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SUMMARY

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State Innovation Waivers: Frequently Asked Questions

Section 1332 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) provides states with the option to waive specified requirements of the ACA. In the absence of these requirements, a state is to implement its own plan to provide health insurance coverage to state residents that meets the ACA's terms.

Under a state innovation waiver, a state can apply to waive ACA requirements related to qualified health plans, health insurance exchanges, premium tax credits, cost-sharing subsidies, the individual mandate, and the employer mandate. The state can apply to waive any or all of these requirements, in part or in their entirety.

To obtain approval for a waiver application, a state must show that the plan it will implement in the absence of the waived provision(s) meets certain requirements. The state's plan must ensure that as many state residents have health insurance coverage under the plan as would have had coverage absent the waiver, and the coverage must be as affordable and comprehensive as it would have been absent the waiver. Additionally, the state's plan cannot increase the federal deficit.

The Secretary of the Department of Health and Human Services (HHS) and the Secretary of the Treasury share responsibility for reviewing state innovation waiver applications and deciding whether to approve applications. State innovation waivers cannot extend longer than five years, unless a state requests continuation and the appropriate Secretary does not deny such request. The earliest a state innovation waiver could take effect was January 1, 2017.

As of the date of this report, 21 states—Alaska, Colorado, Delaware, Georgia, Hawaii, Idaho, Maine, Maryland, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, Washington, and Wisconsin—have approved state innovation waivers. (However, New York requested, and was approved, to terminate its approved waiver effective July 1, 2026). The most common feature of approved state innovation waivers are reinsurance programs, as 18 of the 21 approved waivers include a variant of a statewide individual market reinsurance program. These reinsurance programs typically offset a portion of the insurer's high-cost claims for certain individual market enrollees, reducing the insurer's overall risk and contributing to lower premiums in the individual market.

Idaho, Massachusetts, Ohio, and Vermont have submitted applications and received notification that their applications were incomplete. In October 2025, Idaho indicated that it is seeking to amend its approved waiver to incorporate a plan similar to the one discussed in its incomplete application. It does not appear that Massachusetts, Ohio, or Vermont has modified their incomplete applications in response to the notification (as of the date of this report). Three states—California, Iowa, and Oklahoma—submitted waiver applications and have since withdrawn their applications.

Contents

Tables

Contacts

Section 1332 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) allows states to apply for waivers of specified provisions of the ACA. Under a state innovation waiver, a state is expected to implement a plan (in place of the waived provisions) that meets certain minimum requirements. The state's plan must provide coverage to as many state residents as would be covered absent the waiver, that coverage must be as affordable and comprehensive as it would be absent the waiver, and the state's plan cannot increase the federal deficit.

This report answers frequently asked questions about how states can use and apply for state innovation waivers and summarizes states' submitted waiver applications.

Which ACA Provisions May a State Waive Under a State Innovation Waiver?

A state may apply to waive *any or all* of the ACA provisions listed below.[1]

- **Part I of Subtitle D of the ACA:** Part I of Subtitle D comprises Sections 1301-1304. In general, the provisions in Part I relate to the establishment of qualified health plans (QHPs).[2]
- **Part II of Subtitle D of the ACA:** Part II of Subtitle D comprises Sections 1311-1313, which largely include provisions related to the establishment of health insurance exchanges and related activities.
- **Section 1402 of the ACA:** This section includes the provision of cost-sharing reductions to eligible individuals who purchase individual market coverage through a health insurance exchange.[3]
- **Section 36B of the Internal Revenue Code (IRC):** This section includes the provision of premium tax credits to eligible individuals who purchase individual market coverage through a health insurance exchange.
- **Section 4980H of the IRC:** This section includes the shared responsibility requirement for large employers (often called the *employer mandate*).[4]
- **Section 5000A of the IRC:** This section includes the requirement for individuals to maintain health insurance coverage (often called the *individual mandate*).[5]

Each part noted above is comprised of many provisions, which makes the scope of the provisions that can be waived under a state innovation waiver quite broad. For example, Part I of Subtitle D of the ACA includes provisions that outline requirements for health plans to be certified as QHPs.

[1] 42 U.S.C. §18052(a)(2).

[2] A qualified health plan (QHP) is a plan that meets certain requirements and is certified to be sold through a health insurance exchange (in the non-group or small-group market). Although QHPs are certified to be sold through exchanges, they also can be sold in the non-group or small-group market outside of exchanges. For more information, see CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates*.

[3] For more information about the current status of the cost-sharing reductions, see archived CRS Insight IN10786, *Payments for Affordable Care Act (ACA) Cost-Sharing Reductions*.

[4] For more information about the employer mandate, see CRS Report R45455, *The Affordable Care Act's (ACA's) Employer Shared Responsibility Provisions (ESRP)*.

[5] For more information about the individual mandate, see CRS Report R44438, *The Individual Mandate for Health Insurance Coverage: In Brief*. The 2017 tax revision, P.L. 115-97, effectively eliminated the individual mandate penalty beginning in 2019. However, the 2017 tax revision did not make any other substantive changes to the statutory language establishing the mandate and its associated penalty.

It defines the essential health benefits (EHB) package that each QHP must offer, places limitations on the enrollee cost sharing that QHPs may impose, and requires that QHPs provide coverage meeting a minimum level of actuarial value.[6] Additionally, Part I of Subtitle D establishes requirements for catastrophic health plans and determines eligibility for such plans.

Which Federal Agencies Have the Authority to Grant a Waiver?

The Secretary of the Department of Health and Human Services (HHS) has authority to review and grant waiver requests for provisions not included in the IRC; the Secretary of the Treasury has authority to review and grant requests to waive provisions in the IRC (the availability of premium tax credits and the application of the employer and individual mandates).[7]

What Are the Minimum Requirements for a Successful Application?

The Secretary of HHS or the Treasury is to assess a waiver application to determine whether the state's plan meets the requirements related to coverage, affordability, comprehensiveness, and federal-deficit neutrality.[8]

The interpretation of these four statutory requirements has been expressed in regulations and guidance by different Administrations and changed over time. The current interpretation of these requirements was established by the Biden Administration in 2021 and seeks "to strengthen the ACA and increase enrollment in comprehensive, affordable health coverage among the remaining underinsured and uninsured."[9] This interpretation is described in **Table 1**. It replaced a previous interpretation that was initially outlined by the first Trump Administration in 2018 and sought to "promote private market competition and increase consumer choice."[10]

The Secretary or Secretaries (as appropriate) may grant a request for a state innovation waiver if a state's application meets the requirements.

HHS and the Treasury note that their assessment of a state's waiver application considers changes to the state's health care system that are contingent only upon approval of the waiver.[11] Their assessment does not consider policy changes that are dependent on further state action or other federal determinations. For example, the Secretary's or Secretaries' (as appropriate) assessment of a state innovation waiver application would not consider changes to Medicaid or the state Children's Health Insurance Program (CHIP) that require approval outside of the state innovation

[6] Note that essential health benefit (EHB) and related cost-sharing and actuarial value requirements apply to all non-grandfathered plans in the individual and small group markets, including QHPs. For more information about the essential health benefits package, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*.

[7] 42 U.S.C. §18052(a)(6).

[8] 42 U.S.C. §18052(b)(1) and 45 C.F.R. §155.1308(f)(3)(iv).

[9] Department of the Treasury and Department of Health and Human Services (HHS), "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond," 86 *Federal Register* 53412, September 21, 2021. Hereinafter, Section 1332 2021 Rule.

[10] Section 1332 2021 Rule.

[11] Section 1332 2021 Rule.

waiver process, and resulting costs or savings attributable to Medicaid or CHIP changes outside of the state innovation waiver process would not be considered when determining whether the state innovation waiver meets the deficit-neutrality requirement. HHS and the Treasury indicate that this is the case regardless of whether a state's application for a state innovation waiver is submitted alone or in coordination with another waiver application. (For more information about the coordinated waiver process, see "May States Submit State Innovation Waiver Applications in Coordination with Other Federal Waiver Applications?")

