

MAINE STATE LEGISLATURE

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Maine Bureau of Insurance

MGARA Sustainability and Policy Options Analysis

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Executive Summary

Maine's Guaranteed Access Reinsurance Association (MGARA) has helped to stabilize premiums and support affordability in the state's Affordable Care Act (ACA) markets for more than a decade. However, changes to the program and its funding have reduced the program's value by more than half, which is projected to further diminish in 2026 and beyond. Since the merger of the individual and small group markets in 2023, the population covered by MGARA has nearly doubled, while program funding has not adequately increased to provide the same level of value. Wakely was retained to better understand the current market dynamics and evaluate policy levers to improve the sustainability of the MGARA program.



Status quo state funding of \$4 PMPM will lead to continuing decline in MGARA impact, with only 4.3% premium reduction by 2028.

For each 1% premium reduction, approximately \$10.6 million in total program funding is needed.

Higher state funding is needed to generate higher federal pass-through funding.

The key findings include:

1. **MGARA Impact to Continue to Decline:** Under the existing \$4 per member per month (PMPM) state assessment, combined with a reduction in federal pass-through funds, Wakely estimates that MGARA's premium impact will continue to erode, with premium reductions declining to 4.3% by 2028.
2. **Additional Funding Needed to Alter Trajectory:** In order to reduce premiums, for each 1% reduction annually, approximately \$10.6 million in total program funding is needed, with \$5.7 million of that amount funded by the federal government. To achieve meaningful premium reduction, the MGARA program requires a material increase in state funding, which brings in more federal pass-through funding, and a shift from its current reliance on a single, static source of state revenue.
3. **Multiple Funding Options Possible:** Multiple funding options were evaluated by Wakely. These included increasing the current per member assessment and augmenting the current assessment with other fees or assessments.
4. **Changes to federal rules limit funding options:** Due to change enacted at the federal level in 2025, states face new restrictions in their ability to use provider-based fees and assessments to fund health coverage programs.
5. **Non-traditional funding sources warrant consideration:** Given ongoing affordability challenges, it may be prudent to consider non-traditional funding sources as part of a comprehensive strategy. Such sources as donations, other taxes to raise revenue, mandate, etc. have been successfully implemented in other jurisdictions to fund health-

related initiatives, align with public health objectives, and provide diversified revenue streams.

Table 1 below summarizes the projected impact of various MGARA funding options on premiums and market enrollment, highlighting the estimated state and federal pass-through funding associated with each option. Typically, when states do reinsurance programs in the individual market only, the necessary state funding is less than federal pass-through funding. In the results below, federal pass-through funding is less than state funding due to the fact that pass-through funding is based on the premium tax credit savings for the subsidized portion of the enrollees, but the program is applied to the entire merged market. If state funding was only used in the individual market, the state funding would likely be less compared to federal funding because the ratio of subsidized to unsubsidized enrollment would be higher. The ratio of subsidized to unsubsidized enrollment is significantly lower in the merged market, and pass-through savings from the PTC are being spread across the individual and small group market (merged market) where the small group market does not receive federal subsidies.

Table 1 – MGARA Funding Analysis Summary

Scenario	State Assessment Funding (millions)	Federal Pass-through Funding (millions)	MGARA Premium Reduction %	Change in ACA Merged Market Enrollment %
\$4 PMPM Assessment (Baseline)	\$28.3 to \$28.6	\$19.8 to \$25.4	-4% to -5%	NA
\$6 PMPM Assessment	\$42.4 to \$42.9	\$30 to \$38.2	-7% to -8%	0.3% to 0.8%
3.0% Premium Assessment on Fully Insured Market	\$79.9 to \$85.5	\$39.4 to \$75	-11% to -15%	0.5% to 2.2%
1.5% Premium Assessment on Fully Insured Market & \$6 PMPM Assessment	\$82.2 to \$85	\$49.5 to \$74.9	-12.1% to -14.9%	0.8% to 2.6%

The following report provides background on current trends in Maine's individual and small group markets, evaluates potential funding options to improve MGARA's sustainability, and estimates the near-term impact of these options on premiums and enrollment across both markets.

Introduction

Maine has a long history of programs designed to stabilize the individual market. Maine Guaranteed Access Reinsurance Association (MGARA) began operation in 2012. MGARA currently operates as a Section 1332 reinsurance waiver program (which began in 2019 and is approved through 2027). In 2020, the Maine Legislature enacted LD 2007, the Made for Maine Health Coverage Act, which, among other provisions, merged the individual and small group Affordable Care Act (ACA) health insurance markets into a single risk pool effective January 1, 2023. This decision was part of a plan to expand the risk pool, stabilize the health insurance market and extend state and federal funding through the MGARA reinsurance program to the small group market. Maine is the only state to implement a reinsurance program in the small group market.

While the number of lives covered by the reinsurance program nearly doubled after the merging of the two markets, the program funding from the state remained unchanged through a market-wide (fully insured and self-funded commercial health insurance markets) assessment of \$4 PMPM, which has been in place since the program's inception in 2012. In addition, Maine also collects interest on state reinsurance dollars which generates a small amount of state funding. In plan years 2019- 2021, when the state had a hybrid reinsurance model that was conditions and parameter based, the state also collected a ceding premium equal to 90% of premiums received from consumers for all policies ceded, whether on a mandatory or discretionary basis. The premium impact of reinsurance has decreased from a 14% impact in 2022-2023 to approximately 7% in 2024-2025, which was expected with the merger of the market.

Maine Bureau of Insurance (BOI) engaged Wakely to conduct a comprehensive review, assessment, and recommendations to best assist the sustainability of the MGARA program and improve affordability and stability in Maine's merged market. In this paper Wakely performed baseline market assessment, provides estimates on the future baseline trends of MGARA, and provides policy options and their associated impact.

This document has been prepared for the sole use of Maine BOI. Wakely understands that the report may be made public. Any distribution of this report should be made in its entirety. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

Historical Maine Market Assessment

Background

Maine's ACA market has undergone significant structural changes over the last several years. In 2019, the state implemented a Section 1332 reinsurance waiver and leveraged MGARA to stabilize premiums in the individual market. The program was designed to offset the cost of high claims and has remained a key mechanism supporting affordability. In 2023, Maine merged¹ its individual and small group markets into a single risk pool. This change extended the reinsurance program to the small group market and was expected to decrease premiums and attract more covered members. The next section outlines key trend in market enrollment and cost.

Market Enrollment Trends

While the focus of this report is on the financial sustainability of the MGARA program, it is important to note the challenges the state faced leading up to the 2020 decision to merge the individual and small group markets. Figure 1a below shows that from 2015 to 2019 enrollment in the small group market fell from 73,943 to 55,544, a 25% reduction (18,399 fewer covered lives).

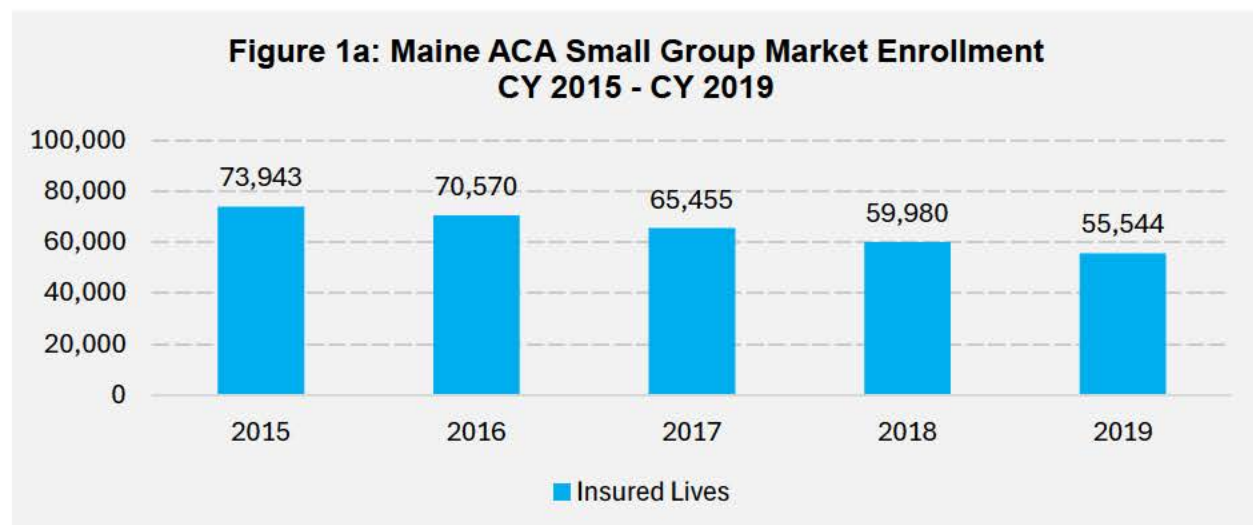


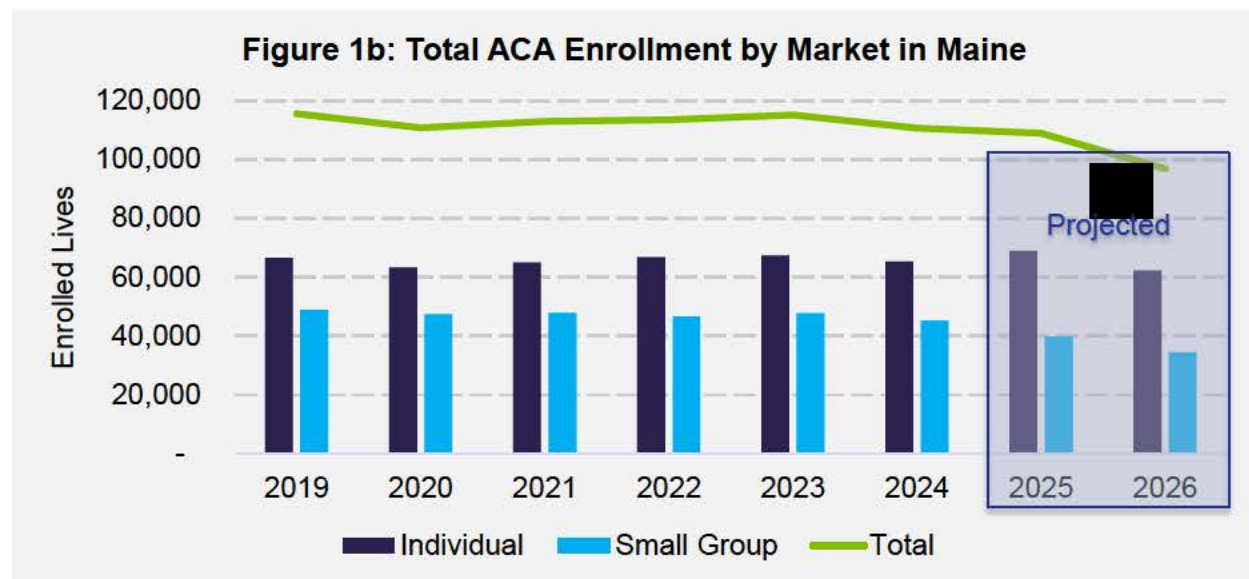
Figure 1b below shows the individual and small group markets enrollment in Maine from 2019 through 2024, and the projected enrollment in 2025 and 2026. Between 2019 and 2022, Maine's individual and small group markets were relatively small but stable. Both markets experienced

¹ The individual and small group markets were merged into a single risk pool for purposes of risk adjustment, loss ratio purposes, and rate setting (though it allows quarterly rate adjustments for small group plans that do not renew on a calendar year basis).

moderate fluctuations in membership (ranging from -5.0% to 2.9% annual changes in enrollment), but overall issuer participation did not grow meaningfully despite strong financial performance during this period.

Several factors affected the performance during this period, including a sharp decrease in utilization of medical services due to the COVID-19 pandemic; implementation of a small group premium subsidy program that ran from November 2021 through July 2023; and the establishment of enhanced premium tax credits (ePTCs) from the federal government that took effect in 2021.²

The state's Section 1332 application, which was submitted in February 2022, noted that the small group market experienced both declines in membership and increases to premiums and was on a trajectory for continued decline. This decline ultimately contributed to the state's decision to merge the two markets, effective January 1, 2023. In 2023, outside the waiver, the state also required insurers in the small group market to offer Clear Choice plans, which are standardized plans that were already offered in the individual market.

