ISSUE BRIEF
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The Benefits and Limitations of State-Run Individual Market Reinsurance

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ABSTRACT

ISSUE: Cost is a major barrier for many individuals seeking to enroll in or use comprehensive health insurance, despite historic gains in coverage since the Affordable Care Act (ACA). Though state policymakers have numerous options for improving the affordability of individual market coverage, they have most often chosen to implement state-run reinsurance programs. Reinsurance has been popular with states because the ACA's temporary federal reinsurance program was successful and because state reinsurance can be funded in significant part with federal dollars available through an ACA Section 1332 waiver.

GOAL: Examine the benefits and limitations of waiver-funded state reinsurance programs.

METHODS: Analysis of state reinsurance programs; applicable federal and state laws, regulations, and guidance; and other state and federal proposals to address coverage affordability.

KEY FINDINGS AND CONCLUSIONS: States have customized waiver-funded reinsurance to meet their specific needs. States with reinsurance have experienced significantly lower individual market premiums and stable insurer participation. However, these premium reductions generally only benefit unsubsidized enrollees and the impact on coverage take-up is unclear. States prioritizing broader improvements should consider other policies in tandem with or in lieu of reinsurance, but need federal leadership and support to succeed.

TOPLINES

- To make individual market coverage more affordable, states have considered a range of policies but have pursued one approach more than others: reinsurance.
- The success of reinsurance in reducing unsubsidized premiums has made individual market coverage more affordable, but the broader impact of these programs on the cost of coverage has been more modest.

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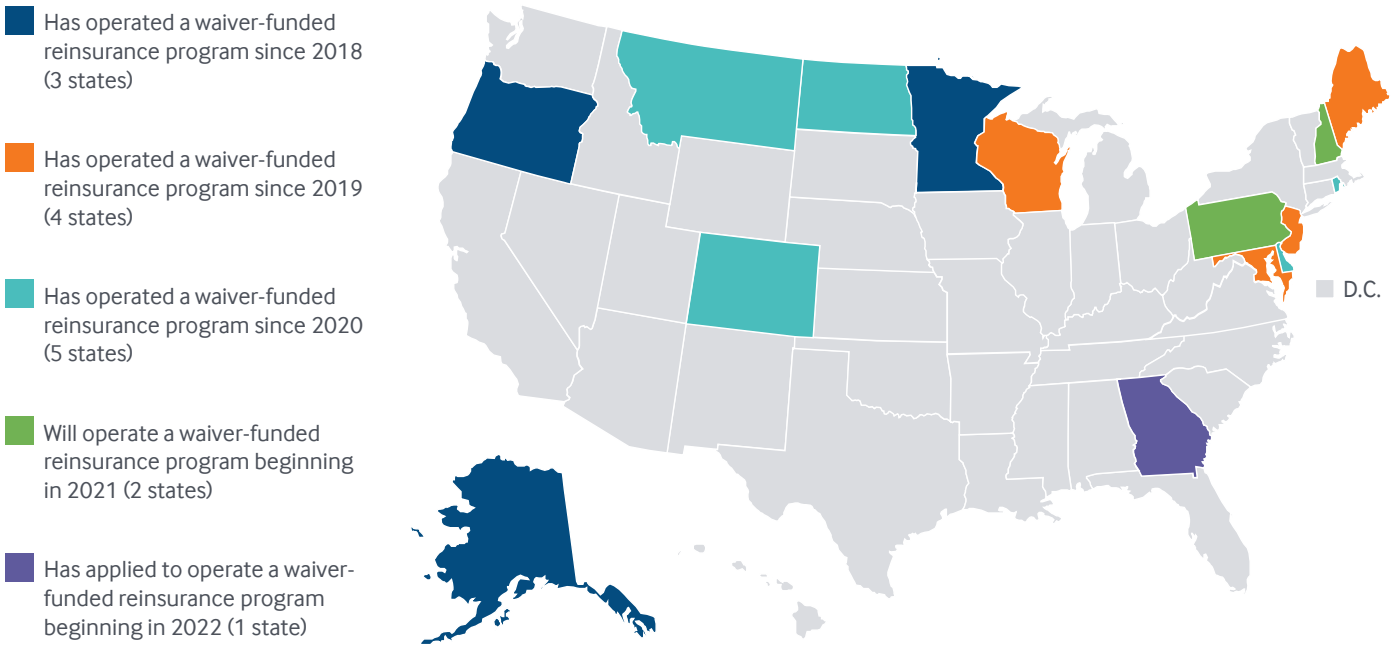
INTRODUCTION

