into law on April 10, 2018. Available online at https://www.marylandhbe.com/wp-content/uploads/2018/04/Ch_38_sb0387E.pdf

[34] HB 258 was signed into law on May 25, 2019. Available online at http://mgaleg.maryland.gov/2019RS/Chapters_noln/CH_597_hb0258t.pdf

[35] HB 413 was signed into law on April 12, 2022. Available online at https://mgaleg.maryland.gov/2022RS/Chapters_noln/CH_59_hb0413t.pdf

[36] A3380 was signed into law on May 30, 2018. Available online at https://www.njleg.state.nj.us/2018/Bills/A3500/3380_R1.PDF

[37] 2017 Wisconsin Act 138 was signed into law on February 27, 2018. Available online at https://docs.legis.wisconsin.gov/2017/related/acts/138

State	First Year of Operation Under a Waiver	State Funding Sources[24]
Colorado	2020	Colorado funds the state portion of its section 1332 state-based reinsurance program and the Colorado Option through the Colorado Health Insurance Affordability Enterprise (Enterprise). The Enterprise was established under Colorado Senate Bill 20-215 in June 2020.[38] The main source of funding for the Enterprise is drawn from a fee on health insurers who would otherwise be subject to the now repealed federal Health Insurance Provider Fee under Section 9010 of the ACA. For PYs 2022 and 2023 only, Colorado administered a special assessment on hospitals. A portion of the state's health insurance premium tax revenue also went to the Enterprise. Money from the state's general fund is available for section 1332 waiver administration.
Delaware	2020	Delaware funds the state portion of its section 1332 state-based reinsurance program through an assessment on carriers and any person or entity subject to state regulation that provides either 1) products that would otherwise be subject to the federal Health Insurance Providers Fee under Section 9010 of the ACA; or 2) products subject to a state assessment. The state assessment is 2.75% of premium annually in years that the Health Insurance Providers Fee is waived, and 1% of premium annually in years that the Health Insurance Providers Fee is assessed.[39]
Montana	2020	Montana funds the state portion of its section 1332 state-based reinsurance program through a 1.2% annual state assessment on major medical health insurance premiums.[40]
North Dakota	2020	North Dakota funds the state portion of its section 1332 state-based reinsurance program through a state assessment on insurers writing in the small and large group health insurance markets. North Dakota allows insurers to deduct the assessment from the state premium tax.[41] The PY 2020 assessment on the insurers was approximately $22M. Assessments were suspended in the third quarter of PY 2020 and continued through PY 2022. North Dakota resumed the assessment for PY 2023.
Rhode Island	2020	Rhode Island funds the state portion of its section 1332 state-based reinsurance program from penalties collected from the state individual mandate.[42] Previously in PY 2020 and before individual mandate penalties were collected, Rhode Island received a one-time state appropriation for the Health Insurance Market Integrity Fund to support operation and administration of the program.[43]
Pennsylvania	2021	Pennsylvania funds the state portion of its section 1332 state-based reinsurance program through a portion of a user fee that is 3.0% of premiums and assessed on issuers participating in the Pennsylvania Health Insurance Exchange and other available state sources. This fee only affects individual market issuers, as there are currently no participating SHOP issuers.[44]

[38] SB20-215 was signed into law on June 30, 2020. Available online at https://leg.colorado.gov/sites/default/files/2020a_215_signed.pdf
[39] HB 193 was signed into law on June 20, 2019. Available online at http://legis.delaware.gov/BillDetail/47632
[40] SB 125 was signed into law on April 30, 2019. Available online at https://leg.mt.gov/bills/2019/BillPdf/SB0125.pdf
[41] HB 1106 was signed into law on April 18, 2019. Available online at https://www.legis.nd.gov/assembly/66-2019/documents/19-8068-05000.pdf
[42] S 2934 was signed into law on July 3, 2018. Available online at http://webserver.rilin.state.ri.us/BillText/BillText18/SenateText18/S2934A.pdf
[43] H 8351 was signed into law on July 3, 2018. Available online at http://webserver.rilin.state.ri.us/BillText/BillText18/HouseText18/H8351.pdf
[44] Act 42 was signed into law on July 2, 2019. Available online at https://www.insurance.pa.gov/Documents/Act%2042%20Codified.pdf