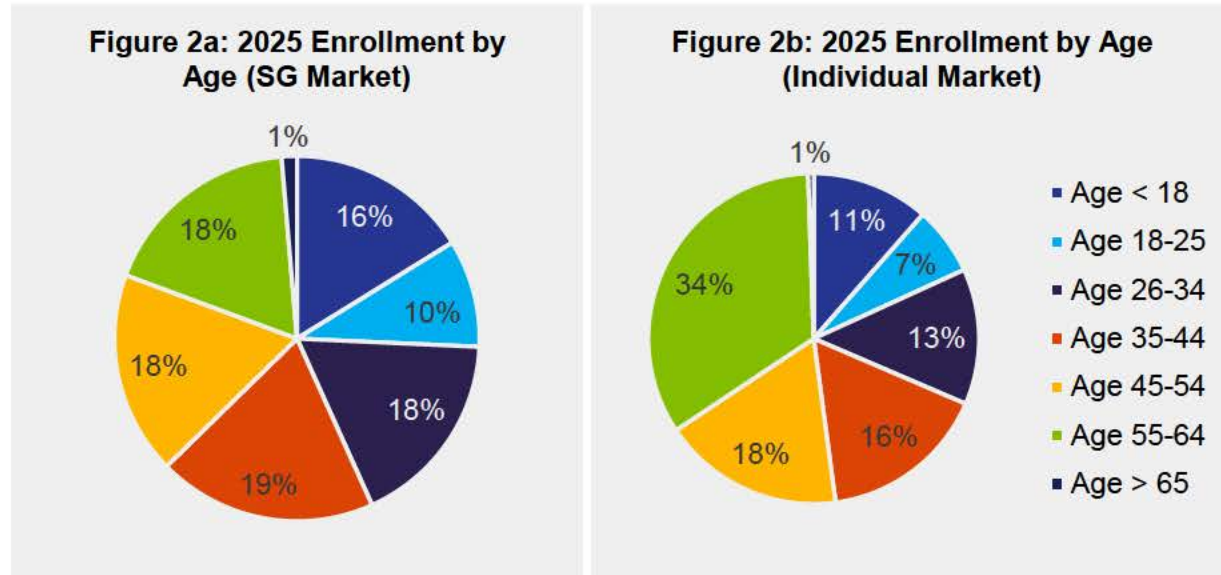


The first year of the merged market achieved combined enrollment increases of ~1% as well as net underwriting gains for the majority of issuers. However, the merging of the two market risk pools has had several implications on cross-subsidization between the individual and small group markets and is discussed below.

² The American Rescue Plan Act and later the Inflation Reduction Act provided additional enhanced premium tax credits. For further details please see <https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics>

Beginning in 2024, overall enrollment began to decline, driven primarily by contraction in the small group market. Individual market enrollment was steady during this period. The make-up of enrollees remained relatively stable across the subsidization status, age, geography, and plan metal levels, although the individual market showed a minor shift from bronze to gold plan selections, likely due to the availability of ePTCs. In the individual market, enrollment among low-income individuals, particularly those between 100 and 150 percent of the federal poverty level (FPL), dropped sharply in 2020 after the state's Medicaid expansion in 2019 and remained low thereafter. Meanwhile, enrollment growth starting in 2021 was concentrated among higher-income individuals, which is largely attributable to enactment of ePTCs which extended subsidies to consumers over 400% of the FPL for the first time.

There are marked differences in the enrollees' demographics between the two markets. Notably, the small group market is significantly younger than the individual market, with a higher proportion of children under 18 (16% and 11%, respectively) and a lower proportion of members over age 55 (18% and 34% respectively), leading to average age rating factors³ as filed in 2026 rates of 1.50 in the small group market and 1.77 in the individual market. This is consistent with the assumption the state made at the time of the merged market waiver application as the state noted the merged market would have improved morbidity due to the younger and relatively healthier small group population.



Small group market also has a higher proportion of enrollees residing in Rating Area 1 (60-61% during the 2019-2025) compared to the individual market (43-47%). Finally, there are differences

³ <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/downloads/statespecagecrv053117.pdf>

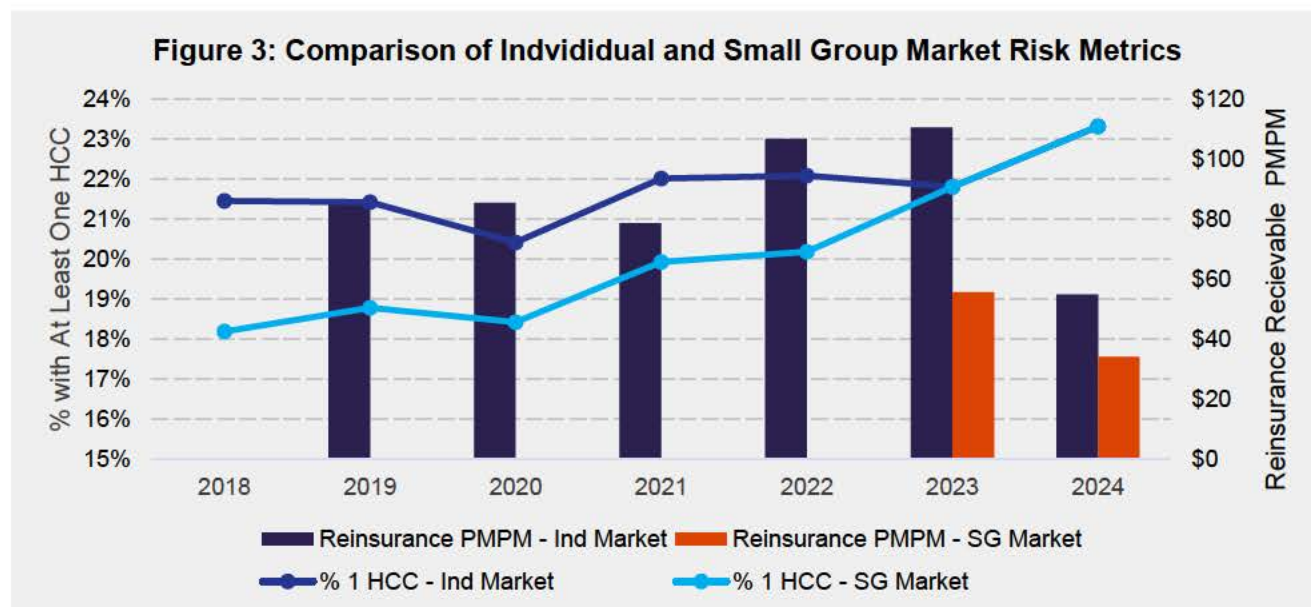
between the markets in plan selections, with 89% of the individual enrollment in 2025 in bronze and silver plans, compared to 78% of the small group enrollment in gold and silver plans.

Please see **Appendix A** for exhibits on the changing demographics (geography, age, plan metal tier, and income (individual market only).

Risk Pool Composition

The member demographic and plan selection differences discussed above have direct implications on risk adjustment transfers and the changes in those transfers pre- and post-merged market implementation. Prior to the merged market implementation, each market segment served as its own risk pool, the risk adjustment transfers between the issuers participating within the market are zero-sum. However, the result of the markets merging is that the small group market transfers payments, via risk adjustment, towards the individual market on a statewide basis.

The risk adjustment transfer amounts in the small group market segment were 4.4% and 6.3% of the average SG premium in 2023 and 2024, respectively. The percentage of zero claimants in each market by year suggests a similar outlook and is consistent with lower average reinsurance payments (PMPM) incurred in the small group market. Figure 3 below presents the comparison of these metrics for each market over time.

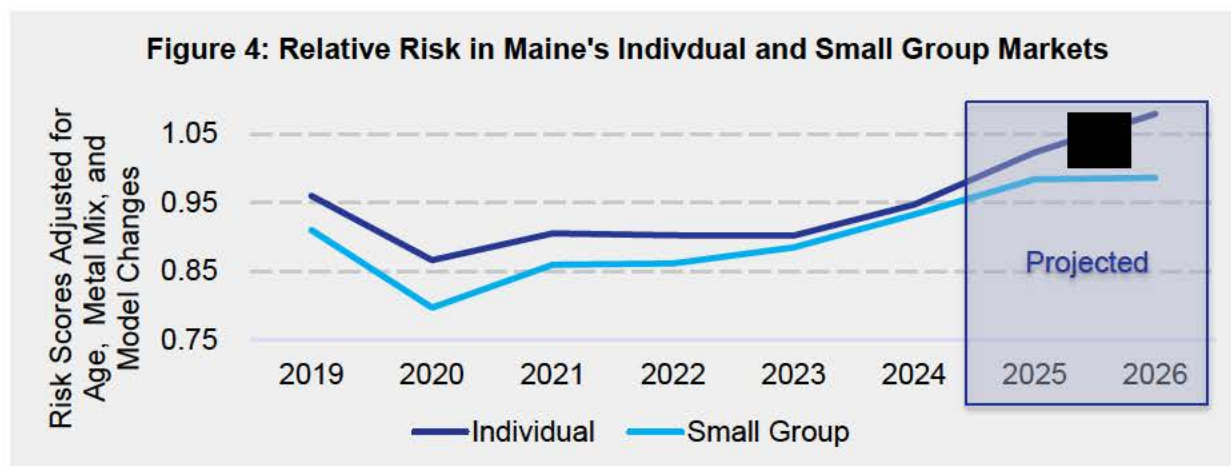


The risk profile of the individual market declined between 2019 to 2020, partly due to COVID-19 related suppressed utilization and Medicaid expansion. The risk profile of both markets remained relatively stable through 2022 and 2023, with the small group average risk profile slightly healthier

on average than the individual market. Additionally, Maine's legislature expanded the Medicaid program to cover children in families with incomes up to 300% FPL, which took effect in October 2023.⁴ The removal of many children from the individual market likely adversely affected the morbidity of the risk pool.

Starting in 2024, the risk profile rose sharply across both markets, contributing to premium increases in 2024 and 2025, as well as a sharper rise in premiums in 2026. These changes in morbidity may have been driven by Medicaid redetermination beginning in 2023Q3 as well as the expansion of Medicaid eligibility for children noted above.

In addition, the state established a small employer premium relief program⁵ that was in effect from November 2021 through July 2023. This federally funded program provided \$42.8 million in premium reimbursements to insurers to reduce small group premiums by \$50 per covered employee per month, with additional premium reductions for employees based on their family size. Savings were shared between employers and employees in proportion to their premium contributions, with employers retaining discretion to pass through a greater share, or all, of the premium relief to their workers. The end of this program may have also affected the risk profile of the market, as well as small group enrollment. Figure 4 below shows the change in relative risk in both markets. Relative risk is calculated as plan liability risk scores, normalized for changes in the average age, metal mix, and year to year changes in the HHS risk adjustment model. The 2025 and 2026 figures represent aggregated issuer projections.



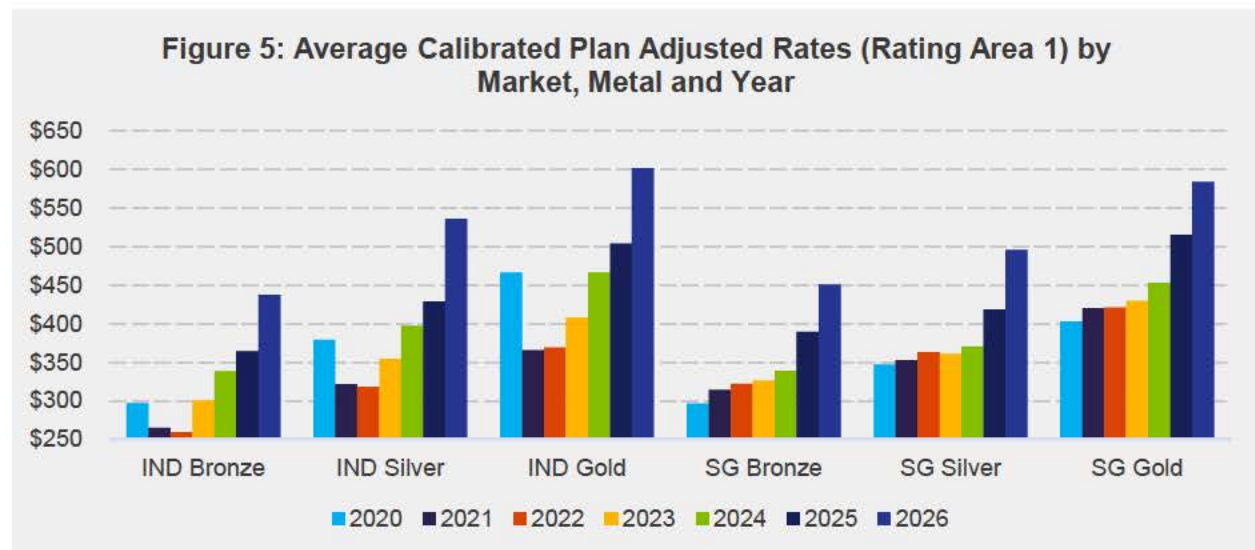
⁴ Prior to this change, MaineCare's income limit for children was 208% of family income
<https://www.maine.gov/dhhs/about/rulemaking/mainecare-rule-303a-household-income-standard-children-and-chip-changes-2024-08-21>

⁵ [Small Business Health Insurance Premium Relief Program | Maine Recovery & Jobs Plan](#)

Consumer Affordability

From 2019 through 2022, average premiums in Maine's individual market declined steadily, reflecting the effectiveness of the MGARA reinsurance program, generally favorable experience, and the reduction in utilization of medical services during the Covid pandemic, particularly in 2020 and 2021. Small group premiums remained stable or slightly below trend during the same period. After the markets were merged in 2023, individual premiums increased by roughly 9% while small group premiums declined 1%, reflecting the net effect of higher market average index rate (reflecting older and less healthy individual market) offset by the reinsurance recoveries for higher cost claimants.

However, this initial stabilization was only short-term. Premium growth resumed across both segments beginning in 2024 and continued into 2025 and 2026. These increases have narrowed the affordability gains achieved in earlier years. Benchmark premiums, represented by the second-lowest cost silver plan, followed a similar pattern. Rates rose modestly in 2023 and then more sharply in 2024-2026. Despite these increases, Maine's benchmark rate changes have remained in line with national trends. Figure 5 presented below reflects the membership weighted average calibrated plan adjusted rates for rating area 1 representing age 21 rates and averaging these across issuers participating in each market.



