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Overview of Health Insurance Exchanges

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SUMMARY

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Overview of Health Insurance Exchanges

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) required health insurance exchanges to be established in every state. Exchanges are virtual marketplaces in which consumers and small business owners and employees can shop for and purchase private health insurance coverage and, where applicable, be connected to public health insurance programs (e.g., Medicaid). In general, states must have two types of exchanges: an *individual exchange* and a *small business health options program (SHOP) exchange.* Exchanges may be established either by the state itself as a *state-based exchange (SBE)* or by the Secretary of Health and Human Services (HHS) as a *federally facilitated exchange (FFE).* Some states have *SBE-FPs*: they have SBEs but use the federal information technology platform (FP), including the federal exchange website www.HealthCare.gov.

A primary function of the exchanges is to facilitate enrollment. This generally includes operating a web portal that allows for the comparison and purchase of coverage; making determinations of eligibility for coverage and financial assistance; and offering different forms of enrollment assistance, including Navigators and a call center. Exchanges also are responsible for several administrative functions, including certifying the plans that will be offered in their marketplaces.

The ACA generally requires that the private health insurance plans offered through an exchange are *qualified health plans (QHPs).* To be a certified as a QHP, a plan must be offered by a state-licensed health insurance issuer and must meet specified requirements, including covering the *essential health benefits (EHB)*. QHPs sold in the individual and SHOP exchanges must comply with the same state and federal requirements that apply to QHPs and other health plans offered outside of the exchanges in the individual and small-group markets, respectively. Additional requirements apply only to QHPs sold in the exchanges. Exchanges also may offer variations of QHPs, such as child-only or catastrophic plans, and non-QHP dental-only plans.

Individuals and small businesses must meet certain eligibility criteria to purchase coverage through the individual and SHOP exchanges, respectively. There is an annual *open enrollment period* during which any eligible consumer may purchase coverage via the individual exchanges; otherwise, consumers may purchase coverage only if they qualify for a *special enrollment period.* In general, small businesses may enroll at any time during the year. There are plans available in all individual exchanges, and, as of February 2020, about 10.7 million people obtained health insurance through the individual exchanges. (2021 open enrollment data for all states are expected in spring 2021.) Nationwide SHOP exchange enrollment estimates are not regularly released; in addition, there are no SHOP exchange plans available in more than half of states in 2021.

Plans sold through the exchanges, like private health insurance plans sold off the exchanges, have premiums and out-of-pocket (OOP) costs. Consumers who obtain coverage through the individual exchange may be eligible for federal financial assistance with premiums and OOP costs in the form of *premium tax credits* and *cost-sharing reductions*. Small businesses that use the SHOP exchange may be eligible for *small business health insurance tax credits* that assist with the cost of providing health insurance coverage to employees.

The federal government spent an estimated $1.8 billion on the operation of exchanges in FY2020, and it projected $1.2 billion in spending for FY2021. Much of the federal spending on the exchanges is funded by *user fees* paid by the insurers who participate in FFE and SBE-FP exchanges. States with SBEs finance their own exchange administration; states with SBE-FPs also finance certain costs (e.g., consumer outreach and assistance programs, including Navigator programs).

This report provides an overview of the various components of the health insurance exchanges. It begins with summary information about the types of exchanges and their administration. Sections on the individual and SHOP exchanges discuss eligibility and enrollment, plan costs and financial assistance available to eligible consumers and small businesses, insurer participation, and other topics. The final sections address types of enrollment assistance available to exchange consumers and federal funding for the exchanges.

Contents

Figures

Tables

Appendixes

Contacts

Introduction

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) required *health insurance exchanges* (also known as *marketplaces*) to be established in every state. The ACA exchanges are virtual marketplaces in which consumers and small businesses can shop for and purchase private health insurance coverage and, where applicable, be connected to public health insurance programs (e.g., Medicaid).[1] Certain consumers and small employers are eligible for financial assistance for private health insurance purchased (only) through the exchanges. Exchanges are intended to simplify the experience of obtaining health insurance. They are not intended to supplant the private market outside of the exchanges but rather to provide an additional source of private health insurance coverage options.

The exchanges may be administered by state governments and/or the federal government. Regardless, the major functions of the exchanges are (1) to facilitate consumers' and small businesses' purchase of coverage (by operating a web portal, making determinations of eligibility for coverage and any financial assistance, and offering different forms of enrollment assistance) and (2) to certify, recertify, and otherwise monitor the plans that are offered in those marketplaces.

Although a relatively small proportion of people in the U.S. obtain their coverage through the exchanges,[2] the administration and functioning of these marketplaces are ongoing topics of interest to congressional audiences and other stakeholders. An understanding of the exchanges can provide context for current health policy discussions and proposals related to health care coverage and costs, the roles of the public and private sectors in the provision of health coverage, and more.

This report provides an overview of key aspects of the health insurance exchanges. It begins with summary information about types and administration of exchanges and the plans sold in them. Sections on the individual and small business exchanges discuss eligibility and enrollment, plan costs and financial assistance available to eligible consumers and small businesses, insurer participation, and other topics. The final sections describe types of enrollment assistance available to exchange consumers and provide information on federal funding for the exchanges. Appendixes offer further details, including exchange types by state.

[1] In this report, the terms *consumers* and *individuals* generally are used interchangeably, as are *small businesses* and *small employers*.

[2] For example, as of February 2020, about 10.7 million people obtained health insurance through the individual exchanges. This figure is approximately 3% of the current U.S. population of 330 million people. See **Table 2** regarding exchange enrollment estimates and sources. For current U.S. population, see U.S. Census, "U.S. and World Population Clock," accessed September 2, 2020, at https://www.census.gov/popclock/.

Overview

Types and Administration of Exchanges

Individual and SHOP Exchanges

The ACA required health insurance exchanges to be established in all states and the District of Columbia.[3] In general, the health insurance exchanges began operating in October 2013 to allow consumers to shop for health insurance plans that began as soon as January 1, 2014.

There are two types of exchanges—*individual exchanges* and *small business health options program (SHOP) exchanges*.[4] These exchanges are part of the individual (also called non-group) and small-group segments of the private health insurance market, respectively.[5] In an individual exchange, eligible consumers can compare and purchase non-group insurance for themselves and their families and can apply for premium tax credits (PTCs) and cost-sharing subsidies (see "Premium Tax Credits and Cost-Sharing Reductions," below). In a SHOP exchange, small businesses can compare and purchase small-group insurance and can apply for small business health insurance tax credits ("Small Business Health Care Tax Credit," below); in addition, employees of small businesses can enroll in plans offered by their employers on a SHOP exchange.

Each exchange covers a whole state.[6] Within a given exchange, private insurers may offer plans that cover the whole state or only certain areas within the state (e.g., one or more counties). Plans sold within a given exchange may cover services offered by providers located in more than one state.

In general, consumers and small businesses may obtain coverage within their state's individual or SHOP exchange, respectively, or they may shop in the individual or small-group health insurance markets outside of the exchanges, which existed prior to the ACA and continue to exist.[7] Outside of the ACA exchanges, consumers can purchase coverage through agents or brokers, or they can purchase it directly from insurers. In addition, there were and still are privately operated websites that allow the comparison and purchase of coverage sold by different insurers, broadly similar in concept to the ACA exchanges.[8]

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[3] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) also gave the territories the option of establishing exchanges, but none elected to do so, by the statutory deadline of October 1, 2013. See 42 U.S.C. §18043.

[4] The term *individual exchange* is used for purposes of this report. It is not defined in exchange-related statute or regulations.

[5] The private health insurance market includes both the *group market* (largely made up of employer-sponsored insurance) and the *individual market* (which includes plans directly purchased from an insurer). The group market is divided into small- and large-group market segments; a *small group* is typically defined as a group of up to 50 individuals (e.g., employees), and a *large group* is typically defined as one with 51 or more individuals.

[6] There is an option for states to coordinate in administering regional exchanges or for a single state to establish subsidiary exchanges that serve geographically distinct areas (see 45 C.F.R. §155.410), but none have done so.

[7] However, plans are not available in all small business health options program (SHOP) exchanges in 2021.

[8] An example of a privately owned website that allows for comparison and purchase of coverage from different insurers is ehealthinsurance.com. Note that some types of coverage sold outside of the federal and state exchanges, potentially including some types of coverage available on private sites like this one, are not subject to some or all federal health insurance requirements. For more information, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

State-Based and Federally Facilitated Exchanges

A state can choose to establish its own *state-based exchange* (SBE). If a state opts not to administer its own exchange, or if the Department of Health and Human Services (HHS) determines the state is not in a position to do so, then HHS is required to establish and administer the exchange in the state as a *federally facilitated exchange* (FFE).

There is one variation on the SBE approach: a state may have a *state-based exchange using a federal platform* (SBE-FP), which means the state oversees the exchange but uses the federally facilitated information technology (IT) platform, or *federal platform* (FP) (i.e., HealthCare.gov).

There is also a variation on the FFE approach: a state may have a *state partnership FFE*, which allows the state to manage certain aspects of its exchange while HHS manages the remaining aspects and has authority over the exchange. In early guidance on this option, HHS indicated a state could elect to perform some plan management and/or certain consumer assistance functions, and HHS would perform other functions, including facilitating enrollment through the federal HealthCare.gov platform and funding Navigator entities in the state.[9] In federal and private resources that track exchange data, this variation may not be reported on separately but rather may be included in overall counts of FFEs, which is the model this report generally follows.[10]

In rulemaking finalized January 19, 2021 (the 2022 Notice of Benefit and Payment Parameters, or "Payment Notice"[11]), HHS and the Department of the Treasury established new "direct enrollment" variations of the exchange types: FFE-DE, SBE-DE, and SBE-FP-DE.[12] States electing these options would "adopt a private sector-based enrollment approach as an alternative to the consumer-facing enrollment website operated by the Exchange (for example, HealthCare.gov for the FFEs)." In other words, consumers would enroll in exchange plans via private agents or brokers, rather than on an exchange website like HealthCare.gov. The exchange would still have to "make available a website listing basic [qualified health plan] QHP information for comparison," but this website would direct consumers to "approved partner websites for consumer shopping, plan selection, and enrollment activities." Per the final rule, this will be an option for SBEs as of plan year (PY) 2022, and for FFEs and SBE-FPs as of PY2023. The final rule was published but did not take effect before the presidential transition, and as such, may be reconsidered by the Biden Administration.[13]

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[9] See Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO), "General Guidance on Federally-facilitated Exchanges," May 16, 2012, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf. Also see CMS, CCIIO, "Guidance on State Partnership Exchange," January 3, 2013, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf. For more information about Navigators, see "Navigators and Other Exchange-Based Enrollment Assistance" in this report.

[10] This report focuses on the three types of exchanges that are commonly discussed in CMS resources, but other entities may also track states with variations of state partnership FFEs. For example, the Kaiser Family Foundation (KFF) notes FFEs in which the state conducts plan management activities at "State Health Insurance Marketplace Types, 2021," at https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/.

[11] See 2022 Payment Notice, starting page 6143, regarding information in this paragraph. The Notice of Benefits and Payment Parameters, or Payment Notice, is an annually published rule that includes updates and policy changes related to the exchanges and private health insurance. See **Table D-1** for Payment Notice citations.

[12] For additional discussion of direct enrollment, see "Online Enrollment versus Direct Enrollment" in the SHOP section of this report.

[13] See Office of Management and Budget, "Memorandum for the Heads of Executive Departments and Agencies," 86 *Federal Register* 7424, January 28, 2021.

For PY2021, 30 states have FFEs, 15 states have SBEs, and 6 states have SBE-FPs.[14] A few states have changed approaches one or more times (e.g., initially worked to create an SBE but then switched to an SBE-FP or FFE model). Changes in the first few years varied in terms of whether the state moved toward more or less federal involvement, but in several cases, a state transitioned from a fully state-based approach to an SBE-FP (i.e., transitioned toward more federal involvement). Recent and ongoing transitions are generally in the direction of less federal involvement. As of the publication of this report, five states are transitioning or considering transitions for PY2022 or beyond.[15]

SHOP exchanges may be federally facilitated (FF-SHOP) or state-based (SB-SHOP).[16] For PY2021, there are 32 FF-SHOPs and 18 SB-SHOPs. However, in more than half of these states, no insurers are offering medical plans in the SHOP exchange, meaning there is effectively no SHOP exchange there.[17] One state is exempted from operating a SHOP exchange.[18] For the 2021 plan year, most states' individual and SHOP exchanges are administered in the same way (i.e., both state-based or both federally facilitated). However, a handful of states have different approaches for their individual and SHOP exchanges. Some resources refer to this as a *bifurcated* approach.

See **Figure 1** for individual and SHOP exchange types by state in PY2021, and see **Table A-1** for additional information, including on state transitions to different exchange types.

[14] See **Table A-1** for details and citations for this paragraph. In tallies throughout this report, the District of Columbia is counted as a state.

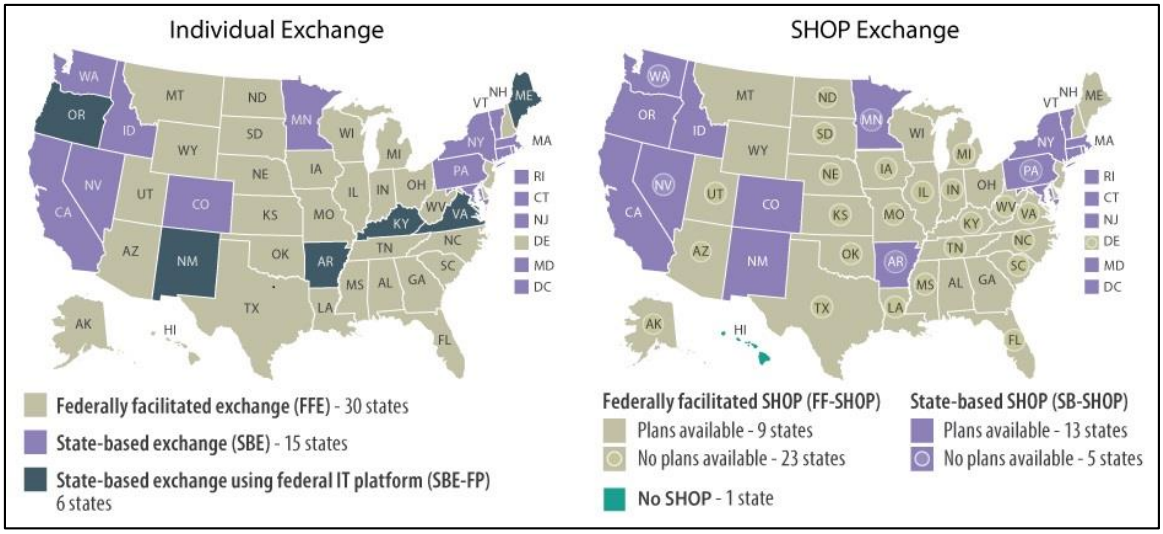
[15] One of these states, Georgia, received approval through the Section 1332 state innovation waiver process shift to its own Georgia Access Model, essentially a direct enrollment approach, beginning in PY2023. This 1332 process allows states to waive specified ACA provisions, including provisions related to the establishment of health insurance exchanges and related activities. See CRS Report R44760, *State Innovation Waivers: Frequently Asked Questions* for more information.