State	First Year of Operation Under a Waiver	State Funding Sources[24]
New Hampshire	2021	New Hampshire funds the state portion of its section 1332 state-based reinsurance program through a premium assessment of 0.6% of the previous year's second lowest cost silver plan without-waiver rate across all licensed health insurance issuers in the state's individual and group health insurance markets with some exceptions.[45, 46]
Georgia	2022	Georgia funds the state portion of its section 1332 state-based reinsurance program through state general funds.[47]
Virginia	2023	Virginia funds the state portion of its section 1332 state-based reinsurance program through state appropriations allotted in the Commonwealth Health Reinsurance Program Special Fund.[48]
Idaho	2023	Idaho funds the state portion of its section 1332 state-based reinsurance program through an annual premium tax allotment, and one-time deposit of $25 million in 2022, and an assessment on the health insurance market on an as needed basis to achieve the state's target premium reduction.[49]

[45] HB 4 (Chaptered Law 346 of 2019) was signed into law on October 2, 2019. Available online at https://gencourt.state.nh.us/bill_status/legacy/bs2016/billText.aspx?id=11242019&txtFormat=html&sy=2019

[46] RSA 404-G:3. Available online at http://www.gencourt.state.nh.us/rsa/html/xxxvii/404-g/404-g-mrg.htm

[47] HB 911 was signed into law on May 12, 2022. Available online at https://www.legis.ga.gov/legislation/61136

[48] 22 HB 2332 was signed into law on March 31, 2021. Available online at https://lis.virginia.gov/cgi-bin/legp604.exe?212+ful+CHAP0480+pdf

[49] HB 611 was signed into law on March 23, 2022. Available online at https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2022/legislation/H0611.pdf

Premiums

Table 5 presents the actual impact of the section 1332 state-based reinsurance programs on statewide average premiums each year of the waiver's operation compared to the estimated impact on statewide average premiums in the first year of the waiver (i.e., as estimated in the original state waiver application). From PYs 2018 through 2023, states implementing section 1332 state-based reinsurance programs for the individual market have reduced statewide average second-lowest-cost silver plan (SLCSP) premiums by a range of 3.75% to 41.17% relative to premiums absent the waiver, as shown in *Table 5*.

TABLE 5
Statewide Average SLCSP Premium Impact in Individual Market of Section 1332 State-Based Reinsurance Programs[50]

State	First Year of Operation Under a Waiver	Estimated Statewide Average Premium Reduction in First Year of Waiver[51]	Actual Statewide SLCSP Premium Reduction from Waiver Compared to No Waiver[52]					
			2018	2019	2020	2021	2022	2023
Alaska	2018	Up to a 20% reduction	30.18%	33.95%	37.12%	41.17%	38.05%	38.79%
Minnesota	2018	Up to a 20% reduction	16.78%	20.16%	21.29%	21.31%	14.37%	20.38%
Oregon	2018	Up to a 7.5% reduction	7.15%	6.71%	8.00%	8.05%	8.09%	8.59%
Maine	2019	Up to a 9% reduction (initial waiver); Up to an 8% reduction (waiver amendment)[53]		13.86%	7.24%	9.11%	10.91%	12.46%
Maryland	2019	Up to a 30% reduction		39.63%	35.83%	34.00%	29.80%	32.56%
New Jersey	2019	Up to a 15% reduction		15.49%	16.93%	16.02%	16.03%	14.60%
Wisconsin	2019	Up to a 11% reduction		9.92%	11.04%	13.04%	13.12%	12.50%
Colorado	2020	Up to a 16% reduction (initial waiver); Up to a 22.3% reduction (waiver amendment)[54]			22.44%	18.47%	21.70%	19.66%
Delaware	2020	Up to a 20% reduction[55]			13.78%	15.80%	15.00%	15.60%

[50] The statewide average premium is an average of premiums among rating areas in the state, with each rating area given an equal weight. Enrollment data by rating area are unavailable.
[51] The estimated statewide average premium reduction for the first year of the waiver is provided by each state as part of its waiver application.
[52] The actual statewide average premium reductions are calculated using per person per month premium information submitted by each state for pass-through calculations pertaining to each year of the approved waiver. Consistent with the specific terms and conditions of its waiver, each state provides to the Departments: (1) the final second lowest cost silver plan (SLCSP) rates for a representative individual (e.g., a 21-year-old nonsmoker) in each rating area with the approved waiver; and (2) the state's estimate of what the final SLCSP rates for a representative individual in each rating area would have been absent approval of the waiver for each year of the approved waiver.
[53] The first year of Maine's initial waiver was PY 2019 for the individual market and the first year of its amended waiver was PY 2023 for the individual and small group market. The values in Table 5 apply to the individual market. Maine estimated a 6% premium reduction in the small group market as a result of its waiver amendment. At the time of this report's publication, In PY 2023, Maine's projected and actual average monthly premium rates in the small group market were $608.25 and $525.80, respectively. These numbers may be adjusted upon finalization of small group insurers' financial statements.
[54] The first year of Colorado's initial waiver was PY 2020 for the individual market and the first year of its amended waiver was PY 2023 for the individual and small group market. The values in Table 5 apply to the individual market. Colorado estimated a 5% premium reduction in the small group market in PY 2023 as a result of the Colorado Option as part of the state's waiver amendment. In PY 2023, Colorado's projected average premium rate in the small group market was $568.05 per member per month. This was calculated as the sum of all carriers' projected 2023 premium divided by the sum of all carriers' projected member months. The actual average premium in the small group market will require a data call to carriers to capture actual 2023 enrollment.
[55] Delaware estimated a 13-20% average premium reduction, depending on the level of funding expected to be available for each plan year, plus any additional assumed morbidity improvement, as explained in its application.