The Affordable Care Act (ACA) produced historic expansions in coverage and has provided millions of Americans — including many who have experienced hardship during the COVID-19 pandemic — with vital access to comprehensive health insurance.[1] Even so, cost continues to present a major barrier to coverage for many.[2] Though federal subsidies for ACA marketplace coverage can substantially reduce costs for eligible individuals, the uninsured rate remains relatively high among people with moderate and lower incomes.[3] Meanwhile, many individuals — including those with incomes above the eligibility threshold, those who fall into the "family glitch," and undocumented residents — do not qualify for federal financial assistance.[4] Following large premium increases in 2017 and 2018, individual market enrollment among those who do not receive a federal subsidy dropped precipitously and has not rebounded.[5]

Though states have considered a range of policies to make individual market coverage more affordable, they have pursued one approach more than others: reinsurance.[6] By 2021, 14 states will operate individual market reinsurance programs, each designed to moderate premium increases and provide market stability by offsetting some costs borne by insurers of covering enrollees with high medical expenses.[7] For the first three years of ACA marketplace coverage (2014–2016), a federal reinsurance program lowered premiums and stabilized markets nationwide.[8] Efforts to make that program permanent foundered, but its success — and, crucially, states' ability to finance reinsurance with federal dollars available through the ACA's Section 1332 waiver program — paved the way for states to establish their own programs (Exhibit 1).

Exhibit 1. State Individual Market Reinsurance Programs Supported by Section 1332 Waiver Funding, by Year of Adoption



Notes: Section 1332 of the ACA authorizes states to apply to waive specified provisions of the health law to facilitate state-specific programs for improving coverage. If a state's "innovation waiver" program is forecast to reduce federal spending, the state is entitled to have these savings passed through to it for purposes of implementing the program. The states identified in this map have secured, or are seeking, approval for innovation waivers that use these federal "pass-through" funds to partially finance the state's reinsurance program.

Data: Authors' analysis.

At the federal level, the rationale for deploying reinsurance as part of the emergency response to COVID-19 has weakened considerably. The pandemic has reduced overall demand for health care services, boosting insurer profits, and has had only a modest — and often negligible — effect on 2021 individual market premiums, making an additional influx of funds unnecessary.[9] Yet for states weighing whether to maintain or pursue waiver-funded reinsurance over a longer time horizon, considerations differ.

This brief examines states' efforts to implement reinsurance programs, and considers flexibilities in funding and program design, the effect of reinsurance on individual market premiums, and trends in enrollment and insurer participation. Finally, it identifies the limitations of state-run reinsurance and key considerations for states.

PROGRAM FUNDING AND DESIGN: A STRAIGHTFORWARD FRAMEWORK WITH OPTIONS TO INNOVATE

Funding

States' reinsurance programs receive substantial funding from the federal government, with "pass-through" dollars available through an ACA Section 1332 waiver. In 10 of the 12 states where programs have commenced operations, waiver funding covers the majority of program costs and in all states, it is this federal support that has made reinsurance viable. Still, states must cover a share of costs and have developed several funding mechanisms to do so.

Eight of the 12 states rely at least in part on insurer assessments to finance their obligations, while five have used general appropriations to cover some or all state costs (Appendix Exhibit 1). But states have increasingly pursued other funding sources. Two states with individual mandates — New Jersey and Rhode Island — use the penalty dollars they collect to fund reinsurance.[10] Pennsylvania, which recently assumed responsibility for its ACA marketplace from the federal government, will finance its new reinsurance program with savings generated by running its coverage portal more efficiently.[11]

Other states have acted quickly and creatively to repurpose revenue from an expiring federal tax on health insurers. When Congress temporarily suspended the federal health insurance provider tax for 2019, Maryland required insurers — which benefit from and lobbied for reinsurance — to pay a fee equivalent to their forgone tax obligation to fund the program.[12] Later, after Congress permanently repealed the tax, Colorado and New Jersey followed a course similar to Maryland and established state replacements to help fund both reinsurance and forthcoming coverage subsidy programs.[13]

WHAT ARE SECTION 1332 WAIVERS?

- Section 1332 of the ACA allows states to apply to the federal government to waive certain provisions of the health law to implement their own programs to improve health insurance coverage.
- States can waive rules governing the ACA's marketplaces, premium and cost-sharing subsidies, and essential health benefits, among others.
- States may not waive ACA protections for people with preexisting conditions, prohibitions on health status and gender rating, and nondiscrimination rules.
- States can access federal funding through the waiver. If a state's waiver plan is forecast to reduce federal spending on marketplace subsidies, the federal government will pass through those savings to the state for the purpose of implementing its waiver.
- The program does not give states carte blanche to waive federal law. A waiver cannot be approved unless it complies with statutory "guardrails" that disallow any proposal likely to undermine comprehensive and affordable coverage, cover fewer people, or impose additional costs on the federal government.
- States must have statutory authority to submit the waiver application to the federal government and implement the waiver program.