Table 1. Requirements for a Successful State Innovation Waiver Application

(as described in statute, regulations, and other guidance)

Statute	Current Interpretation
Coverage: The state's plan must provide coverage to at least a comparable number of individuals as the provisions of Title I of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) would provide.	At least as many individuals who are forecasted to have minimum essential coverage (MEC) absent a waiver must have MEC under the waiver.[a] This requirement generally must be forecast to be met for each year the waiver is in effect. In considering whether this requirement is met, the plan's impact on all state residents, regardless of coverage type, will be considered and the plan's effects on different groups of individuals in the state, particularly those considered vulnerable or underserved, will be assessed.[b] A state plan that satisfied this requirement in the aggregate but reduced coverage for vulnerable or underserved populations would be highly unlikely to be approved. Whether the plan sufficiently prevents gaps in or discontinuations of coverage also will be considered.
Affordability: The state's plan must provide coverage and cost-sharing protections that are at least as affordable as the provisions of Title I of the ACA.	Individuals' health care coverage under the waiver must be as affordable as coverage would be absent the waiver. Affordability is generally measured by comparing the sum of an individual's premium contributions and cost-sharing responsibilities for a health plan to the individual's income. Spending on health care services that are not covered by a health plan may be considered if the services are affected by the state's plan. This requirement generally must be forecast to be met for each year the waiver is in effect. In considering whether this requirement is met, the plan's impact on all state residents, regardless of coverage type, will be considered, and the plan's effects on different groups of individuals in the state, particularly those with large health care spending burdens and those considered vulnerable or underserved, will be assessed.[b] A state plan that satisfied this requirement in the aggregate but increases the number of individuals with large health care spending burdens would not be approved. A state plan that satisfied this requirement in the aggregate but reduced affordability for vulnerable or underserved populations would be highly unlikely to be approved. In addition, a state plan that increases the number of individuals with coverage that does not have specified cost-sharing-related protections would also not be approved.

Statute	Current Interpretation
Comprehensiveness: The state's plan must provide coverage that is at least as comprehensive as the essential health benefits (EHB),[c] as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS).	Individuals' health care coverage under the waiver must be at least as comprehensive overall as their coverage would be absent the waiver. Comprehensiveness is measured by comparing coverage under the plan to coverage under the state's EHB benchmark plan (including with respect to each individual EHB category) or coverage under the state's Medicaid program and/or the State Children's Health Insurance Programs (CHIP), as appropriate.[c] This requirement generally must be forecast to be met for each year the waiver is in effect. In considering whether this requirement is met, the proposal's impact on all state residents, regardless of coverage type, will be considered, and the effects of the proposal on different groups of individuals in the state, particularly those considered vulnerable or underserved, will be assessed.[b] A state plan that satisfied this requirement in the aggregate but reduced comprehensiveness for vulnerable and underserved populations would be highly unlikely to be approved.
Deficit Neutral: The state's plan must not increase the federal deficit.	Projected federal spending net of federal revenues must be equal to or lower than it would be absent the waiver. The state's plan must not increase the federal deficit over the period of the waiver or in total over the 10-year budget plan submitted by the state as part of its application.[d]

Source: Congressional Research Service's compilation and summary of statute (42 U.S.C. §18052(b)(1)) and regulations (45 C.F.R. §155.1308(f)(3)(iv), and 86 *Federal Register* 53466, September 27, 2021).

Notes: The Secretary of the Department of Health and Human Services (HHS) is to review requests to waive provisions not included in the Internal Revenue Code (IRC); the Secretary of the Treasury is to review requests to waive provisions in the IRC (the availability of premium tax credits and the application of the employer and individual mandates).

a. MEC is defined in the tax code (26 U.S.C. §5000A(f)) and includes most types of comprehensive coverage, including public coverage, such as coverage under programs sponsored by the federal government (e.g., Medicaid, Medicare), as well as private insurance (e.g., employer-sponsored insurance, non-group coverage).

b. Vulnerable and underserved individuals include "low-income individuals, older adults, those with serious health issues or who have a greater risk of developing serious health issues, and people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality" (86 *Federal Register* 53412, September 27, 2021, p. 53465).

c. Under the ACA, certain health plans must cover the EHB. The ACA does not explicitly define the EHB; rather, it lists 10 broad categories from which benefits and services must be included and requires the Secretary of HHS to further define the EHB. For information about the 10 categories as well as how the EHB are currently defined, see the Center for Consumer Information and Insurance Oversight (CCIIO) webpage, "Information on Essential Health Benefits (EHB) Benchmark Plans," at https://www.cms.gov/marketplace/resources/data/essential-health-benefits.

d. The state innovation waivers cannot extend longer than five years unless a state requests continuation and such request is not denied by the appropriate Secretary. Statute requires that an application for a waiver include a 10-year budget plan that is budget neutral for the federal government (42 U.S.C. §18052(a)(1)(B)(ii)). This determination takes into account costs associated with changes to federal administrative processes.

May a State Modify Its Use of the Federally Facilitated Health Insurance Exchange Platform Under a State Innovation Waiver?

HHS administers all federally facilitated exchanges (FFEs), and it operates the same information technology platform (Healthcare.gov) in each state that has an FFE. Some states administer their

own state-based exchanges, except they also use the federal information technology platform (SBE-FP).[12]

Initially, it was not possible for states that use the federal technology platform to make eligibility and enrollment changes related to that platform. Since then, HHS and the Treasury have indicated that technical enhancements made it feasible for the Centers for Medicare & Medicaid Services (CMS) to support certain state-specific variations.[13] States are asked to work with HHS early in the waiver application process to determine whether proposed operational modifications or technical changes can be accommodated.

States are responsible for funding all FFE platform modifications and associated operational support. Any changes to CMS administrative processes are taken into account when determining whether a waiver application satisfies the deficit neutrality requirement; however, waiver costs for technical and specialized services that CMS typically provides to states (and states cover the cost of) would not be included in such determinations.[14]

Are There Any Limitations on the Scope of State Innovation Waivers?

HHS and the Treasury described some federal operational considerations that may limit the scope of the waivers.[15] Specifically, the Internal Revenue Service (IRS) generally is not able to accommodate any state-specific changes to federal tax rules. HHS and the Treasury have indicated that states considering a state innovation wavier that would modify premium tax credit eligibility or amounts could consider waiving the provision entirely and creating a state-level subsidy program.[16]

However, the IRS may be able to accommodate small changes to the administration of federal tax provisions, in particular when such changes overlap with the IRS's current capabilities.[17] As an example, waivers that would require the IRS to expand premium tax credit eligibility to individuals with household income under 100% of the federal poverty level (FPL) may be feasible, because it incorporates a similar special rule that the IRS currently administers.[18] Another example of an approved waiver that included changes to federal tax rules is New York's waiver that removed premium tax credit eligibility for individuals under age 65 with income at or below 250% of FPL and replaced those subsidies with Essential Plan Expansion coverage under the waiver.[19]

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[12] For more information about exchange types, see CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates*.

[13] Department of the Treasury, HHS, "Waivers for State Innovation," 80 *Federal Register* 78131, December 16, 2015. Department of the Treasury, HHS, "State Relief and Empowerment Waivers," 83 *Federal Register* 53575, October 24, 2018.

[14] Specifically, the Centers for Medicare & Medicaid Services (CMS) services covered under the Intergovernmental Cooperation Act (ICA) are not considered for deficit neutrality purposes.

[15] Section 1332 2021 Rule.

[16] Section 1332 2021 Rule.

[17] States are responsible for funding all changes to IRS administrative processes associated with waiver implementation. These costs are incorporated into the assessment of whether a waiver application satisfies the deficit neutrality requirement.

[18] For more information about how household income is calculated to determine premium tax credit eligibility, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*.

[19] For a description of New York's waiver, see **Table 2**.

What Is the Application Process for a State Innovation Waiver?

A state seeking a state innovation waiver must enact a law that allows the state to carry out the actions under the waiver prior to submitting an application for a waiver.[20] In certain circumstances, a state can be considered to have enacted such a law by coupling a state law that enforces ACA provisions and/or the state plan with administrative or executive actions.[21]

Prior to submitting an application, a state generally must provide a public notice and comment period and conduct public hearings regarding the state's application.[22] Upon conclusion of these activities, a state may submit its application to the Secretary of HHS, which should be sufficiently in advance of the implementation date to allow for federal public notice and comment, federal review, and state implementation of the waiver should it be approved.

