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Overview of Health Insurance Exchanges

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Summary

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) requires health insurance exchanges to be established in every state. Exchanges are marketplaces where individuals and small businesses can shop for and purchase private health insurance coverage. 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). In states with FFEs, the exchange may be operated solely by the federal government or in conjunction with the state.

Persons who obtain coverage through the individual exchange may be eligible for financial assistance from the federal government. The financial assistance in the individual exchanges is available in two forms: premium tax credits and cost-sharing subsidies. Small businesses that use the SHOP exchange may be eligible for small business health insurance tax credits. The tax credits assist small businesses with the cost of providing health insurance coverage to employees.

The ACA generally requires that health insurance plans offered through an exchange are Qualified Health Plans (QHPs). Typically in order to be certified as a QHP, a plan must offer the essential health benefits, comply with cost-sharing limits, and meet certain market reforms. Exchanges may also offer other types of health insurance plans such as catastrophic and dental-only plans.

This report provides an overview of the various components of the health insurance exchanges. The report includes summary information about how exchanges are structured, the intended consumers for health insurance exchange plans, and consumer assistance available in the exchanges, as specified in the ACA. The report also describes the availability of financial assistance for certain exchange consumers and small businesses and outlines the range of plans offered through exchanges. Moreover, the report provides a brief summary of the implementation and operation of exchanges in 2014 and 2015. Finally, the report summarizes *King v. Burwell* and outlines the case's implications for health insurance exchanges.

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Introduction

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) requires health insurance exchanges (also known as *marketplaces*) to be established in every state. ACA exchanges are marketplaces in which individuals and small businesses can shop for and purchase private health insurance coverage. Exchanges are intended to simplify the experience of providing and obtaining health insurance. They are not intended to supplant the private market outside of the exchanges but to provide an additional source of private health insurance coverage.

This report provides an overview of the various components of the health insurance exchanges. The report includes summary information about how exchanges are structured, the intended consumers for health insurance exchange plans, and consumer assistance available in the exchanges, as specified in the ACA. The report also describes the availability of financial assistance for certain exchange consumers and small businesses and outlines the range of plans offered through exchanges. Moreover, the report provides a brief summary of the implementation and operation of exchanges in 2014 and 2015. Finally, the report summarizes *King v. Burwell* and outlines the case's implications for health insurance exchanges. While the report provides a high-level description of exchanges, it also includes references to other CRS reports that provide further information.

Exchange Structure and Operation

The ACA required health insurance exchanges to be established in all states. These health insurance exchanges were in operation in October 2013 to allow consumers to shop for health insurance plans that began as soon as January 1, 2014. ACA exchanges are marketplaces in which individuals and small businesses can shop for and purchase private health insurance coverage. Each state has two types of exchanges—an *individual exchange*¹ and a *small business health options program (SHOP) exchange*. An individual exchange is where individuals can purchase nongroup insurance and apply for premium and cost-sharing subsidies. A SHOP exchange is where small businesses can purchase small-group insurance and apply for small business health insurance tax credits. These exchanges may be operated under the same or separate governing structures. In this report, the use of the term *exchange* without the qualifier of *individual* or *SHOP* refers to both types of exchanges.

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

There are varying levels of state involvement in FFEs. In many states with FFEs, the exchange is wholly operated and administered by HHS. In some cases, states may partner with HHS to establish and administer the exchange. For the 2015 coverage year, 34 states have FFEs, 13 states

¹ The term *individual exchange* is used for purposes of this report. It is not defined in exchange-related statute or regulations.

Pursuant to state law, exchanges may also allow insurance agents and brokers to help individuals and small employers obtain coverage through exchanges.² Unlike consumer assistance personnel, agents and brokers may enroll individuals and small employers in coverage through exchanges.

For more information about exchange consumer assistance, see CRS Report R43243, *Health Insurance Exchanges: Health Insurance “Navigators” and In-Person Assistance*.

Exchange Funding

The ACA provided an indefinite appropriation for HHS grants to states to support the planning and establishment of exchanges. For each fiscal year between FY2011 and FY2014, the HHS Secretary determined the total amount that was made available to each state for exchange grants.

None of the aforementioned exchange grants could be awarded after January 1, 2015, and exchanges were expected to be self-sustaining beginning in 2015. The ACA allows exchanges to generate funding to sustain their operations, including by assessing fees on participating health insurance plans. To raise funds for each of the FFEs, beginning in 2014, HHS is assessing a monthly fee on each health insurance plan that offers plans through a FFE.