Program Parameters

Nearly all state reinsurance programs follow a "claims-based" model similar to the ACA's temporary federal program: they reimburse insurers a percentage (i.e., the coinsurance rate) of all high-cost claims that exceed a specified threshold (i.e., the attachment point), up to a cap. In contrast, Alaska has a "conditions-based" program, under which insurers are reimbursed for the costs of enrollees with specified high-cost health conditions. Maine uses a hybrid of the two models (Appendix Exhibit 2).

States have used design and program parameters to attain specific policy outcomes. For example, Colorado policymakers structured their program to have the greatest impact in areas that have historically faced the highest health care and premium costs. The state adjusts the coinsurance rate by region: in the most expensive areas, the state picks up a larger share of eligible claims, thereby providing greater premium relief.[14] Georgia plans to establish a program with similar parameters in 2022.[15]

In Alaska, insurance regulators modified the list of conditions covered by the reinsurance program to include symptoms of COVID-19.[16]

WAIVER-FUNDED REINSURANCE: LOWER UNSUBSIDIZED PREMIUMS AND STABLE INSURER PARTICIPATION, BUT ENROLLMENT EFFECTS UNCLEAR

Premiums

Every state that has implemented a waiver-funded individual market reinsurance program has experienced lower unsubsidized premiums as a result (Exhibit 2). The magnitude of these savings, largely a function of program funding levels and market size, has varied substantially. Rhode Island's program, operating with a budget of $15 million, reduced rates in its inaugural year (2020) by an average of about 4 percentage points. In Maryland, the state's $462 million program lowered average premiums by nearly 40 percentage points in its first year (2019). In most states, reinsurance has produced an annual reduction in premiums of more than 10 percentage points.

Exhibit 2. Impact of Waiver-Funded State Reinsurance Programs on Individual Market Unsubsidized Premiums, 2018–2020

	Average percentage-point reduction in unsubsidized premium rates because of reinsurance		
State	**2018**	**2019**	**2020**
Alaska	30.2%	34.0%	37.1%
Colorado	—	—	22.4%
Delaware	—	—	13.8%
Maine	—	13.9%	7.2%
Maryland	—	39.6%	35.8%
Minnesota	16.8%	20.2%	21.3%
Montana	—	—	8.9%
New Jersey	—	15.5%	16.9%
North Dakota	—	—	20.0%
Oregon	7.2%	6.7%	8.0%
Rhode Island	—	—	3.8%
Wisconsin	—	9.9%	11.0%

Note: The table displays the difference in the average statewide premium with waiver-funded reinsurance and without it, where each rating area within the state is weighted equally.

Data: Center for Consumer Information and Insurance Oversight, State Relief and Empowerment Waivers: State-Based Reinsurance Programs, June 2020.

These programs have continued to generate premium reductions in the years following initial implementation. The reinsurance programs in Alaska and Minnesota have produced successively greater impact in each year of operation, with Alaska's premium reductions topping 30 percentage points every year. Maryland's program, meanwhile, caused a roughly 36 percentage point drop in premiums in its second year.

Marketplace Enrollment

Though reinsurance has demonstrably reduced unsubsidized individual market premiums, its effect on marketplace enrollment is less clear. During program development, nearly all states projected that reinsurance would generate only a small (less than 3%) boost in take-up. Raw enrollment trends suggest the positive effects may indeed have been limited (Exhibit 3). Seven of the 12 states with reinsurance programs have seen marketplace plan selections decline by at least 2 percent following program implementation, while two states have experienced corresponding increases. In three states, plan selections were flat.

These data do not rule out the possibility that reinsurance has affected enrollment. When these programs were being implemented, plan selections across the country trended downward. Evidence suggests that broader policy developments in the individual market, including massive cuts to consumer enrollment assistance programs,

Exhibit 3. Total Number of Consumers Who Selected a Marketplace Plan by the End of Open Enrollment, 2017–2020