The Secretary of HHS is to transmit any application seeking to waive requirements in the IRC to the Secretary of the Treasury for review. The Secretary or Secretaries (as appropriate) are to review a state's application to determine whether it is complete. A state's application is not considered complete unless it includes the materials identified in regulations.[23] The materials include, but are not limited to, information about the enacted state legislation allowing the state to carry out the actions under the waiver, a description of the plan or program the state expects to implement in place of the waived provisions, and analyses showing that the state's plan or program meets the requirements for granting a waiver. If a state's application is not complete, the state is to be notified about the missing elements and given an opportunity to submit them. Once the Secretary or Secretaries (as appropriate) make a preliminary determination that a state's application is complete, the entire application is to be made available to the public for review and comment.[24]

The final decision of the Secretary or Secretaries on a state's application must be issued no later than 180 days after the determination that the Secretary of HHS received a complete application from a state.[25]

Is Any Federal Funding Available Under a State Innovation Waiver?

It is possible for a state to receive federal funding under an approved waiver. A state's receipt of a state innovation waiver could result in the residents of the state not receiving the "premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible."[26] If this occurs, the state is to receive the aggregate amount of subsidies that would have been

[20] 42 U.S.C. §18052(b)(2).

[21] 45 C.F.R. §155.1308(f)(3)(i).

[22] The Secretaries of HHS and Treasury may modify state and federal public notice and comment requirements during unforeseen and urgent situations (e.g., natural disasters, public health emergencies) where a delay would threaten access to health insurance, access to health care, or human life. 45 C.F.R. §155.1318.

[23] 45 C.F.R. §155.1308(f).

[24] See footnote 22.

[25] 42 U.S.C. §18052(d)(1) and 45 C.F.R. §155.1316(c).

[26] 42 U.S.C. §18052(a)(3).

available to the state's residents had the state not received a state innovation waiver—this is referred to as *pass-through funding*. The amount of pass-through funding is to be determined annually by the appropriate Secretary and may be updated at any time to account for changes in state or federal law. The state is to use the pass-through funding for purposes of implementing the plan or program established under the waiver.[27]

How Long Can a State Innovation Waiver Be in Effect?

State innovation waivers are approved for a period of up to five years. States may request to extend approved waivers for additional periods of up to five years.[28]

A state wanting to extend a waiver for up to five additional years must notify HHS and the Treasury of its intent at least one year prior to the end of the approved waiver. Once notified, the HHS and the Treasury would communicate the information that must be included in the waiver extension request. A state must solicit public feedback and then can submit a waiver extension request.

Once the Secretary or Secretaries (as appropriate) make a preliminary determination that a state's waiver extension request is complete, the waiver extension request is to be made available to the public for review and comment.

Waiver extension requests are to be deemed granted unless, within 90 days of the determination that the Secretary of HHS received a complete request from a state, the appropriate Secretary either denies the request or informs the state that additional information or actions are needed for the Secretary to consider such request. If additional information or responses are needed, any further review would take at most 90 days from the date the additional information or responses are provided.

May States Modify an Approved State Innovation Waiver?

A state with an approved waiver is allowed to apply to the Secretaries to make a change to the plan or program established under the waiver.[29]

A state wanting to amend an approved waiver is encouraged to notify HHS and the Treasury of its intent at least 15 months prior to the implementation date of the proposed waiver amendment. Once notified, HHS and the Treasury would communicate the information that must be included in the waiver amendment request, which is similar to the information provided with a new waiver application. HHS and the Treasury also would communicate whether the waiver amendment request would be subject to additional or different requirements. A state generally must solicit public feedback before submitting an amendment request.

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[27] 42 U.S.C. §18052(a)(3).

[28] 42 U.S.C. §18052(e). Section 1332 2021 Rule, 86 *Federal Register* 53412, September 21, 2021, pp. 53486-53488.

[29] This includes situations where a state was seeking changes that were not allowed under the terms and conditions that the state agreed to with the Departments when the waiver was approved, and situations where a waiver would affect any of the waiver requirements related to coverage, affordability, comprehensiveness, and federal-deficit neutrality. 45 C.F.R. §155.1330. Section 1332 2021 Rule.

Once the Secretary or Secretaries (as appropriate) make a preliminary determination that a state's application is complete, the waiver amendment request is to be made available to the public for federal review and comment.

The Secretary or Secretaries would evaluate the original waiver and the waiver amendment together to determine if the "combined" waiver satisfies the minimum requirements for a successful waiver.

The final decision of the Secretary or Secretaries on a state's waiver amendment request must be issued no later than 180 days after the determination that the Secretary of HHS received a complete waiver amendment request. Any subsequent pass-through funding would incorporate the changes made by the waiver amendment.

May States Submit State Innovation Waiver Applications in Coordination with Other Federal Waiver Applications?

The Secretaries were required to develop a process for coordinating applications for state innovation waivers and applications for other existing waivers under federal law relating to the provision of health care, including waivers available under Medicare, Medicaid, and CHIP.

Under the coordinated process, a state may submit a single application for a state innovation waiver and any other applicable waivers available under federal law.[30] The single application must comply with the procedures described for state innovation waiver applications and the procedures in any other applicable federal law under which the state seeks a waiver.[31]

However, each waiver is evaluated independently. As discussed in the answer to the question "What Are the Minimum Requirements for a Successful Application?," HHS and the Treasury assess a state innovation waiver based on its own terms and that assessment of the state innovation waiver will not consider the impact of changes that require separate federal approval (e.g., a Medicaid waiver). This is the case even if the state submits a single application for multiple waivers.

How Many States Have Applied for State Innovation Waivers?

As of the date of this report, 27 states have submitted applications for state innovation waivers.[32] HHS and the Treasury have approved 21 applications from Alaska, Colorado, Delaware, Georgia, Hawaii, Idaho, Maine, Maryland, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, Washington, and

[30] 42 U.S.C. §18052(a)(5).

[31] 45 C.F.R. §155.1302(a).

[32] For information about each state's application, see CMS, Center for Consumer Information and Insurance Oversight (CCIIO), "Section 1332: State Innovation Waivers," at https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers.

Wisconsin, though New York requested, and was approved, to terminate its waiver effective July 1, 2026.[33]

The most common feature of approved state innovation waivers are reinsurance programs, as 18 of the 21 approved waivers include a variant of a statewide individual market reinsurance program.[34] These reinsurance programs typically offset a portion of the insurer's high-cost claims for certain individual market enrollees, reducing the insurer's overall risk and contributing to lower premiums in the individual market.

Idaho, Massachusetts, Ohio, and Vermont received notification from HHS and the Treasury that their applications were incomplete. In October 2025, Idaho indicated that it is seeking to amend its approved waiver to incorporate a plan similar to the one discussed in its incomplete application.[35] It does not appear that Massachusetts, Ohio, or Vermont has modified their incomplete applications in response to the notification.

California, Iowa, and Oklahoma have withdrawn their applications.[36]

See **Table 2** for more details.

[33] New York State Department of Health, Submission to the Centers for Medicare and Medicaid Services (CMS): New York State's Request to Terminate the Section 1332 State Innovation Waiver and Return to the Basic Health Program, October 20, 2025, https://info.nystateofhealth.ny.gov/sites/default/files/1332%20Termination%20Notice%2010-20-25.pdf.

[34] Waivers with reinsurance programs may also have other features, as described in **Table 2**. CMS has issued data briefs that compare various aspects of the state-based reinsurance programs implemented through the Section 1332 waiver process. See CMS, CCIIO, *Data Brief on State Innovation Waivers: Section 1332 Waivers*, April 2024, https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf. For more information on reinsurance, see CRS In Focus IF10707, *Reinsurance in Health Insurance*.

[35] Letter from Dean L. Cameron, Idaho Department of Insurance Director, to Robert F. Kennedy Jr., Secretary of Health and Human Services, and Scott Bessent, Secretary of the Treasury, October 1, 2025, https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-id-loi-amendment-and-response-letter.pdf.

[36] To read the withdrawal letters, see CMS, CCIIO, "Section 1332: State Innovation Waivers," at https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers.