State	First Year of Operation Under a Waiver	Estimated Statewide Average Premium Reduction in First Year of Waiver[51]	Actual Statewide SLCSP Premium Reduction from Waiver Compared to No Waiver[52]					
			2018	2019	2020	2021	2022	2023
Montana	2020	Up to an 8% reduction			8.89%	9.38%	9.22%	8.26%
North Dakota	2020	Up to a 20% reduction			20.03%	12.14%	10.71%	8.38%
Rhode Island	2020	Up to a 5.9% reduction			3.75%	6.40%	4.96%	5.47%
Pennsylvania	2021	Up to a 4.6% reduction				4.92%	5.92%	4.34%
New Hampshire	2021	Up to a 16% reduction				13.90%	13.96%	13.40%
Georgia	2022	Up to a 10.2% reduction					16.68%	19.20%
Virginia	2023	Up to a 15.6% reduction						17.14%
Idaho	2023	Up to a 12% reduction						12.50%
Overall State Average Premium Reduction Among States with Approved Section 1332 State-Based Reinsurance Waivers[56]			12.73%	17.84%	17.65%	14.13%	14.50%	15.22%

[56] Overall statewide average premium reduction for a given PY uses risk adjustment premium data available from the prior PY to weight each state's premium reduction and estimate an overall premium reduction across states with approved section 1332 state-based reinsurance waivers. For example, for PY 2023 the "Appendix A to 2022 Benefit Year Risk Adjustment Summary Report" was used. See https://www.cms.gov/marketplace/health-plans-issuers/premium-stabilization-programs.

Issuer Participation

Table 6 shows changes in individual market Exchange issuer participation among states with section 1332 state-based reinsurance programs. *Figures 1 and 2* illustrate the change in individual market Exchange issuer participation in these states comparing PYs 2017 (before any reinsurance waivers were operational)[57] and 2023 on national maps.

Table 7 presents changes in small group market issuer participation among states with section 1332 waivers impacting the small group market.

Table 8 presents a summary of the percentage of enrollees with access to 1, 2, or 3+ individual market Exchange issuers in states with operational section 1332 state-based reinsurance programs, compared to the percentage of individual market Exchange enrollees in all states across the U.S.

TABLE 6
Individual Market Issuer Exchange Participation in States with Section 1332 State-Based Reinsurance Programs[58]

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation[59]						
		2017	2018	2019	2020	2021	2022	2023
Alaska	2018	1	1	1	2^ Re-entry: Moda	2	2	2
Minnesota	2018	4	4	4	4	5^ Entry: Quartz Health Solutions	5	5[60] Exit: Health Partners Entry: Health Partners (HIOS Swap)
Oregon	2018	6	5 Exit: ATRIO Health Plans	5	5	6^ Entry: Cambia Health Solutions	6	6
Maine (Pooled Market)	2019	3	2 Exit: Anthem	3^ Re-entry: Anthem	3	3	3	4^ Entry: Taro Health
Maryland[61]	2019	3	2 Exit: Cigna	2	2	3^ Re-entry: United-Health Group	3	3

[57] Note that Alaska began operating a state reinsurance program in 2017, prior to the first year of its approved section 1332 state-based reinsurance waiver.
[58] For states with a Federally-facilitated Exchange (FFE), CMS issuer counts are based upon the number of unique Health Insurance Oversight System (HIOS) IDs. Issuers represent the organization within an insurance company that is responsible for insurance offerings in a given state. Registering an entity as an Issuer within HIOS will generate a unique Issuer ID. FFE 2023 data reflected in this table are self-reported from the Exchanges to CMS. These data are point in time as of October21, 2022. State-Based Exchange (SBE) 2022 data reflected in this table are self-reported from the Exchanges to CMS. These data are point in time as of October 25, 2021. Note that Maine merged its individual and small group markets in PY 2023. Issuers offering partial county coverage are considered participating in a county and are included in the total number of issuers in a county. Issuers that partially cover counties do not cover every zip code in the county.
[59] ^Denotes a new issuer participating (entry or re-entry) in the individual market from the previous year.
[60] HealthPartners in Minnesota exited PY 2023 under their exiting HIOS ID and entered the same state under a different HIOS ID.
[61] To ensure that the total counts of issuers within a state or county are consistent with SBE reporting BlueChoice (HIOS 28137), CFMI (HIOS 45532), and GHMSI (HIOS 94084) in Maryland have been aggregated to the parent company level (CareFirst BlueCross BlueShield).