Issuer Participation and Experience

There are four issuers that have operated in the market historically (Anthem, Maine Community Health Options, Harvard Pilgrim Health Care, and United HealthCare). United HealthCare is unique in that it has historically only operated in the small group market and has minimal market share. Taro Health Plan entered both the individual and small group markets in 2023. No issuers

exited Maine's individual market during the study period, however, Aetna did exit the small group market in 2025, although its market share was quite modest. Overall, Anthem had the largest total merged market share in 2024 (43%), followed by Harvard Pilgrim Healthcare (26%) and Maine Community Health Options (25%).

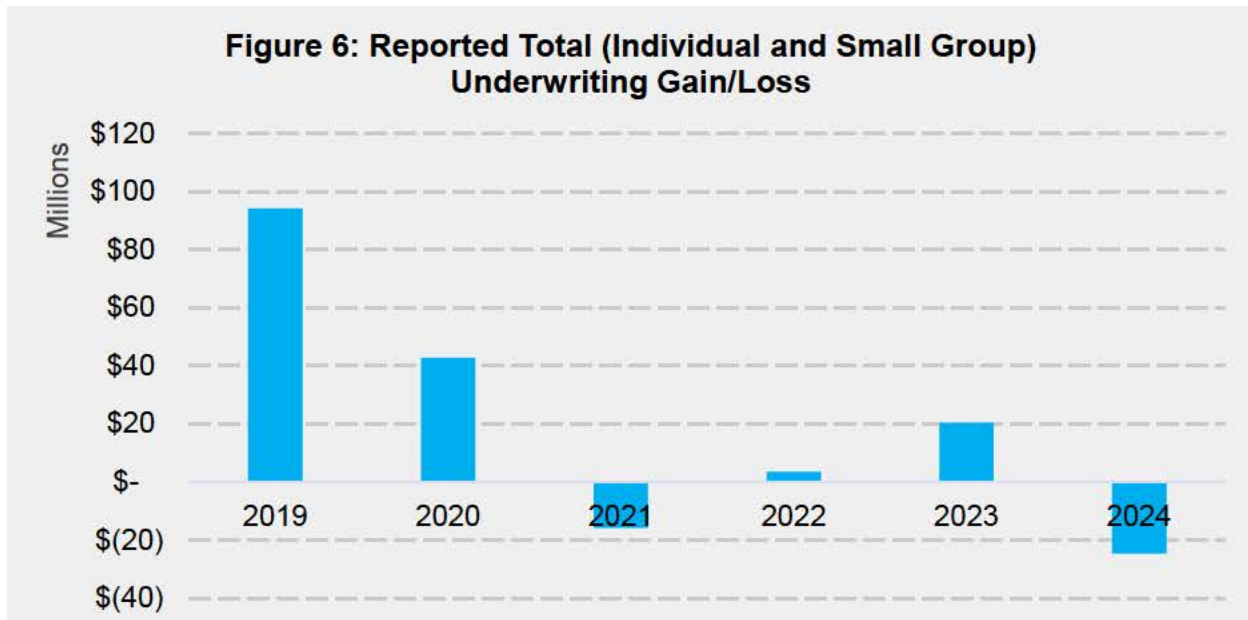
The number of plans offered in the individual market grew consistently from 49 options in 2019 to 101 options in 2023, and more than 80 plan options have been available each year since. The small group market also has extensive offerings. From 2019-2022 there were between 211 and 230 plan options each year. That number grew to 339 in 2023 but has since decreased to 167 plan offerings in 2025.

Issuer experience in Maine's ACA market has evolved in line with these structural changes. Between 2019 and 2022, the individual market was profitable for the majority of issuers. Volatility in issuer experience was driven by less favorable results for smaller issuers (e.g., Maine Community Health Options) and new market entrants (e.g., Taro Health), as compared to established and/or national carriers (e.g., Anthem and Harvard Pilgrim Health Care). Additionally, after briefly leaving the market in 2018, Anthem reentered the individual market in 2019 at the same time the state's section 1332 waiver took effect.

The small group market also demonstrated steady and generally favorable experience for the majority of issuers over the same period. In 2023, both markets maintained favorable claim experience despite modest shifts in premiums associated with the merged market. However, by 2024, issuer claim experience began to deteriorate.

The general pattern in both markets of favorable experience in 2020, and 2022–2023 is partially attributable to the impacts of the COVID-19 pandemic and the American Rescue Plan Act (ARPA), which was enacted in response. In 2020, healthcare utilization was suppressed during the pandemic as enrollees deferred non-essential medical services. Starting in 2021, there was an uptick in utilization as consumers sought treatment for these deferred services, which led to an increase in claims relative to the prior year. ARPA introduced enhanced premium tax credits that helped to improve affordability and stabilize enrollment, particularly among healthier consumers, resulting in a larger and more balanced risk pool.

Issuer performance is gauged using the annual 945 financial reports, which show underwriting gains and losses after consideration for administrative expenses, MLR rebates, and other retention components. Figure 6 shows the total underwriting gains and losses across both the individual and small group markets reported by issuers from 2019-2024, the latest available year of data. The figures support the general observation of declining issuer financial performance and greater volatility over the last four years.



Overall, while the ACA markets in Maine were financially sound through 2023, the subsequent period has been characterized by increased volatility, higher claim costs, and diminished value of the reinsurance program. These trends have contributed to declining issuer profitability and affordability pressures for consumers.

Section 1332 Reinsurance Waiver Program

Reinsurance Program Background

Reinsurance programs are designed to decrease premiums for consumers. As has been demonstrated in other states, reinsurance payments to issuers are passed on to consumers in the form of lower premiums. Consequently, the issuer can lower premiums without incurring losses. Over the past few decades, there have been several types of reinsurance programs approved under the Section 1332 waiver program. The most common type of reinsurance program is a claim-based reinsurance program, also referred to as retrospective reinsurance.

A claim-based reinsurance program pays a portion of claim costs, based on a prescribed coinsurance rate, between an attachment point (the point at which the claim cost begin to be reimbursed) and a cap (the point at which the reinsurance payments stop). Policy makers traditionally trade-off between having a higher coinsurance, and thereby providing greater funding, and lower coinsurance, which can encourage insurers to maximize cost management programs. One of the benefits of a claim-based reinsurance program is that it reimburses a portion of all paid claims for members that reach the attachment point, not just a select few. As a result,

acute events (e.g., neonatal babies) or conditions that are more expensive than initially realized (e.g., a novel drug) are included.

In addition, claim-based reinsurance programs are typically easier to operationalize and maintain compared to other types of reinsurance programs. Issuers are very familiar with claim-based reinsurance programs and can easily incorporate such programs into their premium rates. Intense analysis on which conditions should be selected for coverage is not needed. The ease of operational implementation may be one of the reasons why HHS selected a claim-based reinsurance program rather than a condition-based reinsurance program when implementing the transitional reinsurance program from 2014-2016 ⁶. Finally, claim-based reinsurance payments automatically adjust for higher unit costs. For example, if rural areas experience higher claim costs relative to the rest of the state, on a per-capita basis, rural areas will receive more funding.

The main drawback of a claim-based reinsurance program is that it may incentivize over-utilization. The larger the claim costs, the greater the reimbursement (up to the cap). Additionally, there have been concerns that provider contracts could be altered to provide incentives for reaching the reinsurance attachment point (i.e., gaming). As a result, unless the coinsurance rate is sufficiently low, claim-based reinsurance programs may result in greater spending than other reinsurance programs, which may negate some of the effectiveness of the program and reward inefficient plans. Finally, there may be some distortions as issuers may be over-compensated for high-risk enrollees as they would be reimbursed both with reinsurance claims and by risk adjustment payments (although this should be reflected in their premium rates). To mitigate this concern, the Centers for Medicare and Medicaid Services (CMS), in a letter to Minnesota⁷, noted that any adjustments a state might consider to its risk adjustment methodology to avoid over-compensation would need to be operationalized by the state. The state of Maryland, which is providing a generous reinsurance program, has implemented a dampening factor⁸ to minimize the over-compensation by both programs. However, Colorado examined whether to implement a dampening factor and found that it did not meaningfully impact outcomes.

The original structure of Maine's reinsurance program that was put in place in 2012 was a condition-based reinsurance program, also referred to as prospective reinsurance. From 2019 to 2021 Maine operated a hybrid model that was conditions based coupled with an attachment point model. In this program, a portion of the premiums paid by the members with eligible medical conditions for the prospective reinsurance program was ceded to MGARA as funding for the reinsurance program. These ceded premiums totaled \$44.2 million in 2019, \$40.7 million in 2020,

⁶<https://www.cms.gov/marketplace/health-plans-issuers/premium-stabilization-programs/transitional-reinsurance-program>

⁷ <https://www.cms.gov/files/document/1332-mn-extension-approval-letter-stcs.pdf>

⁸ A dampening factor is a coefficient that adjusts the reinsurance payments to account for the interaction between the risk adjustment program and the state reinsurance program to ensure that for high-risk members the sum of both reinsurance and risk adjustment is not higher than claims.

and \$33.3 million in 2021. When the methodology was changed to a claim-based reinsurance program (also referred to as retrospective reinsurance), the MGARA program lost the premium revenue as a source of funding⁹, which has contributed to the strain on the program's funding sustainability and reserve balance.

There is currently one state that has a condition-based reinsurance program, Alaska. In this model, issuers are reimbursed for medical and prescription drug claims for enrollees who meet a predefined set of high-cost conditions, with reinsurance applying to *all claims* incurred by those enrollees. Idaho currently uses a hybrid model with parameters that are established using conditions and claims-based parameters. In the hybrid model, claims are paid for any enrollee with one of the specified conditions but only up to an attachment point. Operationally, some states with prior high-risk pools found condition-based reinsurance administratively simpler due to existing systems for identifying and managing high-cost conditions.

Maine switched from condition-based (prospective) to claim-based (retrospective) reinsurance in part to simplify the administration and in part due to the challenge of prospectively identifying small group enrollees who should be ceded to the reinsurance program in advance of the plan year. The prospective model also shifts the insurer risk of high risk individuals to MGARA without the added benefit of premium reductions in the merged market, since the ceded high cost members are still part of the single risk pool for premium setting purposes.

Reinsurance State Funding in Other States

States operating reinsurance programs have adopted a variety of approaches to finance the state share of program costs. These approaches generally fall into three categories: (1) reliance on state general funds, (2) use of a combination of general funds and dedicated taxes or fees and assessments or (3) exclusive reliance on taxes, fees, assessments, and other non-general fund sources. A review of funding structures across states provides important context for evaluating financially sustainable options.

Several states—including Georgia, Nevada, Virginia, and Wisconsin—rely primarily on state general funds to finance the state share of reinsurance costs. Other states, such as Idaho, New Jersey, and North Dakota, use a blended approach that combines general fund appropriations with taxes, fees, or assessments. The majority of states with reinsurance programs, including

⁹ The ceded premium collected is added to the premium carriers collect from the merged market, which offsets the reduction in premium by removing the charge to carriers for ceding members.

Alaska¹⁰, Colorado, Delaware, Maine, Maryland, Minnesota, Montana¹¹, New Hampshire, Oregon, Pennsylvania, and Rhode Island, rely predominantly on taxes, fees, or assessments rather than state general funds. Most assessments are paid by insurers and are ultimately distributed across the broader health insurance market through premiums. Colorado transitioned (and in Minnesota's case will transition) from reliance on state general funds to an exclusive reliance on fees. Idaho has indicated plans to contribute a one-time initial funding amount, with future state contributions potentially provided on an ad hoc basis.

All of these states, except for Maine, have assessments on issuers as a percentage of premium, meaning that as premiums rise (due to inflation and other factors), state reinsurance funds also increase proportionately. Maine, by contrast, has a flat \$4 per member per month (PMPM) assessment that has been static since 2012 – as premiums and claims costs have risen, the flat fee has not increased. Many of these states also supplement their funding with additional non-governmental revenue sources explained further below. Additionally, Pennsylvania and New Jersey are leveraging a portion of their state's Exchange user fees collected towards the state funding for the state reinsurance programs.

A key policy consideration is the interaction between funding mechanisms and federal pass-through funding under Section 1332 waiver. When fees or assessments are tied directly to the reinsurance waiver, they are discounted from the calculated program impact, resulting in lower federal pass-through amounts and a reduced net premium reduction effect. Maine's current assessment (\$4 PMPM) is not tied directly to the waiver and hence does not result in a lower pass-through amount. The implementation of a new issuer assessment may face opposition from affected stakeholders and may not increase sufficiently with overall medical inflation, presenting uncertainty regarding the adequacy of new revenue sources. Careful design of the funding mechanisms would be required to ensure long-term sustainability and minimize unintended market impacts.

In addition to the primary funding mechanisms discussed above, several states supplement reinsurance funding with alternative revenue sources. These include interest or investment income earned on state reinsurance funds, as utilized in Maine, Colorado, Idaho, and Maryland. Some states, including Colorado and Maryland, also allow for gifts, grants, or donations from public or private sources to fund the program.

