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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.

Consumers 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 about 16.3 million people obtained health insurance through the individual exchanges during the 2023 open enrollment period. 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 2023, similar to 2022.

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 exchanges 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 exchanges 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 $2.09 billion on the operation of exchanges in FY2022, projected $2.38 billion in spending for FY2023, and proposed $2.31 billion for FY2024. 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., their own Navigator programs).

This report provides an overview of key aspects of the health insurance exchanges, including types and administration of exchanges, eligibility and enrollment, plan costs and financial assistance, insurer participation, and exchange financing. It also includes information about policy changes enacted under the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) and the budget reconciliation measure known as the Inflation Reduction Act (), as well as recent administrative policy changes, including those made in response to the Coronavirus Disease 2019 (COVID-19) pandemic and related economic recession.

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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.

The report includes information about policy changes enacted under the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) and the budget reconciliation measure known as the Inflation Reduction Act (P.L. 117-169), as well as recent administrative policy changes, including those made in response to the Coronavirus Disease 2019 (COVID-19) pandemic and related economic recession.

[1] In this report, the terms *consumers* and *individuals* generally are used interchangeably, often to refer to consumers purchasing coverage directly from insurers for themselves and/or their families via the individual exchanges. Similarly, *small businesses* and *small employers* may be used interchangeably, often in reference to such employers and/or their employees purchasing coverage via the SHOP exchanges.

[2] For example, about 16.3 million people obtained health insurance through the individual exchanges during the 2023 open enrollment period (November 1, 2022, through January 15, 2023, in most states). This figure is approximately 4.88% of the U.S. population of about 334.4 million people as of February 2023. See **Table 1** regarding exchange enrollment estimates and sources. The U.S. population estimate is part of a series of monthly projections made by the U.S. Census Bureau based upon the 2020 Census, 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 nongroup and small-group segments of the private health insurance market, respectively.[5] In an individual exchange, eligible consumers can compare and purchase nongroup insurance for themselves and their families and can apply for premium tax credits and cost-sharing reductions (PTCs and CSRs) that are available only through the exchanges (see "Premium Tax Credits and Cost-Sharing Reductions").

In a SHOP exchange, small businesses can compare and purchase small-group insurance and can apply for small business health insurance tax credits (see "Small Business Health Care Tax Credit"); 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 an 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 nongroup 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] Broadly, private health insurance includes group plans (largely, employer-sponsored insurance) and nongroup plans (i.e., plans that consumers purchase directly from insurers). 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 2023.

[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.

In rulemaking finalized January 19, 2021 (the 2022 Notice of Benefit and Payment Parameters, or "Payment Notice"[10]), HHS and the Department of the Treasury established new "direct enrollment" variations of the exchange types: FFE-DE, SBE-DE, and SBE-FP-DE. 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 would have been 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. The Biden Administration subsequently repealed the establishment of these DE exchange type options.[11]

"Direct Enrollment" (DE) and the Exchanges

Although current regulations do not allow states to adopt a direct enrollment *exchange type* (e.g., FFE-DE), there are ongoing uses of DE approaches and systems in the exchanges. In general, DE can be a way for consumers to enroll in an exchange plan directly on an insurer's or web-broker's website or otherwise with an agent or broker, rather than enrolling on an exchange website (e.g., HealthCare.gov).

[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] See 2022 Payment Notice, "Part 1," starting page 6143, regarding information in this paragraph. The Notice of Benefit 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. Because different parts of the Final 2022 Payment Notice were published in January 2021, May 2021, and September 2021, the informal references "Part 1," Part 2," and "Part 3" are used to distinguish them in this report. See **Table D-1** for Payment Notice citations.

[11] 2022 Payment Notice, "Part 3," starting on page 53424.

In the individual exchanges, consumers can enroll on their exchange website and may also have DE options. In FF-SHOP and some SB-SHOP exchanges, DE is the only enrollment option. See "Enrollment Processes and Options" in the SHOP section of this report, and "Brokers, Agents, and Other Third-Party Assistance Entities" in the Exchange Enrollment Assistance section, for more information.

For PY2023, 30 states have FFEs, 18 states have SBEs, and three states have SBE-FPs.[12] 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 and more state involvement. For example, as of PYs 2020-23, the following states have transitioned from FFE to SBE-FP, and/or from SBE-FP to SBE: Nevada, New Jersey, Pennsylvania, Maine, Virginia, Kentucky, and New Mexico.[13] After pursuing an alternative approach in recent years, Georgia is now seeking to transition from FFE to SBE.[14]

SHOP exchanges may be federally facilitated (FF-SHOP) or state-based (SB-SHOP).[15] Most states' individual and SHOP exchanges are administered in the same way (e.g., both state-based or both federally facilitated). However, in about half of the states, no insurers are offering medical plans in the SHOP exchange, meaning there is effectively no SHOP exchange there.[16] For PY2023, there are 8 FF-SHOPs and 15 SB-SHOPs with medical plans, 27 states with no SHOP medical plans, and one state exempted from operating a SHOP exchange.[17]

See **Figure 1** for individual and SHOP exchange types by state in PY2023, and see Table **A-1** for additional information, including on state transitions to different exchange types.

[12] In tallies throughout this report, the District of Columbia is counted as a state.

[13] For some considerations regarding such transitions, 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.

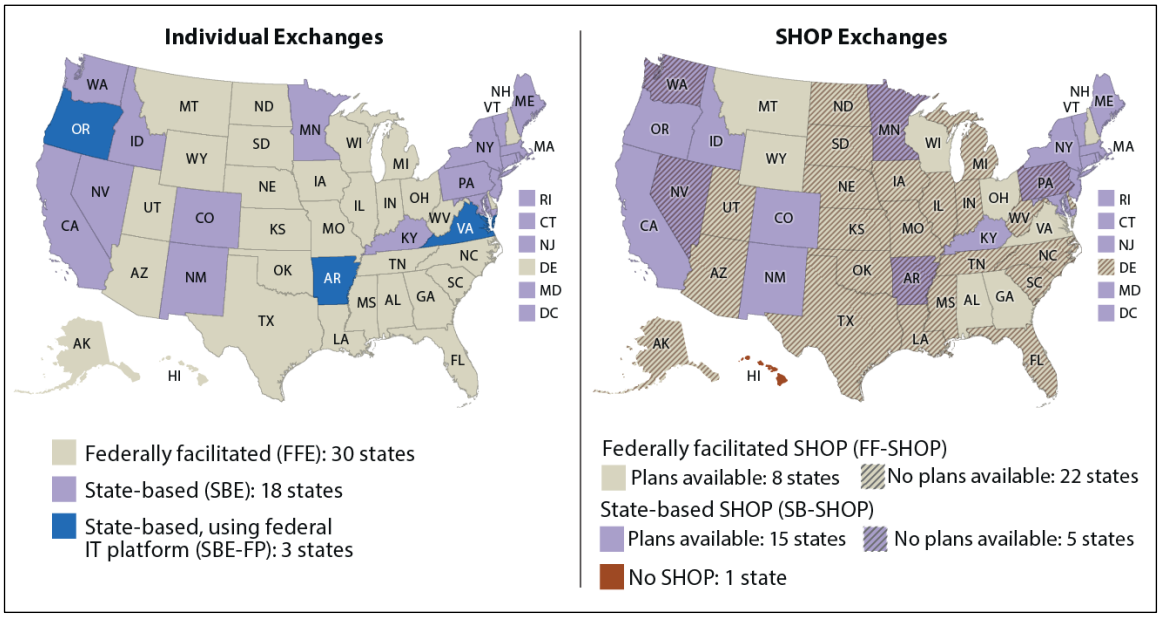
[14] In 2020, Georgia received approval through the Section 1332 state innovation waiver process to shift to its own Georgia Access Model, essentially a direct enrollment exchange type, beginning in PY2023. However, the Georgia Access Model component of the waiver was suspended for PY2023 in 2022. For more information about the 1332 waiver process, which 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*. In February 2023, Georgia indicated its intention to transition to an SBE approach. See State of Georgia Office of Commissioner of Insurance and Safety Fire, Letter to CCIIO, February 14, 2023, at https://oci.georgia.gov/document/document/georgia-sbe-blueprint-letter-cms/download.

[15] As of June 2018, states could 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. See "Enrollment Processes and Options" in the SHOP section of this report for more information.

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

[17] Hawaii received a Section 1332 waiver exempting it from operating a SHOP exchange. Initially set to expire after PY2021, the waiver was extended through PY2026 in December 2021.

Figure 1. Individual and SHOP Exchange Types by State, Plan Year 2023



Source: 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 the calendar year, but group plan years, including in the SHOP exchanges, may start at any time during a calendar year. See report "Overview" regarding individual and SHOP exchanges, and federal and state administration of exchanges.
In about half of the 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 section of this report for more information. There are medical plans available in all individual exchanges.
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.[18]

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.[19] 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.[20] 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

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

[19] 42 U.S.C. §18031(b)(1)(A).