Table 2. States That Have Applied for State Innovation Waivers

(as of March 20, 2026)

State	Application Information		Waiver Information		
	Submitted	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
			Approved Waivers		
Alaska	Initial Waiver:—Jan. 3, 2017 Waiver Extension—Mar. 17, 2022	Initial Waiver Approved—July 17, 2017 Waiver Extension Approved—July 13, 2022	Alaska established a state-based, conditions-based reinsurance program, the Alaska Reinsurance Program (ARP), to help health insurance issuers offering plans in the individual market offset the entire cost of covering enrollees with 1 or more of 34 specified high-cost conditions.[b] Under the approved waiver, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] to the extent the provision prohibits issuers from including expected reinsurance payments from the ARP when establishing market-wide index rates. The expected effect of allowing issuers to consider the ARP payments when setting market-wide rates is to reduce premiums in the individual market, and the expected effect of the reduced premiums is reduced federal spending on premium tax credits for residents of Alaska. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Alaska is to use the pass-through funding to support ARP and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Alaska. *Alaska's waiver extension did not include any substantial changes to the approved waiver.*	CY2018: $58.5 million CY2019, $68.7 million CY2020: $76.7 million CY2021: $122.3 million CY2022: $119.4 million CY2023: $129.1 million CY2024: $110.1 million CY2025: $118.4 million	CY2018-CY2027

Colorado	Initial Waiver—May 20, 2019 Waiver Extension—Apr. 30, 2021 Waiver Amendment—Nov. 30, 2021	Initial Waiver Approved—July 31, 2019 Waiver Extension Approved—Aug. 13, 2021 Waiver Amendment Approved—June 23, 2022	Colorado's approved waiver currently consists of a state-based, claims cost-based reinsurance program, a state-based public option health insurance program, and a state-based subsidy program for certain enrollee populations. The reinsurance component of the waiver has been effective since CY2020, while the public option and subsidy components were added with a waiver amendment and have been effective since CY2023. **Initial Waiver:** Colorado established a state-based, claims cost-based reinsurance program. The program reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. The reimbursement percentage varies across geographic rating areas in the state. Colorado's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider Colorado reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Colorado will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Colorado is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers.[d] The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Colorado. *Colorado's waiver extension did not include any substantial changes to the approved waiver.* **Waiver Amendment:** Colorado established the Colorado Option, which is a state-based public option health insurance program that is offered on Colorado's health insurance exchange and outside of the exchange. Under the Colorado Option program, issuers in the individual and small group markets are required to offer Colorado Option plans that must meet specified premium reduction targets (and satisfy other requirements). Issuers must offer Colorado Option plans in 2023 with premiums that are 5% lower than the lowest-premium plan offered by the issuer in that county in 2021, adjusted for inflation (CPI-U, Medical Component). In 2024, Colorado Option plans must have a premium that is 10% lower than the 2021 rate, as adjusted for inflation. In 2025, Colorado Option plans must have a premium that is 15% lower than the 2021 rate, as adjusted for inflation. For 2026 and later years, Colorado Option plan premiums may only increase to account for inflation. Colorado expects premium reductions to come from "lower provider rates, reductions in profits, and reduced utilization through effective care management."[e] Colorado's approved waiver amendment waives the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool and the ACA provision requiring issues to consider all enrollees in the small group market offer by the issuer to be members of a single risk pool.[f] This allows issuers to attribute health care savings (e.g., resulting from lower provider rates) only to Colorado Option plan premiums instead of spreading such savings across the issuer's Colorado Option and non-Colorado Option individual and small group market plans. Waiving this requirement also allows issuers to adjust premiums to satisfy the premium reduction targets for Colorado Option plans. The	CY2020: $169.4 million CY2021: $182.7 million CY2022: $196.7 million CY2023: $245.0 million CY2024: $361.7 million CY2025: $339.1 million	Initial Waiver—CY2020-CY2022 Amended Waiver—CY2023-CY2027

State	Application Information		Waiver Information		
	Submitted	Status	Overview	Pass-Through Funding[a]	Effective Period
			projected decrease in individual market premiums is expected to decrease federal spending on premium tax credits for residents of Colorado. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Colorado is to use the pass-through funding to support a state-based subsidy program. The state-based subsidy provides increased cost-sharing subsidies for premium tax credit eligible individuals from 150%-200% of the federal poverty level starting in 2022. The state-based subsidy also provides premium assistance and cost-sharing subsidies to individuals ineligible for federal premium assistance (e.g., due to immigration status, lack of documentation, or the "family glitch") up to a certain income threshold starting in 2023. Other state-based subsidy program eligibility criteria apply, and the income thresholds may vary depending on funding availability. The approved waiver amendment does not modify the eligibility criteria for federal premium tax credits for residents of Colorado. *Colorado's waiver amendment also included an extension of the approved reinsurance-aspect of the waiver from CY2026 through CY2027. It did not change other aspects of the reinsurance component of the waiver.*		
Delaware	Initial Waiver—July 10, 2019 Waiver Extension—April 2, 2024, updated May 21, 2024	Initial Waiver Approved—Aug. 20, 2019 Waiver Extension Approved—July 31, 2024	Delaware established a state-based, claims cost-based reinsurance program, the Delaware Health Insurance Individual Market Stabilization Reinsurance Program, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Delaware's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider Delaware reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Delaware will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Delaware is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Delaware. *Delaware's waiver extension did not include any substantial changes to the approved waiver.*	CY2020: $21.7 million CY2021: $38.9 million CY2022: $35.0 million CY2023: $46.7 million CY2024: $64.7 million CY2025: $49.3 million	CY2020-CY2029

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
Georgia	December 23, 2019, modified July 31, 2020, and updated Oct. 9, 2020	Approved—Nov. 1, 2020 Partial Suspension—Apr. 29, 2022	Georgia's approved waiver has two parts: a state-based, claims cost-based reinsurance program and the Georgia Access Model. The second part of the waiver, the Georgia Access Model, was suspended prior to implementation and is pending Georgia satisfying certain requirements. With respect to first part of the waiver, Georgia established a state-based, claims cost-based reinsurance program. Starting in 2022, the program is to reimburse issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. The reimbursement percentage is to vary across geographic rating areas in the state. Georgia's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider Georgia's reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Georgia will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Georgia is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Georgia. With respect to the suspended part of the waiver, Georgia planned to shift its individual market exchange enrollment to the Georgia Access Model beginning in CY2023. Under the Georgia Access Model, residents would no longer have been able to enroll in individual market coverage through the federally facilitated exchange and would have instead only been able to utilize commercial market web brokers or buy directly from issuers. Residents still would have had to be eligible for premium tax credits while enrolling in coverage through the Georgia Access Model. Under this part of the waiver, ACA requirements relating to the state establishment of health insurance exchanges would have been waived to the extent they are inconsistent with the Georgia Access Model.[g] As a result, Georgia would have been able to implement the Georgia Access Model.	CY2022: $255.2 million CY2023: $526.5 million CY2024: $756.7 million CY2025: $1,015.8 million	CY2022-CY2026

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
Hawaii	Initial Waiver—Aug. 10, 2016 Waiver Extension—Aug. 13, 2021	Initial Waiver Approved—Dec. 30, 2016 Waiver Extension Approved—Dec. 10, 2021	Under the approved waiver, multiple ACA provisions relating to the establishment and operation of a Small Business Health Options Program (SHOP) exchange, as they pertain to small employers and SHOP exchanges, are waived.[h] As a result, Hawaii is no longer required to operate SHOP exchanges for small employers. The amount that small employers in Hawaii would have received in small business tax credits for coverage purchased through a SHOP exchange is provided to the state in pass-through funding to support a program that assists small employers with the cost of health insurance coverage. *Hawaii's waiver extension did not include any substantial changes to the approved waiver.*	CY2017: $428,864 CY2018: $933,130 CY2019: $287,409 CY2020: $120,361 CY2021: $60,865 CY2022: $29,503 CY2023: $51,033 CY2024: $45,269 CY2025: $45,372[i]	CY2017-CY2026
Idaho	May 5, 2022	Approved—Aug. 16, 2022	Idaho established a state-based, conditions-based reinsurance program, the Idaho Individual High Risk Reinsurance Pool, to help health insurance issuers offering plans in the individual market offset the cost of covering a percentage of claims for enrollees with specified high-cost conditions between an attachment point and a cap. Idaho's waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] to the extent the provision prohibits issuers from including expected reinsurance payments when establishing market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Idaho will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Idaho is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Idaho.	CY2023: $51.5 million CY2024: $97.9 million CY2025: $148.7 million	CY2023-CY2027