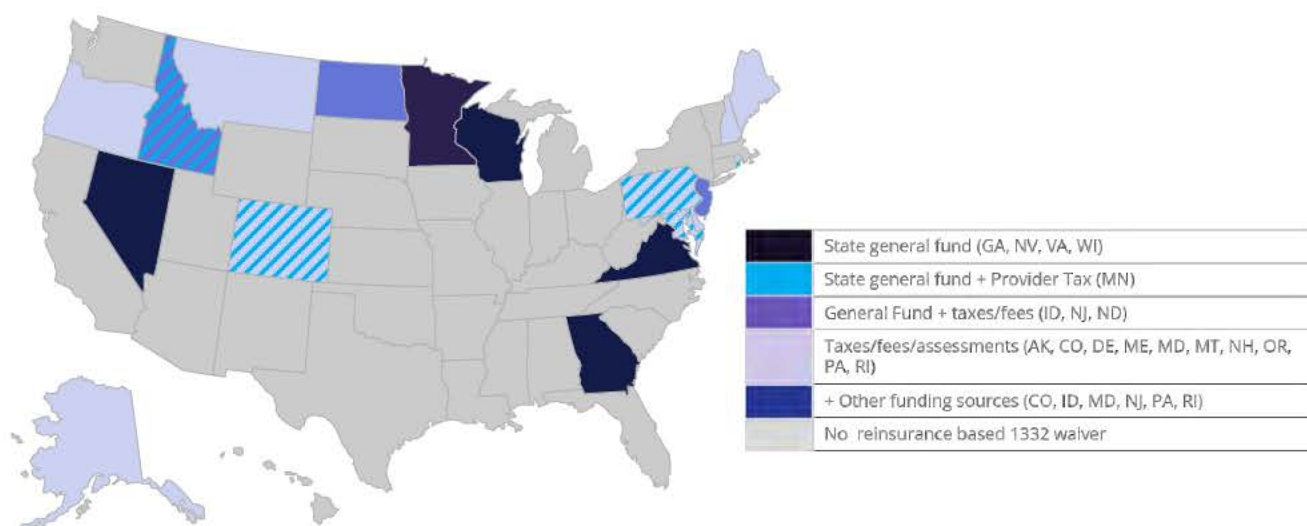
Other potential sources include user fees and assessments collected by the health insurance Exchange, as seen in Maryland and Pennsylvania, as well as personal responsibility or individual

¹⁰ Alaska funds the state portion of its section 1332 state-based reinsurance program through a separate fund within Alaska's general fund called the Alaska Comprehensive Health Insurance Fund which is financed by the state's premium tax.

¹¹ The funding assessment in Montana is tied to a premium collected in a prior year to the program application year, which creates additional misalignment during the period of enrollment discontinuity.

mandate assessments, such as those implemented in New Jersey and Rhode Island. While these sources are generally supplemental in nature, they may improve funding stability when combined with other mechanisms. Figure 7 provides a visual representation of the types of funding mechanisms by state. Please see **Appendix B** for a summary of state specific 2025 waiver impacts and funding sources.

Figure 7: Reinsurance Funding by State



The amount of state funding is directly proportional to the overall program impact. Figure 8 presents state-specific metrics for plan year 2024 on the average pass-through funding per member per month (PMPM), the approximate state funding PMPM, and the estimated percentage reduction in premiums resulting from the reinsurance program based on the public data sources¹². The program impact ranges from a 4% to 31% reduction in premiums, with Maine's 2023-2025 program impact at the bottom of the range (approximately 7.5% reduction). The state funding ranges from \$2 to \$130 PMPM when calculated over the market billable membership for a consistent comparison¹³. While the funding mechanisms do differ by state, these figures suggest that in the three states with similar value programs, the state funding contributed to the program ranged from \$17 to \$29 million (see Table 2). Federal pass-through funding as a percentage of

¹² We approximated the total program cost and premium impacts by relying on public data sources including 1332 CMS Key Metrics PT funding summary, 2024 Open Enrollment Period data by state, and several assumptions around claim to premium ratio in all states. Note that this analysis does not reflect the actual reinsurance payments made to issuers, and values should be used as approximate relative estimates by state.

¹³ You will note that for Maine, the state assessment is \$22 PMPM, which is higher as a result of using only the merged market member months as the denominator, rather than all covered individuals – including fully insured and self-funded arrangements – that is the true base of \$4 PMPM collection.

total costs for the program are also generally higher in states with a higher subsidized population than in those with a lower subsidized population. Generally, most states have around 60-90% of their reinsurance programs paid for with federal pass-through funding, with the exception of Minnesota which has a smaller subsidized population given the implementation of the Basic Health Program.¹⁴

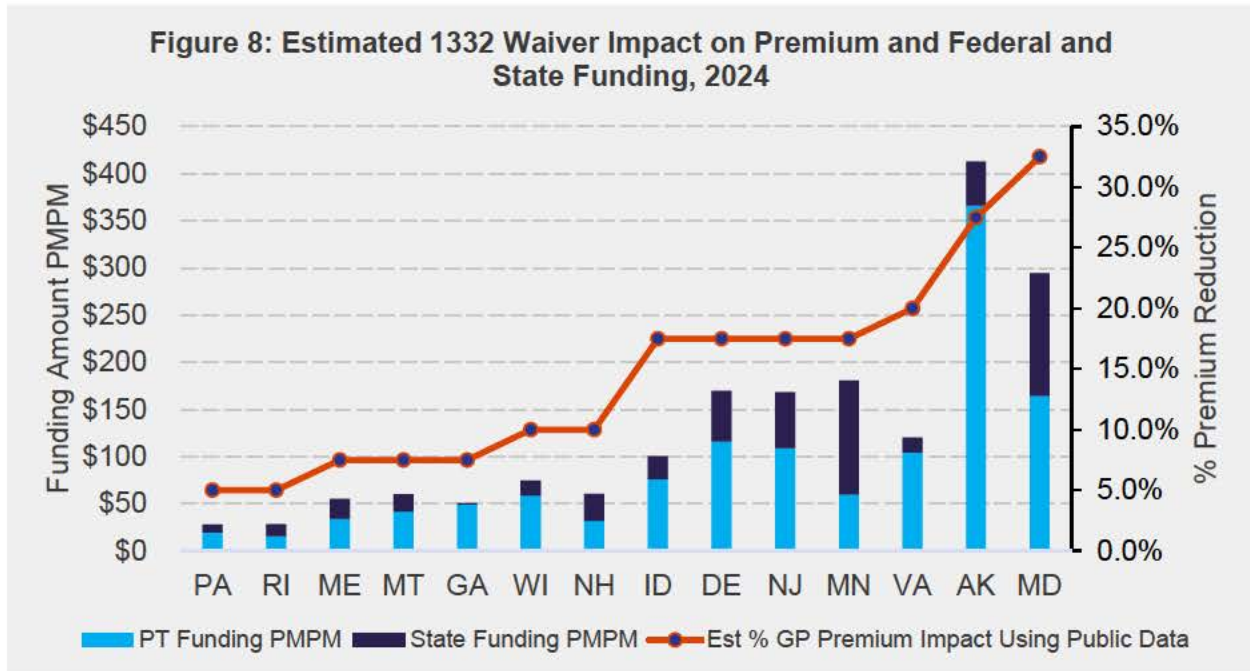


Table 2 - 2024 Estimated Reinsurance Funding and Impact by State

State	Approximate % Premium Impact	PT Funding PMPM	State Funding PMPM	PT Funding (millions)	State Funding (millions)
Maine	7.5%	\$33.8	\$21.5	\$45.7	\$29.1
Montana	7.5%	\$41.6	\$18.8	\$36.8	\$16.6
Georgia	7.5%	\$49.1	\$1.6	\$769.3	\$24.5

¹⁴ The Basic Health Program is a health coverage option under section 1333 of the ACA that allows for state to create a health benefit program for state residents with incomes between 138-200% of the FPL.

MGARA Sustainability and Funding Options Analysis

MGARA Program Parameters and Impact Over Time

Maine's state-based reinsurance program played a central role in stabilizing the ACA market. From 2019 through 2022, MGARA operated exclusively within the individual market and was effective at reducing premiums. During this period, reinsurance recoveries ranged between 13% to 19% of premiums, and premiums were approximately 14% to 17% lower than they would have been without the program. The program's reserve balance grew steadily through 2022, reflecting a sustainable funding position, due in part to the availability of ePTCs that became effective in 2021.

The merger of the individual and small group markets in 2023 significantly altered the program's dynamics. Extending reinsurance coverage to small group enrollees increased the number of participants but did not increase the state's contribution to program funding. In 2023, reinsurance recoveries remained high in the individual market at roughly 18% of premiums and reached about 10% in the small group market. However, MGARA's reserve declined by an estimated 43%, or about \$30 million, during that year. This reduction in reserve also occurred in 2022 (declined \$15.7 million, or 18.5%), which suggests that the substantial 2023 decrease is not solely attributable to the merging of the markets (the chosen reinsurance parameters and underestimate of the cost of the reinsurance program also contributed substantially to the change in reserves).

In other states that do not hold a reserve for their reinsurance program, parameters are adjusted retrospectively to avoid overfunding or underfunding in addition to including multiple types of funding sources. Federal pass-through funding results from the premium reduction of the program. The higher the premium reduction from the reinsurance eligible claims, the higher the pass-through. In Maine, the state has received \$1.40-\$1.90 in federal pass-through for every \$1 the state invested in the reinsurance program from 2021 through 2023.

In light of changes to program costs in 2022 and 2023, the MGARA Board implemented substantial parameter changes beginning in 2024. The program's coinsurance rate, which had previously covered all claim costs between the attachment point and cap, was reduced to 75%. In addition, the attachment point increased from \$90,000 to \$135,000, while the cap remained at \$275,000. These changes reduced overall reinsurance recoveries to 7% to 9% of premiums in the individual market and 6% to 7% percent in the small group market in 2024 and 2025. The coinsurance rate is scheduled to decrease to 60% in 2026. Table 3 presents the historical changes in the MGARA parameters and premium impacts.

Table 3 - Historical and Projected MGARA Parameters and Premium Impacts

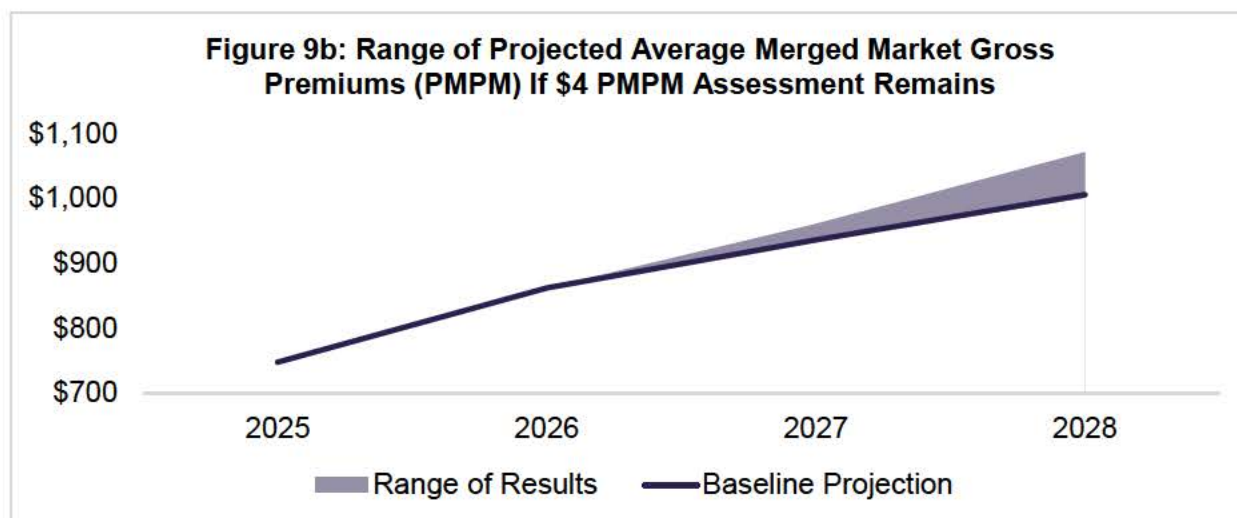
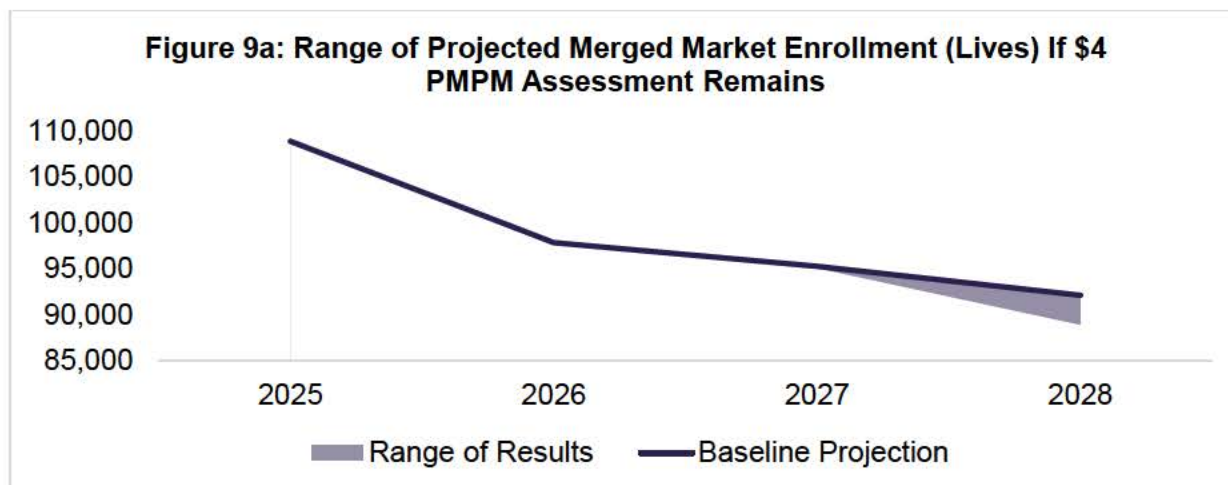
Plan Year	Attachment Point	Cap ¹⁵	Coinsurance	Type	Premium Impact, %
2019	\$47,000	\$77,000	90%	Prospective ¹⁶	-5.1%
	\$77,000	\$1,000,000	100%		
2020	\$65,000	\$95,000	90%	Prospective	-5.5%
	\$95,000	\$1,000,000	100%		
2021	\$65,000	\$95,000	90%	Prospective	-9.8%
	\$95,000	\$1,000,000	100%		
2022	\$76,000	\$250,000	100%	Retrospective	-13.8%
2023	\$90,000	\$275,000	100%	Retrospective	-13.9%
2024	\$135,000	\$275,000	75%	Retrospective	-7.1%
2025	\$135,000	\$275,000	75%	Retrospective	-7.9%
2026	\$135,000	\$275,000	60%	Retrospective	-6.7%
2027 Assumed	\$135,000	\$275,000	60%	Retrospective	-4.9% to -5.1% Estimated
2028 Assumed	\$135,000	\$275,000	60%	Retrospective	-4.3% to -4.8% Estimated