[16] As of June 2018, states can no longer select a state-based SHOP using the federal IT platform (SB-FP-SHOP) approach, except that the two states with that model at that time (Nevada and Kentucky) could maintain it. According to CMS, those states no longer use that model. For more information, see "Online Enrollment versus Direct Enrollment in the SHOP section of this report.

[17] See "Insurer Participation" in the SHOP Exchanges section of this report for more information.

[18] Hawaii received a Section 1332 waiver exempting it from operating a SHOP exchange.

Figure 1. Individual and SHOP Exchange Types by State, Plan Year 2021



Sources: Congressional Research Service (CRS) illustration. See data sources in **Table A-1**.

Notes: SHOP = small business health options program; IT = information technology. Counts of "states" include the District of Columbia. In the individual exchanges, *plan year* is generally that calendar year, but group coverage plan years, including in the SHOP exchanges, may start at any time during a calendar year. See "Types and Administration of Exchanges" in this report regarding individual and SHOP exchanges, and federal and state administration of exchanges.

In more than half of states, no insurers are offering medical plans in the SHOP exchange, meaning there is effectively no SHOP exchange there. These states have a circle symbol in the SHOP Exchange map above. See "Insurer Participation" in the SHOP Exchanges section of this report for more information.

Hawaii received a Section 1332 waiver exempting it from operating a SHOP exchange. For more information, see CRS Report R44760, *State Innovation Waivers: Frequently Asked Questions*.

Exchange Administration

Whether state-based or federally facilitated, exchanges are required by law to fulfill certain minimum functions. ACA provisions related to the establishment and operation of the exchanges are codified at 42 U.S.C. §§18031 et seq. Other federal provisions also are relevant, for example regarding the requirements for plans that may be sold through the exchanges.[19]

A primary function of the exchanges is to provide a way for consumers and small businesses to compare and purchase health plan options offered by participating insurers.[20] This generally includes operating a web portal that allows for comparing and purchasing coverage, making determinations of eligibility for coverage and financial assistance, and offering different forms of enrollment assistance.

Exchanges also are responsible for several administrative functions, including certifying the plans that will be offered in their marketplaces.[21] This includes annually certifying or recertifying plans to be sold in their exchanges as *qualified health plans* (QHPs, discussed below). QHP certification involves a review of various factors, including the plan's benefits, cost-sharing structure, provider network, premiums, marketing practices, and quality improvement activities,

[19] See "Qualified Health Plans" in this report.

[20] 42 U.S.C. §18031(b)(1)(A).

[21] 42 U.S.C. §18031(d)(4).

to ensure compliance with applicable federal and state standards.[22] The QHP certification process is to be completed each year in time for insurers to market their plans and premiums during the exchanges' annual open enrollment period (see "Open and Special Enrollment Periods").

Exchanges' other administrative activities include collecting enrollment and other data, reporting data to and otherwise interacting with the Departments of HHS and the Treasury, and working with state insurance departments and federal regulators to conduct ongoing oversight of plans.

Qualified Health Plans

In general, health insurance plans offered through exchanges must be *qualified health plans* (QHPs).[23] A QHP is a plan offered by a state-licensed insurer that is certified to be sold in that state's exchange, covers the *essential health benefits* (EHB) package, and meets other specified requirements.[24] Covering the EHB package means covering 10 broad categories of benefits and services, complying with limits on consumer cost sharing on the EHB, and meeting certain generosity requirements (in terms of *actuarial value*).[25]

QHPs are subject to the same state and federal requirements that apply to health plans offered outside of exchanges.[26] Thus, a QHP offered through an individual exchange must comply with state and federal requirements applicable to individual market plans; a QHP offered through a SHOP exchange must comply with state and federal requirements applicable to small-group market plans. For example, the requirement to cover the EHB applies to individual and small-group plans both in and out of the exchanges.

There are additional requirements that apply only to QHPs sold in the exchanges. For example, an insurer wanting to sell QHPs in an exchange must offer at least one silver-level and one gold-level plan in all of the areas in which the insurer offers coverage within that exchange. In addition, QHPs must meet network adequacy standards, including maintaining provider networks that are "sufficient in number and types of providers" and include "essential community providers."[27]

A QHP is the only type of comprehensive health plan an exchange may offer, but QHPs may be offered outside of exchanges, as well. Besides standard QHPs, other types of plans may be available in a given exchange, including child-only plans, catastrophic plans, consumer operated and oriented plans (CO-OPs), and multi-state plans (MSPs). Technically, these are also QHPs.

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[22] 42 U.S.C. §18031(c)(1); 42 U.S.C. §18031(e). For more information, see, for example, CMS, CCIIO, "Final 2021 Letter to Issuers in the Federally-facilitated Exchanges," May 7, 2020, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf. Hereinafter referred to as "CMS 2021 Letter to Issuers."

[23] 42 U.S.C. §18031(d)(2)(B).

[24] 42 U.S.C. §18021(a)(1).

[25] 42 U.S.C. §18022. For brief explanation of actuarial value (AV) and cost-sharing limits, see "Premiums and Cost Sharing" in this report. For more information on the essential health benefits, cost-sharing limits, and AV requirements, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[26] For more information about federal requirements applicable to different types of plans, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*. This report also addresses states' roles as the primary regulators of health insurance.

[27] See, for example, 42 U.S.C. §§18021, 18023, and 18031; and 45 C.F.R. §§156.200 et seq. Also see the CMS 2021 Letter to Issuers. Network adequacy standards are at 45 C.F.R. §156.200. The requirement regarding silver and gold plans is discussed in "Premiums and Cost Sharing" in this report.

Stand-alone dental plans (SADPs) are the only non-QHPs offered in the exchanges. See **Table B-1** for more information.

Under federal law, insurers are not required to offer plans in the exchanges, just as they are not required to offer plans in markets outside the exchanges. If an insurer does want to offer a plan in an exchange, it must meet applicable federal and state requirements, as discussed in this section and the prior one on "Exchange Administration." Insurer participation in the individual and SHOP exchanges is discussed in the sections below.

Individual Exchanges

Eligibility and Enrollment

Consumers may purchase health insurance plans for themselves and their families in their state's individual exchange. Consumers may enroll as long as they (1) meet state residency requirements;[28] (2) are not incarcerated, except individuals in custody pending the disposition of charges; and (3) are U.S. citizens, U.S. nationals, or "lawfully present" residents.[29] Undocumented individuals are prohibited from purchasing coverage through the exchanges, even if they were to pay the entire premium without financial assistance.

Consumers can use their state's exchange website (HealthCare.gov or a state-run site) to apply for coverage and financial assistance and to compare and enroll in plans. The ACA requires exchanges to provide a "single, streamlined form" that consumers can use to apply for "all applicable State health subsidy programs within the State."[30] This means that through one form, consumers can be determined eligible for exchange financial assistance (see "Premium Tax Credits and Cost-Sharing Reductions" in this report), as well as Medicaid and the State Children's Health Insurance Program (CHIP), as discussed below.[31] The exchange website displays all exchange plans available to a consumer, with estimates of the consumer's costs, including monthly premiums that reflect the application of any federal financial assistance for which they are eligible.

In addition to using their exchange website, consumers can apply and enroll by phone, by mail, or in person, as available by state. Enrollment assistance is available for those who want it (e.g., through exchange Navigators or through agents or brokers; see "Exchange Enrollment Assistance" in this report).

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[28] State residency may be established through a variety of means, including actual or planned residence in a state, actual or planned employment in a state, and other circumstances. See 45 C.F.R. §155.305.

[29] U.S. citizens and U.S. nationals are eligible for coverage through the exchanges. *Lawfully present* immigrants are also eligible for coverage through the exchanges. Examples of *lawfully present* immigrants include those who have *qualified non-citizen* immigration status without a waiting period, humanitarian statuses or circumstances, valid non-immigrant visas, and legal status conferred by other laws. See 45 C.F.R. §155.305 and HealthCare.gov, "Coverage for Lawfully Present Immigrants," at https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.

[30] 42 U.S.C. §18083, 45 C.F.R. §155.405.

[31] Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. CHIP is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have annual income above Medicaid eligibility levels but have no health insurance. The "applicable State health subsidy programs" also include the Basic Health Program, which is operational in two states: Minnesota and New York.

Interaction with Medicaid, CHIP, and Medicare

In conjunction with the streamlined application mentioned above, exchanges must have systems for coordinating with the Medicaid and CHIP programs on eligibility determinations and enrollment into those programs, for eligible consumers. These systems may vary by state.[32]

Consumers who are eligible for Medicaid or CHIP may choose to buy exchange coverage instead, but they would not be eligible for financial assistance for exchange coverage (i.e., PTCs or cost-sharing reduction subsidies).

There are some limitations on the sale of exchange plans to Medicare-eligible or Medicare-enrolled individuals.[33] In short, it is generally illegal to sell an individual exchange plan to someone enrolled in Medicare because it would duplicate coverage.

Open and Special Enrollment Periods

Consumers may enroll in coverage through the exchanges only during specified enrollment periods.

Anyone eligible for exchange plan coverage may enroll during an annual *open enrollment period* (OEP).[34] The OEP typically takes place in fall of the year preceding the *plan year* (PY; the calendar year in the individual exchanges) during which the coverage is effective. The OEP for PY2021 coverage was November 1, 2020, to December 15, 2020, for FFE and SBE-FP states. States with SBEs may extend their OEPs, and many do. See **Table 1**, including table notes, for details.

Before and during an OEP, consumers already enrolled in coverage through an exchange should receive notification from the exchange and from their insurer about the opportunity to make any updates to their application data and/or coverage choices. Insurers must notify consumers of changes to their plans such as premiums, benefit coverage, or provider networks (such changes generally cannot be made during a plan year, only in preparation for, and as applicable to, a new

[32] 45 C.F.R. Part 155, Subpart D, including §155.302. Regarding FFE and SBE-FP states, also see "Medicaid & CHIP Eligibility" in Section 2.1 of CMS, *FFE and FF-SHOP Enrollment Manual*, June 26, 2018, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/General-Resources-Items/FFM-and-FF-SHOP-Enrollment-Manual. Information for consumers is at Medicare.gov, "Medicare & the Marketplace," at https://www.medicare.gov/about-us/medicare-the-marketplace. Hereinafter referred to as CMS, *FFE and FF-SHOP Enrollment Manual*. Regarding SBE states, also see Sara Rosenbaum et al., *Streamlining Medicaid Enrollment: The Role of the Health Insurance Marketplaces and the Impact of State Policies*, Commonwealth Fund, March 30, 2016, at https://www.commonwealthfund.org/publications/issue-briefs/2016/mar/streamlining-medicaid-enrollment-role-health-insurance.

[33] Medicare is a federal health insurance program that pays for covered health care services for most people aged 65 and older and for certain permanently disabled individuals under the age of 65. The prohibition on selling an individual exchange plan to someone enrolled in Medicare does not apply to employment-based coverage, including coverage sold in the SHOP exchanges. See CMS, "Medicare and the Marketplace," updated December 2019, at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html. Also see Section 2.6.8 of CMS, *FFE and FF-SHOP Enrollment Manual*, June 26, 2018, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/General-Resources-Items/FFM-and-FF-SHOP-Enrollment-Manual. Information for consumers is at Medicare.gov, "Medicare & the Marketplace," at https://www.medicare.gov/about-us/medicare-the-marketplace. CMS, *FFE and FF-SHOP Enrollment Manual*.

[34] 45 C.F.R. §155.410.

plan year).[35] If an existing exchange plan enrollee does not take any action during the OEP, they generally will be automatically reenrolled in the same plan for the upcoming plan year.[36]

Table 1. Open Enrollment Periods for Individual Exchanges on the Federal Platform, by Plan Year

	Plan Year							
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
HealthCare.gov OEP	Oct. 1, 2013-Mar. 31, 2014	Nov. 15, 2014-Feb. 15, 2015	Nov. 1, 2015-Jan. 31, 2016	Nov. 1, 2016-Jan. 31, 2017	Nov. 1, 2017-Dec. 15, 2017	Nov. 1, 2018-Dec. 15, 2018	Nov. 1, 2019-Dec. 15, 2019	Nov. 1, 2020-Dec. 15, 2020

Source: CRS analysis of Department of Health and Human Services (HHS) reports on enrollment during annual open enrollment periods. See the "Pre-effectuated Enrollment Data" section of CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics* for reports by year.

Notes: FFE = federally facilitated exchange; OEP = open enrollment period; PY = plan year; SBE = state-based exchange; SBE-FP = state-based exchange using the federal information technology platform; SEP = special enrollment period. See "State-Based and Federally Facilitated Exchanges" in this report for more information.

The *HealthCare.gov OEP* applies to FFE and SBE-FP states. In some years, there also have been federal OEP extensions or SEPs for broadly applicable situations, such as in the 2018 OEP, due to natural disasters in 2017. See "Open and Special Enrollment Periods" in this report for more information.

The OEPs of SBEs may be longer in a given year. For PY2020, 9 of 13 SBEs extended their OEPs. See CMS, "2020 Marketplace Open Enrollment Period Public Use Files" at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files.

Consumers also may be allowed to enroll for coverage in an exchange if they qualify for a *special enrollment period* (SEP). Generally, consumers qualify for SEPs due to a change in personal circumstances—for example, a change in marital status or number of dependents—or loss of qualifying coverage.[37] HHS also may choose to offer SEPs or extend an OEP for some or all

[35] See Section 2.6 of CMS, *FFE and FF-SHOP Enrollment Manual*; the "Reenrollment Communications to Enrollees" section cites CMS guidance: *Updated Federal Standard Renewal and Product Discontinuation Notices*, September 2016, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Updated-Federal-Standard-Renewal-and-Product-Discontinuation-Notices-090216.pdf. There, see "Instructions for Attachment 2."

[36] For more information about plan renewal options and processes, including automatic renewals of enrollees in their existing plans or in alternate plans if their existing ones will no longer be available, see Section 2.6 of CMS, *FFE and FF-SHOP Enrollment Manual*. Although this manual describes processes for HealthCare.gov states, SBEs also have processes for automatic reenrollment.

[37] *Qualifying coverage* generally means the types of *minimum essential coverage* (MEC) that are identified in the Internal Revenue Code (IRC) Section 5000A and its implementing regulations. Most types of comprehensive coverage are considered MEC, including public coverage (e.g., Medicaid, Medicare), as well as private insurance (e.g., employer-sponsored insurance and non-group insurance). For other types of coverage losses that can trigger an exchange special enrollment period (SEP), see 45 C.F.R. §155.420. Also see 45 C.F.R. §147.104 regarding SEPs applicable to the individual and group markets overall.

consumers due to broadly applicable circumstances.[38] Subject to statutory requirements, HHS may make changes to SEPs.[39]

Federal SEPs apply to FFEs, SBE-FPs and generally to SBEs, but SBEs have flexibility regarding implementation of some SEPs. SBEs also may create their own SEPs, subject to applicable federal and state laws. Federal SEPs for the individual exchanges may or may not apply to the federal SHOP exchanges and/or to the individual market outside the exchanges.[40]

Eligibility for Medicaid or CHIP may be determined at any point during the calendar year and has no connection to an applicant's state's exchange OEP.