[20] 42 U.S.C. §18031(d)(4).

structure, provider network, premiums, marketing practices, and quality improvement activities, to ensure compliance with applicable federal and state standards.[21] 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).[22] 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.[23] Covering the EHB package means covering 10 broad categories of benefits, complying with limits on consumer cost sharing on the EHB, and meeting certain generosity requirements (in terms of *actuarial value or AV*).[24] As discussed later in this report, an AV is an estimate of the "percentage of total average costs for covered benefits" to be paid by a plan. Plan AVs are associated with metal levels (90% AV for platinum plans, 80% for gold, 70% for silver, and 60% for bronze), and the higher the AV percentage, the lower the cost sharing, on average.[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 (or nongroup 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.[27] 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 that use provider networks must meet network adequacy standards, including maintaining provider networks that are "sufficient in number and types of providers" and include *essential community providers* (i.e., certain types of providers that serve predominantly low-income and medically underserved individuals). As of PY2023, QHP issuers in FFEs must meet

[21] 42 U.S.C. §18031(c)(1); 42 U.S.C. §18031(e). For more information, also see CMS, CCIIO, *2023 Final Letter to Issuers in the Federally Facilitated Exchanges*, April 28, 2022, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf. Hereinafter referred to as "CMS, *2023 Final Letter to Issuers*."

[22] 42 U.S.C. §18031(d)(2)(B).

[23] 42 U.S.C. §18021(a)(1).

[24] 42 U.S.C. §18022.

[25] See "Cost Sharing, Maximum Out-of-Pocket Limits, and Actuarial Value Levels" for more information.

[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 *CMS, 2023 Final Letter to Issuers.*

"time and distance" standards related to network adequacy requirements.[28] Also as of PY2023, QHP issuers in FFEs and SBE-FPs must offer standardized plans, as explained below.

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. 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.

Standardized Plans

In the 2023 Payment Notice finalized in May 2022, HHS indicated that insurers offering QHPs in FFEs and SBE-FPs[29] are required to offer "standardized plans" starting in PY2023. In general, a *non-standardized plan* is one that meets the requirements outlined above (i.e., QHP and other applicable federal or state requirements), but otherwise may vary in terms of benefits, cost sharing, and/or other features. A *standardized plan* also meets those requirements, and meets certain other parameters—particularly in terms of cost-sharing requirements—outlined by HHS in the 2023 Payment Notice. Standardized plans may still vary in other ways.

Specifically, HHS designed a standardized plan option for each metal level of plan offered in the exchanges, and specified variations of them. For each of these standardized plans, cost-sharing requirements are set for certain categories of benefits and overall (e.g., the plan's deductible and annual out-of-pocket limit). QHP issuers must offer a standardized plan "at every product network type ... , at every metal level, and throughout every service area that they offer non-standardized QHP options in the individual market."[30] For example, if an insurer offers *a non-standardized* gold health maintenance organization (HMO) QHP in a given service area, such insurer must also offer a *standardized* gold HMO QHP throughout that service area.[31]

For tables outlining the cost-sharing requirements, and for other details, including on exchanges' and other entities' displays of standardized plan options, see the 2023 Payment Notice. Other

[28] QHP network adequacy standards, including time and distance requirements, are at 45 C.F.R. §156.230. Essential community provider requirements are at 45 C.F.R. §156.235.

[29] 2023 Payment Notice, starting on page 27310; codified at 45 C.F.R. §156.201. This policy does not apply in SBEs, although some states with SBEs already do or plan to require QHP issuers to offer standardized plans. This policy also does not apply in FFEs or SBE-FPs where a state has its own requirements for standardized plans as of January 1, 2020 (Oregon), and there are variations of the requirements to accommodate certain states' cost-sharing laws (Delaware and Louisiana).

[30] 2023 Payment Notice, page 27312.

[31] CMS, *HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet,* April 28, 2022, at https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet. A plan's service area is the geographic area – generally a whole county or group of counties – in which it is available to consumers. See HealthCare.gov, "Service area," at https://www.healthcare.gov/glossary/service-area/. Also see 45 C.F.R. §155.1055.

resources provide further background on this issue, including prior federal rulemaking on standardized plans and certain state approaches.[32]

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;[33] (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.[34] 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."[35] 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.[36] 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, in person, and/or via approved partner websites (i.e., via direct enrollment), as available by state. Enrollment assistance is available for those who want it (e.g., through exchange Navigators or through agents or brokers).[37]

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[32] See, for example, HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces,* December 28, 2021, at https://aspe.hhs.gov/reports/standardized-plans-health-insurance-marketplaces. Also see Katie Keith, "Final 2023 Payment Rule, Part 2: Standard Plans And Other Exchange Provisions," *Health Affairs Forefront,* April 30, 2022, at https://www.healthaffairs.org/do/10.1377/forefront.20220430.953129/.

[33] 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.

[34] 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/.

[35] 42 U.S.C. §18083, 45 C.F.R. §155.405.

[36] 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.

[37] See "Exchange Enrollment Assistance" in this report for information on Navigators, agents and brokers, and approved web brokers and other technology providers.

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.[38]

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 reductions).

There are some limitations on the sale of exchange plans to Medicare-eligible or Medicare-enrolled individuals.[39] In short, it is generally illegal to sell an individual exchange plan to someone enrolled in or entitled to Medicare because it would duplicate coverage.

Open and Special Enrollment Periods

Consumers may enroll in coverage through the exchanges only during specified "open" and "special" enrollment periods.

Open Enrollment Periods

Anyone eligible for exchange plan coverage may newly enroll (or make changes to existing coverage) during an annual *open enrollment period* (OEP).[40] 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 annual federal OEP is November 1 to January 15, for FFE and SBE-FP states.[41] This means, for example, that the OEP for PY2023 was November 1, 2022, to January 15, 2023.[42] This is also the default OEP for SBEs, but states with SBEs may extend their OEPs, and they may also choose to offer a shorter OEP than is federally offered, as long as the SBE's OEP is at least November 1-December 15.[43]

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[38] 45 C.F.R. Part 155, Subpart D, including §155.302. Regarding FFE and SBE-FP states, also see Section 2.1.2 of CMS, *Federally-facilitated Exchange (FFE) and Federally-facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual*, July 28, 2022, at https://www.cms.gov/files/document/ffeffshop-enrollment-manual-2022.pdf. Hereinafter referred to as "CMS, *FFE and FF-SHOP Enrollment Manual (2022)*." 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.

[39] Social Security Act §1882(d)(3)(A)(i). Medicare is a federal 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 or entitled to Medicare does not apply to employment-based coverage, including coverage sold in the SHOP exchanges. See CMS, "Medicare and the Marketplace," updated December 2021, at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html. Also see Section 3.4.8 of CMS, *FFE and FF-SHOP Enrollment Manual (2022).* Information for consumers is at Medicare.gov, "Medicare & the Marketplace," at https://www.medicare.gov/about-us/medicare-the-marketplace.

[40] 45 C.F.R. §155.410.

[41] These annual OEP dates were updated via rulemaking, effective as of the PY2022 OEP (in fall 2021). See the 2022 Payment Notice, "Part 3," starting on page 53429. See prior year OEPs at 45 C.F.R. §155.410(b) and (e).

[42] Consumers enrolling by December 15 of a given OEP are to have coverage beginning January 1. Consumers enrolling December 16-January 15 are to have coverage beginning February 1.

[43] For PY2023 SBE OEPs, see CMS, "State Exchange OE Chart PY 2023," at https://www.cms.gov/files/document/state-exchange-open-enrollment-chart.pdf. For PY2022 and prior year SBE OEP information, see the CMS page of

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.[44] 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.[45]

Special Enrollment Periods

Outside of an OEP, consumers may only enroll in coverage (or switch plans) via the exchange if they qualify for a *special enrollment period* (SEP). Generally, consumers qualify for SEPs due to a *qualifying life event* (QLE), also called a *triggering event*.[46] This includes, for example:

- **Loss of *qualifying coverage*,** which includes most types of comprehensive coverage (e.g., Medicare, Medicaid, and group and nongroup private insurance).[47] This SEP also applies when a dependent turns 26 and is no longer eligible to be covered on a parent's plan. This SEP does *not* apply in certain circumstances, such as loss of coverage due to failure to pay premiums, or voluntarily ending coverage during a plan year.[48]
- **Change in household size**, for example due to a change in marital status or number of dependents, or due to a death in the family.[49] Regarding dependents, birth and adoption (and other specified scenarios) are QLEs that trigger SEPs but generally not pregnancy.[50]

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marketplace public use files at https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files.

[44] See Section 3.2.5 of CMS, *FFE and FF-SHOP Enrollment Manual (2022)*; its "Reenrollment Communications to Enrollees" section cites CMS, *Updated Federal Standard Renewal and Product Discontinuation Notices in the Individual Market (Required for Notices Provided in Connection with Coverage Beginning in the 2021 Plan Year),* July 31, 2020, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-Federal-Standard-Notices-for-coverage-beginning-in-the-2021-plan-year.pdf. There, see "Instructions for Attachment 2," item 20.

[45] 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 3.2 of CMS, *FFE and FF-SHOP Enrollment Manual (2022)*. Although this manual describes processes for HealthCare.gov states, SBEs also have processes for automatic reenrollment.