State	2017	2018	2019	2020	Change in plan selections, pre/post program implementation*
Reinsurance programs implemented in 2018					
Alaska	19,145	18,313	17,805	17,696	–7.6%
Minnesota	109,974	116,358	113,552	110,042	0.1%
Oregon	155,430	156,105	148,180	145,264	–6.5%
Total U.S.	***12,216,003***	***11,750,175***	***11,444,141***	***11,409,447***	***–6.6%***
Reinsurance programs implemented in 2019					
Maine	79,407	75,809	70,987	62,031	–18.2%**
Maryland	157,832	153,584	156,963	158,934	3.5%
New Jersey	295,067	274,782	255,246	246,426	–10.3%
Wisconsin	242,863	225,435	205,118	195,498	–13.3%
Total U.S.	***12,216,003***	***11,750,175***	***11,444,141***	***11,409,447***	***–2.9%***
Reinsurance programs implemented in 2020					
Colorado	161,568	161,764	170,325	166,852	–2.0%
Delaware	27,584	24,500	22,562	23,962	6.2%
Montana	52,473	47,699	45,374	43,822	–3.4%
North Dakota	21,982	22,486	21,820	21,666	–0.7%
Rhode Island	29,456	33,021	34,533	34,634	0.3%
Total U.S.	***12,216,003***	***11,750,175***	***11,444,141***	***11,409,447***	***–0.3%***

Note: The table displays total plan selections at the end of each open enrollment period, not effectuated enrollments.

* The change in enrollment pre/post program implementation shows the percentage change in plan selections from the year prior to implementation of the reinsurance program to 2020. For example, the entry for Maryland shows the percentage change in plan selections from 2018 and 2020. For the U.S. total, the change in enrollment column reflects the percentage change in plan selections nationwide from the corresponding year to 2020.

** Maine expanded Medicaid in early 2019. As a result, marketplace enrollees with incomes between 100% and 138% of the federal poverty level became eligible for Medicaid and likely left the marketplace to enroll in public coverage.

Data: Authors' analysis of the Centers for Medicare and Medicaid Services' annual marketplace open enrollment period public use files.

support by the Trump administration for skimpier coverage products sold outside of the marketplaces, and ongoing legal challenges to the ACA, may have played a role in depressing marketplace enrollment.[17] This negative effect may have swamped any increase in take-up due to reinsurance.[18] Conversely, because reinsurance may reduce the buying power of subsidized enrollees (by decreasing the size of the premium tax credit), it is possible these programs have marginally reduced sign-ups.[19] Additional analysis, controlling for critical factors, is needed to determine the extent to which the programs have influenced enrollment.

Insurer Participation

Along with moderating premiums, a core objective of reinsurance is to offer certainty and stability to the market, to encourage ongoing and increased participation by insurers. In this regard, the programs appear to have been effective. Since implementation, all states have enjoyed stable insurer participation (Exhibit 4). Four states have gained one insurer, while seven have recorded no net change. Only one state has seen a reduction in their total number of carriers. In Oregon, an insurer with a small share of marketplace enrollment withdrew prior to the 2018 plan year.

THE LIMITS OF REINSURANCE

The success of reinsurance in reducing unsubsidized premiums has made coverage more affordable for the many consumers who, because they are ineligible for federal subsidies, bear the full burden of rate increases. The broader impact of these programs on the cost of coverage, however, has been more modest.

Partly, this is because of the interaction between reinsurance and the ACA's subsidy structure. The size of an eligible enrollee's premium subsidy depends on her household income and the cost of a benchmark plan sold in the marketplace.[20] As unsubsidized premiums have risen, so too has the value of the premium tax credit, and this increased buying power has generally insulated subsidized enrollees from rate hikes.[21] But this effect works both ways.

Exhibit 4. Individual Market Insurer Participation, Marketplace Plans Only, 2017–2020

State	2017	2018	2019	2020	Change in participation, pre/post program implementation*
Reinsurance programs implemented in 2018					
Alaska	1	1	1	2	+1
Minnesota	4	4	4	4	—
Oregon	6	5	5	5	–1
Reinsurance programs implemented in 2019					
Maine	3	2	3	3	+1
Maryland	3	2	2	2	—
New Jersey	2	3	3	3	—
Wisconsin	15	11	12	12	+1
Reinsurance programs implemented in 2020					
Colorado	7	7	7	8	+1
Delaware	2	1	1	1	—
Montana	3	3	3	3	—
North Dakota	3	2	3	3	—
Rhode Island	2	2	2	2	—

Note: The table displays the total number of insurers that offered qualified health plans through the state's ACA marketplace in the given year.

* The change in participation pre/post program implementation shows the difference between the number of insurers participating in the state's marketplace in 2020, compared to the number of insurers that participated in the marketplace in the year prior to implementation of the reinsurance program.

Data: Authors' analysis of state rate filings and data from HealthCare.gov.