As a result of these changes, the program's premium-reduction impact has declined significantly. Although MGARA's reserve rebounded in 2025 (increased 27%), the fixed \$4 PMPM assessment continues to constrain the program's ability to provide premium relief.

Wakely developed a baseline scenario, in which the \$4 PMPM assessment remained and reinsurance parameters were annually updated such that MGARA retained a reserve of at least \$20 million. Under the baseline scenario, the estimated range of premium impacts in 2027 – 2028 is decreasing further to a range of -4.3% to -5.1% in premiums with the average merged market premiums exceeding \$1,000 PMPM (Figure 9b), and the merged market enrollment dropping just below 90,000 (Figure 9a). This is largely driven by a reduction in the federal pass-through funding as a result of the expiration of ePTCs in PY 2026. **Appendix C** documents the key assumptions and methodology used in this analysis.

¹⁵ For 2019 to 2021 claims above \$1M the program pays net of amounts covered by the federal risk adjustment program high-cost risk pool.

¹⁶ The prospective program had conditions as parameters as well (8 conditions): [CCIIO DATA BRIEF SERIES Data Brief on State Innovation Waivers: Section 1332 Waivers](#)



MGARA Funding Alternatives

In evaluating potential funding approaches for the MGARA program, several desirable characteristics were identified to ensure long-term sustainability and effectiveness of the program. Funding sources should be stable and predictable from year to year, allowing revenues to be easily quantified and relied upon in program planning. At the same time, funding mechanisms should be responsive to changes in market conditions, such as shifts in enrollment, premium levels, and federal pass-through funding amounts.

To support affordability and market stability, funding approaches that maximize risk pooling were prioritized, with an emphasis on broad application to minimize the per-unit financial burden on any single participant. Feasibility of implementation was also a key consideration, particularly the ability to achieve stakeholder consensus in an environment where there may be resistance to new taxes, fees, or assessments. Finally, funding options were evaluated with the goal of

minimizing strain on the MGARA reserve and avoiding depletion of the reserve below the desired \$20 million threshold.

Insurer-based taxes, fees, and assessments were evaluated as potential funding sources, with several important considerations identified. As noted earlier, if such fees are tied directly to the reinsurance waiver, they may be discounted when calculating the waiver's impact, resulting in lower federal pass-through funding amounts. In addition, new or increased taxes, fees, or assessments may face stakeholder opposition, which could affect the feasibility of implementation. One potential mitigation strategy is to phase in new funding mechanisms over time, thereby reducing the immediate financial impact on affected entities.

Wakely evaluated a range of alternative funding scenarios, which are summarized in Table 4. One scenario examined a \$6 per member per month (PMPM) assessment to assess the impact of increasing the original \$4 PMPM assessment in line with inflation through 2028. Under current law, the MGARA board is authorized to increase the assessment by \$2 PMPM to cover net losses (M.R.S. 24-A, Sec. 3957(5)). To date, the board has used reserve funds rather than increase the monthly assessment to cover prior year losses.

Additional scenarios were designed to target an overall premium reduction of approximately 10% to improve affordability and market stability. Wakely also evaluated the potential to increase the Exchange user fee as a funding mechanism. Since very few small employer groups (SG) are served through the SHOP Exchange, the Exchange user fee needed to achieve the necessary funding levels would be relatively high and apply almost entirely to individual market enrollees, limiting the practicality and benefits of this approach.

While a provider tax was initially considered as a potential means to fund the reinsurance program, recent statutory and regulatory changes by the federal government place significant restrictions on a state's ability to assess provider taxes. As a result, the option of imposing a provider tax to fund the reinsurance program was not fully evaluated.

Certain funding approaches were not evaluated as part of this analysis. These include differentiated assessments across market segments, such as applying a higher assessment to the large group (LG) market and a lower assessment to the ACA market. Such an approach could potentially be tied to penalties, for example, for failure to offer adequate coverage by large employers, but would introduce additional administrative complexity.

Table 4 – Summary of Alternative Funding Options

Funding Scenario	PMPM (Fully Insured and Self-Funded Markets)	% of Premium (Fully Insured Markets Only)
\$4 PMPM Assessment	\$4.00	
\$6 PMPM Assessment (from \$4)	\$6.00	
3.0% of Premium Assessment on Fully Insured Market		3.0%
1.5% of Premium Assessment on Fully Insured Market & \$6 PMPM Assessment on Self-Insured Groups	\$6.00	1.5%

Evaluation of Alternative MGARA Funding Scenarios

Wakely evaluated several alternative funding mechanisms for the MGARA program to assess their relative effectiveness in supporting reinsurance funding, stabilizing premiums, and mitigating projected market pressures in 2027 and 2028. Each scenario was assessed based on its estimated revenue generation, responsiveness to claims trend, potential interaction with federal pass-through (PT) funding under the Section 1332 waiver, and its impact on premiums and enrollment in the merged market.

While some of the proposed options may seem sizable, it should be restated that in order to reduce premiums by 1%, approximately \$10.6 million in total program funding is needed, with roughly 54% of the total amount comprised of federal funding. A higher reinsurance impact translates into greater federal pass-through funding.

Table 5 presents a summary of the high-level metrics of each funding alternative. Note that while a richer reinsurance program would result in a lower per member premium amount in addition to a higher assessment, the additional enrollment incentivized by the reduced rates would offset some of the revenue reduction. The ranges in Table 5 are measured relative to the corresponding 'Low' or 'High' assumptions in the baseline scenario. For example, the 'Low' results for the \$6 PMPM assessment are compared with the baseline 'Low' results for the \$4 PMPM assessment, and similarly for the 'High' results.

Table 5 - Alternative MGARA Funding Scenarios Projected Results

Scenario	State Assessment Funding (millions)	Federal Pass-through Funding (millions)	MGARA Premium Reduction %	Change in ACA Merged Market Enrollment %	Change in ACA Merged Market Enrollment #
\$4 PMPM Assessment (Baseline)	\$28.3 to \$28.6	\$19.8 to \$25.4	-4% to -5%	NA	NA
\$6 PMPM Assessment	\$42.4 to \$42.9	\$30 to \$38.2	-7% to -8%	0.3% to 0.8%	200 to 700
3.0% Premium Assessment on Fully Insured Market	\$79.9 to \$85.5	\$39.4 to \$75	-11% to -15%	0.5% to 2.2%	500 to 2,000
1.5% Premium Assessment on Fully Insured Market & \$6 PMPM Assessment	\$82.2 to \$85	\$49.5 to \$74.9	-12.1% to -14.9%	0.8% to 2.6%	700 to 2,500

The sections below discuss specific considerations for each funding alternative analyzed.

\$6 PMPM Assessment (Increase from \$4 PMPM)

This scenario evaluated an increase in the existing assessment from \$4 per member per month (PMPM) to \$6 PMPM. This scenario reflects an adjustment broadly consistent with cumulative medical inflation from 2019 through 2028. While the increase provides some additional funding relative to the current assessment, the modeled results indicate only minimal improvement in reinsurance impact compared to baseline projections. In addition, this approach does not include a mechanism for future inflation adjustments, which limits its long-term sustainability as medical costs continue to grow.

3.0 Percent Premium Assessment on Fully Insured Market

Another scenario considered a 3.0 percent assessment applied to fully insured premiums. Because this assessment would not apply to self-funded plans, it would be levied on a narrower funding base, resulting in a higher effective burden on the fully insured market. Roughly two-thirds of the commercial market is enrolled in self-funded arrangements. An assessment that applies only to the fully insured market could also prompt some groups that are currently fully insured to shift to self-funding to avoid the assessment. By 2028, this assessment is estimated to be equivalent to approximately \$27 PMPM across the fully insured membership. This assessment accounts for inflation, as it is tied to premiums.

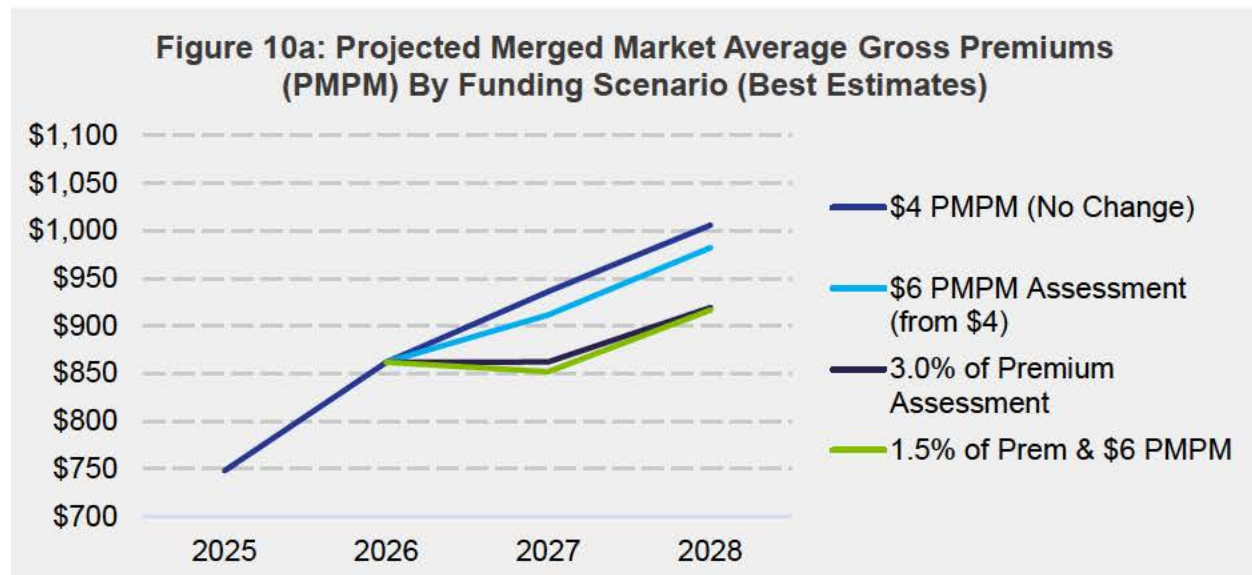
1.5 Percent Premium Assessment on Fully Insured Market and a \$6 PMPM Assessment

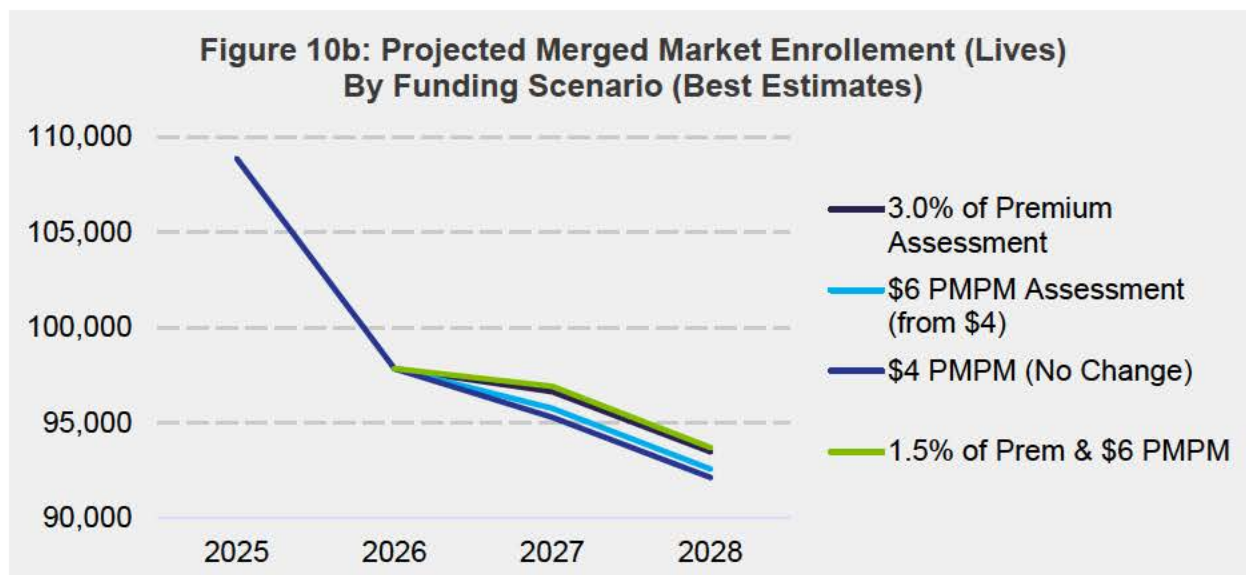
This scenario evaluated increasing the PMPM assessment to its maximum allowable amount (\$6 PMPM) while layering in an additional 1.5 percent assessment applied to fully insured premiums. This combined approach offers some inflation protection and a far more substantial baseline of funding.