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation[59]						
		2017	2018	2019	2020	2021	2022	2023
New Jersey	2019	3	4^ Entry: Mulberry Health (Oscar)	4	4	4	5^ Entry: Centene	5^ Exit: Indepen-dence Blue Cross Entry: CVS Health
Wisconsin	2019	15	11 Exits: Anthem, Franciscan Health Solutions, Gundersen Health System, Molina Healthcare	12^ Re-entry: Molina	13^ Re-Entry: WPS Health Plan, Inc.	14^ Re-entry: Anthem	14	13 Exit: Wisconsin Physicians Service Insurance Corporation
Colorado	2020	7	7	7	8^ Entry: Oscar Health	8	8	6 Exits: Bright Health, Oscar Health
Delaware	2020	3	1 Exits: Aetna (two separate HIOS IDs)	1	1	1	1	3^ Re-entry: CVS Health Entry: Ameri-Health Caritas
Montana	2020	3	3	3	3	3	3	3
North Dakota	2020	3	2 Exit: Medica	3^ Re-entry: Medica	3	3	3	3
Rhode Island	2020	2	2	2	2	2	2	2
Pennsylvania	2021	8	9^ Entry: Highmark (additional HIOS ID)	11^ Entry: Centene Re-entry: Geisinger Health (additional HIOS ID)	12^ Entry: Mulberry Health (Oscar)	12	13^ Entry: Cigna	13
New Hampshire	2021	4	3 Exit: Minuteman Health	3	3	3	3	3

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation[59]						
		2017	2018	2019	2020	2021	2022	2023
Georgia	2022	5	4 Exit: Humana	4	6^ Entries: Care-Source, Mulberry Health (Oscar)	6	11^ Re-entries: Aetna, United-Health Group Entries: Cigna, Friday Health Plans, Bright Health	10 Exit: Bright Health
Virginia	2023	11	7 Exits: CVS Health (two HIOS IDs), Piedmont Community Health, United-Health Group	8^ Entry: Virginia Common-wealth University (VCU) Health System	9^ Entry: Oscar Health	9^ Exit: VCU Health System Entry: United Health Group	12^ Entry: Bright Health Re-entries: CVS Health (two HIOS IDs)	12^ Exit: Bright Health Re-entry: CVS Health (additional HIOS)
Idaho	2023	5	4 Exit: Cambria Health Solutions	4	4	5^ Re-entry: Cambia Health Solutions	6^ Entry: Molina Healthcare	8^ Entry: Moda, St. Luke's Health System

TABLE 7
Small Group Market Issuer Participation in States with Section 1332 Waivers Impacting the Small Group Market