In states where reinsurance has reduced unsubsidized premiums, it also has decreased the size of the premium tax credit.[22] Subsidized enrollees can generally compensate for this reduction in their buying power by shopping around during open enrollment.[23] But for these consumers, reinsurance does little to improve affordability (though greater market stability and insurer participation may produce benefits over time). Indeed, there is some reason to believe that even modest decreases in buying power may push some to disenroll.[24]

Reinsurance also has not addressed the underlying drivers of health care costs. While current programs offset expensive claims, they are not designed to encourage more efficient care management or lower provider prices. A reinsurance program could be developed with such objectives: Colorado initially sought to fund its program by requiring hospitals to bring their reimbursement rates into line with a pricing benchmark linked to Medicare rates. However, the Trump administration signaled it would not approve a waiver program that regulates provider payments, forcing the state to abandon this approach.[25]

Finally, though most reinsurance programs are set to last for at least five years (i.e., the initial term of a Section 1332 waiver), states may find it difficult to sustain their share of funding. In particular, economic damage wrought by the pandemic could complicate near-term financing plans and act as a barrier to program adoption.[26] If and when a state program is scheduled to expire, policymakers will face the task of winding it down without spiking rates, a challenge for which there is no clear solution.

DISCUSSION

Whether via tax deduction, tax credit, or direct funding, the federal government subsidizes the health insurance costs of the vast majority of Americans.[27] Individual market consumers ineligible for ACA subsidies are the major exception.

By lowering individual market premiums, state-operated reinsurance effectively subsidizes coverage for this population, providing help unavailable elsewhere. Premium reductions, market stability, and access to federal financing to establish the programs have engendered rare bipartisan support for reinsurance. Consequently, reinsurance has frequently gained traction among state policymakers, even as other affordability reforms have not.

Yet, these substantive and practical advantages do not make reinsurance, on its own, a sufficient solution to the problem of affordability. Nor do they suggest reinsurance is a necessary approach for all states; alternatives may prove superior. Policymakers must carefully consider their objectives as they weigh potential reforms.

For example, if a state aims to make comprehensive coverage more affordable for a broad swath of residents, the effect of reinsurance will be limited. In contrast, state-run coverage subsidy programs, which can be tailored to help both consumers ineligible for ACA subsidies and those for whom such assistance may be insufficient, are likely to have a more substantial impact.[28]

States that run their own marketplaces, and therefore have administrative and operational control over enrollment, may find that subsidies offer a better return than reinsurance or that these initiatives should proceed in tandem. States that lack such flexibility and find it harder to develop a coordinated subsidy program have other options. Large benefits can be expected from expanding Medicaid, if the state has not already done so.[29] On a smaller scale, states could set standard cost-sharing parameters for marketplace health plans that promote high-value care — for example, requiring that such services be covered before a deductible is met.[30]

For states seeking to address underlying health care costs, waiver-funded reinsurance has little to offer at the moment.[31] Yet, if states were freed to pursue waivers that include provider price regulations (the Trump administration's prohibition on such waivers is simply a policy preference and not grounded in federal law), they could employ cost containment measures within their programs.

Many state reforms, including both reinsurance and subsidies, require a sustained financial commitment. Yet in many states, funding such initiatives is a continuing challenge made even harder by the pandemic. To make comprehensive coverage affordable, consumers need federal leadership and support.

Appendix Exhibit 1. First-Year Program Costs and State Funding Sources for Waiver-Funded State Reinsurance Programs

State (year)	Total planned program cost	State share of costs*	STATE FUNDING SOURCES			
			Assessment on:			
			Health insurers	Providers	General funds	Other
Alaska (2018)	$60m	3%	X	—	—	X Assessment applies to all lines of insurance
Colorado (2020)	$250m	32%	X**	X**	X**	—
Delaware (2020)	$27m	19%	X	—	—	—
Maine (2019)	$93m	33%	X	—	—	X Premiums for policies ceded to program
Maryland (2019)	$462m	19%	X	—	—	—
Minnesota (2018)	$136m	4%	—	X	X	—
Montana (2020)	$35m	35%	X	—	—	—
New Jersey (2019)	$295m	39%	—***	—	X	X Revenue from individual mandate
North Dakota (2020)	$47m	55%	X	—	—	—
Oregon (2018)	$90m	39%	X	—	—	X Excess funds held by two other state programs†
Rhode Island (2020)	$15m	65%	—	—	X	X Revenue from individual mandate
Wisconsin (2019)	$200m	36%	—	—	X	—

Note: Except where otherwise indicated in the notes, the table provides data for the first year in which the state's reinsurance program operated with funding secured by an ACA Section 1332 waiver.