Maine	Initial Waiver—May 9, 2018 Waiver Amendment—Feb. 10, 2022, addended Mar. 23, 2022	Initial Waiver Approved—July 30, 2018 Waiver Amendment—July 15, 2022	**Initial Waiver:** Maine established a state-based reinsurance program administered by the Maine Guaranteed Access Reinsurance Association (MGARA). From CY2019-CY2021, the program operated as a conditions-based reinsurance program, which helped health insurance issuers offering plans in the individual market offset the cost of a percentage of claims for enrollees with one or more of eight specified high-cost conditions between an attachment point and a cap. Under this structure, health insurance issuers offering plans in the individual market also had the discretion to include additional enrollees in the program if such determinations are made during the first 60 days of an enrollee's plan year. Since CY2022, the reinsurance program has operated as a claims cost-based reinsurance program. Under the claims cost-based version of the reinsurance program, issuers selling coverage in the state's individual market are reimbursed for a percentage of enrollees' claims between an attachment point and a cap irrespective of the health condition of the enrollee. Maine's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider MGARA payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Maine will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the approved waiver, Maine is to use the pass-through funding to support MGARA and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Maine. **Waiver Amendment:** Maine extended its state-based, claims cost-based reinsurance program to also apply to the small-group market by combining the individual and small-group markets into a single risk pool and extending the reinsurance program to the combined risk pool. Maine also allowed for quarterly rating adjustments for non-calendar year small group plans that are now part of the combined risk pool. Maine's approved waiver amendment waives the ACA provisions requiring issuers to consider all enrollees in plans offered by the issuer to be members of a single risk pool,[j] which allows issuers to consider MGARA payments when setting market-wide index rates for the combined risk pool. It also waives the provision that prohibits quarterly rating adjustments for non-calendar year small group plans when there is a merged risk pool.[k] The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Maine will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the approved waiver, Maine is to use the pass-through funding to support MGARA and corresponding payments to issuers. The approved waiver amendment does not modify the eligibility criteria for premium tax credits for residents of Maine. *Maine's waiver amendment also included an extension of the approved reinsurance-aspect of the waiver from CY2026 through CY2027.*	CY2019: $62.3 million CY2020: $26.3 million CY2021: $39.3 million CY2022: $45.8 million CY2023: $61.4 million CY2024: $45.7 million CY2025: $43.4 million	Initial Waiver—CY2019-CY2022 Waiver Amendment—CY2023-CY2027

Maryland	Initial Waiver—May 31, 2018, addended Aug. 4, 2018 Waiver Extension—Mar. 30, 2023 Waiver Amendment—July 15, 2024 Initial Request to Suspend Waiver Amendment—Oct. 20, 2025, updated Nov. 6, 2025	Initial Waiver Approved—Aug. 22, 2018 Waiver Extension Approved—June 28, 2023 Waiver Amendment Approved—Jan. 15, 2025 Waiver Amendment Suspension Approved—Dec. 29, 2025	**Initial Waiver:** Maryland established a state-based, claims cost-based reinsurance program administered by the Maryland Health Benefit Exchange, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Maryland's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider the state's reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Maryland will decrease. The state requested to receive a portion of the resulting reductions in federal spending as pass-through funding. Under the waiver, Maryland is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers beginning in CY2019 and continuing through CY2021, unless additional funds become available. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Maryland. *Maryland's waiver extension did not include any substantial changes to the approved waiver.* **Waiver Amendment:** Maryland created the Qualified Resident Enrollment Program, which allows all qualified Maryland residents to enroll in health insurance through an exchange, regardless of immigration status. Maryland's approved waiver amendment waives the ACA provision that prohibits individuals who are not United States citizens, United States nationals or aliens lawfully present in the United States from being able to enroll in health insurance coverage through an exchange, which would allow such individuals to enroll in exchange coverage.[l] The expected effect is that there will be a negligible impact on premiums. Maryland did not request pass-through funding under the waiver amendment (unless it is subsequently determined that pass-through funding is warranted). The approved waiver amendment does not modify the eligibility criteria for premium tax credits for residents of Maryland, as such the newly-eligible individuals still would not be eligible for the premium tax credit. *Maryland's waiver amendment did not change the reinsurance component of the waiver.* *The Qualified Resident Enrollment Program portion of the amended waiver was suspended until CY2028, pending Departmental approval to continue the program. Maryland requested this suspension in order to first address substantial information technology system changes resulting from changes in federal law (P.L. 119-21) and regulations (Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability; 90 Federal Register 27074).*	CY2019: $373.4 million CY2020: $447.3 million CY2021: $474.5 million CY2022: $344.1 million CY2023: $473.0 million CY2024: $526.7 million CY2025: $577.8 million	Initial Waiver—CY2019-CY2028 Waiver Amendment (incl. suspension)—CY2028, pending Departmental approval to continue the program[m]
Minnesota	Initial Waiver—May 30, 2017	Initial Waiver Approved—Oct. 19, 2017	Minnesota established a state-based, claims cost-based reinsurance program, the Minnesota Premium Security Plan (MSPS), which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap.	CY2018: $130.7 million	CY2018-CY2027

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
	Waiver Extension—Dec. 22, 2021, revised May 12, 2022	Waiver Extension Approved—July 13, 2022	Minnesota's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider MSPS payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Minnesota will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding.[n] Under the waiver, Minnesota is to use the pass-through funding to support MSPS and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Minnesota. *Minnesota's waiver extension did not include any substantial changes to the approved waiver.*	CY2019: $84.8 million CY2020: $86.1 million CY2021: $142.7 million CY2022: $91.1 million CY2023: $119.5 million CY2024: $129.9 million CY2025: $179.3 million	
Montana	Initial Waiver—June 19, 2019 Waiver Extension—May 17, 2024	Initial Waiver Approved—Aug. 16, 2019 Waiver Extension Approved—Sep. 17, 2024	Montana established a state-based, claims cost-based reinsurance program, the Montana Reinsurance Program, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Montana's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider Montana reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Montana will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Montana is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Montana. *Montana's waiver extension did not include any substantial changes to the approved waiver.*	CY2020: $22.5 million CY2021: $30.8 million CY2022: $29.7 million CY2023: $28.4 million CY2024: $35.8 million CY2025: $51.8 million	CY2020-CY2029

Nevada	Dec. 29, 2023, addended Aug. 23, 2024 and Jan. 1, 2025	Jan. 10, 2025	Nevada's approved waiver consists of a state-based public option health insurance program, and a Market Stabilization Program. The Market Stabilization Program includes a state-based, claims cost-based reinsurance program, premium assistance for certain populations, a "quality incentive payment program," and a "provider retention program." Nevada established Battle Born State Plans (BBSP), which are state-based public option health insurance plans that are offered on Nevada's health insurance exchange. Under the public option health insurance program, issuers offering a bid to participate in Nevada's Medicaid Managed Care program also must submit a good faith bid to offer at least one bronze, one silver, and one gold BBSP, and one non-BBSP silver plan in each rating area through the exchange. BBSP plans must meet specified premium reduction targets (and satisfy other requirements). Issuers must offer BBSP plans in 2026 with premiums that are 3% lower than the 2024 second-lowest cost silver plan, adjusted for inflation, utilization, and morbidity. In 2027 and 2028, Nevada will negotiate premium reduction amounts with the intention of ensuring that issuers, in 2029, achieve a 15% reduction in premiums relative to the 2024 second-lowest cost silver plan, adjusted for inflation, utilization, and morbidity. For 2030, issuers must maintain the 15% premium reduction. These reductions are expected to be derived from lower provider rates, administrative efficiencies, and the implementation of reinsurance. The Market Stabilization Program includes a state-based, claims cost-based reinsurance program, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Under the approved waiver, the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to adjust premiums to satisfy the premium reduction targets for BBSPs and allows issuers to consider reinsurance program payments when setting market-wide index rates. The projected decrease in individual market premiums is expected to decrease federal spending on premium tax credits for residents of Nevada. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Nevada is to use the pass-through funding to support the reinsurance program, and provide premium assistance to individuals renewing a policy whose net premium is higher under the waiver program than it would have been without the waiver (due to the effect of BBSPs on premium tax credit amounts). If additional pass-through funding is available, Nevada is to use the funds to support a quality incentive payment program that pays BBSP issuers for achieving state-defined quality goals, and a provider retention program that acts as a loan repayment program to providers committing to live and work in Nevada for four years. The approved waiver amendment does not modify the eligibility criteria for federal premium tax credits for residents of Nevada.		CY2026-CY2030
New Hampshire	Initial Waiver—Apr. 23, 2020	Initial Waiver Approved—Aug. 5, 2020	New Hampshire established a state-based, claims cost-based reinsurance program, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap.	CY2021: $31.5 million	CY2021-CY2030