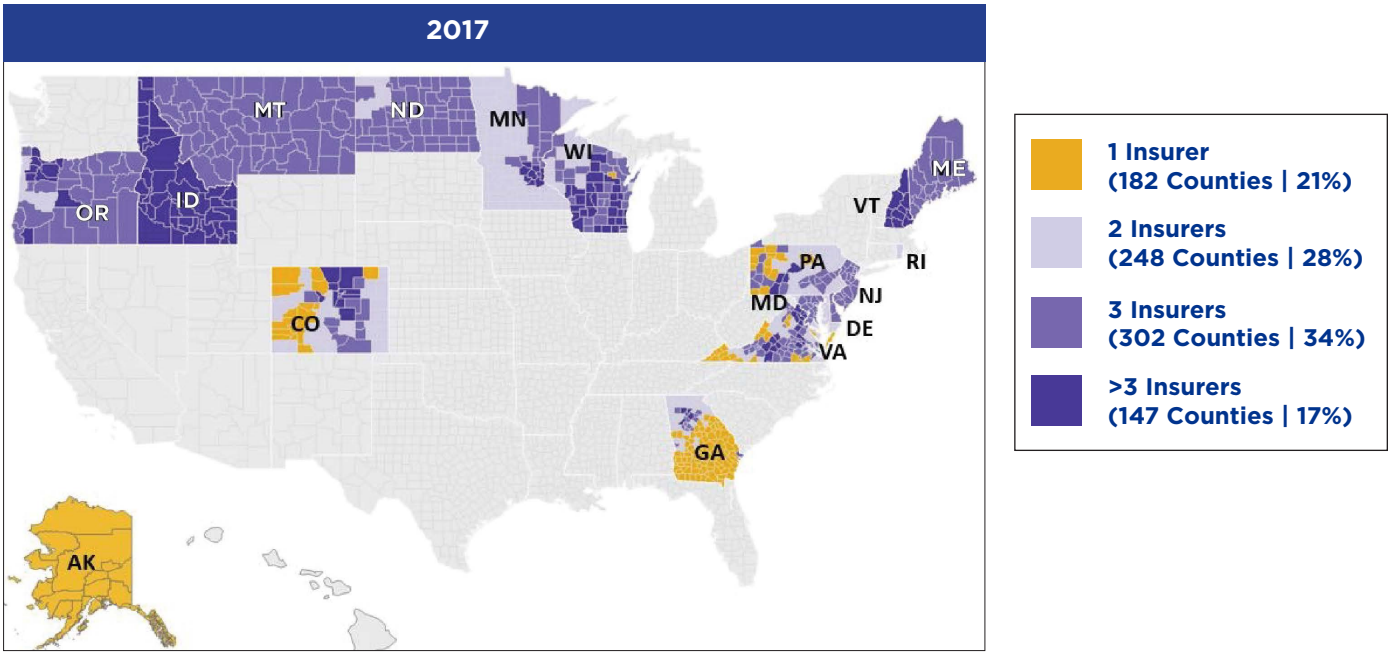
State	First Year of Waiver Impacting the Small Group Market	2017			2018			2019			2020			2021			2022			2023		
		On	Off	Total	On	Off	Total	On	Off	Total	On	Off	Total	On	Off	Total	On	Off	Total	On	Off	Total
Hawaii	2017	1	4	5	0	5	5	0	5	5	0	5	5	0	5	5	0	5	5	0	5	5
Colorado	2023	5	8	13	1[62]	12	13	1	11	12	1	11	12	1	12	13	1	11	12	1	10	11
Maine	2023	3	4	7	1	6	7	1	6	7	1	6	7	1	6	7	1	7	8	2	7	9

[62] Kaiser Foundation represents the single issuer on-Exchange in Colorado from PYs 2018-2023.

FIGURES 1 AND 2

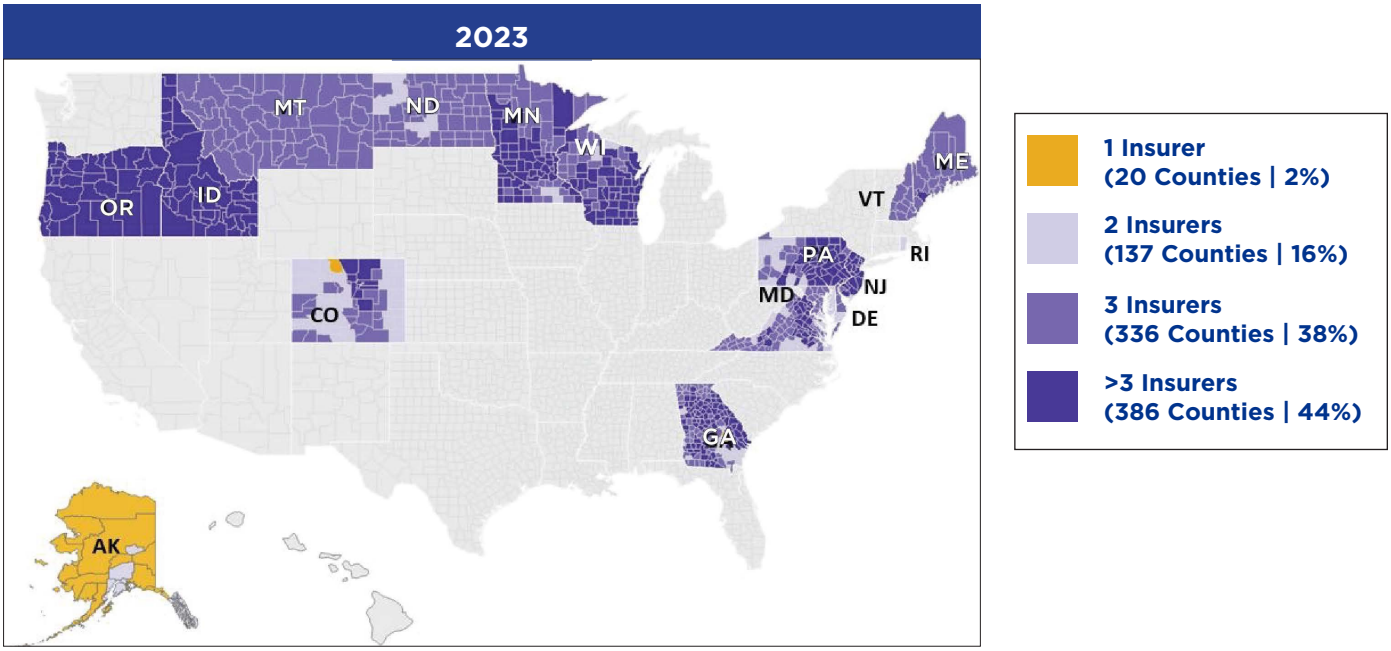
Individual Market Issuer Participation on the Exchanges in States with Section 1332 State-Based Reinsurance Programs[63]