* The state's share of program funding equals the difference of the total planned program cost and the amount of federal pass-through funding allocated for the year identified (as determined by the federal government), expressed as a percentage.

** Legislation enacted in 2020 significantly changed the state funding mechanisms for Colorado's reinsurance program. The new law eliminates general fund support for the program; eliminates the assessment on hospitals for two years but establishes a new hospital assessment beginning in 2022; and imposes a fee on insurers starting in 2021.

*** Beginning in 2021, New Jersey will impose an assessment on health insurers that will be used, in part, to fund the state's reinsurance program.

† Oregon used excess funds from other state programs in 2018, only. Starting in 2020, the state's insurer assessment was expanded to apply to stop loss insurance.

Data: Authors' analysis of state Section 1332 reinsurance waiver applications, related federal correspondence, and state implementing legislation, regulations, and guidance; Center for Consumer Information and Insurance Oversight, State Relief and Empowerment Waivers: State-Based Reinsurance Programs, June 2020.

Appendix Exhibit 2. Key Characteristics of Waiver-Funded State Reinsurance Programs During the First Year of Implementation

State (year)	Program design	Total planned program cost	Attachment point	Coinsurance rate	Cap	Other features
Alaska (2018)	Condition-based	$60m	—	—	—	Program covers all claims costs for 33 specified conditions*
Colorado (2020)	Claims-based	$250m	$30,000	Tier 1: 45% Tier 2: 50% Tier 3: 85%**	$400,000	—
Delaware (2020)	Claims-based	$27m	$65,000	75%	$215,000	—
Maine (2019)	Hybrid	$93m	$47,000	$47,000–$77,000: 90% >$77,000: 100%***	None***	Payment parameters apply to: 1) all policies covering an individual with one of eight specified conditions; and 2) other policies ceded to the program by the insurer
Maryland (2019)	Claims-based	$462m	$20,000	80%	$250,000	—
Minnesota (2018)	Claims-based	$136m	$50,000	80%	$250,000	—
Montana (2020)	Claims-based	$35m	$40,000	60%	$101,750	—
New Jersey (2019)	Claims-based	$295m	$40,000	60%	$215,000	—
North Dakota (2020)	Claims-based	$47m	$100,000	75%	$1m	—
Oregon (2018)	Claims-based	$90m	$95,000	59%	$1m	—
Rhode Island (2020)	Claims-based	$15m	$40,000	50%	$97,000	—
Wisconsin (2019)	Claims-based	$200m	$50,000	50%	$250,000	—

Note: Except where otherwise indicated in the notes, the table provides data for the first year in which the state's reinsurance program operated with funding secured by an ACA Section 1332 waiver.

* In 2020, Alaska regulators modified the list of reimbursable conditions to include symptoms of COVID-19.

** Colorado's program is designed to be more generous (i.e., pay a higher coinsurance rate) in geographic areas that historically have the highest health care costs and the highest health insurance premiums. As specified in its implementing legislation, the program should produce reductions in claims costs of between 15%–20% for geographic areas in Tier 1; 20%–25% for areas in Tier 2; and 30%–35% for areas in Tier 3. The state set coinsurance rates at levels designed to achieve these targets.

*** For claims above $1 million, Maine's program pays net of amounts covered by the federal risk adjustment program high-cost risk pool.

Data: Authors' analysis of state Section 1332 reinsurance waiver applications, related federal correspondence, and state implementing legislation, regulations, and guidance; and Center for Consumer Information and Insurance Oversight, State Relief and Empowerment Waivers: State-Based Reinsurance Programs, June 2020.

NOTES

1. For information about how the Affordable Care Act (ACA) has produced historic coverage gains, see, e.g., David Blumenthal, Sara R. Collins, and Elizabeth J. Fowler, "The Affordable Care Act at 10 Years — Its Coverage and Access Provisions," *New England Journal of Medicine* 382, no. 10 (Mar. 5, 2020): 963–69; Sherry A. Glied, Sara R. Collins, and Saunders Lin, "Did the ACA Lower Americans' Financial Barriers to Health Care?," *Health Affairs* 39, no. 3 (Mar. 2020): 379–86; and Jennifer Tolbert et al., *Key Facts About the Uninsured Population* (Henry J. Kaiser Family Foundation, Dec. 2019). For information about access to coverage under the ACA during the COVID-19 pandemic, see, e.g., Rachel Schwab, Justin Giovannelli, and Kevin Lucia, "During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the Uninsured," *To the Point* (blog), Commonwealth Fund, May 19, 2020; and Bowen Garrett and Anuj Gangopadhyaya, *How the COVID-19 Recession Could Affect Health Insurance Coverage* (Urban Institute, May 2020).