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
	Waiver Extension—Aug. 21, 2024	Waiver Extension Approved—Nov. 19, 2024	New Hampshire's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of New Hampshire will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, New Hampshire is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of New Hampshire. *New Hampshire's waiver extension did not include any substantial changes to the approved waiver.*	CY2022: $26.6 million CY2023: $32.0 million CY2024: $28.0 million CY2025: $34.1 million	
New Jersey	Initial Waiver—July 2, 2018 Waiver Extension—July 6, 2023, amended July 11, 2023	Initial Waiver Approved—Aug. 16, 2018 Waiver Extension Approved—Aug. 15, 2023	New Jersey established a state-based, claims cost-based reinsurance program, the New Jersey Health Insurance Premium Security Plan, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. New Jersey's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider the state's reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of New Jersey will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, New Jersey is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of New Jersey. *New Jersey's waiver extension did not include any substantial changes to the approved waiver.*	CY2019: $180.2 million CY2020: $190.0 million CY2021: $282.1 million CY2022: $323.0 million CY2023: $375.3 million CY2024: $608.9 million CY2025: $554.8 million	CY2019-CY2028

New York	Initial Waiver—May 12, 2023, addended Aug. 23, 2023, Nov. 14, 2023, and Dec. 18, 2023 Waiver Amendment—June 28, 2024 Waiver Extension—Dec. 9, 2024, updated Dec. 11, 2024 Termination Request—Oct. 20, 2025	Initial Waiver Approved—Mar. 1, 2024 Waiver Amendment Approved—Sep. 25, 2024 Waiver Extension Approved—Jan. 15, 2025 Termination Request Approved—Mar. 20, 2026	**Initial Waiver:** New York's approved waiver shifts its Essential Plan program from operating under Basic Health Program (BHP) authority to operating under Section 1332 waiver authority, which allows New York to generally mirror the program as it operated under BHP authority but expand Essential Plan program eligibility to certain populations. As operated under Section 1332 waiver authority, CMS refers to the program as the *Essential Plan Expansion*. New York suspended its BHP for the duration of the waiver. As a BHP, the Essential Plan provided coverage to premium tax credit-eligible individuals aged 19-64 with estimated incomes above the Medicaid ceiling and up to 200% of FPL, but eligibility expands under the Essential Plan Expansion to also include premium tax credit-eligible individuals aged 19-64 with estimated incomes between 200% and 250% of FPL, and Deferred Action for Childhood Arrivals (DACA) recipients aged 19-64 with estimated incomes up to 250% of FPL. In addition, Essential Plan Expansion enrollees that became pregnant and eligible for Medicaid are given the choice to maintain Essential Plan coverage through the postpartum period, as opposed to transitioning to Medicaid. New York's approved waiver also includes an Insurer Reimbursement Implementation Plan (IRIP). Under the IRIP, New York provides payments to issuers in lieu of approving increased individual market premiums that were expected to result from the removal of premium tax credit-eligible individuals with estimated incomes between 200% and 250% of FPL from the individual market. Under the approved waiver, multiple ACA provisions are waived. The ACA provisions pertaining to premium tax credit eligibility and cost-sharing reduction eligibility are waived for individuals under age 65 who are determined by the exchange to have estimated household income at or below 250% of FPL (with some exceptions). As a result of this waiver, these individuals no longer are eligible for premium tax credit amounts or cost-sharing reductions, but instead receive their coverage through the Essential Plan Expansion. The expected effect is that federal spending on premium tax credits for residents of New York would decrease. These amounts are combined with savings attributable to the suspension of the BHP, and New York receives the total reductions in federal spending as pass-through funding. In addition, the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to determine market-wide index rates as if those with estimated household income between 200% and 250% of FPL still were included in the single risk pool. The expected effect is that individual market premiums would not increase as a result of excluding those with estimated household income between 200% and 250% of FPL from the single risk pool due to their enrollment in the Essential Plan Expansion. New York uses the pass-through funding to implement the Essential Plan Expansion and IRIP. **Waiver Amendment:** New York's waiver amendment expands the uses of federal pass-through funding to allow the state to use the funding on three new cost-sharing reduction programs for exchange enrollees. The first program expands the cost-sharing reductions available to those with incomes between 100% and 250% of FPL to apply to individuals with incomes between 100% and 400% of FPL. The second program reduces cost-sharing to $0 for non-hospital-based diabetes-related services, supplies, and prescription drugs. The third	CY2024: $10.0 billion CY2025: $15.9 billion CY2026 (Interim):[o] $2 billion	Initial Waiver—Apr. 1, 2024-Dec. 31, 2024 Waiver Amendment—CY2025-July 1, 2026

State	Application Information		Waiver Information		
	Submitted	Status	Overview	Pass-Through Funding[a]	Effective Period
			program reduces cost-sharing to $0 for outpatient covered services, supplies, and prescription drugs during pregnancy and postpartum. New York uses pass-through funding to provide payments to issuers offsetting the costs to provide these cost-sharing reduction programs. New York's waiver amendment did not request to waive additional ACA requirements. *New York's waiver extension did not include any substantial changes to the approved waiver* New York requested termination of its approved waiver and reactivation of its BHP by July 1, 2026 due to changes in premium tax credit eligibility included in the budget reconciliation law sometimes referred to as the One Big Beautiful Bill Act (P.L. 119-21). The termination was approved and the reactivation will go into effect July 1.		
North Dakota	Initial Waiver—May 10, 2019 Waiver Extension—Aug. 30, 2024, updated Oct. 2, 2024	Initial Waiver Approved—July 31, 2019 Waiver Extension Approved—Nov. 7, 2024	North Dakota established a state-based, claims cost-based reinsurance program, the Reinsurance Association of North Dakota (RAND), which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. North Dakota's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider RAND payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of North Dakota will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, North Dakota is to use the pass-through funding to support RAND and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of North Dakota. *North Dakota's waiver extension did not include any substantial changes to the approved waiver.*	CY2020: $21.5 million CY2021: $20.5 million CY2022: $19.0 million CY2023: $14.5 million CY2024: $20.8 million CY2025: $38.1 million	CY2020-CY2029

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
Oregon	Initial Waiver—Aug. 31, 2017 Waiver Extension—Mar. 31, 2022, addended Apr. 22, 2022	Initial Waiver Approved—Oct. 18, 2017 Waiver Extension Approved—July 13, 2022	Oregon established a state-based, claims cost-based reinsurance program, the Oregon Reinsurance Program (ORP), which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Oregon's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider ORP payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Oregon will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Oregon is to use the pass-through funding to support ORP and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Oregon. *Oregon's waiver extension did not include any substantial changes to the approved waiver.*	CY2018: $54.5 million CY2019: $41.8 million CY2020: $54.4 million CY2021: $73.7 million CY2022: $71.3 million CY2023: $77.1 million CY2024: $68.3 million CY2025: $86.0 million	CY2018-CY2027
Pennsylvania	Initial Waiver—Feb. 11, 2020 Waiver Extension—Dec. 30, 2024	Initial Waiver Approved—July 24, 2020 Waiver Extension Approved—Apr. 24, 2025	Pennsylvania established a state-based, claims cost-based reinsurance program, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Pennsylvania's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Pennsylvania will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Pennsylvania is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Pennsylvania. *Pennsylvania's waiver extension did not include any substantial changes to the approved waiver.*	CY2021: $120.2 million CY2022: $124.2 million CY2023: $115.4 million CY2024: $121.1 million CY2025: $165.3 million	CY2021-CY2030