(Figure 1) # of PY 17 Exchange Insurers



Map is as of 11/02/2017 for FFE and SBE-FP and as of 11/17/2017 for SBE states. Values may not add to 100% due to rounding.

(Figure 2) # of PY23 Exchange Insurers



Map is as of 10/08/2021 for FFE and SBE-FP and as of 10/25/2021 for SBE states. Values may not add to 100% due to rounding.

[63] For illustrative purposes, PY 2017 is provided as a comparison year to PY 2023 because section 1332 waivers were not yet operational in PY 2017, and the first waivers went into effect in PY 2018. Note that for some states, issuers exited the state's individual marketplace prior to the state's implementation of a section 1332 state-based reinsurance program, and some states' waivers began operating as recently as PY 2023. For each state's first year of operation and issuer count across PYs 2017 through 2023, please refer to Table 6 above.

TABLE 8
Percent of Enrollees with Access to 1, 2, 3+ Individual Market Exchange Issuers in States with Section 1332 State-Based Reinsurance Programs, Compared to Overall U.S.[64]

Section 1332 State-based Reinsurance Waiver States	1 Issuer				2 Issuers				3+ Issuers			
	2020	2021	2022	2023	2020	2021	2022	2023	2020	2021	2022	2023
	4%	3%	1%	<1%	14%	9%	8%	7%	82%	88%	91%	93%
Overall U.S.	**9%**	**3%**	**2%**	**1%**	**18%**	**15%**	**8%**	**6%**	**73%**	**82%**	**90%**	**93%**

[64] Methodology note for *Table 8*: This analysis weights national averages by Open Enrollment Period county-level enrollment to calculate national level weighted averages. For SBE states whose enrollment data are not available at the county-level, the analysis proportionately allocated state-level enrollment by the population of each county. This imputation method was tested against actual enrollment data for FFE states and found to provide a suitable estimate of county-level enrollment. Enrollment data were obtained from CMS. Values and visualization may not add up to 100% due to rounding.

Enrollment

Table 9 displays individual market enrollment both on- and off-Exchange for states that began implementing section 1332 state-based reinsurance programs in PYs 2018, 2019, 2020, 2021, and 2022.

TABLE 9
Individual Market Subsidized[65] and Unsubsidized Average Monthly Enrollment for Select States with Section 1332 State-Based Reinsurance Programs, Compared to Overall U.S.[66]

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment	2020 Individual Market Average Monthly Enrollment	2021 Individual Market Average Monthly Enrollment	2022 Individual Market Average Monthly Enrollment
Alaska[67]	2018	**Total**	**17,596**	**15,898**	**16,761**	**16,533**	**16,814**	**19,007**	**23,090**
		Percent Change[68]		-10%	+5%	-1%	2%	13%	21%
		Subsidized	14,065	13,442	14,125	13,254	13,062	14,625	18,433
		Percent Change		-4%	+5%	-6%	-1%	12%	26%
		Unsubsidized	3,531	2,456	2,636	3,279	3,753	4,382	4,657
		Percent Change		-30%	+7%	24%	14%	17%	6%
Minnesota	2018	**Total**	**240,312**	**154,471**	**148,943**	**150,950**	**159,113**	**163,634**	**164,062**
		Percent Change		-35%	-4%	1%	5%	3%	0.3%
		Subsidized	42,631	61,932	62,832	59,219	57,668	59,707	66,044
		Percent Change		+45%	+1%	-6%	-3%	4%	11%
		Unsubsidized	197,681	92,539	86,111	91,731	101,445	103,927	98,019
		Percent Change		-53%	-7%	7%	11%	2%	-6%
Oregon	2018	**Total**	**224,670**	**210,384**	**190,899**	**177,715**	**176,021**	**172,995**	**172,055**
		Percent Change		-6%	-9%	-7%	-1%	-2%	-0.5%
		Subsidized	87,436	95,919	98,489	95,106	93,949	93,779	103,766
		Percent Change		+10%	+3%	-3%	-1%	0%	11%
		Unsubsidized	137,234	114,465	92,410	82,609	82,071	79,216	68,289
		Percent Change		-17%	-19%	-11%	-1%	-3%	-14%