2. See, e.g., Munira Z. Gunja and Sara R. Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?* (Commonwealth Fund, Aug. 2019); and Ashley Kirzinger et al, *Data Note: Americans' Challenges with Health Care Costs* (Henry J. Kaiser Family Foundation, June 2019).

3. Tolbert et al., *Key Facts*, 2019.

4. Eligibility for the ACA's premium tax credit depends on factors including household income, immigration status, and access to other forms of affordable and adequate coverage. Individuals with a household income above 400% of the federal poverty level are ineligible for premium subsidies, as are undocumented immigrants. And under a current rule, families who have access to employer-sponsored insurance are ineligible for premium subsidies if the cost of coverage for the individual employee meets the legal definition of "affordable" — even if the cost of coverage for the entire family would fail the affordability test. This policy, known as the "family glitch," is widely viewed as inconsistent with the intent, and arguably the text, of the ACA, and renders more than 6 million people ineligible for federal subsidies. See Matthew Buettgens, Lisa Dubay, and Genevieve M. Kenney, "Marketplace Subsidies: Changing the 'Family Glitch' Reduces Family Health Spending But Increases Government Costs," *Health Affairs* 35, no. 7 (July 2016) 1167–75; and Tricia Brooks, "The Family Glitch," Health Policy Brief, *Health Affairs*, Nov. 10, 2014.

5. Rachel Fehr, Cynthia Cox, and Larry Levitt, *Data Note: Changes in Enrollment in the Individual Health Insurance Market Through Early 2019* (Henry J. Kaiser Family Foundation, Aug. 2019); and Centers for Medicare and Medicaid Services, *Health Insurance Exchanges 2020 Open Enrollment Report* (CMS, Apr. 1, 2020). In addition to cost, other factors likely contributed to the decrease in enrollment, including substantial reductions in federal funding for outreach and enrollment, the repeal of the individual mandate penalty, and promotion by the Trump administration of skimpier coverage products. See note 17, below.

6. Justin Giovannelli, JoAnn Volk, and Kevin Lucia, *States Work to Make Individual Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership* (Commonwealth Fund, Jan. 2020).

7. Justin Giovannelli, Kevin Lucia, and Sabrina Corlette, "What Is Your State Doing to Affect Access to Adequate Health Insurance?," map, Commonwealth Fund, last updated Oct. 1, 2020.

8. American Academy of Actuaries, *Drivers of 2017 Health Insurance Premium Changes* (AAA, May 2016); and American Academy of Actuaries, *Drivers of 2016 Health Insurance Premium Changes* (AAA, Aug. 2015).

9. Reed Abelson, "Major U.S. Health Insurers Report Big Profits, Benefiting from the Pandemic," *New York Times*, Aug. 5, 2020; and Daniel McDermott et al., *An Early Look at 2021 Premium Changes on ACA Exchanges and the Impact of COVID-19 on Rates* (Henry J. Kaiser Family Foundation, July 2020).

10. "New Jersey 1332 Waiver Application," State of New Jersey, July 2, 2018; and "Rhode Island's 1332 Waiver Application," State of Rhode Island, July 8, 2019.

11. "Pennsylvania's 1332 Waiver Application," Commonwealth of Pennsylvania, Feb. 11, 2020.

12. Md. Code, Ins. § 6-102.1.

13. Colorado General Assembly, "Health Insurance Affordability Enterprise, SB20-215," State of Colorado, June 30, 2020; and New Jersey State Legislature, "Assembly Bill 20-4389," State of New Jersey, July 31, 2020. In light of the current increase in profitability experienced by many insurers because of the pandemic, additional states may see value in establishing an insurer assessment to safeguard the financial viability of reinsurance and/or other coverage affordability programs.

14. "Colorado 1332 State Innovation Waiver Request Application to Develop a State Reinsurance Program," State of Colorado, May 20, 2019.

15. "Georgia Section 1332 State Empowerment and Relief Waiver Application," State of Georgia, July 31, 2020.