For more information about funding for exchanges, see CRS Report R43066, *Federal Funding for Health Insurance Exchanges*, by Annie L. Mach and C. Stephen Redhead.

Exchange Consumers

The ACA specifies that exchanges are established for the purpose of offering health plan options to individuals and small businesses.

Individuals

Individuals may enroll in plans through their states’ exchanges as long as they (1) meet state residency requirements;³ (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.⁴ Undocumented individuals are prohibited from purchasing coverage through the exchanges, even if they could pay the entire premium.

Individuals may purchase health insurance in the individual exchanges for themselves via individual plans or for their families via family plans.

² For detailed information about how agents and brokers can interact with exchanges, see *Resources for Agents and Brokers in the Health Insurance Marketplaces*, <http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html>.

³ 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 CFR §155.305.

⁴ U.S. citizens and U.S. nationals are eligible for coverage through the exchange. “Lawfully present” immigrants are also eligible for coverage through the exchange. Examples of “lawfully present” include immigrants 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.

Enrollment Periods

Individuals may enroll in exchange coverage only during specified enrollment periods. Most individuals enroll during the annual Open Enrollment Period (OEP). The next OEP, for 2016 exchange coverage, begins November 1, 2015, and ends on January 31, 2016.

Individuals may also be allowed to enroll during a Special Enrollment Period (SEP). Individuals must qualify for enrollment during a SEP. Generally, this is due to a change in personal circumstances; for example, marriage or adoption. HHS may also establish SEPs for other circumstances, such as technical problems submitting insurance applications through the federal IT platform (i.e., HealthCare.gov).

Premium Tax Credits and Cost-Sharing Subsidies

Individuals purchasing coverage through the individual exchanges may be eligible to receive financial assistance. Eligibility for such assistance is based on income and provided in the form of premium tax credits and cost-sharing subsidies.

The premium tax credit is generally available to individuals who do not have access to subsidized public coverage (e.g., Medicaid) or employment-based coverage that meets certain standards.⁵ The credit is designed to reduce an eligible individual's cost of purchasing health insurance coverage through the exchange. The credit itself is both advanceable and refundable, meaning tax filers need not wait until the end of the tax year to benefit from the credit and may claim the full credit amount even if they have little or no federal income tax liability. The amount of the premium tax credit varies from person to person. However, the credit is designed to provide larger credit amounts to individuals with lower incomes compared to those with higher incomes.

In addition to premium tax credits, certain individuals may also be eligible to receive subsidies that go toward cost-sharing expenses,⁶ such as deductibles, coinsurance, and co-payments. Cost-sharing assistance is provided in two forms. The first form of assistance reduces the annual out-of-pocket limit applicable to a given exchange plan.⁷ The second form reduces cost-sharing requirements applicable to a given exchange plan. Individuals may receive both types of cost-sharing subsidies if they meet the applicable eligibility requirements.

For more information about premium tax credits and cost-sharing subsidies, including applicable eligibility criteria, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*, by Bernadette Fernandez.

⁵ For more information on employer requirements for offering employment-based coverage, see CRS Report R43981, *Affordable Care Act (ACA): Employer Shared Responsibility Determinations and Potential Penalties*.

⁶ Cost-sharing is the share of costs an insured individual pays for services out-of-pocket. The term often includes deductibles, coinsurance, and co-payments. A deductible is the amount an insured individual pays before his or her health insurance plan begins to pay for services. Coinsurance is the share of costs, figured in percentage form, an insured individual pays for a health service. A co-payment is a fixed amount an insured individual pays for a health service.

⁷ For more information about the annual out-of-pocket limits, see "Cost-Sharing" section of this report.

Small Businesses

Small businesses that offer health insurance coverage to all of their full-time employees are eligible to use SHOP exchanges. Prior to January 1, 2016, the ACA allows states to define *small* as businesses having either 100 or fewer or 50 or fewer employees. Beginning in 2016, all states must define *small* as businesses with 100 or fewer employees.⁸ Beginning in 2017, states have the option to allow *large* businesses to use SHOP exchanges.

The small business must have its principal business in the SHOP exchange service area or offer coverage to each eligible employee through the SHOP exchange serving the employee's worksite. In order for an employee to be eligible to obtain coverage through a SHOP exchange, a SHOP-eligible employer must offer the employee coverage.