[65] Subsidized and unsubsidized in terms of eligibility for Advance Payments of the Premium Tax Credit (APTC).
[66] For 2016 through 2019 enrollment data, see "Trends in Subsidized and Unsubsidized Enrollment October 9, 2020." Data includes average monthly enrollment in the ACA individual market (on- and off-Exchange) and does not include enrollment in grandfathered or plans subject to "non-enforcement policy" ("grandmothered") plans. Available online at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf.
Enrollment data for 2020, 2021, and 2022 from CCIIO External Data Gathering Environment (EDGE) Summary Risk Adjustment data (2020-2022).
[67] Alaska began operating its reinsurance program in 2017, prior to the first year of its approved section 1332 state-based reinsurance waiver.
[68] Percent changes in enrollment are for 2016 to 2017, 2017 to 2018, 2018 to 2019, 2019 to 2020, 2020 to 2021, and 2021 to 2022.

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment	2020 Individual Market Average Monthly Enrollment	2021 Individual Market Average Monthly Enrollment	2022 Individual Market Average Monthly Enrollment
Maine	2019	**Total**	**82,158**	**77,897**	**72,801**	**67,260**	**62,872**	**64,633**	**68,284**
		Percent Change		-5%	-7%	-8%	-7%	3%	6%
		Subsidized	63,402	57,984	57,883	52,589	47,512	46,731	50,355
		Percent Change		-9%	-0.2%	-9%	-10%	-2%	8%
		Unsubsidized	18,756	19,913	14,918	14,671	15,360	17,902	17,929
		Percent Change		6%	-25%	-2%	5%	17%	0.2%
Maryland	2019	**Total**	**255,560**	**227,207**	**193,227**	**191,824**	**212,311**	**222,051**	**231,572**
		Percent Change		-11%	-15%	-1%	11%	5%	4%
		Subsidized	95,084	98,261	110,632	114,189	122,196	124,222	133,125
		Percent Change		3%	13%	3%	7%	2%	7%
		Unsubsidized	160,476	128,946	82,595	77,635	90,116	97,830	98,447
		Percent Change		-20%	-36%	-6%	16%	9%	0.6%
New Jersey	2019	**Total**	**336,605**	**342,903**	**312,923**	**303,808**	**310,673**	**357,152**	**378,984**
		Percent Change		2%	-9%	-3%	2%	15%	6%
		Subsidized	186,444	185,258	178,312	162,892	167,203	219,802	259,861
		Percent Change		-1%	-4%	-9%	3%	31%	18%
		Unsubsidized	150,161	157,645	134,611	140,916	143,470	137,350	119,123
		Percent Change		5%	-15%	5%	2%	-4%	-13%
Wisconsin	2019	**Total**	**246,712**	**229,302**	**206,934**	**197,421**	**195,886**	**200,670**	**215,381**
		Percent Change		-7%	-10%	-5%	-1%	2%	7%
		Subsidized	174,641	166,310	164,999	157,413	153,445	156,509	176,085
		Percent Change		-5%	-1%	-5%	-3%	2%	13%
		Unsubsidized	72,071	62,992	41,935	40,008	42,441	44,191	39,296
		Percent Change		-13%	-33%	-5%	6%	4%	-11%
Colorado	2020	**Total**	**273,565**	**244,266**	**203,829**	**197,384**	**217,670**	**231,477**	**246,917**
		Percent Change		-11%	-17%	-3%	10%	6%	7%
		Subsidized	85,334	91,335	100,869	111,758	114,103	116,813	134,307
		Percent Change		7%	10%	11%	2%	2%	15%
		Unsubsidized	188,231	152,930	102,960	85,627	103,567	114,664	112,610
		Percent Change		-19%	-33%	-17%	21%	11%	-2%