Special Enrollment Periods and COVID-19

During the Coronavirus Disease 2019 (COVID-19) pandemic and related economic recession, there have been questions about SEPs to allow consumers to enroll in coverage via the exchanges.

In response to COVID-19, most SBEs created SEPs to allow individuals to purchase coverage. These SEPs generally were open in spring 2020, with varied timing and durations. Some were extended one or more times. In general, these SEPs were available to any uninsured individuals eligible for exchange coverage.[41]

In 2020, HHS did not announce a COVID-related federal SEP for all uninsured individuals to enroll in coverage in FFEs and SBE-FPs. However, an existing SEP allows individuals to enroll if they lose their job-based coverage or other qualifying coverage. A June 2020 Centers for Medicare & Medicaid Services (CMS) report on exchange enrollment during the pandemic further stated that "any consumers who qualified for a SEP but missed the deadline as a result of the COVID-19 pandemic—for example, if they were sick with COVID-19 or were caring for someone who was sick with COVID-19—may also be eligible for another SEP."[42] This is similar to federal SEPs announced in relation to prior disasters. In addition, at least as of the second half of 2020, the federal exchange website HealthCare.gov indicated that losing qualifying coverage since the start of 2020 could qualify someone for an SEP, as opposed to the standard eligibility criterion of losing qualifying coverage in the prior 60 days.[43]

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[38] For example, in 2014, the Department of Health and Human Services (HHS) established an SEP due to technical problems submitting insurance applications through the federal information technology platform (i.e., HealthCare.gov). In 2015, HHS established an SEP around tax season for individuals who had not enrolled in 2015 coverage and were subject to the 2014 individual mandate penalty. For 2018 coverage, HHS established an SEP for consumers in states that were affected by the 2017 hurricanes or other severe weather events. See, for example, HHS, HealthCare.gov, "Special Enrollment Periods for Complex Issues," at https://www.healthcare.gov/sep-list/.

[39] Statutory requirements for exchange SEPs are at 42 U.S.C. §18031(c)(6). Multiple examples and discussion of administrative changes made to SEPs are in the HHS final rule, "Patient Protection and Affordable Care Act; Market Stabilization," 82 *Federal Register* 18346, April 18, 2017, at https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization. The background of this rule also provides information on prior administrative actions related to SEPs.

[40] For more information about SEPs, see Section 5 of CMS, *FFE and FF-SHOP Enrollment Manual*.

[41] The National Association of Insurance Commissioners (NAIC) has been tracking various state-level actions related to COVID-19 and insurance, including SEPs announced by SBEs. See NAIC, "Coronavirus Resource Center," "Life and Health" spreadsheet, at https://content.naic.org/naic_coronavirus_info.htm.

[42] CMS, *Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency*, June 2020, at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf.

[43] HealthCare.gov page on special enrollment periods, at https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/.

On January 28, 2021, HHS (via CMS) announced a new COVID-19-related SEP, in effect February 15-May 15, 2021, to allow all exchange-eligible consumers to newly enroll or update their enrollment in an exchange plan.[44] Per the announcement, CMS also will conduct a consumer outreach campaign to promote the SEP. This SEP is available in all states using the HealthCare.gov enrollment platform (FFEs and SBE-FPs); states with SBEs are "strongly encouraged" by CMS to take similar action.

For information about other coverage options following loss of job-based coverage, see CRS In Focus IF11523, *Health Insurance Options Following Loss of Employment*.

Enrollment Estimates

Annual individual exchange enrollment estimates to date are shown in **Table 2**. Given the exchange eligibility determination process, as well as the different time frames of OEPs and SEPs, CMS releases data on exchange enrollment in stages. *Pre-effectuated enrollment* is the number of unique individuals who have been determined eligible to enroll in an exchange plan and have selected a plan. These individuals may or may not have submitted the first premium payment. In general, cumulative and final pre-effectuated enrollment estimates are released during and soon after an annual open enrollment period.

Subsequently, *effectuated enrollment* is the number of unique individuals who have been determined eligible to enroll in an exchange plan, have selected a plan, and have submitted the first premium payment for an exchange plan. Effectuated enrollment estimates generally are point-in-time and may change over the coverage year. For example, due to changes in life circumstances, an individual may disenroll (e.g., if later offered coverage through an employer), or enroll (e.g., given eligibility for an SEP) in an exchange plan, outside of an OEP.

CMS also releases average effectuated enrollment estimates over specified time periods (e.g., over the first half of an enrollment year or monthly for the previous enrollment year). See the "Enrollment Statistics" section of CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics*, for HHS reports and resources detailing different enrollment estimates by year.

[44] CMS, "2021 Special Enrollment Period in response to the COVID-19 Emergency," January 28, 2021, at https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency.

Table 2. Nationwide Individual Exchange Enrollment Estimates, by Plan Year

Nationwide Enrollment Estimate Type	Plan Year							
	2014	2015	2016	2017	2018	2019	2020	2021
Pre-effectuated[a] final for PY OEP	8.0M	11.7M	12.7M	12.2M	11.8M	11.4M	11.4M	Data expected spring 2021
Effectuated, early in the plan year (point-in-time as of date shown)[b]	Early 2014 estimate not found	10.2M, Mar. 2015	11.1M, Mar. 2016	10.3M, Feb. 2017	10.6M, Feb. 2018	10.6M, Feb. 2019	10.7M, Feb. 2020	Data expected summer 2021
Effectuated, late in the plan year (point-in-time or average for month shown)[c]	6.3M, Dec. 2014	8.8M, Dec. 2015	9.1M, Dec. 2016	8.9M, Dec. 2017	9.2M, Dec. 2018	9.1M, Dec. 2019	Data expected summer 2021	Data expected summer 2022

Source: CRS analysis based on Department of Health and Human Services (HHS) reports of individual exchange enrollment. Data sources are in CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics*, in report sections specified in table notes below.

Notes: FFE = federally facilitated exchange; OEP = open enrollment period; PY = plan year; SBE = state-based exchange; SBE-FP = state-based exchange using the federal information technology platform. See "Open and Special Enrollment Periods" and "State-Based and Federally Facilitated Exchanges" in this report.

a. *Pre-effectuated enrollment* is the number of unique individuals who have been determined eligible to enroll in an exchange plan and have selected a plan but may or may not have submitted the first premium payment. Final pre-effectuated enrollment estimates typically are released following an OEP and include any broadly applicable OEP extensions or longer SBE OEPs. For these data sources by year, see the "Pre-effectuated Enrollment Data" section of the report mentioned above.

b. *Effectuated enrollment* is the number of unique individuals who have been determined eligible to enroll in an exchange plan, have selected a plan, and have submitted the first premium payment for an exchange plan. HHS generally releases effectuated enrollment estimates for a point i time early in the plan year and may release additional point-in-time estimates during the year. Data sources by year are in the "Point-in-Time Effectuated Enrollment Data" section of the report mentioned above. For example, the 2020 data is from CMS, *Early 2020 Effectuated Enrollment Snapshot,* July 2020.

c. See table note (b) regarding effectuated enrollment and point-in-time estimates. Average estimates reflect an average over a specified time period, in this case one month. For PY2014 and PY2015, quarterly point-in-time estimates were released, including those shown. Average monthly enrollment data were not provided for those years. For PYs 2016 and on, average monthly enrollment data are provided. Although point-in-time and average monthly estimates are not the same, they are provided here to show late-year enrollment estimates across all plan years. Data sources by year are in the "Point-in-Time Effectuated Enrollment Data" and "Average Monthly Effectuated Enrolment Data" sections of the report mentioned above. For example, the 2018 data is from the end of the report CMS, *Early 2019 Effectuated Enrollment Snapshot,* August 2019.

Premiums and Cost Sharing

Typically, enrollees of private health insurance plans (in or out of the exchanges) pay monthly premiums. They also are generally responsible for out-of-pocket (OOP) costs, or cost sharing, as

they use services. In general, cost sharing includes deductibles, coinsurance, and co-payments, up to an annual maximum amount of OOP spending.[45]

Premiums are set by health insurance issuers and are based on their expected medical claims costs (i.e., the payments they expect to make for covered health benefits for a given group of enrollees, or a given risk pool), administrative expenses, taxes, fees, and profit. The premium-setting process is subject to federal and state requirements, as applicable to plans both in and out of the exchanges. For example, insurers cannot vary premiums based on health status.[46] In addition, insurers that want to offer plans in the exchanges must submit their proposed premiums for federal or state approval (depending on exchange type) each year.[47] If consumers do not pay their premiums, insurers may terminate their coverage, subject to applicable federal and state requirements.[48]

In addition to setting premiums, insurers set cost-sharing levels, or the share of the costs of covered benefits (or medical claims) for which the insurer and enrollee will be responsible. Most health plans sold through the exchanges (and non-grandfathered plans sold in the individual and small-group markets off-exchange[49]) are subject to *minimum actuarial value (AV) standards* and accordingly, are given a precious metal designation (platinum, gold, silver, or bronze).[50] AV is a summary measure of a plan's generosity in terms of cost sharing, estimated for a standard population.[51] Actuarial values by metal level are platinum (AV of 90%), gold (80%), silver (70%), and bronze (60%). For example, for a silver plan, the insurer expects to cover approximately 70% of cost sharing for the plan's enrollees overall. The higher the AV percentage, the lower the cost sharing, on average, for the plan population. However, plans with higher AV also may have higher premiums, on average, to cover their increased share of their enrollees' medical claims costs (assuming other factors affecting premiums remain the same, such as administrative expenses). The AV standards, and the related metal levels, are meant, in part, to help consumers in comparing the value of plans.

[45] A *deductible* is the amount an insured consumer pays for covered health care services before coverage begins (with exceptions). *Coinsurance* is the share of costs, figured in percentage form, an insured consumer pays for a covered health service. A *co-payment* is the fixed dollar amount an insured consumer pays for a covered health service. Once an insured consumer's out-of-pocket spending has met an *out-of-pocket limit* or maximum in a plan year, the insurer will generally pay 100% of covered costs for the remainder of the plan year.

[46] See CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, for more information about this and other requirements related to setting premiums.

[47] See "Exchange Administration" in this report.

[48] See 45 C.F.R. §156.270 regarding insurer termination of enrollee coverage, including for nonpayment of premiums. It also addresses the "grace period" of three consecutive months of premium nonpayment for enrollees who receive a premium tax credit (discussed in the "Premium Tax Credits and Cost-Sharing Reductions" section of this report).

[49] *Grandfathered plans* are individual or group plans in which at least one individual was enrolled as of enactment of the ACA (March 23, 2010) and which continue to meet certain criteria. Plans that maintain their grandfathered status are exempt from some, but not all, federal requirements. There are no grandfathered plans sold through the exchanges, but they may be available off the exchanges. For more information, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*, as well as HHS, "Grandfathered Health Insurance Plans," at https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/.

[50] 42 U.S.C. §18022(d).

[51] Actuarial value (AV) is expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. It is not a measure of plan generosity for an enrolled individual or family, nor is it a measure of premiums or benefits packages. AV calculations are required to apply only to the plan's covered essential health benefits (EHB) that are furnished by an in-network provider, unless otherwise addressed in federal or state law.

With the exception of "catastrophic" plans and stand-alone dental plans (see **Table B-1**), plans must have at least 60% AV to be sold in the exchanges. Insurers selling a given plan in an exchange must offer at least a silver and gold version of the plan throughout each service area in which the insurers offer coverage.[52]

Annual OOP limits also apply to all health plans sold in the exchanges (and to all non-grandfathered individual and group plans sold outside the exchanges).[53] These limits are updated each year through HHS rulemaking (see **Table 3**). Plans may set their OOP limits lower than these maximums.

Additional data on premiums and cost sharing are in **Table 4** at the end of the following section.

Table 3. Annual Out-of-Pocket Limits, by Plan Year

(federally set maximums; insurers may set lower out-of-pocket limits)

	Plan Year							
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Self-only coverage	$6,350	$6,600	$6,850	$7,150	$7,350	$7,900	$8,150	$8,550
Coverage other than self-only	$12,700	$13,200	$13,700	$14,300	$14,700	$15,800	$16,300	$17,100
Percentage increase over prior year	N/A	4%	4%	4%	3%	7%	3%	5%

Source: CRS analysis of relevant federal rulemaking. These amounts are updated each year through an HHS rule called the Notice of Benefit and Payment Parameters, also known as the Payment Notice. For example, the PY2021 rates were finalized in the 2021 Payment Notice, p. 7127. Although a final 2022 Payment Notice was published in January 2021, it did not include these amounts for PY2022. Annual Payment Notices are cited in **Table D-1**.

Notes: PY = plan year. Out-of-pocket (OOP) limits are related to an insured consumer's cost sharing, or OOP spending (including deductibles, coinsurance, and co-payments; see "Premiums and Cost Sharing" in this report for more information). Once this OOP spending meets the plan's OOP limit or maximum in a plan year, the insurer generally will pay 100% of covered costs for the remainder of the plan year. An individual enrolled in a plan by themselves has *self-only coverage*. An individual enrolled in a plan with a spouse and/or dependents has *coverage other than self-only*, or *family coverage*.

Premium Tax Credits and Cost-Sharing Reductions

Consumers purchasing coverage through the individual exchanges may be eligible to receive financial assistance that effectively reduces their cost of that coverage. Eligibility for such assistance is based primarily on income and provided in the form of premium tax credits (PTCs) and cost-sharing reductions (CSRs).[54]

The PTC generally is available to consumers with household incomes between 100% and 400% of the federal poverty level (FPL), with some exceptions, and who do not have access to public coverage (e.g., Medicaid) or employment-based coverage that meets certain standards. The credit is designed to reduce an eligible individual's cost of purchasing health insurance coverage

[52] 45 C.F.R. §156.200(c)(1).

[53] Like AV calculations, the annual out-of-pocket limit is only required to apply to the plan's covered EHB that are furnished by an in-network provider, unless otherwise addressed in federal or state law.

[54] For more information about these forms of consumer financial assistance, including applicable eligibility criteria and illustrative examples, see CRS Report R44425, *Health Insurance Premium Tax Credits and Cost-Sharing Subsidies*.

through the exchange. The amount of the PTC is based on a statutory formula and varies from person to person. It is designed to provide larger credit amounts to individuals with lower incomes compared to those with higher incomes. Although the amount of the PTC is based on the second-lowest-cost silver plan in a consumer's local area, consumers may apply the credit to any bronze- or higher-metal level plan available to them on their state's exchange.

Individuals who receive PTCs also may be eligible for subsidies that reduce cost-sharing expenses.[55] These cost-sharing subsidies (also called CSRs) are applied in two ways. First, an insurer must reduce the annual OOP limit that otherwise would apply to an eligible individual's exchange plan. Second, the insurer must effectively raise the actuarial value of the eligible individual's plan, for example by reducing other cost-sharing requirements beyond the lowered OOP cap. Among other eligibility requirements, CSRs generally are available to consumers who are eligible for PTCs and have incomes between 100% and 250% of the FPL. Although a PTC can be applied to any metal level plan, CSRs are applicable only to silver plans.