For more information about the SHOP exchanges, see CRS Report R43771, *Small Business Health Options Program (SHOP) Exchange*.

Enrollment Periods

Enrollment in a SHOP exchange is not limited to a specified open enrollment period except in certain circumstances.⁹ Specific 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.

Small Business Health Insurance Tax Credit

Under the ACA, certain small businesses are eligible for small business health insurance tax credits. In general, these credits are available only to small businesses that purchase coverage through SHOP exchanges. The intent of the credit is to assist small employers with the cost of providing health insurance coverage to employees. The credits are available to eligible small businesses for two consecutive tax years (beginning with the first year the small employer purchases coverage through a SHOP exchange).

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 full-time equivalents (FTEs) and who have average taxable wages of \$25,400 or less. For tax year 2015, the tax credit is phased out as an employer's number of FTEs increases from 10 to 25 and as average employee compensation increases from \$25,800 to \$51,600.

For more information about the small business health insurance tax credit, see CRS Report R41158, *Summary of the Small Business Health Insurance Tax Credit Under ACA*.

⁸ This requirement applies to the small-group market operating outside of SHOP exchanges as well.

⁹ 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.

Exchange Plans

Qualified Health Plans

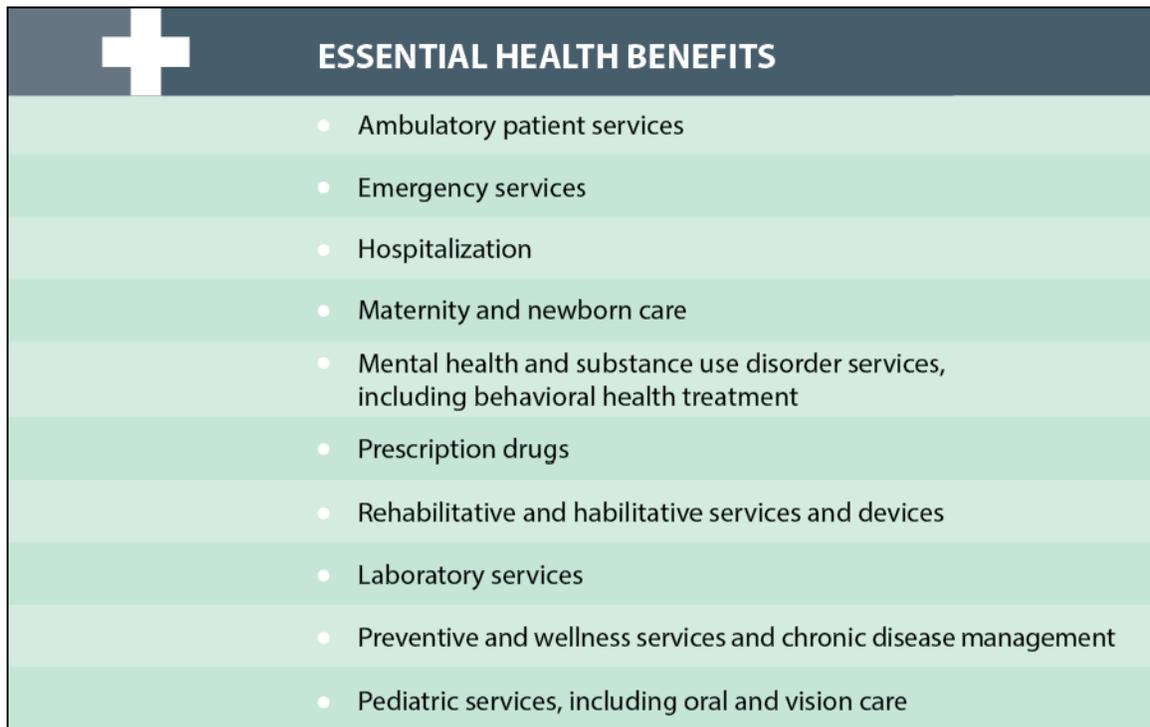
The ACA generally requires that health insurance plans offered through exchanges are Qualified Health Plans (QHPs). Typically in order to be certified as a QHP a plan has to offer the essential health benefits (EHB), comply with cost-sharing limits, and meet certain market reforms. Each exchange is responsible for certifying the plans it offers. However, QHPs can be offered both inside the health insurance exchanges and outside the exchanges on the private health insurance market.

Essential Health Benefits

All QHPs are required to offer a core package of health care services, known as the essential health benefits. The ACA does not specifically define this core package but rather lists 10 benefit categories and requires the HHS Secretary to further define the EHB (see **Figure 2**).