[46] In addition to the examples and their regulatory citations shown here, see HealthCare.gov information on SEPs at https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and https://www.healthcare.gov/sep-list/. Also see 45 C.F.R. §147.104 regarding SEPs applicable to the individual and group markets overall.

[47] 45 C.F.R. §155.420(d)(1), (e)(1). *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.

[48] While exchange plan enrollees may voluntarily terminate their coverage at any time during the plan year, this would not necessarily trigger an SEP through which someone could select a new plan.

[49] 45 C.F.R. §155.420(d)(2).

[50] There is no federal SEP specifically for pregnant individuals, but there are pregnancy-related SEPs in at least eight SBEs: Colorado (as of 2024), Connecticut, Maine, Maryland, New Jersey, New York, Vermont, and Washington, DC. In addition, see 45 C.F.R. §155.420(d)(1)(iii), which specifies that the loss of certain other pregnancy-related coverage (e.g., via Medicaid) would trigger a federal exchange SEP.

- **Becoming newly eligible** for exchange coverage (e.g., by becoming a U.S. citizen or leaving incarceration), **and/or having a change in income** that affects eligibility for federal subsidies for coverage.[51]
- **Change in residence,** such as moving to a new state (or new ZIP code or county within a state), including moves for school or seasonal work.[52]
- **Certain other situations,** including errors or misrepresentations made by exchanges and/or plans,[53] and other exceptional or complex circumstances.[54]

HHS also may choose to offer SEPs or extend an OEP for some or all consumers due to broadly applicable circumstances, or otherwise make SEP changes (subject to statutory requirements).[55] For example, due in part to the COVID-19 pandemic, HHS created an SEP to allow all exchange-eligible consumers to newly enroll or update their enrollment in an exchange plan from February 15, 2021, to August 15, 2021.[56] In addition, for the duration of the COVID-19 emergency declared by the Federal Emergency Management Agency (FEMA), if someone otherwise qualifies for another SEP, but misses their SEP enrollment deadline (generally a 60 day period) due to the impacts of COVID-19, they might still qualify to enroll.[57]

Federal SEPs apply to FFEs, SBE-FPs, and generally to SBEs. However, SBEs have flexibility regarding implementation of some SEPs.[58] SBEs also may create their own SEPs, subject to applicable federal and state laws. SEPs for the individual exchanges may or may not apply to the federal SHOP exchanges and/or to the nongroup market outside the exchanges.[59]

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.

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[51] 45 C.F.R. §155.420(d)(3, 6).

[52] 45 C.F.R. §155.420(d)(7). Note, per HealthCare.gov, that "moving only for medical treatment or staying somewhere for vacation doesn't qualify you for a Special Enrollment Period."

[53] 45 C.F.R. §155.420(d)(4, 5, 12).

[54] 45 C.F.R. §155.420(d)(8-15). These include SEPs related to gaining or maintaining status as an Indian, being a victim of domestic abuse or spousal abandonment, having access to an Individual Coverage Health Reimbursement Account (ICHRA) or being enrolled in COBRA continuation coverage, and more.

[55] Statutory requirements for exchange SEPs are at 42 U.S.C. §18031(c)(6), and Secretarial authority to establish standards for the exchanges is at 42 U.S.C. §18041(a). Also see 45 C.F.R. §155.420(d)(9) regarding SEPs for "exceptional circumstances." Examples of certain 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.

[56] This SEP was initially set to end May 15, 2021, and was later extended to August 15, 2021. See 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, and CMS, "Extended Access Opportunity to Enroll in More Affordable Coverage Through HealthCare.gov," March 23, 2021, at https://www.cms.gov/newsroom/fact-sheets/extended-access-opportunity-enroll-more-affordable-coverage-through-healthcaregov.

[57] Regarding this enrollment flexibility, see HealthCare.gov at https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/. Regarding the COVID-19 emergency declared by FEMA (which, as of February 2023 is set to end on May 11, 2023), see CRS Insight IN12088, *Effects of Terminating the Coronavirus Disease 2019 (COVID-19) PHE and NEA Declarations*.

[58] For example, the COVID-19 SEP, described above, was available in all FFEs and SBE-FPs. States with SBEs were "strongly encouraged" by CMS to take similar action, and all SBEs (15 in PY2021) did so. See page 19 of HHS, 2021 FINAL MARKETPLACE SPECIAL ENROLLMENT PERIOD REPORT, September 15, 2021, at https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf.

[59] For more information about SEPs, see Section 6 of CMS, *FFE and FF-SHOP Enrollment Manual (2022).*

Monthly SEP for Certain Low-Income Populations

As discussed later in this report, consumers may be eligible (based on income and other criteria) to receive premium tax credits (PTCs) that reduce the cost of buying certain health plans offered through the exchanges. In 2021, the American Rescue Plan Act (ARPA; P.L. 117-2) temporarily enhanced eligibility for and the amount of these PTCs. In August 2022, P.L. 117-169, which is commonly known as the Inflation Reduction Act of 2022 (IRA), extended these PTC enhancements through tax year 2025.

Separately, a new federal SEP was created through rulemaking in September 2021, effective as of PY2022.[60] This is a monthly SEP for consumers who are eligible for the PTC and have expected household incomes up to 150% of the federal poverty level (FPL). Specifically, such individuals may newly enroll or switch plans once a month during periods of time when they would qualify for a $0 premium on a benchmark plan due to the PTC.

In the preamble of the rule finalizing this SEP, HHS stated that the SEP eligibility criteria are based on the ARPA enhancements to the PTC. Although this SEP was not required by ARPA and is not exclusive to ARPA, it is effective only during times when PTC enhancements are available, such as those in ARPA and now in the IRA. In other words, the IRA's extension of the PTC enhancements has also effectively extended this SEP.

Consumers eligible for this SEP have certain enrollment options depending on their current enrollment status. For example, current exchange plan enrollees who become eligible under this SEP are only able to change to a silver-level plan, but new enrollees may select any metal-level plan. These options may be more limited than the enrollment options related to other SEPs.[61] The enrollment options and adverse selection concerns are also summarized in a Health Affairs article on the final rule.[62]

This SEP is available in all FFE and SBE-FP states. It is optional for SBEs and at least nine SBEs have implemented it. Insurers are not required to offer this SEP outside of the exchanges.[63] HHS also clarified in the final rule that this new SEP and its related enrollment options do not change eligibility for, or enrollment options for, any other exchange SEP.

SEP Related to the Unwinding of Medicaid Continuous Enrollment

In January 2023, CMS announced a new SEP for eligible consumers who lose Medicaid or CHIP coverage due to the end of these programs' continuous enrollment conditions, which have been in place during the COVID-19 pandemic. For consumers using HealthCare.gov, this SEP is to be available if they apply for coverage or update their applications between March 31, 2023, and July 31, 2024, and attest to an end of Medicaid or CHIP coverage during that period. This SEP is available in all FFE and SBE-FP states. It is optional for SBEs.[64]

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[60] 45 C.F.R. §155.420(d)(16), as added by the 2022 Payment Notice, "Part 3," starting at page 53432. The discussion of the effective date starts on page 53438.

[61] See 45 C.F.R. §155.420(a)(3-4) for enrollment options (e.g., for enrollees and/or their dependents, and for different metal level plans) for different SEPs. Plan metal levels are explained in "Cost Sharing, Maximum Out-of-Pocket Limits, and Actuarial Value Levels" in this report.

[62] Katie Keith, "Biden Administration Finalizes First Marketplace Rule, Including New Low-Income Special Enrollment Period," *Health Affairs Forefront*, September 20, 2021, at https://www.healthaffairs.org/do/10.1377/forefront.20210919.154415/.

[63] 45 C.F.R. §147.104(b)(2)(i)(G), as added by the 2022 Payment Notice, "Part 3."

[64] For further details, including regarding consumers who may be eligible for more than one SEP, see CMS, *Temporary*

Enrollment Estimates

Annual individual exchange enrollment estimates to date are shown in **Table 1**. 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. As of the date of this report, CMS has released a 2023 OEP "Final National Snapshot," estimating that 16.3 million consumers signed up for a plan in the individual exchanges nationwide, between November 1, 2022, and January 15, 2023.[65] Additional pre-effectuated enrollment data will likely be released in spring 2023.

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.

Table 1. Nationwide Individual Exchange Enrollment Estimates, by Plan Year

(in millions)

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Pre-effectuated (final for PY OEP)[a]	8.0	11.7	12.7	12.2	11.8	11.4	11.4	12.0	14.5
Effectuated, early in PY (point-in-time as of date shown)[b]	Early 2014 estimate not found	10.2, Mar. 2015	11.1, Mar. 2016	10.3, Feb. 2017	10.6, Feb. 2018	10.6, Feb. 2019	10.7, Feb. 2020	11.3, Feb. 2021	13.8, Feb. 2022
Effectuated, late in PY (point-in-time or average for month shown)[c]	6.3, Dec. 2014	8.8, Dec. 2015	9.1, Dec. 2016	8.9, Dec. 2017	9.2, Dec. 2018	9.1, Dec. 2019	9.9, Dec. 2020	12.2, Dec. 2021	Dec. 2022 data expected summer 2023

Source: CRS analysis of 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.

Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition– Frequently Asked Questions (FAQ), January 27, 2023, at https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf.

[65] CMS, *Marketplace 2023 Open Enrollment Period Report: Final National Snapshot*, January 25, 2023, at https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-final-national-snapshot.

Notes: OEP = open enrollment period; PY = plan year. In the individual exchanges, a plan year is generally the calendar year. See "Open and Special Enrollment Periods" in this report for more information.

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 state-based exchange (SBE) OEPs. For these data sources by year, see the "Pre-effectuated Enrollment Data" section of the report mentioned above. For example, the 2021 estimate is from CMS, *Health Insurance Exchanges 2021 Open Enrollment Report*, April 2021.

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 in 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 estimate 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 (e.g., the 2018 estimate is from the end of the report CMS, *Early 2019 Effectuated Enrollment Snapshot,* August 2019).

Premiums, Cost Sharing, and Subsidies

Typically, enrollees of private health insurance plans (in or out of the exchanges) pay *premiums* to obtain coverage. They also are generally responsible for *out-of-pocket* (OOP) costs, or *cost sharing*, as they use benefits.

Premiums

Premiums are set by insurers and are based on their expected medical claims costs (i.e., the payments they expect to make to health care providers for covered health benefits for a given group of enrollees), 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.[66] 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.[67] If consumers do not pay their premiums, insurers may terminate their coverage, subject to applicable federal and state requirements.[68]

Data on exchange premiums are in **Table 3** at the end of this section.

Cost Sharing, Maximum Out-of-Pocket Limits, and Actuarial Value Levels

As enrollees receive benefits covered by the plan, the costs for the benefits are paid by the enrollee and/or the plan, depending on the plan's terms. In general, enrollee cost sharing includes

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

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

[68] 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).

deductibles, coinsurance, and co-payments, up to an annual limit on consumer out-of-pocket (OOP) spending.[69]

Federally set maximum OOP limits apply to all health plans sold in the exchanges and to all non-grandfathered nongroup and group plans sold outside the exchanges.[70] The maximum OOP limits are updated each year through HHS rulemaking and/or guidance. See **Table 2** for the maximum limits that apply to most plans. QHP issuers must also offer plan variations with reduced OOP limits for consumers who qualify for cost-sharing reductions, as discussed in the next section. And as of PY2023, certain QHP issuers must also offer standardized plans as specified in rulemaking, some of which would also have lower OOP limits than shown in Table 2.[71] Plans may set their OOP limits lower than the applicable maximums.

Most health plans sold through the exchanges (and non-grandfathered plans sold in the nongroup and small-group markets off-exchange[72]) must provide coverage in compliance with one of four levels of *actuarial value* (AV), which correspond to a precious metal designation.[73] AV is an estimate of the "percentage of total average costs for covered benefits" to be paid by a plan.[74] The four AV levels are 90% for platinum, 80% for gold, 70% for silver, and 60% for bronze.[75]

Given that plans and enrollees collectively pay total costs, AV is the plan counterpart to enrollee cost-sharing expenses. The higher the AV percentage, the lower the cost sharing, on average. For example, a silver plan expects to cover approximately 70% of total costs for covered benefits. Because enrollees' use of such benefits vary, a given silver plan enrollee's actual cost sharing may be more or less than 30% of costs associated with receipt of covered benefits. AV is not a measure of plan generosity for an enrolled individual or family, nor is it a measure of premiums or benefits packages.

With the exception of "catastrophic" plans and stand-alone dental plans (see **Table B-1**), plans sold in the exchanges must have at least 60% AV. An insurer selling plans in an exchange must offer at least a silver and gold plan throughout each service area in which it offers coverage.[76]

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[69] In general, beginning with each plan year, an enrollee pays 100% of the costs of their covered benefits until they meet a threshold amount called a deductible. Exceptions apply. After that, the enrollee pays coinsurance (a percentage amount) or co-payments (a flat amount) for covered benefits, and the plan pays the rest. If an enrollee's spending meets an annual OOP limit, the plan will generally pay 100% of covered costs for the remainder of the plan year.

[70] 45 C.F.R. §156.130(a). The annual out-of-pocket limit is generally 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. See CRS Report R45146, *Federal Requirements on Private Health Insurance Plans* for more information, including about self-only and other-than-self-only coverage, as shown in the table.

[71] See the "Standardized Plans" section of this report.

[72] *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/.

[73] 42 U.S.C. §18022(d).

[74] See the definition of actuarial value in the glossary posted on HealthCare.gov at https://www.healthcare.gov/glossary/actuarial-value/. AV calculations include only costs associated with a plan's covered EHB that are furnished by in-network providers, unless otherwise addressed in federal or state law.

[75] Regulations allow plans to fall within a specified AV range and still comply with one of the four levels; see 45 C.F.R. §156.140(c)(2).

[76] 45 C.F.R. §156.200(c)(1).

Table 2. Maximum Annual Limitations on Cost Sharing, by Plan Year

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

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Self-Only Coverage[a]	$6,350	$6,600	$6,850	$7,150	$7,350	$7,900	$8,150	$8,550	$8,700	$9,100
Coverage Other Than Self-Only[a]	$12,700	$13,200	$13,700	$14,300	$14,700	$15,800	$16,300	$17,100	$17,400	$18,200
Percentage Increase over Prior Year	N/A	3.9%	3.8%	4.4%	2.8%	7.5%	3.2%	4.9%	1.8%	4.6%

Source: CRS analysis of relevant federal rulemaking regarding 45 C.F.R. §156.130(a)(2). These amounts have generally been updated each year through an HHS rule called the Notice of Benefit and Payment Parameters, also known as the Payment Notice. Starting with PY2023, these OOP limits and certain other payment parameters will be published in guidance instead of future Payment Notices. For PY2023 amounts, see CMS, *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2023 Benefit Year*, December 28, 2021, at https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf. This is also referenced in the 2023 Payment Notice, page 27305. Annual Payment Notices are cited in **Table D-1**.

Notes: Once an enrollee's cost sharing (including deductibles, coinsurance, and co-payments) meet the plan's OOP limit in a plan year, the insurer generally will pay 100% of covered costs for the remainder of the plan year. This table shows federally set OOP limits that apply to most plans, but some plan variations must have lower OOP limits. See "Standardized Plans" and "Premium Tax Credits and Cost-Sharing Reductions" in this report. Plans may also set their OOP limits lower than the applicable maximums.

a. If a consumer is solely enrolled in a plan, the self-only limit applies. If a consumer and one or more dependents are enrolled in a plan, both the self-only and the other than self-only limits may apply. See "Maximum Annual Limitation on Cost-Sharing" in CRS Report R45146, *Federal Requirements on Private Health Insurance Plans* for further information.

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 assistance is provided in the form of premium tax credits (PTCs) and cost-sharing reductions (CSRs).[77]

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

[77] 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 Credit and Cost-Sharing Reductions*.

Individuals who receive PTCs also may be eligible for subsidies that reduce cost-sharing expenses.[78] These cost-sharing reductions (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 AV of the eligible individual's plan, for example by reducing other cost-sharing requirements in addition to 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.

Premium Tax Credit and Cost-Sharing Reductions Under the American Rescue Plan Act of 2021 and the Inflation Reduction Act of 2022

Several provisions of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) temporarily expanded eligibility for and the amount of the premium tax credit (PTC) and cost-sharing reductions (CSRs) for certain individuals. For example, ARPA eliminated the eligibility phase-out for households with annual incomes above 400% of the Federal Poverty Level (FPL) and reduced the percentage of annual income used in the credit formula. The temporary formula change benefitted households with incomes between 100% and 150% of FPL the most; such individuals may have received full subsidies to cover the premiums of certain plans.

Enacted in August 2022, P.L. 117-169 (commonly known as the Inflation Reduction Act of 2022) extends the ARPA PTC enhancements – but not its CSR enhancements – through tax year 2025.

For more information about these PTC changes and for discussion of ARPA's CSR changes, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*. See "Monthly SEP for Certain Low-Income Populations" in this report for discussion of a special enrollment period related to the PTC enhancements.

Premium, APTC, and CSR Data

Table 3 summarizes nationwide data on premiums, advance premium tax credit (APTC)[79], and CSRs by year, as available in relevant HHS reports on effectuated enrollment.[80] 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. In addition, the APTC data in the table are not necessarily final for each year, 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.

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 PY2023.[81]

[78] 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.

[79] 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.

[80] In the reports cited in **Table 3**, 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*.