16. Alaska Admin. Code tit. 3 § 31.540.

17. See, e.g., Selena Simmons-Duffin, "Trump Is Trying Hard to Thwart Obamacare. How's that Going?," *National Public Radio*, Oct. 14, 2019; and Dylan Scott, "Obamacare Enrollment Is Shrinking After Trump's Sabotage," Vox, updated Dec. 15, 2017. For an examination of the possible effects of the Trump administration's management of 2018 open enrollment on enrollment outcomes, see Government Accountability Office, *Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance* (GAO, July 2018). For a discussion of the Trump administration's reduction of funding for consumer enrollment assistance, see, e.g., Karen Pollitz, Jennifer Tolbert, and Maria Diaz, *Data Note: Limited Navigator Funding for Federal Marketplace States* (Henry J. Kaiser Family Foundation, Nov. 2019). For a discussion of the impact of federal actions on the state-run marketplaces, see Justin Giovannelli and Emily Curran, *How Did State-Run Health Insurance Marketplaces Fare in 2017?* (Commonwealth Fund, Mar. 2018). For an exhaustive accounting of efforts by the Trump administration to undermine the ACA, see Center on Budget and Policy Priorities, "Sabotage Watch: Tracking Efforts to Undermine the ACA," CBPP, last updated June 22, 2020.

18. Other factors not captured here surely also affected sign-ups. For example, the state with the biggest enrollment decline since reinsurance implementation, Maine, expanded Medicaid during the same period. This decision shifted many marketplace enrollees to public coverage and likely accounts for a significant portion of the observed reduction.

19. See David Anderson, Andrew Sprung, and Coleman Drake, "ACA Marketplace Plan Affordability Is Likely to Decrease for Subsidized Enrollees in 2020," *Health Affairs* Blog, Nov. 22, 2019; and Coleman Drake and Jean M. Abraham, "Individual Market Health Plan Affordability After Cost-Sharing Reduction Subsidy Cuts," *Health Services Research* 54, no. 4 (Aug. 2019): 730–38.

20. For an explanation of the mechanics of the ACA's premium tax credit, see "Key Facts: Premium Tax Credit," *Health Reform: Beyond the Basics* (blog), Center on Budget and Policy Priorities, last updated Aug. 2020.

21. See, e.g., Erik Huth and Peter Fielek, *Has the ACA "Death Spiral" Kicked the Bucket?* (Milliman, July 2019).

22. See Aree Bly and Freddy Quiram, "Colorado Individual Exchange Renewals: Consumer Impact Analysis" presentation by Wakely Consulting Group, Oct. 14, 2019.

23. See Bly and Quiram, "Colorado Individual Exchange," 2019; and John Ingold, "Colorado's Reinsurance Program Has Been Lauded as a Way to Reduce Health Care Costs. Here's the Fine Print.," *Colorado Sun*, Nov. 1, 2019.

24. See Drake and Abraham, "Individual Market," 2019.

25. In 2020, Maine enacted legislation that, among other things, allows for modification of the state's reinsurance program beginning in 2022. See Maine Legislature, "An Act to Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine: LD 2007," State of Maine, Mar. 18, 2020. The new law gives the state authority to exclude from reinsurance certain claims for "high-priced items or services." If a high-priced item or service — defined as one that is covered under Medicare and identified by the state in advance of the plan year — results in a claim amount that is greater than 200% of Medicare rates, that claim is not eligible for reimbursement under the program.

26. Marlene Caride et al., "Letter from Fifteen State-Based Marketplaces to U.S. Senate and House Leadership," National Academy for State Health Policy, June 5, 2020.

27. For example, federal law 1) provides a tax deduction for employees' share of job-based health insurance premiums and creates certain arrangements and accounts, such as health savings accounts and health reimbursement arrangements, that receive preferential tax treatment; 2) provides premium tax credits and cost-sharing reduction subsidies for eligible enrollees in the ACA marketplaces; and 3) funds public coverage programs, including Medicare, Medicaid, the Children's Health Insurance Program, and TRICARE.

28. See, e.g., Aviva Aron-Dine and Matt Broaddus, *Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage* (Center on Budget and Policy Priorities, Mar. 2019); and Aviva Aron-Dine, *Making Health Insurance More Affordable for Middle-Income Individual Market Consumers* (Center on Budget and Policy Priorities, Mar. 2019). California, Massachusetts, and Vermont fund premium or cost-sharing subsidies that provide an additional source of financial assistance for eligible residents to use to purchase coverage. For example, beginning with the 2020 plan year, California provides additional premium subsidies to individuals eligible for the ACA's premium tax credits, as well as financial assistance to residents whose incomes (between 400% and 600% of poverty) render them ineligible for federal subsidies.

29. Rachel Garfield, Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid* (Henry J. Kaiser Family Foundation, Jan. 2020); and Commonwealth Fund, "Status of Medicaid Expansion and Work Requirement Waivers," map, Commonwealth Fund, last updated Oct. 1, 2020.

30. Giovannelli, Volk, and Lucia, *States Work*, 2020.

31. But see Maine's efforts, described in note 25, above.

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