Table 4 summarizes nationwide data on premiums, advance premium tax credit (APTC) [56], and CSRs by year, as available in relevant HHS reports on effectuated enrollment.[57] The average premium and APTC amounts shown in the table may obscure wide variations in actual amounts per consumer, depending on the plan and metal level an individual chooses and/or the factors by which an insurer is able to vary premiums, discussed below.[58] Premium and cost-sharing data on all plans offered in the exchanges, as opposed to such data for plans selected, also are available, including for PY2021.[59]

[55] The ACA requires the HHS Secretary to provide full reimbursements to insurers that provide these cost-sharing subsidies to their enrollees. However, the ACA did not appropriate funds for such payments. In October 2017, the Trump Administration halted these payments, effective immediately, until Congress appropriates funds. Insurers still must provide the subsidies to eligible consumers, but insurers are not reimbursed. See HHS, "Payments to Issuers for Cost-Sharing Reductions," October 12, 2017, at https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

[56] Consumers may choose to receive the credit on a monthly basis, in advance of filing taxes, to coincide with the payment of insurance premiums (technically, advance payments go directly to insurers). Advance payments automatically reduce monthly premiums by the credit amount. This option is called the advance premium tax credit, or APTC. Consumers may instead claim the full credit amount of the PTC when filing their taxes, even if they have little or no federal income tax liability.

[57] In the reports cited in **Table 4**, certain of these data are also available at the state level. In these HHS reports, and in other HHS reports (e.g., on pre-effectuated enrollment) some data may also be available on demographics and/or metal levels of plans. For more information, see CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics*.

[58] In addition, the APTC data in the table are not necessarily final, because when an individual receiving an APTC files his or her tax return for a given year, the total amount of advance payments he or she received in that tax year is reconciled with the amount he or she should have received based on the individual's actual income over the course of the tax year.

[59] For example, an October 2020 CMS report discusses premiums and cost sharing on plans that will be available in HealthCare.gov exchanges (FFEs and SBE-FPs) in PY2021: CMS, CCIIO, *Plan Year 2021 Qualified Health Plan Choice and Premiums in HealthCare.gov States*, October 2020, at https://www.cms.gov/CCIIO/Resources/Data-Resources/QHP-Choice-Premiums. Also see KFF, Average Marketplace Premiums by Metal Tier, 2018-2021, at https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/; and KFF, Cost-Sharing for Plans Offered in the Federal Marketplace, 2014-2021, at https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/.

Table 4. Data on Premiums, Advance Premium Tax Credits, and Cost-Sharing Reductions Nationwide, by Plan Year

(data based on effectuated enrollment in all individual exchanges)

	Plan Year						
	2014[a]	**2015[b]**	**2016[b]**	**2017[c]**	**2018[d]**	**2019[e]**	**2020[f]**
Average total premium per month[g]	N/A	N/A	N/A	$470.52	$597.20	$594.17	$576.16
Average APTC per month[h]	$276	$272	$291	$373.06	$519.89	$514.01	$491.53
Percentage of enrollees receiving APTC[i]	86%	85%	85%	84%	87%	87%	86%
Percentage of enrollees receiving CSR[j]	58%	57%	57%	57%	53%	52%	50%
Data as of	Dec. 2014	Mar. 2015	Mar. 2016	PY2017	Feb. 2018	Feb. 2019	Feb. 2020

Sources: CRS analysis based on specified Department of Health and Human Services (HHS) reports of individual exchange enrollment in private health insurance plans. Titles and publication dates of sources by year are listed below. These sources are fully cited in CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics*, in the "Point-in-Time Effectuated Enrollment Data" section of the report.

Notes: APTC = Advance premium tax credit; CSR = Cost-sharing reduction; PY = Plan year. These are types of financial assistance that effectively reduce premiums and cost sharing, respectively, for eligible consumers obtaining coverage in the individual exchanges.

The average premium and APTC amounts shown above may obscure wide variations in actual amounts per consumer, depending on the metal level plan an individual chooses and/or the factors by which an insurer is able to vary premiums (see "Premiums and Cost Sharing" in this report). In addition, the APTC data in the table are not necessarily final, because when an individual receiving an APTC files his or her tax return for a given year, the total amount of advance payments he or she received in that tax year is reconciled with the amount he or she should have received.

a. Relevant data for PY2014 are available only as of December 2014. These numbers are provided to allow for approximate comparison within the table. Average premium amounts were not provided in this or the following year's report. See *March 31, 2015 Effectuated Enrollment Snapshot,* June 2015.

b. Average premium amounts for PY2015 and PY2016 were not provided in those years' or the following years' reports. See *March 31, 2015 Effectuated Enrollment Snapshot,* June 2015 and *March 31, 2016 Effectuated Enrollment Snapshot*, June 2016, respectively.

c. The June 2017 report provided average APTC data but not average premium data for February 2017. However, the July 2018 report provided average monthly premium and APTC data for the 2017 plan year (total amounts for the year, divided by the total number of member months). The data in this column, from the July 2018 report, are provided to allow for approximate comparison, but they are average monthly estimates for the year rather than the average estimates for a given month as shown in this table for other years. See 2017 *Effectuated Enrollment Snapshot*, June 2017 and *Early 2018 Effectuated Enrollment Snapshot,* July 2018.

d. See *Early 2018 Effectuated Enrollment Snapshot,* July 2018.

e. See *Early 2019 Effectuated Enrollment Snapshot,* August 2019.

f. See *Early 2020 Effectuated Enrollment Snapshot,* July 2020.

g. This definition, or a non-substantive variation of it, appears in one or more reports: "Average total premium per month is the total premium (including APTC and any premium paid by the policyholder) for the month, divided by the number of individuals who had an active policy for the month."

h. This definition, or a non-substantive variation of it, appears in one or more reports: "Average APTC per month is the total amount of APTC for the month for all individuals who received APTC, divided by the number of individuals who received APTC."

i. This definition, or a non-substantive variation of it, appears in one or more reports: "APTC enrollment is the total number of individuals who had an active policy in February 2017, who paid their premium (thus becoming effectuated), and who received an APTC subsidy."

j. This definition, or a non-substantive variation of it, appears in one or more reports: "CSR enrollment is the total number of individuals who had an active policy in February 2017, who paid their premium (thus effectuating their coverage), and received CSRs."

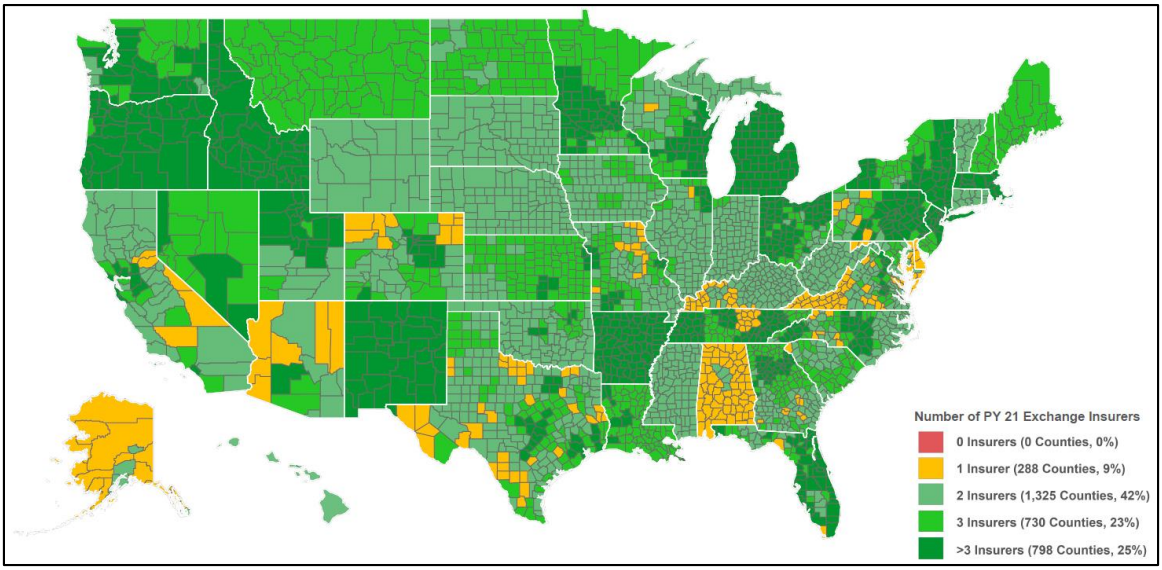
Insurer Participation

As stated earlier (see "Qualified Health Plans"), insurers are not required to participate in the exchanges, but they must meet certain requirements if they do want to offer plans in an exchange.

For each plan year to date, at least one insurer has offered an individual exchange plan in each county in all states. See **Figure 2** for projected insurer participation in PY2021.[60] However, there have been concerns about "bare counties" in one or more plan years, particularly as insurers were making their decisions in 2017 about offering coverage for PY2018.[61]

Figure 2. Plan Year 2021 Insurer Participation in the Individual Exchanges, by County

(CMS map of projected participation as of October 2, 2020)



Source: CMS, CCIIO, "County by County Plan Year 2021 Projected Insurer Participation in Health Insurance Exchanges," published October 16, 2020 at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Health-Insurance-Exchange-Coverage-Maps. This page also has insurer participation maps for PYs 2018 to 2020.

Notes: CCIIO = Center for Consumer Information and Insurance Oversight; CMS = Centers for Medicare & Medicaid Services; PY = plan year.
CMS notes on map: "Values may not add to 100% due to rounding. Federally-Facilitated Exchange (FFE) data

[60] In addition, insurer participation maps for PYs 2018 to 2020 are at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Health-Insurance-Exchange-Coverage-Maps.html. A Kaiser Family Foundation analysis of insurer participation from 2014 to 2020 is discussed later in this section.

[61] See, for example, Teichert, Erica, "Last 'bare' county in the U.S. scores ACA exchange coverage," Modern Healthcare, August 24, 2017, at https://www.modernhealthcare.com/article/20170824/NEWS/170829941/last-bare-county-in-the-u-s-scores-aca-exchange-coverage.

reflected on this map are point in time as of 10/02/2020. State-Based Exchange (SBE) data are preliminary and self-reported from the Exchanges to CMS. These data are point in time as of 10/09/2020 for CO, CT, DC, ID, MA, MD, MN, NV, RI, VT, and WA, and 08/30/2020 for NJ and PA. County-level information for the following SBE states (CA and NY) is representative of PY2020 participation as PY2021 participation has not yet been provided by the Exchanges to CMS."

An insurer might choose to begin, continue, or stop offering coverage in a state or locality, on and/or off an exchange, for various reasons. Fundamentally, insurers make decisions based on their assessment of their *risk*, or likelihood and potential magnitude of loss. Individuals differ in their health insurance risk based on their health status, with sicker individuals considered high risk and expected to have greater health care costs than healthier individuals (i.e., low-risk individuals). Other factors that may affect insurers' risk assessments and decisionmaking regarding market participation include federal and state policies, provider and insurer market competition, and consumer behavior, as well as the potential for uncertainty regarding any of these factors (e.g., the potential for unexpected federal or state policy changes affecting insurers).

In January 2019, the Government Accountability Office (GAO) released a report on insurer participation and related issues in the individual exchanges.[62] The report provided background on a range of potential contributing factors, including the federal requirements imposed by the ACA on plans sold in the individual market, including the exchanges[63]; the consumer financial assistance available only in the exchanges[64]; the three ACA programs—risk corridors, reinsurance, and risk adjustment—meant to mitigate insurers' financial risk in the individual and small-group markets, including in the exchanges[65]; federal policy changes in the years since the enactment of the ACA[66]; and state-level requirements. These and other factors, such as the health of the populations enrolling in exchange plans, had varying impacts on claims costs (the costs insurers pay for their enrollees' health benefits), which in turn impacted insurer participation, as well as insurers' decisions about premium amounts and plan designs (e.g., covered benefits, cost sharing, and provider networks).

Insurer participation generally increased in PY2021 over PY2020. According to an October 2020 CMS report (on FFE and SBE-FP states only),

[62] Government Accountability Office (GAO), *Health Insurance Exchanges: Claims Costs and Federal and State Policies Drove Issuer Participation, Premiums, and Plan Design*, January 2019, at https://www.gao.gov/products/GAO-19-215.

[63] Several provisions of the ACA, such as guaranteed issue of health insurance, generally have increased higher-risk individuals' ability to purchase insurance and restricted insurers' ability to deny or limit coverage to such individuals. The ACA created some new requirements and expanded some existing requirements, including by applying requirements on the individual market that previously existed in one or more segments of the group market. See the appendix of CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[64] See "Premium Tax Credits and Cost-Sharing Reductions" in this report. One of the factors cited in the GAO report as affecting insurers' participation was "federal funding changes," including the ending of federal payments for cost-sharing reduction subsidies in October 2017.

[65] Of the three ACA risk-mitigation programs—risk corridors, reinsurance, and risk adjustment—one was designed to be permanent. The risk corridors and reinsurance programs were in effect from 2014 to 2016; the risk adjustment program also began in 2014 and is still in effect. It assesses charges on applicable private health insurance plans with relatively healthier enrollees and uses collected charges to make payments to private health plans in the same state that have relatively sicker enrollees. See "Other Federal Funding Sources" in this report regarding the charges assessed on insurers via the risk adjustment program. The phaseouts of the other two programs are cited among "federal funding changes" affecting insurers' participation decisions. For descriptions of all three programs and their different approaches, see Table 1 in CRS Report R45334, *The Patient Protection and Affordable Care Act's (ACA's) Risk Adjustment Program: Frequently Asked Questions*.

[66] See Figure 1 in the GAO report discussed in this section.

> Out of the 36 PY21 HealthCare.gov states, 16 states have more QHP issuers participating in PY21 than PY20, and 27 states have counties with more QHP issuers in PY21 than PY20 due to new issuers entering and existing issuers expanding service areas. Only one state (Delaware) has a single QHP issuer in PY21, compared to two states in PY20.[67]

A November 2020 Kaiser Family Foundation analysis of insurer participation in all states' individual exchanges from 2014 to 2021 also indicates such participation is rising for the third consecutive year and "there will be an average of 5.0 insurers per state in 2021, up from a low of 3.5 in 2018 but still below the peak of 6.0 in 2015."[68]

SHOP Exchanges

Eligibility and Enrollment

Certain small businesses are eligible to use the SHOP exchanges. For purposes of SHOP eligibility, a small business, or *small employer*, is generally an employer with not more than 50 employees.[69] States also may define *small employer* as having not more than 100 employees–four states do.[70] As of 2017, all states have the option to allow *large employers* to use SHOP exchanges, as well, but no states have done so.[71]

SHOP eligibility also depends on an employer having at least at least one *common-law employee*.[72] This means, for example, that a person who is self-employed and who has no employees would not be eligible for the SHOP exchange (although they could purchase coverage in the individual exchange, if they meet the other eligibility requirements). In addition, per the definition of common-law employee, neither the business owner nor their business partner(s) nor their spouse or family members (even if involved in the business) count as an employee for purposes of SHOP eligibility.