[81] For example, regarding premiums and cost sharing on plans offered in FFEs and SBE-FPs in PY2023, see CMS, CCIIO, *Plan Year 2022 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces*, October 2022,

Table 3. Data on Premiums, Advance Premium Tax Credits, and Cost-Sharing Reductions Nationwide, by Plan Year

(based on effectuated enrollment in all individual exchanges)

	2014[a]	2015[b]	2016[b]	2017[c]	2018[d]	2019	2020	2021	2022
Average total premium per month[e]	N/A	N/A	N/A	$470.52	$597.20	$594.17	$576.16	$574.59	$586.56
Average APTC per month[f]	$276	$272	$291	$373.06	$519.89	$514.01	$491.53	$485.67	$508.26
Percentage of enrollees receiving APTC[g]	86%	85%	85%	84%	87%	87%	86%	86%	90%
Percentage of enrollees receiving CSR[h]	58%	57%	57%	57%	53%	52%	50%	48%	49%
Data as of	Dec. 2014	Mar. 2015	Mar. 2016	PY 2017	Feb. 2018	Feb. 2019	Feb. 2020	Feb. 2021	Feb. 2022

Source: CRS analysis based on Department of Health and Human Services (HHS) reports of individual exchange enrollment in private health insurance plans, as specified in table notes and cited at CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics* in the "Point-in-Time Effectuated Enrollment Data" section. These PY2022 estimates, for example, were point-in-time as of February 2022, and published in September 2022.

Notes: N/A = not available. PY = plan year. APTCs (advance premium tax credits) and CSRs (cost-sharing reductions) 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, Cost Sharing, and Subsidies" 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. Subsequent year data in this table are from similar subsequent year reports.

at https://www.cms.gov/CCIIO/Resources/Data-Resources/QHP-Choice-Premiums. Hereinafter referred to as "CMS, *QHP Choice, PY2023*." Also see KFF, "Average Marketplace Premiums by Metal Tier, 2018-2023," not dated, 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, 2014-2023," February 2023, at https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/.

e. 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."

f. 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."

g. 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."

h. 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 federally required to participate in the exchanges, but they must meet certain requirements if they do want to offer plans in an exchange.

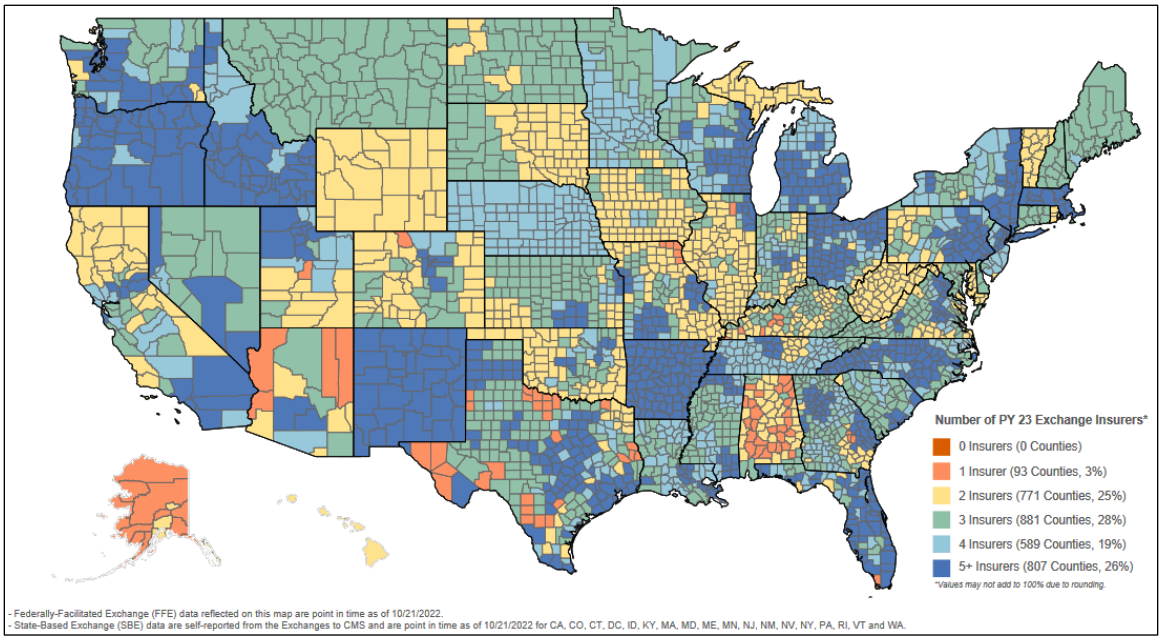
For each plan year to date, at least one insurer has offered an individual exchange plan in each county in all states. However, there have been concerns about "bare counties" in one or more plan years, particularly as insurers were making their decisions in 2017 about offering coverage for PY2018.[82]

See **Figure 2** for CMS projections of insurer participation in all individual exchanges in PY2023. According to a CMS report on FFE and SBE-FP states only, "out of the 33 PY23 HealthCare.gov states, 11 states have more QHP issuers participating in PY23 than PY22, and 22 states have counties with more QHP issuers in PY23 than PY22 due to new issuers entering and existing issuers expanding service areas."[83]

[82] See, for example, Erica Teichert, "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.

[83] CMS, *QHP Choice, PY2023*.

Figure 2. Plan Year 2023 Insurer Participation in the Individual Exchanges, by County



Source: Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), "County by County Plan Year 2023 Insurer Participation in Health Insurance Exchanges," published October 31, 2022, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Health-Insurance-Exchange-Coverage-Maps. This page also has such maps for prior years.

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. In January 2019, the Government Accountability Office (GAO) released a report on insurer participation and related issues in the individual exchanges.[84] The report provided background on a range of policy factors that may have affected insurer participation in various ways, including the following:

- the federal requirements imposed by the ACA on plans sold in the nongroup market, including the individual exchanges;[85]
- the consumer financial assistance available only in the exchanges;[86]
- 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;[87]

[84] 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.

[85] 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 nongroup market that previously existed in one or more segments of the group market.

[86] 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.

[87] 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

- federal policy changes in the years since the enactment of the ACA;[88] 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).

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.[89] States also may define *small employer* as having not more than 100 employees–four states do.[90] As of 2017, all states have the option to allow *large employers* to use SHOP exchanges, as well, but no states have done so.[91]

SHOP eligibility also depends on an employer having at least at least one *common-law employee*.[92] 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.[93] The business may, but is not required to, offer coverage to part-time

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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*.

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

[89] 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.

[90] 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 CMS/CCIIO, "Market Rating Reforms," updated December 2021, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating. Also see **Table A-1**.

[91] 42 U.S.C. §18032(f)(2)(B).

[92] 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.

[93] 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.[94] 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.[95] 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.[96] 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 SEPs for SHOP exchange coverage. Some of the SEPs for the SHOP exchanges are the same as in the individual exchanges.[97]

Enrollment Processes and Options

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.[98] Then, employees review their employer's plan option(s) and enroll if they choose. The process of comparing and enrolling in coverage depends partially on a state's SHOP exchange type:

- 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.[99] This is called *direct enrollment*, and it has been the only option in such states since plan years beginning in 2018.[100] Previously, employers and employees could purchase coverage on HealthCare.gov or via direct enrollment.

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[94] 45 C.F.R. §155.710(e).

[95] 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. See, for example, the HealthCare.gov page on SHOP eligibility and enrollment: https://www.healthcare.gov/small-businesses/choose-and-enroll/qualify-for-shop-marketplace/.

[96] 45 C.F.R. §155.726(b).

[97] 45 C.F.R. §155.726(c). See also Section 4.4 of CMS, *FFE and FF-SHOP Enrollment Manual (2022)*, 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]."

[98] 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/.

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

[100] 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.[101] As of April 2016, HHS indicated SB-SHOPs would need to implement online portals in time for plan years beginning in 2019.[102] 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. For PY2023, of the 15 SB-SHOP states with medical plans offered, nine are using DE approaches only.[103]

Besides exchange website enrollment versus direct enrollment options, a significant factor affecting enrollment processes is whether any insurers are offering plans in that state's SHOP exchange. For PY2023, there are no insurers offering medical plans in SHOP exchanges in about half of states.[104] In such states, the federal or state SHOP web page instructs users to work directly with an agent, broker, or insurer to obtain coverage in the small-group market off-exchange.

See **Table A-1** for more information on SHOP exchange plan availability and enrollment methods, by state.

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.[105] CMS previously estimated 10,700 active small employers and 85,000 employees in the SHOP exchanges as of May 2015.[106]

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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 the 2019 Payment Notice is in **Table D-1**.

[101] 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.

[102] 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*.

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

[104] The number of states with no insurers offering plans in SHOP exchanges in 2023 is based on CRS analysis of the 2023 "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."

[105] 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.

[106] 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/

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.[107]

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

Congressional Member and Staff Enrollment via the DC 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.[108] 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 information earlier in this report on premiums and cost sharing in the individual exchanges, including certain federal requirements that apply to premiums and cost sharing (e.g., AV levels), 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 nongroup and small-group markets, on and off the exchanges.

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 organizations' 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).[109] In general, this credit is available only to small employers with 25 or fewer full-time-equivalent

20170118124128/https:/blog.cms.gov/2015/07/.

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

[108] 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/.

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

(FTE) employees that purchase coverage through SHOP exchanges and contribute at least 50% of premium costs for their full-time employees.[110] (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.[111]) 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, 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.[112]

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 $30,700 or less (in 2023).[113] 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.[114]

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 exchanges (see "Premium Tax Credits and Cost-Sharing Reductions").

The IRS has published information on the number of SBTCs filed in tax years 2010-2016.[115] For 2016, the IRS indicates that 6,952 employers claimed the SBTC.[116]

Insurer Participation

As stated above, as of PY2023, there are no insurers offering SHOP medical plans in about half of states. 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 nongroup market, there were new federal requirements imposed by the ACA on plans sold in the small-group market (including

described in this section.