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
Rhode Island	Initial Waiver—July 8, 2019 Waiver Extension—July 8, 2024	Initial Waiver Approved—Aug. 26, 2019 Waiver Extension Approved—Oct. 28, 2024	Rhode Island established a state-based, claims cost-based reinsurance program, the Rhode Island Reinsurance Program, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Rhode Island's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider Rhode Island reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Rhode Island will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Rhode Island is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Rhode Island. *Rhode Island's waiver extension did not include any substantial changes to the approved waiver.*	CY2020: $5.2 million CY2021: $12.4 million CY2022: $9.7 million CY2023: $10.8 million CY2024: $9.6 million CY2025: $12.2 million	CY2020-CY2029
Virginia	Dec. 30, 2021	May 18, 2022	Virginia established a state-based, claims cost-based reinsurance program, which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Virginia's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider reinsurance program payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Virginia will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Virginia is to use the pass-through funding to support the reinsurance program and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Virginia.	CY2023: $331.9 million CY2024: $481.9 million CY2025: $450.3 million	CY2023-CY2027

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
Washington	May 13, 2022, updated June 8, 2022, and Aug. 3, 2022	Dec. 9, 2022	Washington's approved waiver allows all qualified residents to enroll in health insurance through an exchange, regardless of immigration status, thereby expanding the number of individuals eligible under the state's Cascade Care Savings program. The Cascade Care Savings program is a state-based premium subsidy program for individuals with incomes up to 250% of FPL who purchase silver or gold Cascade Care plans and meet other eligibility criteria.[p] Cascade Care Savings program premium subsidies are a maximum monthly amount that are determined annually depending on available funding. Subsidies are available to eligible individuals who are also eligible for the premium tax credit, and eligible individuals who are not eligible for the premium tax credit, including due to immigration status. For those eligible for the premium tax credit, this subsidy amount is in addition to any premium tax credit amounts (although it cannot be greater than the net premium for the lowest-cost silver Cascade Care plan, after accounting for the premium tax credit). Under the approved waiver, the ACA provision that prohibits individuals who are not United States citizens, United States nationals or aliens lawfully present in the United States from being able to enroll in health insurance coverage through an exchange is waived, which would allow such individuals to enroll in exchange coverage.[l] Per the waiver application, the expected effect is that individual market premiums will decrease as a result these individuals enrolling in coverage, including with support from the state-based subsidy, however, the Departments did not project an increase or decrease in individual market premiums upon waiver approval. To the extent that there are future decreases in individual market premiums, the state is to receive the resulting reductions in federal spending as pass-through funding. Under the waiver, Washington is to use the pass-through funding, if applicable, to support the Cascade Care Savings program. The approved waiver amendment does not modify the eligibility criteria for premium tax credits for residents of Washington, as such the newly-eligible individuals still would not be eligible for the premium tax credit.	Upon approval, the Departments indicated that the waiver was not projected to result in PTC savings, and no pass-through funding has since been posted.	CY2024-CY2028

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
Wisconsin	Initial Waiver—Apr. 18, 2018 Waiver Extension—Aug. 5, 2022	Initial Waiver Approved—July 29, 2018 Waiver Extension Approved—Dec. 1, 2022	Wisconsin established a state-based, claims cost-based reinsurance program, the Wisconsin Healthcare Stability Plan (WIHSP), which reimburses issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Wisconsin's approved waiver is similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool is waived,[c] which allows issuers to consider WIHSP payments when setting market-wide index rates. The expected effect is that individual market premiums will decrease and federal spending on premium tax credits for residents of Wisconsin will decrease. The state is to receive the resulting reductions in federal spending as pass-through funding. Wisconsin is to use the pass-through funding to support WIHSP and corresponding payments to issuers. The approved waiver does not modify the eligibility criteria for premium tax credits for residents of Wisconsin. *Wisconsin's waiver extension did not include any substantial changes to the approved waiver.*	CY2019: $127.7 million CY2020: $142.0 million CY2021: $229.2 million CY2022: $181.9 million CY2023: $213.5 million CY2024: $195.6 million CY2025: $223.3 million	CY2019-CY2028
			Pending Applications		
Idaho	July 15, 2019	Received notification of incomplete application—Aug. 29, 2019	Idaho is seeking to waive the requirements that prevent individuals purchasing health insurance through an exchange from being eligible to claim premium tax credits and cost sharing reductions if they are eligible for other types of qualifying coverage (e.g., Medicaid).[q] At the time the application was submitted, Idaho residents with incomes between 100% and 138% of FPL who purchased health insurance through the individual exchange were eligible for premium tax credits and cost-sharing reductions (assuming other eligibility criteria also were met). However, Idaho was in the process of expanding Medicaid eligibility to individuals with incomes between 100% and 138% of FPL, which was assumed by Idaho to be effective beginning CY2020. Once the Medicaid expansion went into effect, those who were newly eligible for Medicaid would no longer be eligible for premium tax credits and cost-sharing reductions through the exchange. By waiving the specified provisions, Idaho indicates that individuals with incomes between 100% and 138% of FPL would be able to choose between subsidized exchange coverage and Medicaid.	Idaho is not requesting pass-through funding.	N.A.

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
Massachusetts	Sept. 8, 2017	Received notification of incomplete application—Oct. 23, 2017	Massachusetts is seeking to create a Premium Stabilization Fund (PSF), which would be used to reimburse issuers amounts equal to what would have been provided by cost-sharing reduction payments. At the time the application was submitted, cost-sharing reduction payments were still being made to insurers; however, there was uncertainty as to whether the current administration would continue to make payments moving forward. Massachusetts sought to use the waiver process to avoid the need for a rate revision in the event that cost-sharing reduction payments stopped. Under the proposed waiver, the ACA provision that provides for cost-sharing subsidy payments to issuers from HHS would be waived,[r] which Massachusetts indicates would allow the state to substitute these payments with allocations from the PSF. The expected effect is that individual market premiums would decrease and federal spending on premium tax credits for residents of Massachusetts also would decrease. The state would receive the resulting reductions in federal spending as pass-through funding. Under the proposed waiver, Massachusetts would use the pass-through funding for PSF payments to issuers for an initial period of one year, beginning in CY2018, and the state would request the opportunity to renew the waiver through CY2022.	Massachusetts estimated it would receive between $143 and $146 million for CY2018.	N.A.
Ohio	Mar. 30, 2018	Received notification of incomplete application—May 17, 2018	Ohio is seeking to waive the requirement that individuals must maintain minimum essential coverage, as established under the ACA's individual mandate provision.[s] Under the proposed waiver, the requirement would be waived beginning in CY2019.[t]	Ohio is not requesting pass-through funding.	N.A.
Vermont	Apr. 25, 2016	Received notification of incomplete application—June 9, 2016	Vermont is seeking an exemption from the requirement that a state must establish a SHOP exchange for small employers. Under the proposed waiver, Vermont seeks to waive multiple ACA provisions relating to the establishment and operation of a SHOP exchange.[u] As a result, Vermont indicates that employers in the small-group market would purchase qualified health plans directly from an issuer.	Vermont is not requesting pass-through funding.	N.A.