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment	2020 Individual Market Average Monthly Enrollment	2021 Individual Market Average Monthly Enrollment	2022 Individual Market Average Monthly Enrollment
Delaware	2020	**Total**	**34,599**	**28,817**	**23,509**	**22,847**	**25,942**	**28,951**	**33,613**
		Percent Change		-17%	-18%	-3%	14%	12%	16%
		Subsidized	19,330	18,028	17,032	17,276	18,984	21,316	27,090
		Percent Change		-7%	-6%	1%	10%	12%	27%
		Unsubsidized	15,268	10,789	6,477	5,571	6,958	7,635	6,523
		Percent Change		-29%	-40%	-14%	25%	10%	-15%
Montana	2020	**Total**	**75,601**	**60,724**	**53,301**	**49,772**	**50,265**	**53,034**	**58,385**
		Percent Change		-20%	-12%	-7%	1%	6%	10%
		Subsidized	39,605	38,625	35,760	34,241	33,947	35,879	42,830
		Percent Change		-2%	-7%	-4%	-1%	6%	19%
		Unsubsidized	35,995	22,099	17,542	15,531	16,318	17,155	15,555
		Percent Change		-39%	-21%	-11%	5%	5%	-9%
North Dakota	2020	**Total**	**42,329**	**41,619**	**39,553**	**37,613**	**37,363**	**41,113**	**47,358**
		Percent Change		-2%	-5%	-5%	-1%	10%	15%
		Subsidized	16,012	16,399	16,893	17,224	17,003	20,422	26,764
		Percent Change		2%	3%	2%	-1%	20%	31%
		Unsubsidized	26,318	25,221	22,660	20,388	20,360	20,691	20,594
		Percent Change		-4%	-10%	-10%	0%	2%	0%
Rhode Island	2020	**Total**	**45,622**	**43,032**	**44,285**	**44,264**	**44,006**	**42,471**	**41,217**
		Percent Change		-6%	3%	0%	-1%	-3%	-3%
		Subsidized	27,652	23,376	26,394	27,027	26,611	25,993	25,941
		Percent Change		-15%	13%	2%	-2%	-2%	-0.2%
		Unsubsidized	17,970	19,657	17,892	17,237	17,396	16,478	15,276
		Percent Change		9%	-9%	-4%	1%	-5%	-7%
Pennsylvania	2021	**Total**	**571,751**	**494,092**	**456,147**	**411,729**	**395,407**	**419,801**	**432,591**
		Percent Change		-14%	-8%	-10%	-4%	6%	3%
		Subsidized	286,907	289,737	299,649	266,152	250,848	281,553	300,391
		Percent Change		1%	3%	-11%	-6%	12%	7%
		Unsubsidized	284,844	204,355	156,498	145,577	144,559	138,249	132,200
		Percent Change		-28%	-23%	-7%	-1%	-4%	-4%

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment	2020 Individual Market Average Monthly Enrollment	2021 Individual Market Average Monthly Enrollment	2022 Individual Market Average Monthly Enrollment
New Hampshire	2021	**Total**	**96,118**	**96,939**	**84,800**	**44,807**	**47,185**	**53,513**	**58,310**
		Percent Change		1%	-13%	-47%	5%	13%	9%
		Subsidized	30,451	27,844	30,065	28,665	28,847	30,160	34,071
		Percent Change		-9%	8%	-5%	1%	5%	13%
		Unsubsidized	65,667	69,095	54,735	16,142	18,339	23,353	24,239
		Percent Change		5%	-21%	-71%	14%	27%	4%
Georgia	2022	**Total**	**577,748**	**496,550**	**393,308**	**398,692**	**438,401**	**547,221**	**672,162**
		Percent Change		-14%	-21%	1%	10%	25%	23%
		Subsidized	363,833	338,217	330,535	337,826	372,405	475,144	597,385
		Percent Change		-7%	-2%	2%	10%	28%	26%
		Unsubsidized	213,915	158,333	62,773	60,866	65,996	72,076	74,777
		Percent Change		-26%	-60%	-3%	8%	9%	4%
Total U.S.[69]		**Total**	**14,517,542**	**13,018,351**	**12,128,447**	**11,718,848**	**12,340,233**	**13,735,078**	**15,409,054**
		Percent Change		-10%	-7%	-3%	5%	11%	12%
		Subsidized	8,248,839	8,025,959	8,356,247	8,272,321	8,729,299	10,156,332	12,046,783
		Percent Change		-3%	+4%	-1%	6%	16%	19%
		Unsubsidized	6,268,703	4,992,392	3,772,200	3,446,527	3,610,934	3,578,746	3,362,271
		Percent Change		-20%	-24%	-9%	5%	-1%	-6%

[69] Total U.S. enrollment excludes data on plans from Massachusetts and Vermont, because both states had merged individual and small group markets during PYs 2018 through 2021. For PY 2022, only Massachusetts was excluded since Vermont separated their individual and small group markets that year.