For 2014-2016, the HHS Secretary outlined a process where each state identified a single plan, the EHB-benchmark plan, that serves as a reference plan for all QHPs in that state. Accordingly, QHPs must base their benefits package on their state’s EHB-benchmark plan. Given that each state has its own EHB-benchmark plan and given other market factors, QHPs available in the health insurance exchanges will vary in terms of specific covered services as well as benefit amount, duration, and scope.

Figure 2. The 10 Essential Health Benefits



Source: 42 U.S.C. §18022.

Cost-Sharing

QHPs must follow established limits on consumer cost-sharing. The ACA imposes limits on consumers' cost-sharing requirements for the EHB. The limits work in two ways: they prohibit (1) applying deductibles to preventive health services and (2) annual out-of-pocket limits that exceed existing limits in the federal tax code.¹⁰ In 2015, the cost-sharing limit is \$6,600 for an individual plan and \$13,200 for a family plan. For 2016, the cost-sharing limit is \$6,850 for an individual plan and \$13,700 for a family plan.¹¹

Actuarial Value

The ACA requires QHPs to tailor cost-sharing to comply with one of the four levels of actuarial value (AV) (see **Figure 3**). AV is a summary measure of a plan's generosity of coverage. It is expressed as the percentage a given health insurance plan will pay for covered medical expenses, for a standard population. On average, as AV increases, consumer cost-sharing decreases. For example, for a silver-level plan, on average, a plan pays for 70% of covered services and a consumer pays for 30% of the expenses out-of-pocket.

Figure 3. Actuarial Value Levels

Level	Actuarial Value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

Source: 42 U.S.C. §18022.

Market Reforms

A number of ACA provisions focus on changing how health insurance plans offer coverage. Collectively, the market reforms establish federal minimum requirements regarding access to coverage, premiums, benefits, cost-sharing, and consumer protections while generally giving states the authority to enforce the reforms and the ability to expand on the reforms.¹² Some of the reforms apply to all three segments of the private insurance market (nongroup, small-group, and large-group markets). But many of the reforms focus specifically on the nongroup and small-group insurance markets, both inside and outside the exchanges.

¹⁰ The existing limits are those that are applicable to high-deductible health plans that qualify to be paired with tax-advantaged health savings accounts. For more information about these plans, see CRS Report RL32237, *Health Insurance: A Primer*.

¹¹ U.S. Department of Health and Human Services, "Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016," 80 *Federal Register* 10750-10877, February 27, 2015.

¹² Private health insurance is primarily regulated at the state level. The ACA establishes uniform requirements and additional options for all states.

These same market reforms apply to QHPs offered in the individual and SHOP exchanges. The reforms are intended to address perceived failures in the nongroup and small-group markets—such as limited access to coverage and higher costs of coverage—and to provide some parity with the large-group market, which may already have many of these features. The reforms generally address issues related to obtaining coverage, keeping coverage, the cost of purchasing coverage, covered benefits and services, cost-sharing limits, plan requirements, and consumer protections (some of which were discussed earlier in this report).

For more information about the market reform provisions in the ACA, see CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*.

Other Types of Plans Offered Through Exchanges

While all health insurance plans offered through the exchanges must generally be certified QHPs, the exchanges also offer variants of QHPs and a few non-QHPs as allowed under the ACA. These QHP variants and non-QHPs are described below.

Child-Only Plans

Child-only health insurance plans are a type of QHP available in the exchanges. In order to offer child-only plans in an exchange, a health insurance plan must also offer a QHP in the exchange. The ACA requires the plan to offer the child-only exchange plan at the same level as the QHP. Only individuals under age 21 may enroll in child-only exchange plans.

Multi-State Plans

The ACA directs the Office of Personnel Management to contract with private insurance plans in each state to offer at least two comprehensive health insurance options, known as multi-state plans (MSPs). MSPs are designed to offer nationally available QHPs through the exchanges; MSPs are not available outside the exchanges. Individuals enrolled in MSP options have access to the same financial assistance for premium tax credits and cost-sharing subsidies as consumers in other plans.

Consumer Operated and Oriented Plans

The ACA includes the Consumer Operated and Oriented Plan (CO-OP) program to create nonprofit, member-run health insurance companies. 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 CO-OP. The majority of the products offered by a CO-OP must be QHPs sold in the nongroup and small-group markets, including through exchanges.