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

[111] 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.

[112] Internal Revenue Service (IRS), *Small Business Health Care Tax Credit Questions and Answers: Who Gets the Tax Credit,* Question 6D, updated September 2022, at https://www.irs.gov/newsroom/small-business-health-care-tax-credit-questions-and-answers-who-gets-the-tax-credit.

[113] IRS, Rev. Proc. 2022-38, Section 3.10, at https://www.irs.gov/pub/irs-drop/rp-22-38.pdf, referring to 26 U.S.C. §45R(d)(3)(B).

[114] 26 U.S.C. §45R(d)(1)(B).

[115] IRS, *SOI Tax Stats - Affordable Care Act (ACA) Statistics: Credit for Small Employer Health Insurance,* "Premiums," page updated Sept. 2022, at https://www.irs.gov/statistics/soi-tax-stats-affordable-care-act-aca-statistics-credit-for-small-employer-health-insurance-premiums.

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

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.[117] 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.[118]

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.[119]

Each exchange must have a *Navigator* program.[120] Navigators are entities whose employees and/or volunteers

- conduct public outreach and education activities about the exchanges and 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;
- refer consumers to any applicable consumer assistance programs as needed, such as state agencies that assist consumers with questions or complaints about their plans; and
- comply with other Navigator requirements, as specified.

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."[121]

[117] 2018 Payment Notice, page 94144. Citation for this rule is at **Table D-1**.

[118] 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; and GAO, *Enrollment Remains Concentrated among Few Issuers, including in Exchanges*, March 2019, at https://www.gao.gov/assets/gao-19-306.pdf. Also see Timothy Jost, "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/.

[119] 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.

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

[121] 45 C.F.R. §155.210(c)(1)(iii).

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 grants in FFE states is available on the CMS website.[122] Also for FFE states, additional funding was made available for Navigator grantees in March 2021, for purposes of outreach and enrollment efforts regarding the COVID-19 SEP (discussed earlier in this report).[123]

For FFE states, certain Navigator eligibility requirements were changed in the 2019 and 2020 Payment Notices. For example, Navigator entities were no longer required to maintain a physical presence in their exchange service area, and it became optional rather than mandatory for Navigators to provide assistance on certain post-enrollment topics (e.g., eligibility appeals, PTC reconciliation, and how to use health coverage).[124] In the 2022 Payment Notice "Part 3," HHS again required that FFE Navigators provide assistance on the post-enrollment topics but did not reverse the other changes.

Exchanges also must have a *Certified Application Counselor* (CAC) program.[125] 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.[126]

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.[127] Exchanges also provide consumer information and outreach via mail, radio or television ads, and/or other methods. Overall, exchanges' consumer outreach efforts and materials must meet certain standards regarding accessibility for individuals with disabilities or with limited English proficiency.[128]

[122] 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. This includes the 2022 Navigator grants announced in August 2022. CRS is not aware of a compilation of information about Navigator grants in states that administer these programs (those with SBEs and SBE-FPs).

[123] CMS, "CMS Announces Additional Navigator Funding to Support Marketplace Special Enrollment Period," March 1, 2021, at https://www.cms.gov/newsroom/press-releases/cms-announces-additional-navigator-funding-support-marketplace-special-enrollment-period.

[124] Payment Notice citations are in **Table D-1**.

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

[126] 45 C.F.R. §155.215.

[127] 45 C.F.R. §155.205.

[128] 45 C.F.R. §155.205.

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.[129] In general, agents or brokers may be individuals or entities that sell plans for different insurance companies, usually receiving a commission from those companies for doing so. There are also insurance company agents who help people enroll in that company's plans. Different types of "web-brokers" and "direct enrollment technology providers" can also be approved to operate non-exchange websites that interface with exchange websites, to allow consumers to enroll in exchange plans without visiting the exchange website.[130]

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 via the exchange website.[131] Unlike the exchange websites and exchange Navigators and other assistors, however, these entities 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.[132]

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.[133] For each fiscal year (FY) between FY2011 and FY2014, the HHS Secretary determined the total amount that was made available to 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.[134]

Ongoing Federal Spending on Exchange Operation

The federal government spent an estimated $2.09 billion on the operation of exchanges in FY2022, projected $2.38 billion in spending for FY2023, and proposed $2.31 billion for FY2024.[135] See **Table C-1**, which includes these numbers as well as estimated and prior year

[129] 45 C.F.R. §155.220. Definitions of terms discussed in this section, and other related terms, are at 45 C.F.R. §155.20.

[130] For more information, see CMS, "Direct Enrollment and Enhanced Direct Enrollment," updated May 2022, at https://www.cms.gov/programs-and-initiatives/health-insurance-marketplaces/direct-enrollment-and-enhanced-direct-enrollment.

[131] 45 C.F.R. §155.220.

[132] See "Enrollment Processes and Options" in the SHOP section of this report for more information.

[133] 42 U.S.C. §18031(a).

[134] 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.

[135] CMS, *Justification of Estimates for Appropriations Committees, Fiscal Year 2024*, March 13, 2023, at https://www.cms.gov/files/document/cms-fy-2024-congressional-justification-estimates-appropriations-

federal spending on the exchanges by activity (e.g., information technology, Navigator grants), as provided 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 some functions for all exchanges, including SBEs, such as "verifying eligibility data for financial assistance through the Marketplace or other health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP)."[136]

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.[137] 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.[138]

To raise funds for the exchanges it administers and/or provides a web platform, HHS assesses a monthly fee on each health insurance issuer that offers plans through an FFE or SBE-FP. 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**.

These user fee amounts are allowed to fund only federal activities or functions specific to the FFE and SBE-FP exchanges; the user fees cannot fund federal activities that serve all exchanges (including SBEs).[139] 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. Most of the total federal spending on exchange operations is funded by these user fees, as shown in **Table C-2**. Other funding sources, including for federal activities applicable also to SBEs, are discussed in the next section.

In prior years, user fees were also 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

committees.pdf. See "Federal Marketplace Programs" table and narrative, pages 199-204, and "Health Insurance Marketplaces Transparency Table," pages 237-238. Hereinafter referred to as "CMS Budget Justification, FY 2024."

[136] Page 200 of the CMS Budget Justification, FY2024.

[137] 31 U.S.C. §1324(b).

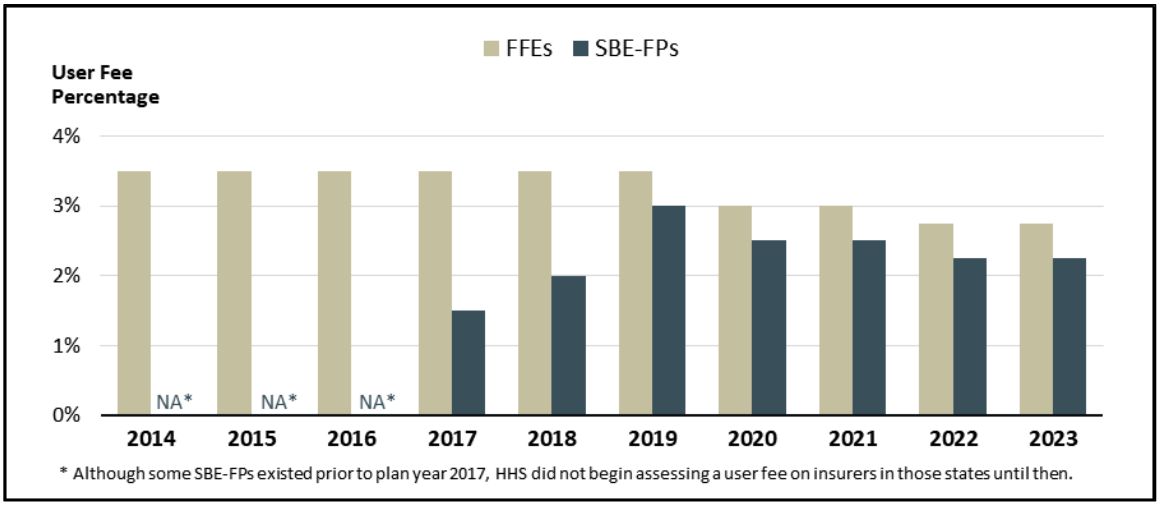
[138] 42 U.S.C. §18031(d)(5)(A).

[139] 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, FY2024, pages 200-201.

SB-FP-SHOPs, due to the reduced functionality of the federal SHOP website also announced in that rule.[140]

Figure 3. Federal User Fees 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-FP = state-based exchange using the federal information technology (IT) platform. See "Types and Administration of Exchanges" for discussion of exchange types. State-based exchanges' (SBEs') assessment of user fees, if any, varies, as discussed below in this report.

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.[141] There is currently no mandatory HHS appropriation for exchange activities.[142] An overview of recent and currently proposed funding sources is in **Table C-2**.

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).

[140] 2019 Payment Notice (cited in **Table D-1**), page 17007. See "Enrollment Processes and Options" regarding the reduced functionality of the federal SHOP website.

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

[142] 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, and it is also not shown in subsequent CJs. See **Table C-2** for citations.