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
			Withdrawn Applications		
California	Dec. 19, 2016	Withdrawn—Jan. 18, 2017	California sought to provide undocumented immigrants with the ability to purchase unsubsidized insurance through its exchange. Under this waiver, the ACA provision that prohibits the marketing of nonqualified health plans (QHPs) on the exchanges would have been waived,[v] which California indicates would have allowed "California Qualified Health Plans (CQHP)" to be offered through its exchange. CQHPs would have differed from QHPs only in that undocumented individuals could purchase CQHPs and enrollment in CQHPs would disqualify individuals from receiving premium tax credits and cost-sharing subsidies.	California did not request pass-through funding.	N.A.
Iowa	Aug. 21, 2017	Withdrawn—Oct. 23, 2017	Iowa sought to allow issuers in its individual market to offer one standard health plan, to provide age- and income-based premium tax credits to individuals purchasing the standard plans, and to support a state-based reinsurance program. Under this waiver, Iowa sought to waive the following ACA provisions.[w] • Iowa applied to waive the provisions establishing premium tax credits and cost-sharing reductions. Iowa indicates that it would have received the resulting reductions in federal spending as pass-through funding and would have allocated this funding to its age- and income-based premium tax credit and its reinsurance program. • Iowa applied to waive the provision that defines the coverage levels based on actuarial value. Iowa indicates waiving the provision would authorize issuers to offer one standard plan to consumers. The standard plan would be similar in actuarial value to a silver-tier plan and would be purchased directly from an issuer. • Finally, Iowa applied to waive the provision that provides the Secretary with 180 days to review all state innovation waiver requests. Iowa indicates that waiving the provision would have allowed for expedited review of its waiver application. The Iowa waiver would have begun in CY2018 and would have allowed Iowa to request renewal of the program for CY2019 if necessary.	Iowa estimated it would have received $422 million for CY2018.	N.A.

	Application Information		Waiver Information		
State	**Submitted**	**Status**	**Overview**	**Pass-Through Funding[a]**	**Effective Period**
Oklahoma	Aug. 16, 2017	Withdrawn—Sept. 29, 2017	Oklahoma established a state-based reinsurance program, the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP), though the operation of the program was conditional upon receiving federal funds to implement and sustain the OMSP. Had the waiver been approved, the OMSP would have reimbursed issuers selling coverage in the state's individual market for a percentage of enrollees' claims between an attachment point and a cap. Oklahoma's withdrawn waiver was similar to other reinsurance-type waivers in that the ACA provision requiring issuers to consider all enrollees in individual plans offered by the issuer to be members of a single risk pool would have been waived,[c] which would have allowed issuers to consider OMSP payments when setting market-wide index rates. The expected effect was that individual market premiums would have decreased and federal spending on premium tax credits for residents of Oklahoma also would have decreased. The state would have received the resulting reductions in federal spending as pass-through funding. Under the waiver, Oklahoma would have used the pass-through funding for OMSP payments to issuers beginning in CY2018.	Oklahoma estimated it would have received $309 million for CY2018 and $1,395 million over the period CY2018-CY2022.	N.A.

Source: Various documents available on the CMS website, "Section 1332: State Innovation Waivers," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html, viewed January 25, 2021.

Notes: Estimated pass-through funding describes either the amount of pass-through funding that a state estimates it will receive in its waiver application or, when available, the amount of pass-through funding CMS estimates it will provide to the state as determined annually by the Secretary of the Department of Health and Human Services and/or the Secretary of the Department of the Treasury (as appropriate). For more information on reinsurance, see CRS In Focus IF10707, *Reinsurance in Health Insurance*.

a. As indicated by CMS. At the time of this report's publication, CMS has not communicated the total amount of pass-through funding for approved waivers in CY2026. New York was provided interim pass-through funding of $2 billion for CY2026 with a final CY2026 pass-through funding amount to be determined after the date of publication of this report.

b. For CY2018-CY2019, the Alaska Reinsurance Program (ARP) offset the entire cost of covering enrollees with 1 or more of 33 specified high-cost conditions, with severe COVID-19 cases being added as a condition starting in CY2020.

c. Specifically, ACA §1312(c)(1).

d. Although waivers can be approved for a period of up to five years, the initial Colorado application requested, and was approved for, an effective period from CY2020 through CY2021.

e. Colorado Division of Insurance, *Colorado Section 1332 Innovation Waiver Amendment Request Colorado Option*, November 20, 2021, https://drive.google.com/file/d/1SUy-iNz3i7IIRTPTqy2OJgNYH1oyN5mX/view.

f. Specifically, ACA §1312(c)(1) and (c)(2).

g. Specifically, ACA §1311(b), (c), (d), (e), and (i) only to the extent that it is inconsistent with the Georgia Access Model.

h. Specifically, the following ACA §§: 1301(a)(1)(C)(ii); 1301(a)(2); 1304(b)(4)(D)(i) and (ii); 1311(b)(1)(B); 1312(a)(2); 1312(f)(2)(A); and 1321(c)(1).

i. The final amounts of pass-through funding received by Hawaii account for budget sequestration.

j. Specifically, ACA §1312(c)(1), (2), and (3).

k. Specifically, ACA §1312(c)(3).

l. Specifically, ACA §1312(f)(3).

m. Maryland's waiver amendment was initially approved with an effective date of January 1, 2026, but the effective date of the waiver amendment was subsequently postponed until January 1, 2028. Maryland indicated that it may be able to implement the waiver amendment earlier than 2028 if time and resources allow.

n. In addition to what is described in the table about Minnesota's approved waiver, Minnesota's waiver application and waiver extension application also requested that the state receive, in pass-through funding, the amount that the federal government would save in payments to Minnesota's Basic Health Program (BHP) because of premium reductions due to MSPS. This request was not granted under the approved waiver and waiver extension due to pass-through funding being limited to savings based on "premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible." (42 U.S.C. §18052(a)(3)). Subsequent BHP rulemaking addressed this issue by incorporating the effects of an approved Section 1332 waiver into the BHP payment methodology to counteract BHP funding reductions resulting from an approved Section 1332 waiver. For details, see Letter from Mark Dayton, Governor of Minnesota to Thomas Price, Secretary of the U.S. Department of Health and Human Services, September 19, 2017, http://mn.gov/gov-stat/pdf/2017_09_19_Governor_Dayton_Letter_to_Secretary_Price_1332_Waiver.pdf, and Letter from Mark Dayton, Governor of Minnesota, to Seema Verma, Administrator of the Centers for Medicare & Medicaid Services, October 16, 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-MN.pdf, Letter from Grace Arnold, Minnesota Department of Commerce Commissioner (Temporary), and Jodi Harpstead, Minnesota Department of Human Services Commissioner, to Elizabeth Richter, Centers for Medicare and Medicaid Services Acting Administrator, February 5, 2021, https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-mn-bhp-request-response-letter.pdf, and Centers for Medicare & Medicaid Services, "Basic Health Program; Federal Funding Methodology for Program Year 2023 and Changes to the Basic Health Program Payment Notice Process," 87 *Federal Register* 77722, December 20, 2022.

o. New York's pass-through funding is made available to the state in two portions, with the interim funding representing the first portion.

p. Cascade Care Plans have a standard benefit design, and include Cascade Plans and Cascade Select Plans. Cascade Select Plans are Washington's public option plans and satisfy additional requirements. American Indian and Alaska Natives do not need to purchase Cascade Care silver or gold plans for premium subsidy eligibility purposes and instead may purchase any qualified health plan.

q. Idaho applied to waive ACA §1402 and 26 U.S.C. §36B(c)(2)(B), the latter of which was added to the Internal Revenue Code by ACA §1401.

r. Massachusetts applied to waive ACA §1402(c)(3)(A).

s. Ohio applied to waive 26 U.S.C. §5000A(a), which was added to the Internal Revenue Code by ACA §1501.

t. Ohio's House Bill 49 requires Ohio's department of insurance to submit a 1332 waiver application that includes a request to waive the ACA's individual and employer mandates. In its waiver application, Ohio acknowledges that the 2017 tax revision (P.L. 115-97) effectively eliminates the penalty associated with the individual mandate beginning in CY2019 but points out that the law does not eliminate the individual mandate. As such, Ohio's 1332 waiver application requests to waive the individual mandate (however, the application does not include a request to waive the employer mandate).

u. Vermont applied to waive the following ACA §§: 1311(b)(1)(B); 1311(c)(3); 1311(c)(4); 1311(c)(5); 1311(d)(1); 1311(d)(2); 1311(d)(4)(A); 1311(d)(4)(B); 1311(d)(4)(C); 1311(d)(4)(D); 1311(d)(4)(E); 1311(d)(4)(G); 1311(k); 1312(a)(2); 1312(f)(2)(A).

v. California applied to waive ACA §1311(d)(2)(B)(i).

w. Iowa applied to waive ACA §§1402; 1401(a); 1302(d); and 1332(d).

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