Catastrophic Plans

The ACA establishes other plans that are not QHPs. One such plan is a *catastrophic plan*. A catastrophic plan offered through exchanges provides the EHB and coverage for at least three primary care visits; however, it imposes very high deductibles and does not meet the minimum

requirements related to coverage generosity (i.e., actuarial value).¹³ Catastrophic plans may be offered only in the individual market for (1) individuals under age 30, and (2) persons exempt from the ACA requirement to obtain health coverage (described below) because no affordable coverage is available or they have a hardship exemption.¹⁴ Premium tax credits and cost-sharing subsidies may not be used toward catastrophic plans.

Dental-Only Plans

Dental-only plans are another type of non-QHP that may be offered in exchanges. Dental plans may be offered either as stand-alone plans or in conjunction with QHPs. Premium tax credits and cost-sharing subsidies may not be used toward dental-only plans.

Exchange Enrollment

Measuring exchange enrollment can be difficult. Given the exchange eligibility determination process as well as the OEPs and SEPs, data on exchange enrollment is released in stages—pre-effectuated and effectuated enrollment.

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. 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, however, may change over time. For example, due to changes in life circumstances, an individual may un-enroll (e.g., because he or she was later offered coverage through an employer) or enroll (e.g., because he or she was eligible for a SEP) in an exchange plan. Accordingly, exchange enrollment estimates are often reported for a particular time frame.

HHS regularly releases data on exchange enrollment. For the most current enrollment estimates, see the HHS website.¹⁵ For maps on exchange enrollment, see CRS Report IN10282, *Maps of 2015 Individual Exchange Enrollment by Zip Code*.

Status of Exchange Implementation

This section provides a brief summary of the implementation and operation of exchanges in 2014 and to date in 2015.

¹³ While catastrophic plans technically do not meet the generosity requirements for coverage, a catastrophic plan may be considered as meeting such coverage generosity requirements so long as it meets the other catastrophic plan requirements described above.

¹⁴ Individuals who suffer a hardship with respect to the capability to obtain health insurance coverage may receive hardship exemptions. HHS has identified a number of circumstances that allow individuals to receive hardship exemptions. For more information on hardship exemptions, see CRS Report R41331, *Individual Mandate Under the ACA*.

¹⁵ HHS, <http://www.hhs.gov/healthcare/index.html>.

2014 Coverage Year

As required by the ACA, 2014 was the first year in which health insurance coverage was available through exchanges in every state. In 2014, for the individual exchanges, 17 states had SBEs, while 34 states had FFEs. Among SHOP exchanges, 19 were SBEs and 32 were FFEs.

The OEP for 2014 coverage for all exchanges began October 1, 2013. The FFEs and some SBEs experienced difficulties related to the functionality of their websites during the OEP. In many cases the problems hindered consumers' and small businesses' ability to purchase health plans offered through exchanges. Additionally, implementation of certain features of exchanges, particularly for SHOP exchanges, was delayed for part or all of 2014. For example, small businesses using federally-facilitated SHOP exchanges were not able to purchase coverage online during any part of 2014.

One way in which HHS responded to the problems and delays was to find ways to provide access to exchange coverage to consumers and small businesses. HHS extended the OEP, identified alternative ways to enroll in coverage available through exchanges, and shortened the length of time between when an individual signed up for coverage and the date when the coverage began.

By the end of the 2014 OEP (October 1, 2013, through March 31, 2014) and a SEP (through April 19, 2014), the pre-effectuated enrollment¹⁶ for the individual exchanges in all states and the District of Columbia was 8.0 million individuals. Among those individuals, approximately 85% received premium tax credits.¹⁷ On October 15, 2014, the effectuated enrollment in the individual exchanges was 6.7 million individuals.¹⁸ An estimate of how many effectuated individuals received a premium tax credit is not available. Estimates for nationwide enrollment in the SHOP exchanges in 2014 are not currently available.

2015 Coverage Year

The overall number of states with state-based and federally-facilitated individual and SHOP exchanges did not change between 2014 and 2015.

The OEP for 2015 coverage began November 1, 2014. Overall, the exchanges have had fewer operational difficulties in 2015, particularly with respect to IT infrastructure. This is the case for both state-based and federally-facilitated exchanges.