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.

American Rescue Plan Act Grants for Exchange Modernization

Section 2801 of the ARPA provided for new grants to be awarded to health insurance exchanges "for purposes of enabling such Exchange to modernize or update any system, program, or technology utilized by such Exchange to ensure such Exchange is compliant with all applicable requirements." The HHS Secretary was authorized to determine specified aspects of the grant funding application process. Eligibility for these grants was limited to SBEs and SBE-FPs. The legislation specified that FFEs were not eligible through its reference to exchanges established under 42 U.S.C. Section 18041(c).

For this grant program, $20 million was appropriated for FY2021, out of Treasury funds not otherwise appropriated. The funding was to remain available until the end of FY2022. In September 2021, CMS awarded $20 million in grants to 21 SBEs and SBE-FPs that applied for them.[143]

See "Premium Tax Credits and Cost-Sharing Reductions" regarding other ARPA provisions relevant to the exchanges and the plans sold in them.[144]

[143] See CMS, *2021 State Marketplace Modernization Grant Awards*, September 10, 2021, at https://www.cms.gov/files/document/state-based-marketplace-modernization-grant-awardee-list-2021.pdf.

[144] For information about other health provisions in ARPA, see CRS Report R46777, *American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions*.

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) 2023, there are 30 FFEs, 18 SBEs, and 3 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.

SHOP exchanges may be federally facilitated (FF-SHOP) or state-based (SB-SHOP).[145] For PY2023, there are 30 FF-SHOPs and 20 SB-SHOPs. One state (Hawaii) is exempted from operating a SHOP exchange. However, in about half of all states, no insurers are offering medical plans in the SHOP exchange, meaning there is effectively no SHOP exchange there.

For PY2023, most states' individual and SHOP exchanges are administered in the same way (i.e., both state-based or both federally facilitated). However, a few 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. It also shows SHOP exchange types by state and provides details on SHOP plan availability and enrollment method.

Table A-1. Exchange Types and Key Details by State, Plan Year 2023

State	Exchange Website	Individual Exchange Type[a] (with 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: 18** **SBE-FP: 3** (plans and online enrollment available in all counties, all states)	**FF-SHOP**: 8 states with plans (all DE only); 22 without plans **SB-SHOP**: 15 states with plans (9 are DE only); 5 without plans **No SHOP:** 1
Alabama	HealthCare.gov	FFE	FF-SHOP, DE only[c]
Alaska	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Arizona	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Arkansas	My Arkansas Insurance; HealthCare.gov	SBE-FP as of PY17 (initially FFE)[e]	SB-SHOP, but no medical plans[f]
California	Covered California	SBE	SB-SHOP (up to 100 employees)[g]
Colorado	Connect for Health Colorado	SBE	SB-SHOP, DE only[h] (up to 100 employees)[g]
Connecticut	Access Health CT	SBE	SB-SHOP

[145] 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.

State	Exchange Website	Individual Exchange Type[a] (with notes on exchange type transitions, if applicable)	SHOP Exchange Type[b] (with notes on plan availability and enrollment options)
Delaware	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
District of Columbia	DC Health Link	SBE	SB-SHOP
Florida	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Georgia	HealthCare.gov	FFE [j]	FF-SHOP, DE only[c]
Hawaii	HealthCare.gov	FFE as of PY17[i] (initially SBE, then SBE-FP for PY16)[e]	No SHOP exchange per waiver[k]
Idaho	Your Health Idaho	SBE as of PY15 (initially SBE-FP)[e]	SB-SHOP, DE only[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	kynect	SBE as of PY22 (initially SBE, then SBE-FP as of PY17)[e]	SB-SHOP, DE only[h]
Louisiana	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Maine	CoverME.gov	SBE as of PY22 (initially FFE, then SBE-FP as of PY21)[e]	SB-SHOP, DE only[h]
Maryland	Maryland Health Connection	SBE	SB-SHOP, DE only[h]
Massachusetts	Massachusetts Health Connector	SBE	SB-SHOP
Michigan	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Minnesota	MNsure	SBE	SB-SHOP, but no medical plans[f]
Mississippi	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Missouri	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Montana	HealthCare.gov	FFE[i]	FF-SHOP, DE only[c]
Nebraska	HealthCare.gov	FFE[i]	FF-SHOP, but no medical plans[d]
Nevada	Nevada Health Link	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, DE only[c]
New Jersey	Get Covered NJ	SBE as of PY21 (initially FFE, then SBE-FP as of PY20)[e]	SB-SHOP, DE only[h]
New Mexico	beWellnm	SBE as of PY22 (initially SBE-FP)[e]	SB-SHOP
New York	New York State of Health	SBE	SB-SHOP, DE only[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, DE only[c]

State	Exchange Website	Individual Exchange Type[a] (with notes on exchange type transitions, if applicable)	SHOP Exchange Type[b] (with notes on plan availability and enrollment options)
Oklahoma	HealthCare.gov	FFE	FF-SHOP, but no medical plans[d]
Oregon	Oregon Health Insurance Marketplace; HealthCare.gov	SBE-FP as of PY15 (initially SBE)[e]	SB-SHOP, DE only[h]
Pennsylvania	Pennie	SBE as of PY21 (initially FFE, then SBE-FP as of PY20)[e]	SB-SHOP, but no medical plans[f]
Rhode Island	Health Source RI	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	Vermont Health Connect	SBE	SB-SHOP, DE only[h] (up to 100 employees)[g]
Virginia	Cover Virginia; HealthCare.gov	SBE-FP as of PY21 (initially FFE)[e] Transitioning to SBE for future PY[l]	FF-SHOP, DE only[c]
Washington	Washington Healthplanfinder	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, DE only[c]
Wyoming	HealthCare.gov	FFE	FF-SHOP, DE only[c]

Sources: CRS analysis of data at the sources indicated in notes section below.

Notes: SHOP = Small business health options program. FFE = Federally facilitated individual exchange; FF-SHOP = Federally facilitated SHOP exchange. SBE = State-based individual exchange; SB-SHOP = State-based SHOP exchange. SBE-FP = State-based individual exchange using the federal information technology (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** for the 2023 exchange types by state in map form.

a. **2023 individual exchange types:** See footnotes 1-4 at Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), "Health Insurance Exchange Public Use Files (Exchange PUFs) General Information" (PY2023), at https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.

b. **2023 SHOP exchange types:** See footnotes cited in the CMS/CCIIO resource at table note (a). Also see HealthCare.gov, "Select your state," at https://www.healthcare.gov/small-businesses/employers/. 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 (that offer plans) use a direct enrollment approach only,** meaning HealthCare.gov does not offer online SHOP plan enrollment but instead instructs users to connect with agents or brokers to enroll in plans through the state's SHOP exchange. See HealthCare.gov, "How to offer SHOP health insurance to your employees," at https://www.healthcare.gov/small-businesses/choose-and-enroll/enroll-in-shop/. See "Enrollment Processes and Options" in the SHOP section of this report for more information.

d. **No insurers are currently offering SHOP medical plans in these FF-SHOP states**. (Some may be offering SHOP dental plans, however.) See CMS/CCIIO Exchange PUFs (PY2023): "Business Rules PUF (updated October 17, 2022), at the web page cited in table note (a). For areas where there are no SHOP plans, HealthCare.gov suggests that small businesses contact agents, brokers, and/or insurers directly to learn about other coverage options.

e. **While most states have maintained the same type of individual exchange they initially opted for, some have transitioned to different exchange types.** Citations for prior year exchange types: **PY2014:** ASPE, *Addendum to the Health Insurance Marketplace Summary Enrollment Report,* April 2014, at https://aspe.hhs.gov/pdf-report/addendum-health-insurance-marketplace-summary-enrollment-report. **PY2015-2016:** Footnote 3 of CMS March 2015 and March 2016 *Effectuated Enrollment Snapshots* at https://www.cms.gov/newsroom/fact-sheets/march-31-2015-effectuated-enrollment-snapshot and https://www.cms.gov/newsroom/fact-sheets/march-31-2016-effectuated-enrollment-snapshot, respectively. **PY2017-2022:** CMS, "Open Enrollment Period Public Use Files" (PUFs) and/or PUF FAQs for each year, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products.

f. **No insurers are currently offering SHOP medical plans in these SB-SHOP states.** (Some may be offering SHOP dental plans, however.) Some state exchange websites suggest that small businesses contact agents, brokers, and/or insurers directly to learn about other coverage options. See links in table.

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. Only four states use the threshold of 100; see links in table. See SHOP "Eligibility and Enrollment" in this report for more information.

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, brokers, insurers, or assistors – or to submit a paper application to the exchange—to enroll in plans through the state's SHOP exchange. See links in table.

i. In some FFE states, the federal government performs all exchange administration functions, but in these FFE states, the state partners with the federal government to perform some plan management functions. See footnotes cited in the resource at table note (a).

j. Georgia initially 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. However, this component of the waiver was later suspended for PY2023. The 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. In February 2023, Georgia indicated its intention to transition to an SBE approach. See State of Georgia Office of Commissioner of Insurance and Safety Fire, Letter to CCIIO, February 14, 2023, at https://oci.georgia.gov/document/document/georgia-sbe-blueprint-letter-cms/download.

k. Hawaii received a Section 1332 waiver exempting it from having SHOP exchange, initially for PYs 2017-2021 then extended through PY2026. This is 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.

l. Regarding Virginia's ongoing transition to a state-based exchange, see https://scc.virginia.gov/pages/Health-Benefit-Exchange-(6).