To participate in a SHOP exchange, a small business must offer coverage to all of its *full-time employees,* which, for purposes of SHOP eligibility, means those employees working 30 or more hours per week on average.[73] The business may, but is not required to, offer coverage to part-time

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[67] CMS, CCIIO, *Plan Year 2021 Qualified Health Plan Choice and Premiums in HealthCare.gov States,* October 2020, at the webpage "Qualified Health Plan Choice and Premiums in HealthCare.gov States," at https://www.cms.gov/CCIIO/Resources/Data-Resources/QHP-Choice-Premiums. The corresponding CMS report from October 2019, posted on the same webpage, also showed increasing insurer participation for PY2020 over PY2019.

[68] Rachel Fehr et al., "Insurer Participation on the ACA Marketplaces, 2014-2021," Kaiser Family Foundation, November 2020, at https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/.

[69] For purposes of SHOP eligibility, the number of employees is determined using the "full-time equivalent" (FTE) employees calculation method. See 45 C.F.R. §155.20, "Small employer," which references 26 U.S.C. §4980H. Also see CRS Report R45455, *The Affordable Care Act's (ACA's) Employer Shared Responsibility Provisions (ESRP)* for discussion of FTE calculations.

[70] California, Colorado, New York, and Vermont are the only states that define small businesses as having 100 or fewer employees for the purpose of participation in the SHOP exchanges. See **Table A-1**.

[71] 42 U.S.C. §18032(f)(2)(B). No states have allowed large employers (as defined by the state) use of their SHOP exchanges.

[72] For discussion of the SHOP eligibility requirement to have at least one common-law employee, see HHS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," March 27, 2012, 77 *Federal Register* 18309**,** page 18399.

[73] For purposes of SHOP eligibility, the definition of *full-time employee* is at 45 C.F.R. §155.20.

or other employees, and/or to the spouses and dependents of any employees offered coverage.[74] Employees and their enrolling family members must meet the same citizenship and other eligibility requirements that apply in the individual exchanges.

Enrollment Periods

Enrollment in a SHOP exchange is not limited to a specified OEP, except in certain circumstances.[75] Such circumstances aside, a SHOP exchange must allow employers to enroll any time during a year, and the employer's plan year must consist of the 12-month period beginning with the employer's effective date of coverage.[76] Whereas plans sold in the individual exchanges generally align with the calendar year, plans sold in the SHOP exchanges need not (thus, statutory or regulatory provisions affecting the SHOP exchanges may refer to "plan years beginning in" a given year).

There are special enrollment periods for SHOP exchange coverage. Some of the special enrollment periods for the SHOP exchanges are the same as in the individual exchanges.[77]

Online Enrollment versus Direct Enrollment

For an employee to obtain coverage through a SHOP exchange, a SHOP-eligible employer must select one or more plan options on the SHOP exchange for its employees to choose from.[78] Then, employees compare their employer's plan options and enroll if they choose. The process of comparing and enrolling in coverage depends partially on the type of SHOP exchange a state has:

- In states with FF-SHOPs (i.e., states with SHOP exchanges using the federal HealthCare.gov platform), employers and employees are able to browse and compare plan options on HealthCare.gov, but they need to work directly with a SHOP-registered agent, broker, or insurer to purchase coverage.[79] This is called *direct enrollment*, and it has been the only option in such states since plan years beginning in 2018.[80] Previously, employers and employees could purchase coverage on HealthCare.gov or via direct enrollment.

[74] 45 C.F.R. §155.710(e).

[75] It is possible for SHOP exchanges to establish minimum participation rates and minimum contribution rates. Businesses that do not comply with established rates cannot be prohibited from obtaining coverage through SHOP exchanges; rather, health insurance plans may limit the availability of coverage for any employer that does not meet an allowed minimum participation or contribution rate to an annual enrollment period—November 15 through December 15 of each year.

[76] 45 C.F.R. §155.726(b).

[77] 45 C.F.R. §155.726(c). See also Section 3.4 of the CMS, *FFE and FF-SHOP Enrollment Manual*, which notes that SHOP exchange SEPs "cross-referenc[e] most, but not all, of the qualifying events listed at 155.420(d) [which lists SEPs for the individual exchanges]. Specifically, SEPs described in 45 CFR §155.420(d)(1)(ii), (3), and (6) do not apply in SHOPs."

[78] A business with locations or employees in multiple states has options for offering SHOP coverage to all its eligible employees. See 45 C.F.R. §155.710 and HealthCare.gov, "SHOP Coverage for Multiple Locations and Businesses," at https://www.healthcare.gov/small-businesses/provide-shop-coverage/business-in-more-than-one-state/.

[79] HealthCare.gov, "Overview of SHOP: Health insurance for small businesses," at https://www.healthcare.gov/small-businesses/choose-and-enroll/shop-marketplace-overview/.

[80] HHS finalized this change in the 2019 Payment Notice (page 16996), citing generally low employer participation in the SHOP exchanges and decreasing insurer participation (both discussed elsewhere in the SHOP section of this report). HHS also confirmed in the 2019 Payment Notice that because of these reductions in federal SHOP web portal functionality, state-based SHOP exchanges would no longer be able to use the federal IT platform. In other words, HHS eliminated the SB-FP-SHOP option (discussed in "State-Based and Federally Facilitated Exchanges"). The two

- States administering their own SB-SHOP websites initially were allowed to use a direct enrollment approach, due to early difficulties some states had in getting their SHOP exchange websites online.[81] As of April 2016, HHS indicated SB-SHOPs would need to implement online portals in time for plan years beginning in 2019.[82] However, in the 2019 Payment Notice, when HHS transitioned HealthCare.gov SHOP exchanges to direct enrollment (see previous bullet), HHS also announced SB-SHOPs had the option of retaining or returning to a direct enrollment approach or maintaining enrollment sites if they had created them. As of September 2020, 6 of the 15 SB-SHOP states are using a direct enrollment approach only.[83]

Besides exchange website enrollment versus direct enrollment options, a significant factor affecting access to SHOP plans is whether any insurers are offering plans in that state's SHOP exchange. For PY2021, there are no insurers offering medical plans in SHOP exchanges in more than half of states.[84] In such states, the federal or state SHOP webpage instructs users to work directly with an agent, broker, or insurer to obtain coverage in the small-group market off-exchange.

Following is a summary of SHOP exchange plan availability and enrollment methods, by SHOP exchange type, for PY2021. See **Table A-1** for more information, including by state.

- **FF-SHOP, 32 states:** all direct enrollment only, 9 with and 23 without SHOP plans.
- **SB-SHOP, 18 states:** 7 states with plans and SHOP website enrollment option, 6 with plans and direct enrollment only, and 5 with no SHOP plans.
- **No SHOP, 1 state:** state received waiver allowing it not to have a SHOP.[85]

states that used this option at the time, Kentucky and Nevada, were allowed to continue doing so if desired, despite the reduced functionality of HealthCare.gov for SHOP. However, they have since transitioned their SHOPs to other types (see **Table A-1**). Citation for this rule is in **Table D-1**.

[81] For iterations of guidance on this topic issued between 2014 and 2016, see CMS, CCIIO, "Extension of State-Based SHOP Direct Enrollment Transition," April 18, 2016, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/1332-and-SHOP-Guidance-508-FINAL.PDF.

[82] Ibid. In April 2016, CMS also outlined different options for those states to consider, including transitioning to the federal IT platform (becoming an SB-FP-SHOP) or applying for an ACA Section 1332 waiver to obtain an exception to the requirement to have a SHOP exchange at all. For more information about ACA Section 1332 waivers, see CRS Report R44760, *State Innovation Waivers: Frequently Asked Questions*.

[83] See **Table A-1**.

[84] The number of states with no insurers offering plans in SHOP exchanges in 2021 is based on CRS analysis of the 2021 "Business Rules" public use file at CMS, "Health Insurance Exchange Public Use Files (Exchange PUFs)," at https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf, as well as information available on HealthCare.gov and state exchange websites. Comparable information about insurer participation in SHOP exchanges in prior years may not be consistently available. However, a 2019 GAO report indicates that in 2015-2017, there was at least one insurer participating in each of the 46 of 51 states for which it had such data for all three of those years. See Table 7 in GAO, *Private Health Insurance: Enrollment Remains Concentrated Among Few Issuers, Including in Exchanges*, March 21, 2019, at https://www.gao.gov/products/GAO-19-306. Hereinafter referred to as "GAO Enrollment Report, March 2019."

[85] See footnote 18. See **Table A-1** for details and citations.

Enrollment Estimates

Unlike individual exchange enrollment data, SHOP exchange enrollment data are not released annually. However, CMS estimated that there were approximately 27,000 small employers and 233,000 employees using the SHOP exchanges across the country in January 2017.[86] CMS previously estimated 10,700 active small employers and 85,000 employees in the SHOP exchanges as of May 2015.[87]

According to a 2019 GAO report that included 2016 SHOP exchange enrollment data for 46 states,

> As a proportion of the overall small group market, SHOP exchanges in most states had little enrollment—that is, typically less than 1 percent of the overall small group market ... The District of Columbia, Rhode Island, and Vermont were the only states where the SHOP exchange was more than 3 percent of the overall small group market. The District of Columbia and Vermont require all small group plans to be purchased through the state's SHOP exchange.[88]

In addition, District of Columbia SHOP enrollment includes congressional Members and staff, as discussed below.

Congressional Member and Staff Enrollment via the D.C. SHOP Exchange

Per the ACA, Members of Congress and their staff generally are required to obtain their health insurance through the exchanges in order to receive a government contribution (i.e., their employer's contribution) for their coverage.[89] As implemented, they purchase coverage through the District of Columbia's SHOP exchange. Congressional offices are not eligible for the small business tax credit (discussed below), and congressional Members and staff obtaining coverage through the SHOP are not eligible for the PTC and CSRs that are available to individuals who enroll in coverage offered on the individual exchanges (see "Premium Tax Credits and Cost-Sharing Reductions").

Premiums and Cost Sharing

The section earlier in this report on "Premiums and Cost Sharing" in the individual exchanges, including certain federal requirements that apply to premiums and cost sharing, generally applies in the SHOP exchanges, as well. See CRS Report R45146, *Federal Requirements on Private Health Insurance Plans* for other requirements applicable to the individual and small-group markets, on and off the exchanges.

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[86] This estimate excludes Hawaii, as Hawaii's SHOP exchange was no longer operational in 2017 due to the state's receipt of a 1332 waiver. See CMS, CCIIO, "SHOP Marketplace Enrollment as of January 2017," May 15, 2017, at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SHOP-Marketplace-Enrollment-Data.pdf.

[87] This estimate excludes Vermont and Idaho; these states had not reported 2015 enrollment data to CMS. See CMS, "Update on SHOP Marketplaces for Small Businesses," July 2, 2015, archived at http://wayback.archive-it.org/2744/20170118124128/https:/blog.cms.gov/2015/07/.

[88] See page 24 and Appendix III of the GAO Enrollment Report, March 2019.

[89] Other federal employees may obtain coverage through the Federal Employees Health Benefits Program (FEHB). Like many other employers, the federal government contributes to the cost of its employees' premiums. This is also true for the Congressional Members and staff who obtain coverage through the SHOP. Certain congressional staff may not be required to obtain their coverage through the SHOP, and may be able to otherwise obtain coverage through FEHB. See Office of Personnel Management, "Members of Congress and Designated Staff – General," at https://www.opm.gov/healthcare-insurance/changes-in-health-coverage/changes-in-health-coverage-faqs/.

Employers who offer coverage through the SHOP exchange, like employers who offer coverage otherwise, may choose to subsidize their employees' premiums. This means the employer pays for part of their employees' premiums.

CRS is not aware of HHS or other reports on premium or cost-sharing data specific to the SHOP exchanges.

Small Business Health Care Tax Credit

Certain small businesses are eligible for the small business health care tax credit (SBTC).[90] In general, this credit is available only to small employers with 25 or fewer full-time-equivalent (FTE) employees that purchase coverage through SHOP exchanges and contribute at least 50% of premium costs for their full-time employees.[91] (For the purpose of this tax credit, *full-time employees* are those who work an average of 40 hours per week, whereas for the purpose of SHOP eligibility, *full-time employees* are those who work an average of 30 hours per week.[92]) The intent of the credit is to assist small employers with the cost of providing health insurance coverage to employees. The credit is available to eligible small businesses for two consecutive tax years (beginning with the first year the small employer purchases coverage through a SHOP exchange).

In states with no insurers offering plans through the SHOP exchange (see discussion above), certain eligible employers still may be able to receive the credit. If they received their first year's credit by offering coverage through the SHOP exchange and there were no SHOP plans available the next year, they may receive their second consecutive year's credit with a plan purchased off-exchange.[93]

The maximum credit is 50% of an employer's contribution toward premiums for for-profit employers and 35% of employer contributions for nonprofit organizations. The full credit is available to employers that have 10 or fewer FTE employees who have average taxable wages of $27,800 or less (in 2021).[94] In general, the credit is phased out as the number of FTE employees increases from 10 to 25 and as average employee compensation increases to a maximum of two times the limit for the full credit.[95]

Employees who enroll in a SHOP plan do not receive this tax credit, nor are they eligible for the financial assistance available to certain consumers who purchase coverage on the individual market (see "Premium Tax Credits and Cost-Sharing Reductions" above).

[90] See 26 U.S.C. §45R for eligibility for the Small Business Health Care Tax Credit (SBTC) and credit amount details described in this section.

[91] See the SHOP "Eligibility and Enrollment" section of this report for discussion of full-time equivalent employees.

[92] Regarding SHOP eligibility, see 26 U.S.C. §4980H, 26 CFR §54.4980H-1(a)(21), and 45 CFR §155.20. Regarding the SBTC, see 26 U.S.C. §45R.

[93] Internal Revenue Service (IRS), *Small Business Health Care Tax Credit Questions and Answers: Who Gets the Tax Credit*, Question 6D, updated September 2020, at https://www.irs.gov/newsroom/small-business-health-care-tax-credit-questions-and-answers-who-gets-the-tax-credit.

[94] IRS, Rev. Proc. 2020-45, Section 3.11, at https://www.irs.gov/pub/irs-drop/rp-20-45.pdf, referring to 26 U.S.C. §45R(d)(3)(B).

[95] 26 U.S.C. §45R(d)(1)(B).

The IRS has published information on the number of SBTCs filed in tax years 2010-2016.[96] For 2016, the IRS indicates that 6,952 employers claimed the SBTC.[97]

Insurer Participation

As stated above, as of PY2020, there are no insurers offering SHOP plans in more than half of states.[98]

Some of the factors affecting insurer participation in the individual exchanges (see "Insurer Participation" in the Individual Exchanges section above) also may affect insurer participation in the SHOP exchanges. For example, just as in the individual market, there were new federal requirements imposed by the ACA on plans sold in the small-group market (including the SHOP exchanges), and insurers in the small-group market were or are participating in risk-mitigation programs.