Modeled Results and Market Implications

Figures 10a and 10b below present the “best estimate” outcomes for each funding scenario, rather than the full range of modeled results. The analysis indicates that more aggressive funding scenarios have the potential to meaningfully limit premium increases in 2027 and 2028 relative to baseline projections.

Nevertheless, even under the most aggressive funding options evaluated, enrollment in the merged market is projected to decline in 2027 and 2028. This decline is primarily driven by external policy factors, including the expiration of enhanced premium tax credits and the impacts associated with the OBBBA legislation. As a result, while enhanced MGARA funding can mitigate premium growth, it is not sufficient to fully offset broader federal policy changes affecting affordability and enrollment.





Additional State Funding Options

Public comments have expressed interest in exploring alternative funding sources for Maine's Guaranteed Access Reinsurance Association (MGARA). In response, this section outlines two additional non-health-related funding pathways that could be considered to support the long-term sustainability of the program. Other options that are not discussed include the use of the state of Maine's general fund, leveraging Exchange user fee funding, or the implementation of a coverage mandate. Additionally, there were no analyses performed in which the MGARA reserve was drawn down as a supplementary funding source. Beyond these options states have explored other sources of funding such as usage of soda or snack taxes or usage or creation of other taxes. These options were not evaluated in detail but are presented for discussion and further analysis if there is policy interest.

Several states, tribal governments, and local jurisdictions have implemented excise taxes on sugary beverages and snack foods to fund health-related initiatives and broader community programs. These taxes are often justified on both revenue and public health grounds, as they are designed to discourage consumption of products associated with chronic disease while generating funding for health, education, or infrastructure investments.

Examples from other jurisdictions include the following:

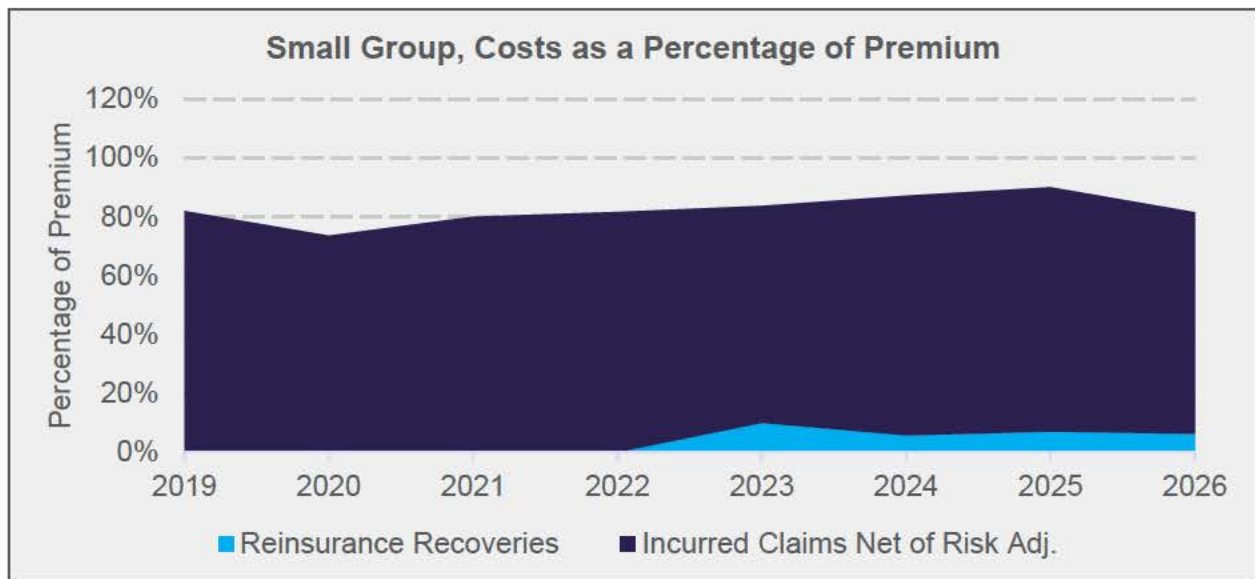
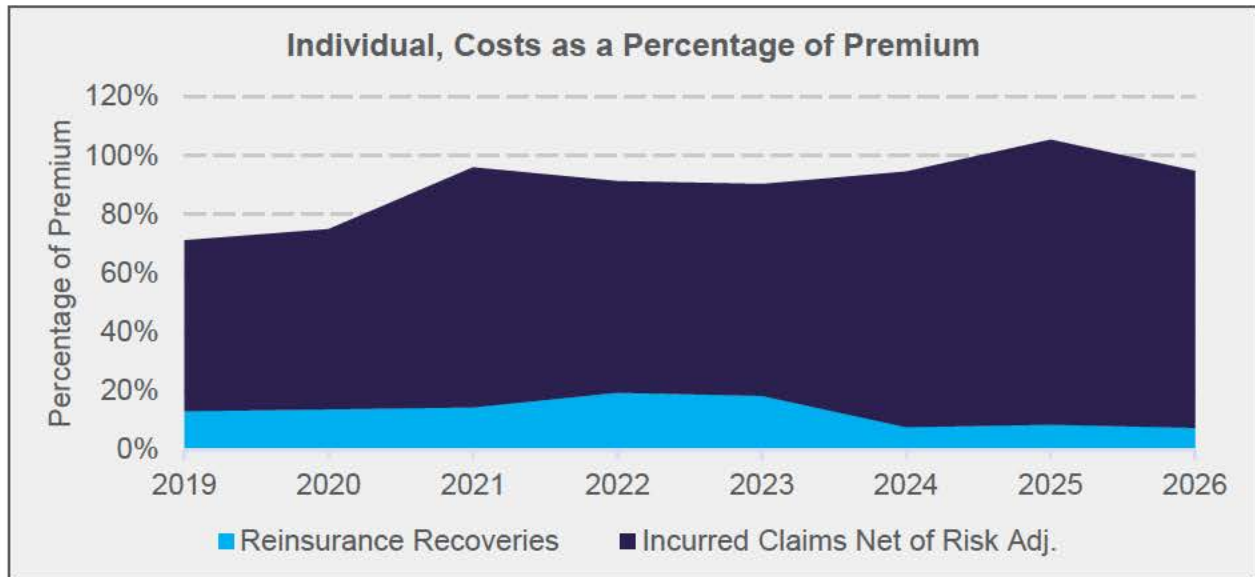
- **Arkansas** levies a tax of \$1.26 per gallon on syrup and \$0.206 per gallon on bottled or canned soft drinks, generating approximately \$40 million annually. Revenues are dedicated to the state's Medicaid Trust Fund.

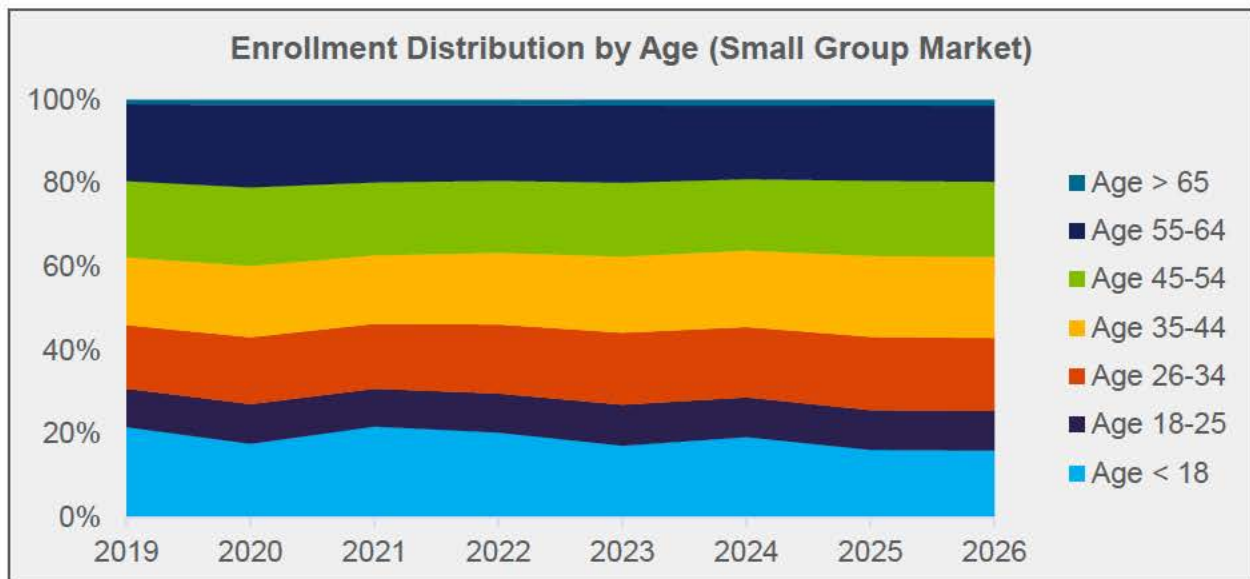
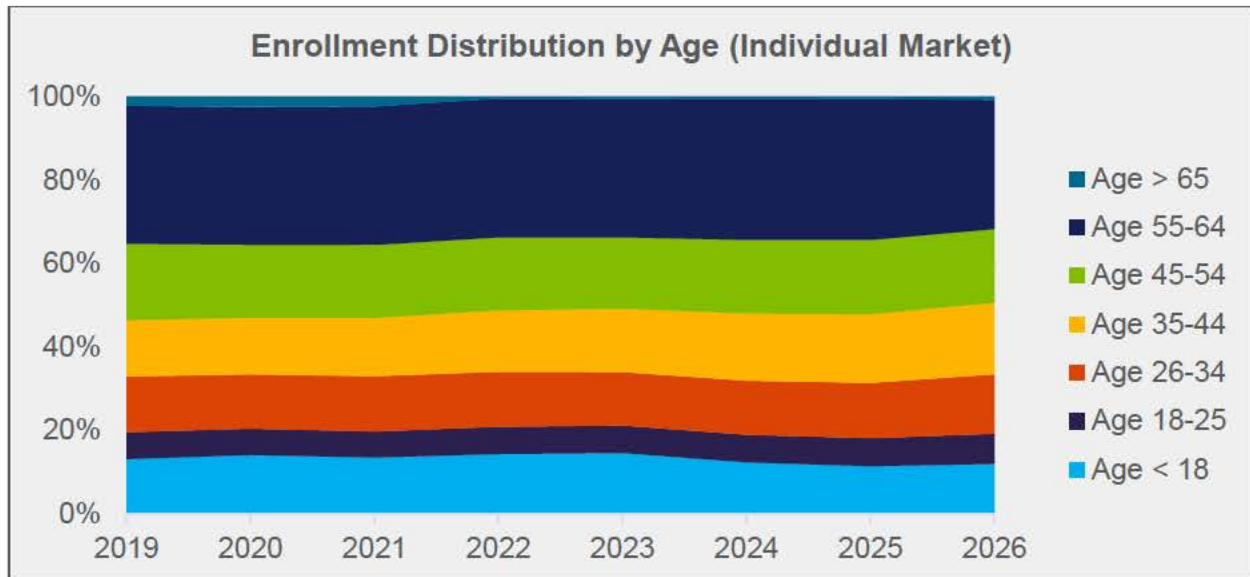
- **West Virginia** implemented a similar beverage tax for several decades, generating approximately \$14 million annually prior to its repeal in 2024. Funds were used to support medical schools and health sciences programs.
- **The Navajo Nation** imposes a 2 percent tax on sugary drinks and snack foods, generating approximately \$7.6 million over four years, with revenues directed toward community wellness projects such as fitness centers, gardens, and walking trails.
- At the local level, **Berkeley, California** imposes a one-cent-per-ounce soda tax that generates approximately \$1.5 million annually for nutrition and health programs, while **Philadelphia, Pennsylvania** levies a 1.5-cent-per-ounce beverage tax that generates approximately \$75 million annually for pre-kindergarten education, parks, and libraries.