Appendix B. Types of Plans Offered Through the Exchanges

In general, health insurance plans offered through exchanges must be qualified health plans (QHPs).[146] See "Qualified Health Plans" in this report regarding QHP certification requirements.

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			
Stand-alone dental plan (SADP)	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. **Stand-alone dental 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).

[146] 42 U.S.C. §18031(d)(2)(B).

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

a. Catastrophic plans are available only to individuals under the age of 30 and individuals who obtain hardship or affordability exemptions through the exchange. 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 nongroup 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 appeared that three were still offering plans as of April 2021. The other 20 CO-OPs offered health plans at one time but have shut down or were in various stages of shutting down. As of November 2022, the three CO-OPs are offering plans for 2023 enrollment; CRS has not reconfirmed the status of the other 20 CO-OPs. See
Maine: Community Health Options: https://www.healthoptions.org/
Idaho, Montana, and Wyoming: Mountain Health CO-OP: https://www.mountainhealth.coop/ and
Wisconsin: Common Ground Healthcare Cooperative: https://www.commongroundhealthcare.org.

c. The ACA directs ACA directs the federal Office of Personnel Management (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 **Table C-1**.[147] 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-2** displays federal exchange spending according to these funding sources.

See "Exchange Spending and Funding" 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.

[147] See, for example, the Consolidated Appropriations Act, 2023 (), Division H, Title II, Sec. 220.

Table C-1. CMS "Health Insurance Marketplaces Transparency Table," Recent Years

($ in thousands)

Activity	FY2018 Actual	FY2019 Actual	FY2020 Actual	FY2021 Actual	FY2022 Actual	FY2023 Enacted	FY2024 PB
Health Plan Bid Review, Management and Oversight	$37,910	$45,797	$45,480	$38,841	$54,255	$56,219	$53,319
Payment and Financial Management	$45,141	$50,220	$39,178	$49,821	$47,780	$57,600	$57,600
Eligibility and Enrollment	$392,660	$348,488	$371,802	$350,482	$391,341	$391,627	$417,907
Consumer Information and Outreach	$591,948	$579,088	$503,271	$843,729	$903,220	$1,090,299	$975,981
Call Center (non-add)	*$525,326*	*$499,053*	*$440,000*	*$477,247*	*$535,219*	*$504,500*	*$489,500*
Navigators Grants & Enrollment Assisters (non-add)	*$12,720*	*$19,499*	*$19,689*	*$91,233*	*$133,293*	*$141,747*	*$141,200*
Consumer Education and Outreach (non-add)	*$10,744*	*$11,231*	*$14,082*	*$245,749*	*$211,592*	*$382,250*	*$280,750*
Information Technology	$767,413	$504,283	$549,369	$515,388	$511,706	$552,830	$561,713
Quality	$7,240	$7,334	$7,063	$6,391	$6,706	$7,777	$8,282
SHOP and Employer Activities	$4,418	$2,117	$200	$197	$195	$195	$195
Other Marketplace	$31,196	$40,290	$63,579	$38,827	$35,400	$62,267	$63,644
Federal Payroll and Other Administrative Activities	$70,892	$77,750	$85,833	$120,071	$134,741	$164,170	$168,924
Total	$1,948,818	$1,655,367	$1,665,775	$1,963,746	$2,085,344	$2,382,984	$2,307,565

Source: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), *Justification of Estimates for Appropriations Committees, Fiscal Year 2024*, March 13, 2022, at https://www.cms.gov/files/document/cms-fy-2024-congressional-justification-estimates-appropriations-committees.pdf. See "Health Insurance Marketplaces Transparency Table," pages 237-238, including for these data for FYs 2010-2017 and for CMS notes on these data. Discussion of spending categories is at "Federal Marketplace Programs" table and narrative, pages 199-204.

Notes: FY = fiscal year; CR = continuing resolution; PB = President's Budget (proposed). Note that actual spending for the proposed budget year depends on the availability of appropriations, among other factors.

Table C-2. CMS Federal Exchange Funding Sources, Recent Years

($ in thousands)

Treasury Account[a]	FY2018 Actual	FY2019 Final	FY2020 Final	FY2021 Final	FY2022 Final	FY2023 Enacted	FY2024 PB
Program Management	$1,944,190	$1,636,111	$1,618,091	$1,939,603	$2,066,898	$2,343,586	$2,263,744
Discretionary Appropriation	$618,164	$263,895	$261,226	$142,455	$143,977	$147,729	$165,122
Program Operations (non-add)	*$580,886*	*$229,384*	*$226,035*	*$119,520*	*$119,685*	*$121,000*	*$137,003*
Federal Administration (non-add)	*$37,278*	*$34,511*	*$35,191*	*$22,936*	*$24,292*	*$26,729*	*$28,119*
Offsetting Collections	$1,304,280	$1,351,893	$1,335,768	$1,776,028	$1,899,955	$2,163,585	$2,060,800
[FFE] User Fee (non-add)[b]	*$1,272,168*	*$1,304,458*	*$1,310,948*	*$1,729,249*	*$1,853,605*	*$2,106,081*	*$2,001,736*
Risk Adjustment User Fee (non-add)	*$32,112*	*$47,435*	*$24,820*	*$46,778*	*$46,350*	*$57,504*	*$59,064*
Other	$21,746	$20,323	$21,097	$21,120	$22,966	$32,272	$37,822
Health Care Fraud and Abuse Control	$4,629	$19,256	$47,684	$24,143	$18,446	$39,398	$43,821
Discretionary Appropriation	$0	$19,256	$47,684	$24,143	$18,446	$39,398	$43,821
Mandatory Appropriation[c]	$4,629	N/A	N/A	N/A	N/A	N/A	N/A
Total, Program Level	$1,948,818	$1,655,367	$1,665,775	$1,963,746	$2,085,344	$2,382,984	$2,307,565
FFE User Fee Amounts as a Percentage of Program Level Funding Sources[d]	65.3%	78.8%	78.7%	88.1%	88.9%	88.4%	86.7%

Sources: Unless otherwise specified, compiled by CRS from Centers for Medicare & Medicaid Services (CMS) annual budget justifications as indicated below, available at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget. Comparable data were not found in prior years' budget justifications.
FY2022-2024 in this table: HHS, CMS, *Justification of Estimates for Appropriations Committees, Fiscal Year 2024* (CMS Budget Justification FY2024), March 13, 2023. See "Federal Marketplace Programs" table, page 199.
FY2021: CMS Budget Justification FY2023, May 6, 2022. See "Federal Marketplace Programs" table, page 199.
FY2020: CMS Budget Justification FY2022, May 31, 2021. See "Federal Marketplaces" table, page 199.
FY2019: CMS Budget Justification FY2021, March 3, 2020. See "Federal Exchanges" table, page 195.
FY2018: CMS Budget Justification FY2020, March 13, 2019. See "Federal Exchanges" table, page 178.

Notes: FY = fiscal year; CR = continuing resolution; PB = President's Budget (proposed); FFE = federally facilitated exchange; N/A = not available. Actual spending for the proposed budget year depends on the availability of appropriations, among other factors.

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

b. Per communication with CMS, this row is inclusive of both federally facilitated exchange and state-based exchange using the federal information technology platform federal user fees.

c. Health Care Fraud and Abuse Control (HCFAC) "Mandatory Appropriation" was listed in the FY2020 table that included these FY2018 amounts but not in the FY2021 or subsequent Budget Justifications. 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."

d. Calculated by CRS.

Appendix D. Additional Resources

HHS "Notice of Benefit and Payment Parameters" by Year

The "Notice of Benefit 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).

Final and proposed Payment Notices can also be found by searching "Notice of Benefit and Payment Parameters" at www.federalregister.gov.

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

For Plan Year	Title	Citation	Publication Date
2023	Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023	87 *Federal Register* 27208	May 6, 2022
2022, "Part 3"[a]	Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond	86 *Federal Register* 53412	September 27, 2021
2022, "Part 2"[a]	Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards	86 *Federal Register* 24140	May 5, 2021
2022, "Part 1"[a]	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	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	85 *Federal Register* 29164	May 14, 2020
2020	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	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	81 *Federal Register* 94058	December 22, 2016
2017	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	80 *Federal Register* 10749	February 27, 2015
2015	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	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, here noted as "Part 1," was published by the Trump Administration, but did not take effect before the presidential transition. The Biden Administration subsequently published two more Final 2022 Payment Notices, repealing some of what had been published in Part 1, and addressing some topics not included in Part 1. In this report and elsewhere, the informal references "Part 1," "Part 2," and "Part 3," are used to distinguish these three final rules.

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 web page): https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces
- **CRS compilation of HHS resources on exchange enrollment and other exchange data:** CRS Report R46638, *Health Insurance Exchanges: Sources for Statistics*

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