There are also factors unique to the SHOP exchanges that may have affected insurer participation. For example, in December 2016, effective January 2018, HHS removed a requirement that in order to participate in a federally facilitated individual exchange, an insurer with more than 20% of the small-group market in that state also would have to participate in that SHOP exchange. In the rule, HHS acknowledged the elimination of this requirement likely would reduce insurer participation, and thus employer and employee participation, in affected SHOP exchanges.[99] Other issues also have been discussed as affecting employer and/or insurer participation in the SHOP exchanges, such as delays in setting up online enrollment capabilities when the SHOPs were being established and the limited duration and administrative complexity of the small business tax credit.[100]

Exchange Enrollment Assistance

Navigators and Other Exchange-Based Enrollment Assistance

Federal statute and regulations require exchanges to carry out certain consumer outreach and assistance functions. These functions generally include in-person and other forms of outreach and assistance.[101]

Each exchange must have a *Navigator* program.[102] Navigators are entities whose employees and/or volunteers conduct public outreach and education activities about the exchanges and

[96] IRS, *SOI Tax Stats - Affordable Care Act (ACA) Statistics: Credit for Small Employer Health Insurance, "*Premiums," page updated Sept. 2020, at https://www.irs.gov/statistics/soi-tax-stats-affordable-care-act-aca-statistics-credit-for-small-employer-health-insurance-premiums.

[97] Ibid. See excel file, "Small Business Health Care Tax Credits Filed in Tax Years 2010–2016," linked on this webpage.

[98] See "Online Enrollment versus Direct Enrollment

[99] 2018 Payment Notice, page 94144. Citation for this rule is at **Table D-1**.

[100] See GAO, *Small Business Health Insurance Exchanges: Low Initial Enrollment Likely due to Multiple, Evolving Factors*, November 2014, at https://www.gao.gov/products/GAO-15-58. Also see Jost, Timothy, "CMS Announces Plans To Effectively End The SHOP Exchange," Health Affairs Blog, May 15, 2017, at https://www.healthaffairs.org/do/10.1377/hblog20170515.060112/full/.

[101] For example, see 42 U.S.C. §18031(i), 45 C.F.R. §155.205, 45 C.F.R. §155.210, and 45 C.F.R. §155.225.

[102] Ibid. Specifically, for the requirement to implement Navigator programs, see 45 C.F.R. §155.210.

QHPs; provide impartial information to consumers (including small employers and their employees) about their insurance options; help consumers access individual and SHOP exchange coverage, exchange financial assistance, and/or public program coverage (e.g., Medicaid or CHIP) if they qualify; and refer consumers to any applicable consumer assistance programs as needed, such as state agencies that assist consumers with questions or complaints about their plans. Navigators also may, but are not federally required to, provide other assistance, such as information or referrals regarding reconciliation of consumers' PTCs via their annual income tax filing.[103] States may impose additional Navigator requirements, as long as "such standards do not prevent the application of the provisions of title I of the Affordable Care Act."[104]

Navigators are funded by the exchanges, via grants (federal or state, depending on exchange type) provided to qualifying organizations. Information on current and prior-year Navigator grantees in FFE states is available on the CMS website.[105] For FFE states, certain eligibility requirements changed in 2018 and 2019. For example, Navigator entities are no longer required to maintain a physical presence in their exchange service area.[106]

Exchanges also must have a *Certified Application Counselor* (CAC) program.[107] CAC staff and/or volunteers also provide impartial information to consumers about their insurance options and can assist them in applying for individual and SHOP exchange coverage, exchange financial assistance, and/or public program coverage (e.g., Medicaid or CHIP) if they qualify. They do not necessarily provide public outreach and education or perform many of the other functions that Navigators do. CACs are not exchange-funded in FFE states and are not required to be exchange-funded in other states.

Although Navigator and CAC assisters can help consumers understand their options, they may not advise them on which plan to select. Once a consumer chooses a plan, the assisters may help them enroll in coverage. Neither Navigators nor CACs may be health insurers or take compensation for selling health policies from insurers or consumers.[108]

Besides facilitating the above assistance programs, exchanges must provide for the operation of a call center and maintain a website (e.g., HealthCare.gov) that meets certain informational requirements.[109] Exchanges also provide consumer information and outreach via mail, radio or television ads, and/or other methods.

[103] Some functions that were previously required are now optional for federally-funded Navigator grantees. See 45 C.F.R. §155.210(e)(9).

[104] 45 C.F.R. §155.210(c)(1)(iii).

[105] For information on FFE Navigator grants, see CMS, "In-Person Assistance in the Health Insurance Marketplaces," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance. Per the list of 2020 grantees, there were no eligible applicants in FFE states South Carolina and Utah. CRS is not aware of a compilation of information about Navigator grants in states that administer these programs (those with SBEs and SBE-FPs).

[106] The eligibility requirement changes were made via the 2019 and 2020 Payment Notices (cited in **Table D-1**). The changes, and existing eligibility requirements, are summarized in the 2019 Navigator funding opportunity announcement, *Cooperative Agreement to Support Navigators in Federally-facilitated Exchanges,* at https://www.grants.gov/web/grants/search-grants.html?keywords=CA-NAV-19-001 (select "archived" option under "opportunity status").

[107] For the requirement to implement certified application counselor programs, see 45 C.F.R. §155.225.

[108] 45 C.F.R. §155.215.

[109] 45 C.F.R. §155.205.

Overall, exchanges' consumer outreach efforts and materials must meet certain standards regarding accessibility for individuals with disabilities or with limited English proficiency.[110]

Brokers, Agents, and Other Third-Party Assistance Entities

Pursuant to state law, exchanges also may certify insurance agents, brokers, and/or web-brokers to help consumers obtain coverage through exchanges.[111]

- An *agent* or *broker* is "a person or entity licensed by the State as an agent, broker or insurance producer."[112] They may be individuals or entities that sell plans for different insurance companies, generally receiving a commission from those companies for doing so; or they may be employees of an insurance company who help people enroll in that company's plans.
- A web-broker is an exchange-certified individual or group of agent(s) or broker(s), or other business entity (including a "direct enrollment technology provider"), "that develops and hosts a non-Exchange website that interfaces with an Exchange to assist consumers with direct enrollment in qualified health plans offered through the Exchange."[113] In other words, they offer privately owned and operated websites that may be similar in concept to the ACA exchange websites, in that they allow for comparison of purchase of different plans.

If certified to sell exchange plans, any of these "third party" entities must follow rules about providing information and access to all plans that would be available to a consumer on the actual exchange website.[114] Unlike the exchange websites and exchange assistors, however, they may also assist consumers with enrolling in plans that are not available on the exchanges.

In states where SHOP exchanges only offer direct enrollment (i.e., consumers cannot purchase SHOP plans via the exchange website), or in states where there are no insurers offering SHOP plans, the SHOP exchange websites direct consumers to these third party assisters, who can help them enroll in SHOP plans and/or small-group plans available off-exchange.[115]

Exchange Spending and Funding

Initial Grants for Exchange Planning and Establishment

The ACA provided an indefinite (i.e., unspecified) appropriation for HHS grants to states to support the planning and establishment of exchanges.[116] For each fiscal year (FY) between FY2011 and FY2014, the HHS Secretary determined the total amount that was made available to

[110] 45 C.F.R. §155.205.

[111] 45 C.F.R. §155.220. Definitions of terms discussed in this section, and of other related terms such as *direct enrollment entity*, are at 45 C.F.R. §155.20.

[112] Ibid.

[113] Ibid. See 45 C.F.R. §155.20 for full definition of this term.

[114] 45 C.F.R. §155.220.

[115] See "Eligibility and Enrollment" in the SHOP section of this report for more information about SHOP exchange enrollment options and plan availability.

[116] 42 U.S.C. §18031(a).

each state for exchange grants. However, none of these exchange grants could be awarded after January 1, 2015, and exchanges were expected to be self-sustaining beginning in 2015.[117]

Ongoing Federal Spending on Exchange Operation

The federal government spent an estimated $1.8 billion on operating the exchanges in FY2020, and it projected $1.2 billion in spending for FY2021.[118] See **Figure C-1**, which includes these numbers as well as estimated and prior year federal spending on the exchanges by activity (e.g., information technology, Navigator grants), in a table that is included by CMS in its annual budget justification to Congress.

In general, this federal spending is specific to FFEs. For example, the federal government funds the Navigator program only in states with FFEs. Some of the federal spending, particularly in terms of information technology and the call center, also is applicable to SBE-FPs, because these state-based exchanges use the federal HealthCare.gov platform. CMS performs and funds ae some functions for all exchanges, including SBEs, such as "verifying consumers' eligibility data for financial assistance through the Exchange or other health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP)."[119]

The costs of the plans themselves are covered by enrollees' premiums and in some cases are subsidized by the federal government (i.e., via PTCs). The costs of the PTCs are financed through a permanent appropriation through the tax code.[120] These tax credit costs are beyond the scope of this report and are not included in the funding totals discussed in this section.

Funding Sources for Federal Exchange Spending

User Fees Collected from Participating Insurers

Exchanges may generate funding to sustain their operations, including by assessing fees on participating health insurance plans.[121] To raise funds for the exchanges it administers and/or for which it provides a web platform, HHS assesses a monthly fee on each health insurance issuer that offers plans through an FFE or SBE-FP. The user fee amounts are allowed to fund only federal activities or functions specific to these exchanges; the user fees cannot fund federal activities that serve all exchanges (including SBEs).[122] The fees are lower for insurers in SBE-FP states because the federal government performs fewer functions for those exchanges than for FFEs, but those insurers also may be subject to exchange participation fees levied by the states.

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[117] 42 U.S.C. §18031(a)(4)(B) specifies that no grant shall be awarded under this subsection after January 1, 2015. See CRS Report R43066, *Federal Funding for Health Insurance Exchanges* (last updated in October 2014) for more information about these planning and establishment grants.

[118] Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2021*, March 3, 2020, at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/FY2021-CJ-Final.pdf. See "Federal Exchanges" table and narrative, page 195-200, and "Health Insurance Exchange Transparency Table," page 241. The HHS FY2020 spending estimate was as of January 2020. Hereinafter referred to as "CMS Budget Justification, FY 2021."

[119] Page 196 of the CMS Budget Justification, FY2021.

[120] 31 U.S.C. §1324(b).

[121] 42 U.S.C. §18031(d)(5)(A).

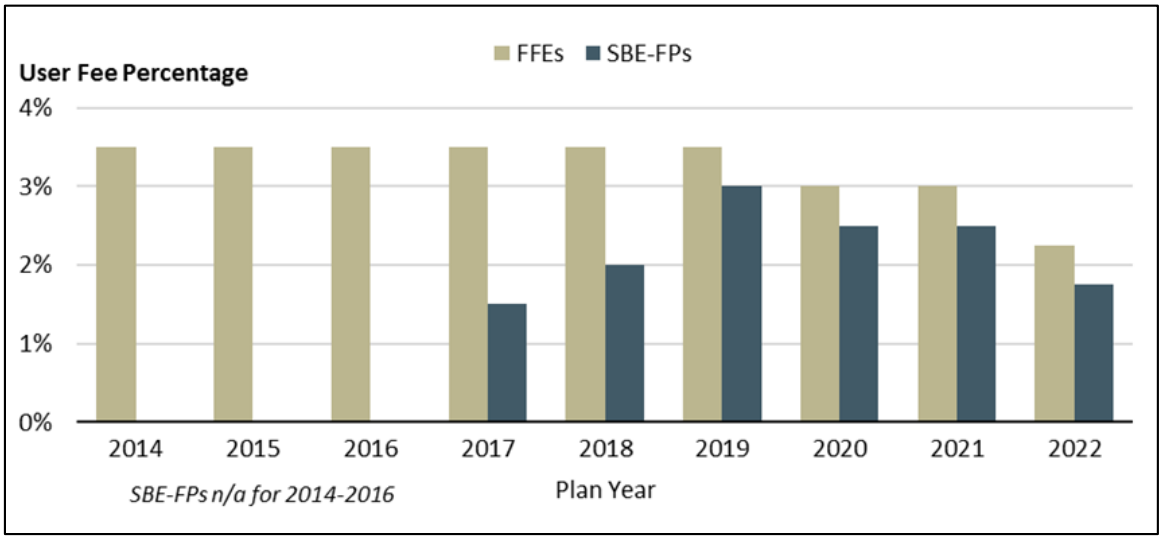
[122] For further discussion, see 2020 Payment Notice (cited in **Table D-1**), Section E.2., page 29216. Also see discussion of CMS activities conducted on behalf of certain versus all exchanges at CMS Budget Justification, FY2021, page 196.

The fee is a percentage of the value of the monthly premiums the insurer collects on exchange plans in a given state, and HHS updates the percentage each year through rulemaking. See **Figure 3**.

User fees also have been assessed on insurers participating in SHOP exchanges. However, HHS announced in the 2019 Payment Notice that as of plan years beginning on or after January 1, 2018, the fees would no longer be assessed on insurers participating in FF-SHOPs and SB-FP-SHOPs, due to the reduced functionality of the federal SHOP website also announced in that rule.[123]

Figure 3. Federal User Fee for Insurers Participating in Specified Types of Individual Exchanges, by Plan Year

(fee is the stated percentage of the value of monthly premiums collected by insurer on exchange plans)



Source: CRS analysis of annual "Payment Notice" federal rules cited in Table D-1, as well as Internal Revenue Service, "Rev. Proc. 2013-25," May 2, 2013, at http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.

Notes: FFE = federally-facilitated exchange. SBE = state-based exchange. SBE-FP = state-based exchange using the federal information technology (IT) platform. See "Types and Administration of Exchanges" for discussion of exchange types.
Although some SBE-FPs existed prior to plan year 2017, HHS did not begin assessing a user fee on insurers in those states until then.
SBEs' assessment of user fees, if any, varies, as discussed in this section of the report.

Most of the total federal spending on exchange operations is funded by these user fees. In FY2018-FY2020, user fees funded between 65.3% and 78.8% of this federal spending.[124] As stated above, the user fees only fund activities specific to FFEs and certain activities for SBE-FPs. Funding sources for federal activities applicable also to SBEs are discussed in the next section.

[123] 2019 Payment Notice (cited in **Table D-1**), page 17007. See "Online Enrollment versus Direct Enrollment" regarding the reduced functionality of federal SHOP websites.

[124] Based on CRS analysis of data provided in CMS Budget Justifications for FY2021 and FY2020 (see **Table C-1**). Comparable data not found in prior years' budget justifications.

For FY2021, CMS proposed that $1.12 billion, or 93.6%, of its overall estimated FY2021 exchange spending would come from anticipated user-fee collections.[125] However, this higher percentage of spending sourced from user fees likely would depend on enactment of a legislative proposal included by CMS in its FY2021 budget. The proposal would "allow user fees collected for FFE operations to be available for any federal administrative Exchange-related operating activity."[126] This means CMS could use the user fees to fund its activities performed for all exchanges, not just for its activities that are specific to FFE and SBE-FP exchanges. If this proposal is not enacted, CMS must continue to use other funding sources for the activities it performs on behalf of all exchanges. See "Ongoing Federal Spending on Exchange Operation" for examples of these different types of activities.

Other Federal Funding Sources

Besides the user fees collected from participating insurers, federal funding for the exchanges (including for federal activities related to all exchanges, including SBEs) largely comes from discretionary appropriations for program management and program integrity. There is also a risk-adjustment user fee, related to the risk-mitigation program briefly mentioned earlier in this report.[127] There is currently no mandatory HHS appropriation for exchange activities.[128] An overview of recent and currently proposed funding sources is in **Table C-1**.