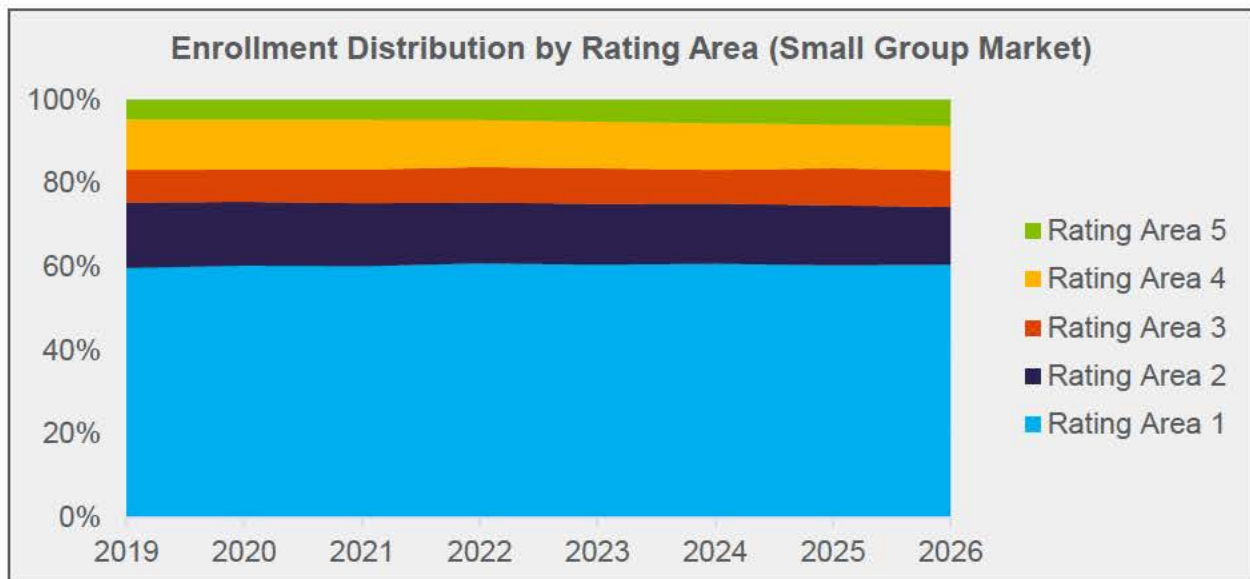
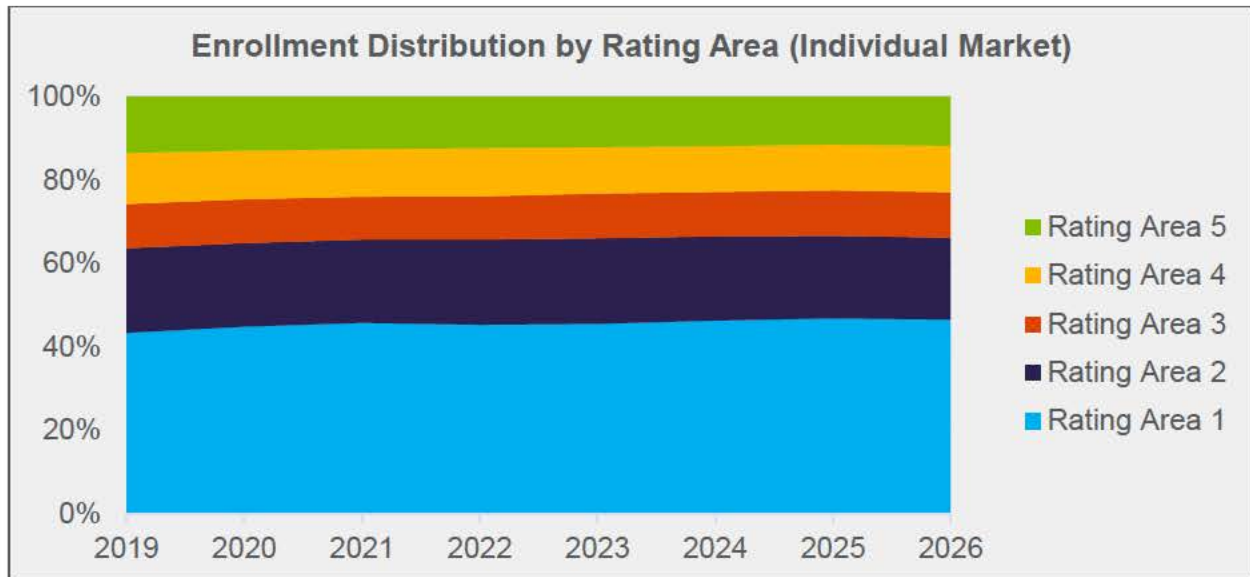
Maine does not currently have a dedicated soda or snack tax. However, the state applies an 8 percent tax on prepared meals and beverages. While grocery staples are exempt, certain snack items—including chips, candy, granola bars, and soda—are subject to taxation. A targeted snack or soda tax could provide a sustainable funding stream for MGARA while aligning with public health objectives by discouraging consumption of products linked to chronic disease. Over time, reduced prevalence of chronic conditions may also contribute to lower healthcare costs, insurance premiums, and reinsurance claims.

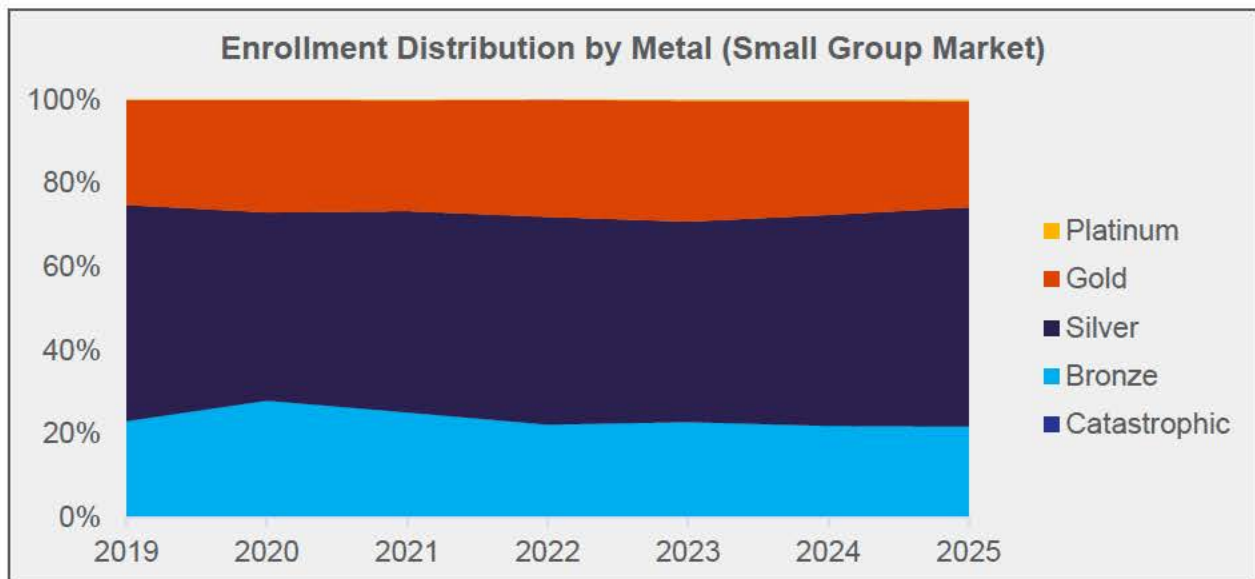
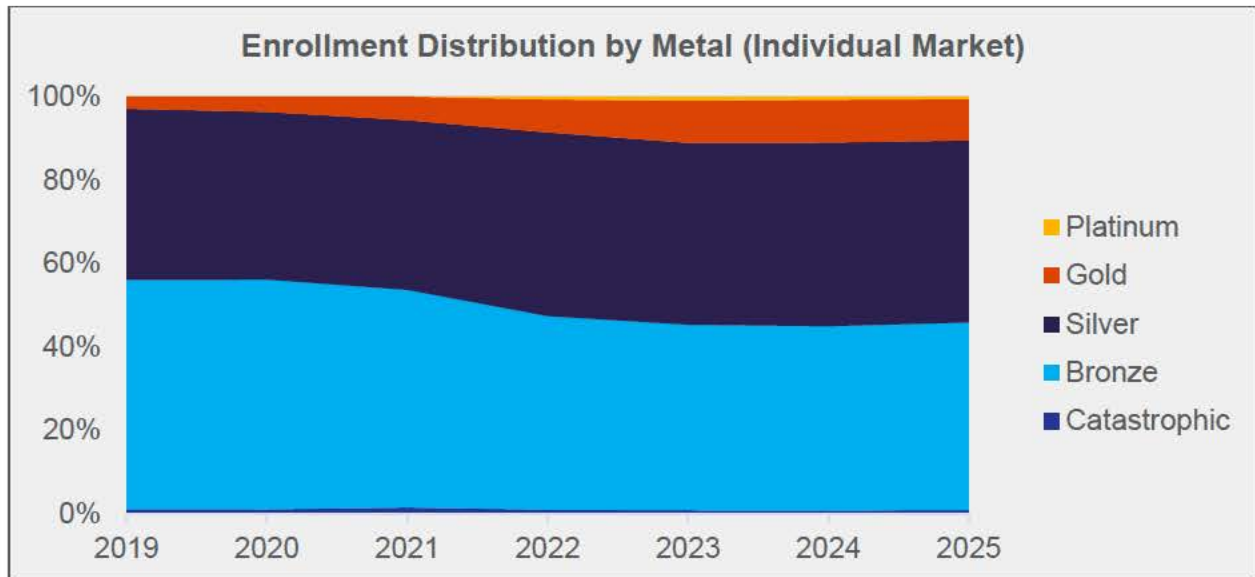
If there is interest in pursuing this option, several next steps could be considered. These include conducting scenario modeling to estimate potential revenue from a snack or soda tax, engaging stakeholders to assess legislative and public support, and discussing these concepts at a future public hearing. Additional technical detail and policy analysis can be developed as needed to support further evaluation.

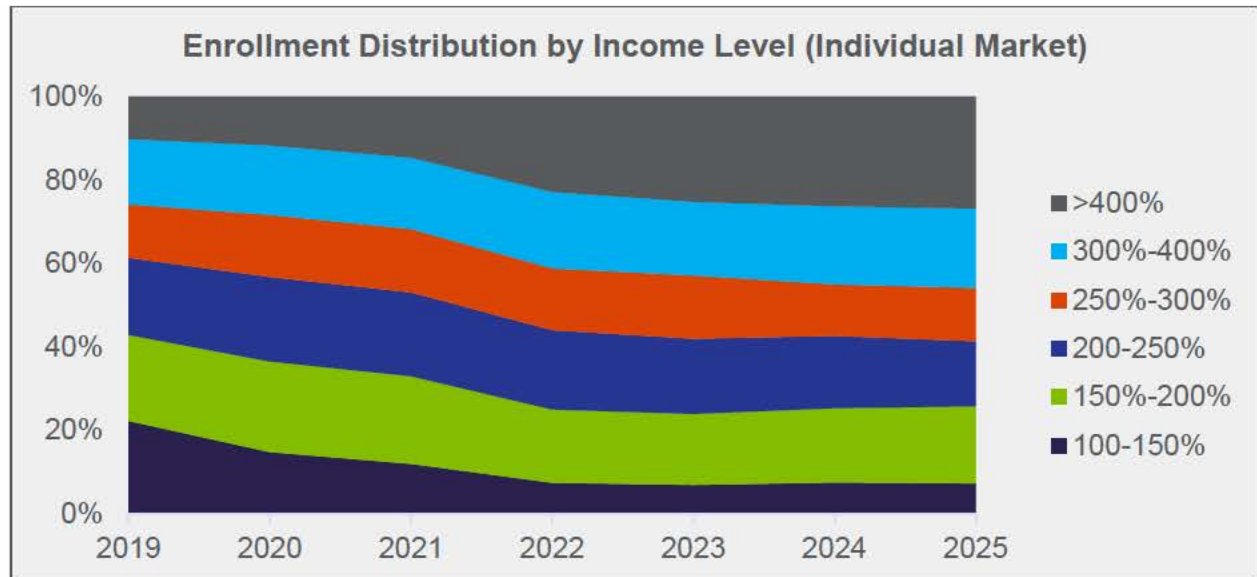
Appendix A: Historical Maine Market Assessment – Additional Exhibits











Appendix B: 1332 Reinsurance Waiver Metrics by Participating States¹⁷

State	2025 Advanced Premium Tax Credit Reduction ¹⁸	General Fund	Issuer Assess- ment	Provider Fee	Mandate Penalty	Notes and Other Funding Sources
Minnesota	-31%	X		X		A portion of past accumulations of the state's 2.0% provider tax, which applies to hospitals and other providers.
Oregon	N/A		X			Starting in PY 2020, 2.0% state premium assessment on major medical premiums and stop loss insurance.
Maine	-10%		X			Assessment of \$4 per member per month on fully-insured and self-funded commercial health insurance markets.
Maryland	-40%		X			In PY 2019, 2.75% premium assessment on certain health insurance carriers. In PY 2020-2028, 1.0% assessment.
New Jersey	-19%	X			X	Revenue raised by shared responsibility payments per the state individual mandate, and if necessary, the state general fund. At the time the mandate was enacted it was expected to generate \$90 to \$100M in penalties.
Wisconsin	-12%	X				State general purpose revenue (GPR), which consists of general taxes, miscellaneous receipts, and revenues collected by the state.
Colorado ¹⁹	-25%	X	X	X		Fee on health insurers who would otherwise be subject to the now repealed federal Health Insurance Provider Fee

¹⁷ Source: <https://www.cms.gov/files/document/ccio-data-brief-042024-508-final.pdf>

¹⁸ Key Components of PPACA Section 1332 Tentative Pass-through Payments. Reinsurance Waivers, 2025. Calculated as the reduction in 2025 APTCs with waiver vs. without waiver, which could reflect enrollment effects. Source: <https://www.cms.gov/files/document/1332-key-components-2025-pass-throughv1.xlsx>

¹⁹ Colorado's reduction also includes impact of the Colorado Option not just reinsurance.