State Financing of the Exchanges

States with SBEs finance their own exchange administration. States with SBE-FPs also finance the costs associated with the exchange functions they administer (whereas the federal user fee is assessed on insurers in such states to finance federally run functions such as the IT platform, as discussed above). States may finance their exchanges by collecting user fees from participating insurers, as the federal government does. In addition, states may use other state funding to support their exchanges. CRS is not aware of an estimate of total or state-level spending on, or financing sources for, SBE and SBE-FP exchanges.

[125] Ibid.

[126] CMS Budget Justification, FY2021, page 199.

[127] See "Insurer Participation" in the Individual Exchanges section of the report.

[128] According to the "Federal Exchanges" table in the FY2020 CMS CJ, a portion of the mandatory Health Care Fraud and Abuse Control (HCFAC) appropriation went to the exchanges in FY2018 and FY2019. However, that table in the FY2021 CJ does not show this for FY2019. See **Table C-1** for citations.

Appendix A. Exchange Information by State

As discussed in this report, the major types of exchanges in terms of state versus federal administration are state-based exchanges (SBEs), federally facilitated exchanges (FFEs), and state-based exchanges using a federal platform (SBE-FPs). For plan year (PY) 2021, there are 30 FFEs, 15 SBEs, and 6 SBE-FPs.

A few states have changed approaches one or more times (e.g., initially worked to create an SBE but then switched to an SBE-FP or FFE model). Changes in the first few years varied in terms of whether the state moved toward more or less federal involvement, but in several cases, a state transitioned from a fully state-based approach to an SBE-FP (i.e., transitioned toward more federal involvement). Recent and ongoing transitions generally are in the direction of less federal involvement. There were three changes for PY2015, one for PY2016, three for PY2017, none for PY2018 or PY2019, three for PY2020, and four for PY2021. As of the publication of this report, five states are known to be transitioning or considering transitions for PY2022 or beyond.

SHOP exchanges may be federally facilitated (FF-SHOP) or state-based (SB-SHOP).[129] For PY2021, there are 32 FF-SHOPs and 18 SB-SHOPs. However, in more than half of states, no insurers are offering medical plans in the SHOP exchange, meaning there is effectively no SHOP exchange there. See "Insurer Participation" in the SHOP Exchanges section of this report for more information. One state is exempted from operating a SHOP exchange.

For PY2021 plan, most states' individual and SHOP exchanges are administered in the same way (i.e., both state based or both federally facilitated). However, a handful of states have different approaches for their individual and SHOP exchanges. Some resources refer to this as a *bifurcated* approach.

Table A-1 shows individual exchange types by state, with information on past changes in individual exchange types and changes underway or planned. It also shows SHOP exchange types by state and provides details on SHOP plan availability and enrollment method.

[129] As of June 2018, states can no longer select the state-based using the federal IT platform (SB-FP-SHOP) approach, except that the two states with that model at that time (Nevada and Kentucky) could maintain it. According to CMS, those states no longer use that model. For more information, see "Online Enrollment versus Direct Enrollment" in the "SHOP Exchanges" section of this report.

Table A-1. Exchange Types and Key Details by State, Plan Year 2021

State	Exchange Website	Individual Exchange Type[a] (and notes on exchange type transitions, if applicable)	SHOP Exchange Type[b] (with notes on plan availability and enrollment options)
U.S. Totals		**FFE: 30** **SBE: 15** **SBE-FP: 6** (plans and online enrollment available in all counties, all states)	**FF-SHOP: 32** (23 have no plans; all are direct enrollment only) **SB-SHOP: 18** (5 have no plans; 6 are direct enrollment only) **No SHOP: 1**
Alabama	HealthCare.gov	FFE	FF-SHOP, via direct enrollment[c]
Alaska	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Arizona	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Arkansas	Myarinsurance.com; HealthCare.gov	SBE-FP as of PY17 (initially FFE)[e]	SB-SHOP, but no medical plans[f]
California	Coveredca.com	SBE	SB-SHOP (up to 100 employees) [g]
Colorado	Connectforhealthco.com	SBE	SB-SHOP, via direct enrollment[h] (up to 100 employees)[g]
Connecticut	Accesshealthct.com	SBE	SB-SHOP
Delaware	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
District of Columbia	DChealthlink.com	SBE	SB-SHOP
Florida	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Georgia	HealthCare.gov	FFE (planning to replace exchange with alternate approach as of PY23) [j]	FF-SHOP, via direct enrollment[c]
Hawaii	HealthCare.gov	FFE as of PY17 [i] (initially SBE, then SBE-FP for PY16)[e]	No SHOP exchange[k]
Idaho	Yourhealthidaho.org	SBE as of PY15 (initially SBE-FP)[e]	SB-SHOP, via direct enrollment[h]
Illinois	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Indiana	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Iowa	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Kansas	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Kentucky	Healthbenefitexchange.ky.gov; HealthCare.gov	SBE-FP as of PY17 (initially SBE) Planning for SBE as of PY22[e]	FF-SHOP, but no medical plans[d]
Louisiana	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Maine	Enroll207.com; HealthCare.gov	SBE-FP as of PY21 (initially FFE)[i] Considering SBE[e]	FF-SHOP, via direct enrollment[c]
Maryland	Marylandhealthconnection.gov	SBE	SB-SHOP, via direct enrollment[h]
Massachusetts	Mahealthconnector.org	SBE	SB-SHOP
Michigan	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Minnesota	Mnsure.org	SBE	SB-SHOP, but no medical plans[f]
Mississippi	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]

State	Exchange Website	Individual Exchange Type[a] (and notes on exchange type transitions, if applicable)	SHOP Exchange Type[b] (with notes on plan availability and enrollment options)
Missouri	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Montana	HealthCare.gov	FFE[i]	FF-SHOP, via direct enrollment[c]
Nebraska	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Nevada	Nevadahealthlink.com	SBE as of PY20 (initially SBE, then SBE-FP as of PY15)[e]	SB-SHOP, but no medical plans[f]
New Hampshire	HealthCare.gov	FFE[i]	FF-SHOP, via direct enrollment[c]
New Jersey	Nj.gov/getcoverednj/	SBE as of PY21 (initially FFE, then SBE-FP as of PY20)[e]	SB-SHOP
New Mexico	Bewellnm.com; HealthCare.gov	SBE-FP Planning for SBE as of PY22[e]	SB-SHOP
New York	Nystateofhealth.ny.gov	SBE	SB-SHOP, via direct enrollment[h] (up to 100 employees)[g]
North Carolina	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
North Dakota	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Ohio	HealthCare.gov	FFE[i]	FF-SHOP, via direct enrollment[c]
Oklahoma	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Oregon	Healthcare.oregon.gov/ marketplace; HealthCare.gov	SBE-FP as of PY15 (initially SBE) Considering SB [e]	SB-SHOP, via direct enrollment[h]
Pennsylvania	Pennie.com	SBE as of PY21 (initially FFE, then SBE-FP as of PY20)[e]	SB-SHOP, but no medical plans[f]
Rhode Island	Healthsourceri.com	SBE	SB-SHOP
South Carolina	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
South Dakota	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Tennessee	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Texas	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Utah	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Vermont	Healthconnect.vermont.gov	SBE	SB-SHOP, via direct enrollment[h] (up to 100 employees)[g]
Virginia	Coverva.org/marketplace; HealthCare.gov	SBE-FP as of PY21 (initially FFE [i]) Planning for SBE as of PY23[e]	FF-SHOP, via direct enrollment[c]
Washington	Wahealthplanfinder.org	SBE	SB-SHOP, but no medical plans[f]
West Virginia	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Wisconsin	HealthCare.gov	FFE	FF-SHOP, via direct enrollment[c]
Wyoming	HealthCare.gov	FFE	FF-SHOP, via direct enrollment[c]

Sources: Congressional Research Service (CRS) analysis of data at the sources indicated in notes section below.

Notes:

SHOP = Small business health options program.

FFE and FF-SHOP = Federally facilitated individual exchange; federally facilitated SHOP exchange.

SBE and SB-SHOP = State-based individual exchange; state-based SHOP exchange.
SBE-FP = State-based individual exchange using the federal information technology (IT) platform; state-based SHOP exchange using the federal IT platform.
Counts of "states" include the District of Columbia. In the individual exchanges, "plan year" is generally that calendar year, but group coverage plan years, including in the SHOP exchanges, may start at any time during a calendar year. See report "Overview" for discussion of exchange types; see **Figure 1** in this report for the 2021 exchange types by state in map form.

a. **2021 individual exchange types:** SBEs and SBE-FPs are listed at Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), "State-based Exchanges," updated November 1, 2019, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces. Remaining states have FFEs. Cross-referenced at Kaiser Family Foundation, "State Health Insurance Marketplace Types, 2021," at https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/, and at state exchange websites as needed.

b. **2021 SHOP exchange types:** HealthCare.gov, "Select your state," at https://www.healthcare.gov/small-businesses/employers/, cross-referenced at state exchange websites or otherwise as needed. Kentucky and Nevada both had SB-FP-SHOPs, but according to communication with CMS, their SHOP types are now as shown in the table. States with no medical plans available in their SHOP exchanges are indicated. In states that do have plans available in their SHOP exchanges, there may or may not be plans available in all areas.

c. **All FF-SHOPs are now using a direct enrollment approach only.** They do not offer online enrollment but instead instruct users to connect with agents or brokers offering plans through the state's SHOP exchange. See "Online Enrollment versus Direct Enrollment" in this report for more information.

d. **No insurers are currently offering medical plans in these FF-SHOPs**. (Some may be offering dental plans, however.) See CMS, Health Insurance Exchange Public Use Files, 2021: Business Rules PUF, at https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf. Contact report author for further information.

e. While most states have maintained the same type of individual exchange they initially opted for, some have transitioned to different exchange types, or are planning to do so.
For transitions to date
2014 exchange types: https://aspe.hhs.gov/pdf-report/addendum-health-insurance-marketplace-summary-enrollment-report
2015 exchange types: FN 3 of https://www.cms.gov/newsroom/fact-sheets/march-31-2015-effectuated-enrollment-snapshot
2016 exchange types: FN 3 of https://www.cms.gov/newsroom/fact-sheets/march-31-2016-effectuated-enrollment-snapshot
2017-2020 exchange types: State level public use files for each year, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products.
2021 and future transitions: See table note (a) regarding 2021 exchange types. Two CMS resources also note PY2020 and PY2021 transitions, as referenced where relevant by state below: **"CMS PY2021 QHP report"** (CMS, CCIIO, *Plan Year 2021 Qualified Health Plan Choice and Premiums in HealthCare.gov States,* October 2020, at https://www.cms.gov/CCIIO/Resources/Data-Resources/QHP-Choice-Premiums); and **"2020 CMS Navigator Recipients"** (CMS, 2020 CMS Navigator Cooperative Agreement Recipients, August 30, 2020, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance).
Kentucky: https://kentucky.gov/Pages/Activity-stream.aspx?n=GovernorBeshear&prId=218
Maine: https://www.maine.gov/dhhs/blog/maine-progresses-toward-state-based-health-insurance-marketplace-2020-08-06. Also see 2020 CMS Navigator Recipients.
New Jersey: https://nj.gov/governor/news/news/562019/approved/20190322a.shtml. Also see CMS PY2021 QHP report.
New Mexico: https://www.bewellnm.com/Special-Enrollment-(1)/partner-resources/State-Based-Exchange-Transition.
Oregon: https://healthcare.oregon.gov/marketplace/gov/Pages/tech-consumer-assistance.aspx.
Pennsylvania: https://www.insurance.pa.gov/Coverage/Pages/State-Based-Exchange.aspx. Also see CMS PY2021 QHP report.
Virginia: https://www.governor.virginia.gov/newsroom/all-releases/2020/august/headline-860017-en.html. Also see 2020 CMS Navigator Recipients.
Also see Sabrina Corlette et al., *States Seek Greater Control, Cost-Savings by Converting to State-Based Marketplaces*, Robert Wood Johnson Foundation, October 2019, at https://www.rwjf.org/en/library/research/2019/10/states-seek-greater-control-cost-savings-by-converting-to-state-based-marketplaces.html.

f. No insurers are currently offering medical plans in these SB-SHOPs. (Some may be offering dental plans, however.) The SHOP website suggests that small businesses contact agents, brokers, and/or insurers directly to learn about coverage options outside of the SHOP. See **Arkansas:** https://myarinsurance.com/pages/manage-shop/
Minnesota: https://www.mnsure.org/employer-employees/index.jsp
Nevada: https://www.nevadahealthlink.com/overview/
Pennsylvania: Confirmed via state officials
Washington: Confirmed via state officials

g. For the purposes of SHOP exchange participation, states may define *small employers* (or small businesses) as employers that have not more than 50 or not more than 100 employees. See SHOP "Eligibility and Enrollment" in this report. Only four states use the threshold of 100. See
California: https://www.coveredca.com/forsmallbusiness/eligible/
Colorado: https://connectforhealthco.com/get-started/options-for-small-business-owners/, "Employer application"
New York: https://nystateofhealth.ny.gov/employer
Vermont: https://info.healthconnect.vermont.gov/smallbusiness_faq

h. **These SB-SHOPs are using a direct enrollment approach only**: They do not offer online enrollment but instead instruct users to connect with agents or brokers offering plans through the state's SHOP exchange. See
Colorado: https://connectforhealthco.com/get-started/options-for-small-business-owners/
Idaho: https://www.yourhealthidaho.org/small-business-insurance/
Maryland: https://mhcsmallbiz.marylandhealthconnection.gov/anonymous-web/#/quote-engine/enroll
New York: https://nystateofhealth.ny.gov/employer
Oregon: https://healthcare.oregon.gov/marketplace/employers/Pages/employers.aspx
Vermont: https://info.healthconnect.vermont.gov/SB

i. In some FFE states, the federal government performs all functions. But in these FFE states, the state partners with the federal government to perform some functions. CMS data do not generally identify these "partnership" variations, but the Kaiser Family Foundation tracks them at the site linked in table note (a).

j. Georgia received approval through the Section 1332 state innovation waiver process to shift to its own "Georgia Access Model," essentially a direct enrollment approach, beginning in PY2023. This 1332 process allows states to waive specified ACA provisions, including provisions related to the establishment of health insurance exchanges and related activities. See CRS Report R44760, *State Innovation Waivers: Frequently Asked Questions* for background on 1332 waivers and for more information about Georgia's waiver.

k. Hawaii received a Section 1332 waiver exempting it from having SHOP exchange for PYs 2017-2021. This was related to the state's pre-existing program and requirements related to employment-based coverage. See the report cited in table note (j) for more information about Hawaii's waiver.

Appendix B. Types of Plans Offered Through the Exchanges

In general, health insurance plans offered through exchanges must be qualified health plans (QHPs).[130] See "Qualified Health Plans" in this report for requirements QHPs must meet to be sold in the exchanges.

A QHP is the only type of comprehensive health plan an exchange may offer, but QHPs may be offered outside of exchanges, as well. Besides standard QHPs, there may be other types of plans available in a given exchange, including child-only plans, catastrophic plans, consumer operated and oriented plans (CO-OPs), and multi-state plans (MSPs). Technically, these are all also QHPs. Stand-alone dental plans (SADPs) are the only non-QHPs offered in the exchanges.

Table B-1. Types of Plans Offered Through the Exchanges

	Summary	PTC and CSR Eligible?	Can Be Offered Outside Exchanges?
Qualified Health Plan (QHP)	A plan that is offered by a state-licensed insurer that meets specified requirements, is certified by an exchange, and covers the essential health benefits (EHB) package.	Yes	Yes
QHP Variations			
Child-Only Health Insurance Plan	A plan in which only individuals under the age of 21 may enroll. If an insurer offers an all-ages QHP in an exchange, it also must offer a child-only plan at the same actuarial level.	Yes	Yes
Catastrophic Plan	A plan that provides the EHB and coverage for at least three primary care visits; however, it does not meet the minimum requirements related to coverage generosity (i.e., actuarial value). Offered in individual but not small business health options program (SHOP) exchanges. Consumer eligibility requirements apply. [a]	No	Yes
Consumer Operated and Oriented Plan (CO-OP)	A plan sold by a nonprofit, member-run health insurance company created via a Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) program. [b]	Yes	Yes
Multi-state Plan (MSP)	A plan sold in the exchanges under contract with the federal Office of Personnel Management (OPM).[c]	Yes	No
Non-QHPs			
Dental-Only Plan	Coverage for dental care. May be offered either as a stand-alone plan or in conjunction with a QHP, as long as it covers pediatric dental benefits that meet relevant EHB requirements.	Yes, in certain circumstances.	Yes

Sources: CRS analysis of statute and regulation. QHP definition: 42 U.S.C. §18021. Child-only and catastrophic plans: 42 U.S.C. §18022. CO-OPs: 42 U.S.C. §18021 and 42 U.S.C. §18042. MSPs: 42 U.S.C. §18021 and 42 U.S.C. §18054. Dental-only plans: 42 U.S.C. §18031(d)(2)(B)(ii), 45 C.F.R. §155.1065, and 45 C.F.R. §155.705. Premium tax credits and cost-sharing reductions: 26 U.S.C. §36B(c)(3)(A) and 42 U.S.C. §18071(f)(1).

[130] 42 U.S.C. §18031(d)(2)(B).

Notes: PTC = premium tax credit. CSR = cost-sharing reduction.

a. Catastrophic plans are available only to individuals under the age of 30 and individuals who obtain hardship or affordability exemptions from the ACA's individual mandate to maintain minimum essential coverage or pay a penalty. See CRS Report R44438, *The Individual Mandate for Health Insurance Coverage: In Brief*.

b. The HHS Secretary is required to use funds appropriated to the CO-OP program to finance start-up and solvency loans for eligible nonprofit organizations applying to become a CO-OP. The majority of products offered by a CO-OP must be QHPs sold in the non-group and small-group markets, including through exchanges. CMS initially awarded loans to 24 CO-OPs, but one of those 24 was dropped from the program prior to offering health plans. See CRS Report R44414, *Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions*. Among the remaining 23 CO-OPs, it appears that 3 remain operational—meaning they are currently offering health plans and there is no indication that they will stop doing so in the future. The other 20 CO-OPs offered health plans at one time but have shut down or are in various stages of shutting down. See
Maine: Community Health Options: https://www.healthoptions.org/
Idaho, Montana, and Wyoming: Mountain Health CO-OP: https://www.mountainhealth.coop/
Wisconsin: Common Ground Healthcare Cooperative: https://www.commongroundhealthcare.org

c. The ACA directs OPM to contract with private insurers in each state to offer at least two QHPs under the MSP program. The term *multi-state plan* is meant to indicate that this program extends across the states, not that the plans themselves are necessarily interstate. There are not currently any multi-state plans available.

Appendix C. Exchange Spending and Funding Details from CMS Budget Justifications

The Centers for Medicare & Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS) is the federal agency responsible for administering the health insurance exchanges. In support of the President's annual proposed budget, CMS, like other agencies, produces a performance budget, also called a budget justification. Actual spending for the proposed budget year depends on the availability of appropriations, among other factors. However, the narratives and tables in each year's budget document are also useful in understanding prior-year spending.

Provisions in annual appropriations acts require CMS to provide, in its budget justification for each fiscal year, "cost information" that "details the uses of all funds used by the Centers for Medicare & Medicaid Services specifically for Health Insurance Exchanges for each fiscal year since the enactment of the ACA and the proposed uses for such funds [for the upcoming fiscal year]" for the categories shown in **Figure C-1**.[131] Each budget justification also includes narrative information about federal spending in each of the categories listed in the table.

The exchanges are largely funded by user fees assessed on the insurers who offer plans in FFE and SBE-FP exchanges. In addition to these user fees, funding comes from discretionary appropriations to the CMS Program Management account, risk-adjustment user fees, and appropriations to the Health Care Fraud and Abuse Control account, among other sources. **Table C-1** displays federal exchange spending according to these funding sources.

See "Exchange" in this report for more information. Find current and prior-year CMS budget justifications at CMS, "Performance and Budget," at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget.

[131] See, for example, the Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Division A, Title II, Sec. 220 and the Consolidated Appropriations Act, 2021 (P.L. 116-260), Division H, Title II, Sec. 220.

Figure C-1. Centers for Medicare & Medicaid Services "Health Insurance Exchanges Transparency Table," FY2021

($ in thousands)

Activity	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget
Health Plan Bid Review, Management and Oversight	$ -	$ 300	$ 21,936	$ 40,595	$ 33,497	$ 43,960	$ 40,520	$ 39,846	$ 37,910	$ 45,797	$ 45,214	$ 18,300
Payment and Financial Management	$ -	$ 1,698	$ 24,998	$ 25,832	$ 49,615	$ 43,733	$ 51,325	$ 47,640	$ 45,141	$ 50,220	$ 63,438	$ 42,183
Eligibility and Enrollment 1/	$ -	$ 2,218	$ 3,433	$ 275,501	$ 339,754	$ 363,768	$ 445,249	$ 484,144	$ 392,660	$ 348,488	$ 358,938	$ 292,842
Consumer Information and Outreach	$ -	$ 2,427	$ 32,610	$ 701,075	$ 704,136	$ 753,238	$ 805,833	$ 640,232	$ 591,948	$ 579,088	$ 529,635	$ 306,550
Call Center (non-add)	*$ -*	*$ -*	*$ 22,000*	*$ 505,446*	*$ 545,600*	*$ 566,178*	*$ 563,638*	*$ 540,197*	*$ 525,326*	*$ 499,053*	*$ 442,700*	*$ 241,900*
Navigators Grants & Enrollment Assisters (non-add)	*$ -*	*$ -*	*$ -*	*$ 107,513*	*$ 97,152*	*$ 75,996*	*$ 99,677*	*$ 51,166*	*$ 12,720*	*$ 19,499*	*$ 20,835*	*$ 13,530*
Consumer Education and Outreach (non-add)	*$ -*	*$ -*	*$ 7,043*	*$ 77,436*	*$ 49,334*	*$ 54,897*	*$ 101,048*	*$ 16,599*	*$ 10,744*	*$ 11,231*	*$ 11,600*	*$ 11,850*
Information Technology	$ 2,346	$ 92,672	$ 166,455	$ 402,553	$ 770,957	$ 798,648	$ 664,083	$ 710,867	$ 767,413	$ 504,283	$ 612,358	$ 430,837
Quality	$ -	$ -	$ -	$ -	$ 17,189	$ 15,634	$ 11,736	$ 7,301	$ 7,240	$ 7,334	$ 8,000	$ 9,700
SHOP and Employer Activities	$ -	$ 366	$ 18,479	$ 25,076	$ 30,541	$ 42,717	$ 34,520	$ 16,500	$ 4,418	$ 2,117	$ 200	$ 200
Other Exchange	$ 1,879	$ 14,906	$ 13,738	$ 4,400	$ 6,728	$ 3,614	$ 12,032	$ 49,584	$ 31,196	$ 40,290	$ 89,321	$ 46,500
Federal Payroll and Other Administrative Activities	$ 429	$ 10,805	$ 43,493	$ 68,429	$ 80,000	$ 80,000	$ 85,000	$ 79,602	$ 70,892	$ 77,750	$ 77,750	$ 50,000
Total	$ 4,654	$ 125,392	$ 325,142	$ 1,543,461	$ 2,032,418	$ 2,145,312	$ 2,150,297	$ 2,075,714	$ 1,948,818	$ 1,655,367	$ 1,784,855	$ 1,197,112

1/ Funding for Enrollment Assisters ended in FY 2017.

NOTE: Fiscal years 2010 through 2019 include obligations as of September 30 of each year.

NOTE: Before the Exchanges were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

NOTE: The FY 2020 Enacted level is an estimate as of January 2020.

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2021*, March 3, 2020, at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/FY2021-CJ-Final.pdf. See "Health Insurance Exchanges Transparency Table," page 241. Discussion of spending categories is at "Federal Exchanges" table and narrative, page 195-200.

Notes: FY = fiscal year.

Table C-1. CMS Federal Exchange Funding Sources for Specified Fiscal Years

($ in thousands)

Treasury Account[a]	FY2018 Actual	FY2019 Final[b]	FY2020 Enacted[b]	FY2021 President's Budget[c]	FY2021 President's Budget +/- FY 2020 Enacted
Program Management	$1,944,190	$1,636,111	$1,720,937	$1,171,728	($549,209)
Discretionary Appropriation	$618,164	$263,895	$296,533	$0	($296,533)
Program Operations (non-add)	*$580,886*	*$229,384*	*$268,937*	*$0*	*($286,937)*
Federal Administration (non-add)	*$37,278*	*$34,511*	*$27,596*	*$0*	*($27,596)*
Offsetting Collections	$1,304,280	$1,351,893	$1,399,404	$1,171,728	($227,676)
Federally-facilitated Exchange User Fee (non-add)[d]	*$1,272,168*	*$1,304,458*	*$1,341,039*	*$1,120,199*	*($220,840)*
Risk Adjustment User Fee (non-add)	*$32,112*	*$47,435*	*$58,365*	*$51,530*	*($6,836)*
Other	$21,746	$20,323	$25,000	$0	($25,000)
Health Care Fraud and Abuse Control	$4,629	$19,256	$63,918	$25,384	($38,534)
Discretionary Appropriation	$0	$19,256	$63,918	$25,384	($38,534)
Mandatory Appropriation[e]	$4,629	n/a	n/a	n/a	n/a
Total, Program Level	**$1,948,818**	**$1,655,367**	**$1,784,855**	**$1,197,112**	**($587,743)**
Exchange User Fee Amounts as a Percentage of Program Level Funding Sources[f]	**65.3%**	**78.8%**	**75.1%**	**93.6%**	**n/a**

Sources: Unless otherwise specified, data are compiled by CRS from the following sources. Comparable data not found in prior years' budget justifications.
FY2019-FY2021 columns in table: Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2021*, March 3, 2020, at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/FY2021-CJ-Final.pdf. "Federal Exchanges" table, page 195.
FY2018 column in table: HHS, CMS, *Justification of Estimates for Appropriations Committees, Fiscal Year 2020,* March 13, 2019, at https://www.cms.gov/files/document/fy2020-cms-congressional-justification-estimates-appropriations-committees.pdf. "Federal Exchanges" table, page 178.

Notes: FY = fiscal year.

a. See source documents for description of Treasury Account categories.

b. The FY2019 Final and FY2020 Enacted amounts were estimates as of January 2020.

c. The FY2021 President's budget amounts were the Administration's proposals for FY2021.

d. Per communication with CMS, this row is inclusive of both FFE and SBE-FP federal user fees.

e. Health Care Fraud and Abuse Control (HCFAC) "Mandatory Appropriation" was listed in the FY2020 table that included the FY2018 amounts, but not in the FY2021 table that included the other amounts. The FY2020 table also showed $5,000 in this row for "FY2019 Enacted," but the FY2021 table did not show any such amounts for "FY2019 Final." Per the FY2020 table, "HCFAC mandatory Wedge funding is subject to an annual allocation process by the Attorney General and Secretary of Health and Human Services."

f. Calculated by CRS.

Appendix D. Additional Resources

HHS "Notice of Benefits and Payment Parameters" (Payment Notices), Final Rule by Year

The "Notice of Benefits and Payment Parameters," also called the "Payment Notice," is a rule published annually by the Department of Health and Human Services (HHS). It addresses the exchanges and certain other private health insurance topics. It includes annual updates, such as changes to insurer user fee amounts, and policy changes, such as modified eligibility requirements for the Navigator program.

The rule is titled according to the upcoming plan year that it addresses. For example, the 2021 Payment Notice was finalized in May 2020, with changes applicable to the 2021 plan year (which is generally the calendar year).

Table D-1. HHS "Notice of Benefits and Payment Parameters," Final Rule by Year

For Plan Year	Title and Link	Citation	Publication Date
2022	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations** [a] https://www.federalregister.gov/documents/2021/01/19/2021-01175/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022	86 *Federal Register* 6138	January 19, 2021
2021	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans** https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021	85 *Federal Register* 29164	May 14, 2020
2020	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020** https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020	84 *Federal Register* 17454	April 25, 2019
2019	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019** https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019	83 *Federal Register* 16930	April 17, 2018
2018	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018, Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program** https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018	81 *Federal Register* 94058	December 22, 2016

For Plan Year	Title and Link	Citation	Publication Date
2017	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017** https://www.federalregister.gov/documents/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017	81 *Federal Register* 12203	March 8, 2016
2016	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016** https://www.federalregister.gov/documents/2015/02/27/2015-03751/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016	80 *Federal Register* 10749	February 27, 2015
2015	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015** https://www.federalregister.gov/documents/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015.	79 *Federal Register* 13743	March 11, 2014
2014	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014** https://www.federalregister.gov/documents/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014	78 *Federal Register* 15409	March 11, 2013

Source: *United States Federal Register* at https://www.federalregister.gov/.

Notes: There have been other rules and agency guidance relevant to the exchanges and private health insurance. This table is meant to be a compilation of only this type of annual rule.

a. The 2022 Payment Notice final rule was published but not in effect before the presidential transition. As such, it may be reconsidered by the Biden Administration. See Office of Management and Budget, "Memorandum for the Heads of Executive Departments and Agencies," 86 *Federal Register* 7424, January 28, 2021. In addition, the final rule published January 19, 2021, did not address all the topics discussed in the November proposed rule, including topics subject to annual updating, like the out-of-pocket maximum for 2022 (see "Premiums and Cost Sharing" in this report). The final rule stated on page 6139 that HHS "intend[s] to address the other topics and proposed policies outlined in the proposed 2022 Payment Notice in future rulemaking, taking into account comments received on those proposals," and on page 6141 that "HHS determined that it was appropriate to address in this final rule only those policies in the proposed 2022 Payment Notice that were most important to advancing the policy goals of reducing fiscal and regulatory burdens across related program areas and providing stakeholders with greater flexibility."

Other Federal Resources

Selected resources are available at the following links.

- Center for Consumer Information and Insurance Oversight (CCIIO) FAQs, letters, and other resources related to the exchanges (also see pages linked to the left side of the webpage): https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces
- CRS compilation of HHS resources on exchange enrollment: CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics*

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