State	2025 Advanced Premium Tax Credit Reduction ¹⁸	General Fund	Issuer Assess- ment	Provider Fee	Mandate Penalty	Notes and Other Funding Sources
						under Section 9010 of the ACA. For PYs 2022 and 2023 only, a special assessment on hospitals. A portion of the state's health insurance premium tax revenue. Money from the state's general fund is available for section 1332 waiver administration.
Delaware	-15%		X			Assessment on carriers and entities that would otherwise be subject to the federal Health Insurance Providers Fee under Section 9010 of the ACA. The state assessment is 2.75% of premium annually in years that the Health Insurance Providers Fee is waived, and 1% of premium annually in years that the Health Insurance Providers Fee is assessed.
Montana	N/A		X			1.2% annual state assessment on major medical health insurance premiums.
North Dakota	-16%		X			A state assessment on insurers writing in the small and large group health insurance markets (\$22M in PY 2020).
Rhode Island	-6%	X			X	Penalties collected from the state individual mandate which ranged from \$8.6M in 2015 and estimated at \$9.7M in 2017. ²⁰ Rhode Island received a one-time state appropriation for the Health Insurance Market Integrity Fund to support operation and administration of the program.
Pennsylvania	-6%		X			A portion of a user fee that is 3.0% of premiums and assessed on issuers participating in the Pennsylvania

²⁰ [HSRI applying for reinsurance, sole proprietor access to employer market](#)

State	2025 Advanced Premium Tax Credit Reduction ¹⁸	General Fund	Issuer Assess- ment	Provider Fee	Mandate Penalty	Notes and Other Funding Sources
						Health Insurance Exchange and other available state sources.
New Hampshire	-16%		X			A premium assessment of 0.6% of the previous year's second lowest cost silver plan without waiver rate across all licensed health insurance issuers in the state's individual and group health insurance markets with some exceptions.
Georgia	-11%	X				State general funds.
Virginia	N/A	X				State appropriations allotted in the Commonwealth Health Reinsurance Program Special Fund.
Idaho	-25%	X	X			An annual premium tax allotment, and one-time deposit of \$25 million in 2022, and an assessment on the health insurance market on an as needed basis to achieve the state's target premium reduction.

Appendix C: Data, Methodology and Limitations

Wakely analyzed funding options for the Maine Guaranteed Access Reinsurance Association (MGARA) to estimate the amount of assessment revenue each funding option would collect, what the premium reduction due to the reinsurance program would be under each funding scenario, and the total change in enrollment that could be expected due to premium reductions.

Wakely collected historical and projected premium and enrollment data from all issuers as the baseline projection for the reinsurance analysis. These projections were provided for both the Individual and Small Group market respectively. Funding for the MGARA program also relies on assessments of the large group market. The total number of covered lives, claims, and premium for this segment was both solicited from the MGARA program and sourced from the annual Health Report Supplement (Rule 945) by company. In order to model the reinsurance funding and reserves, Wakely collected historical program revenues, expenses and reinsurance parameters from MGARA. Starting from the 2025 projections, the following steps were taken to estimate the impact of various funding mechanisms on the state-based reinsurance program for Maine's merged market for 2025-2028.

2025-2026 enrollment, premium, and advanced premium tax credit (APTC) amounts were taken from templates solicited by Wakely from all Maine issuers participating in the merged market, with 2027 and 2028 developing from 2026 issuer projections. Claims were trended at the 2024-2025 rate as reported in 2026 URRTs to avoid any trend distortions from the expiration of the American Rescue Plan. The variable portion of the administrative expenses were kept as a constant percentage of premium. The fixed portion of the administrative expenses was trended at 3.0% per year in both scenarios and was based on the average of the long-term employment total compensation index in the Northeast region published by U.S. Bureau of Labor Statistics for September 2024 and 2025. Wakely considered the impact of OBBBA bill as well as the expiration of enhanced Premium Tax Credits on subsidized and unsubsidized enrollment. All modeling of these policies reflect the laws in their official/proposed states as of December 11, 2025.

The effects of various reinsurance funding programs were then modeled relative to the baseline projection year to determine the impact to the merged market enrollment, premiums, and APTCs. The key factors in modeling the reinsurance impact included the change in the claims incurred by the issuers (net of reinsurance recoveries and reflecting lower market morbidity as a result of additional enrollment), the subsequent reduction in premiums, the additional enrollment take up by the individuals not eligible for the federal APTC premium subsidies (the unsubsidized) in the individual and small group market segments, and the assessment revenue collected under various funding scenarios. Note that the reduction in the incurred claims also affects the portion of premiums used to fund the variable administrative expenses such as premium taxes and other expenses that vary proportionally with the claim costs.

Impact on Enrollment: The impact on enrollment take up was modeled separately for the individual and small group market segments, given the differences in the purchasing decision-making in the two markets. While individuals make coverage purchasing decisions, in the small group market, the employer serves as the intermediary in the plan selection decision that is a two-step process (first, employer is offered a range of plan options by the issuer, and secondly,

employee is offered potentially a subset of plan options by the employer). The take up will ultimately depend significantly on the portion of the premium that is paid by the employer and employee, and the price sensitivity of each party.

The take up in the individual market was modeled based on the elasticities estimated by the Congressional Budget Office (CBO), and Saltzman et al (July 2021) research on selection in the ACA Exchanges. The function computes expected enrollment change based on premium rate changes due to reinsurance. In the small group market, a lower elasticity was used combined with a rate of employer and employee coverage acceptance that further served to dampen this take-up function. The low and high scenarios were intended to estimate lower and higher impact of the reinsurance on market enrollment.

Additionally, based on the analysis of Urban Institute of the impacts of ePTC expiration in the individual market, there is an estimated impact of 3% increase in the employer coverage, which we incorporated into the projections starting on January 1, 2026.

Morbidity: The estimated market-wide impact to morbidity due to uninsured unsubsidized enrollees taking up coverage was estimated based on the CEA study, and included a range of morbidity relativities for which estimated that new market entrants relative to those already enrolled in the merged market. This assumption was varied in the base and high funding scenarios and was used to project the risk pool morbidity changes. The 2024-2027 projected premiums assume that any morbidity changes as a result of increased enrollment will be reflected by carriers simultaneously with the increased enrollment and are reflected in the 2025-2027 premium rates. In reality, this impact may be built in by insurers over time.

Federal Savings: The projected Federal savings are calculated as the difference in the aggregate APTC amounts between the baseline (without reinsurance) and with reinsurance scenarios. In order to model the available pass-through funding for the MGARA program, Wakely estimated the total APTCs that would be paid by the federal government if the reinsurance program was in effect, and if there was no reinsurance program. The “Premium Data for Section 1332 Waiver Pass-Through” calculation templates were used to source the premium reduction due to the reinsurance program in plans year 2025 and 2026. The premium reduction due to reinsurance in 2027 and 2028 was calculated by subtracting the total recoveries from the reinsurance program (estimated as the sum of reinsurance funding, net of operating costs) from the total projected premiums in the market.

Adjusted Federal Savings: A key assumption included in calculating the total funding was an APTC to PTC adjustment based on data released by CMS on the past adjustments made in other state programs. The actual value applied is based on tax return data that is not publicly available. The value of this assumption varies due to the presence of ARP subsidies. For 2025 projection, the PTC adjustment was set at the average of the 2023 adjustment values for states with reinsurance programs. For projection years 2026-2029, the PTC adjustment was set as the average of the 2019 adjustment values (pre-ARP and pre-pandemic).

Assessment Funding - Percentage of Premium: The projected revenue from a percentage of fully insured premium assessment was estimated by projecting total enrollment and total premium for

the large group (fully insured), individual ACA, and small group ACA markets. Average premiums for each market were adjusted to account for the additional costs of the assessment, and enrollment was projected using the newly estimated average premium. To account for the uncertainty regarding how the application of a proposed percent of fully insured premium assessment would interact with pass through funding, Wakely modeled two variants of this assumption. The first assumed that the assessment is only applied to APTC calculations for the "with reinsurance" version of rates. The second assumed that the assessment is applied to APTC calculations for both the "with reinsurance" and "without reinsurance" versions of rates.

Assessment Funding - PMPM Fixed Fee: The projected revenue from a fixed fee assessment was estimated by projecting total enrollment for the large group (fully insured and self-insured), individual ACA, and small group ACA markets. Projected enrollment in each market was adjusted to account for the assessment fee, and how it would increase premiums.

Appendix D: Disclosures and Limitations

Responsible Actuary. We, Ksenia Whittal and Freddy Quiram, are the actuaries responsible for this communication. We are Members of the American Academy of Actuaries and Ksenia is a Fellow of the Society of Actuaries and Freddy is an Associate of the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report. Lina Rashid and Michael Cohen have made significant contributions to this analysis.

Intended Users. This information has been prepared for the sole use of the Maine Bureau of Insurance (BOI) to assess potential funding mechanisms for the state-based reinsurance and 1332 waiver and their impacts on the individual and small group Affordable Care Act markets in the state of Maine from 2025-2028. This analysis cannot be distributed to or relied on by any other third party without the prior written permission of Wakely. It is our understanding that these results may be made public and also shared with the MGARA board. Distribution to parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to Maine Bureau of Insurance.

Data and Reliance. Wakely relied on a number of publicly available data sources to develop the reinsurance estimates. Public data sources rely on issuer reporting integrity to produce reliable results. All policies considered in the modeling reflect laws in their official/proposed states as of December 5th, 2025. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. The analyses, assumptions and results may change based on discussions and if any new information is received that may influence the estimates. Material changes as a result of Federal or state regulations may have a material impact on the results. There are no specifically known relevant events subsequent to the date of engagement that would impact the results of this document.

Contents of Actuarial Report. This document and the supporting exhibits/files constitute the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations. In developing these standard plan designs and the resulting actuarial certification, Wakely followed applicable Actuarial Standards of Practice (ASOP) including:

ASOP No. 23 Data Quality;
ASOP No. 41 Actuarial Communications;
ASOP No. 56 Modeling.

Appendix E: Data Reliance

Wakely has utilized data provided by CMS, BOI, MGARA and Maine issuers in the analyses described in this report. The analyses were performed using the following data.

- 2021 - 2026 ME Unified Rate Review Templates (URRTs)
- 2021 – 2026 ME Rate Templates
- 2019 - 2024 CMS Open Enrollment public use files
- 2014-2023 CMS Medical Loss Ratio (MLR) tables
- 2024 CMS Risk Adjustment Reports
- Maine 2023-2024 Medical Loss Ratio Results for Health Insurance Companies in Maine reports
- Wakely solicited template to MGARA Stakeholders on program funding and reserves
- Wakely solicited template to Maine issuers on historical 2019 - 2024 and projected 2025-2026 on-Exchange and off-Exchange market ACA-compliant experience
- 2021-2026 Reinsurance Waiver Pass-through Funding Reports
- 2021-2026 Premium Data for Section 1332 Waiver Pass-Through Templates
- 2024 Maine 940 Reports, sections IV – V
- 2018 – 2024 Maine Health Report Supplements (Rule 945) by Company
- <https://www.maine.gov/governor/mills/news/federal-government-approves-maines-plan-improve-health-insurance-small-businesses-2022-07-15#:~:text=Under%20the%20now%2Dapproved%20waiver,pooled%20market%20beginning%20in%202023.>
- [https://www.cms.gov/marketplace/resources/regulations-guidance#Premium-Stabilization-Programs:~:text=Coefficients%20\(PDF\)-,April%209%2C%202025,-Final%202024%20Benefit](https://www.cms.gov/marketplace/resources/regulations-guidance#Premium-Stabilization-Programs:~:text=Coefficients%20(PDF)-,April%209%2C%202025,-Final%202024%20Benefit)
- <https://www.bls.gov/news.release/eci.t06.htm>
- <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data>
- “Future of the Individual Market: Impact of the House Reconciliation Bill and Other Changes on the ACA Individual Market” June 2025. Wakely white paper. https://www.wakely.com/wp-content/uploads/2025/06/Reconciliation-Bill-Impacts_6_23_25_FINAL.pdf
- NBER WORKING PAPER SERIES. INERTIA, MARKET POWER, AND ADVERSE SELECTION IN HEALTH INSURANCE: EVIDENCE FROM THE ACA EXCHANGES. Saltzman et al. <http://www.nber.org/papers/w29097>. July 2021