By the end of the 2015 OEP (November 15, 2014, through February 15, 2015) and a SEP (through February 22, 2015), the pre-effectuated enrollment for the individual exchanges in all states and D.C. was 11.7 million individuals. Among those individuals, approximately 87% received premium tax credits.¹⁹ On March 31, 2015, the effectuated enrollment in the individual

¹⁶ For a discussion about the differences between pre-effectuated and effectuated enrollment, see "Exchange Enrollment" section of this report.

¹⁷ HHS, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*, May 1, 2014, http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf.

¹⁸ HHS, *How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period*, November 10, 2014, http://aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf.

¹⁹ HHS, *Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report*, March 10, 2015, http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf.

exchanges was 10.2 million individuals, and approximately 85% received premium tax credits.²⁰ As was the case in 2014, estimates for nationwide enrollment in the SHOP exchanges in 2015 are not available.

The exchanges are experiencing different challenges in 2015. For SBEs, one of those challenges is obtaining funds to sustain operations. As noted earlier in this report, exchanges are expected to be self-sustaining and can no longer obtain federal exchange grants beginning in 2015. The ACA provides that an exchange may charge an assessment or user fee to participating health plans but also allows an exchange to find other ways to generate funds to sustain its operations. Some SBEs have reported projected funding shortfalls for their exchanges and are seeking ways to secure more funding and reduce operating costs.²¹

Supreme Court Case: *King v. Burwell*

Parallel with the Administration's (and states') implementation of the ACA are multiple legal challenges directed at the Administration's decisions and efforts. One of those challenges focuses on the authority of the Internal Revenue Service (IRS) to make available premium tax credits through exchanges, regardless of which entity established a given exchange.

On March 4, 2015, the Supreme Court heard oral arguments in *King v. Burwell*. At issue in *King v. Burwell* and other similar legal challenges is whether the ACA statute supports the promulgation of regulations by the IRS to provide premium tax credits to eligible taxpayers residing in states that declined to establish health insurance exchanges. A decision by the Court is expected by the end of June.

The potential impact of the decision may be significant if the Court invalidates the IRS rule. Such a decision could lead to the termination of tax credits in a majority of states, potentially leaving millions of consumers without a source of subsidized health coverage. Some individuals may choose to drop coverage as a consequence of the loss of tax credits. Other individuals may be motivated to continue to purchase coverage, even without a subsidy, either because the credit amounts they received were minimal, or they have serious health care needs. Health insurance plans may decide to change plan offerings or discontinue offering all coverage in a given state's individual insurance market, given the anticipated loss in enrollment overall and changes in the types of consumers who would be expected to continue to enroll in that market. These consumer and insurance plan actions may, in turn, motivate efforts by Congress, the Administration, and/or states to address the perceived negative effects of the Court decision and address other related issues, such as the tax credit program's interaction with the ACA's other coverage provisions.

For more information about *King v. Burwell* and potential implications of the Supreme Court's decision, see CRS Report R43833, *Premium Tax Credits and Federal Health Insurance Exchanges: Questions and Answers*.

²⁰ Centers for Medicare & Medicaid Services, *March 31, 2015 Effectuated Enrollment Snapshot*, June 2, 2015, <http://cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html>.

²¹ Lena H. Sun and Niraj Chokshi, "Almost Half of Obamacare Exchanges Face Financial Struggles in the Future," *Washington Post*, May 1, 2015.

Additional Resources

For more information on topics related to the health insurance exchanges and other ACA private health insurance provisions, the table below includes a selection of CRS reports that may be of interest.

Table I. Additional Resources

Topic	Report
Health Insurance	CRS Report RL32237, <i>Health Insurance: A Primer</i> .
Private Health Insurance and the ACA	CRS Report R42069, <i>Private Health Insurance Market Reforms in the Affordable Care Act (ACA)</i> .
Exchange Consumer Assistance	CRS Report R43243, <i>Health Insurance Exchanges: Health Insurance “Navigators” and In-Person Assistance</i> .
Exchange Funding	CRS Report R43066, <i>Federal Funding for Health Insurance Exchanges</i> .
Health Insurance Premium Tax Credits	CRS Report R43945, <i>Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015</i> .
Small Business Health Options Program (SHOP)	CRS Report R43771, <i>Small Business Health Options Program (SHOP) Exchange</i> .
Small Business Health Insurance Tax Credit	CRS Report R41158, <i>Summary of the Small Business Health Insurance Tax Credit Under ACA</i> .
Individual Mandate	CRS Report R41331, <i>Individual Mandate Under the ACA</i> .
Employer Mandate	CRS Report R43981, <i>Affordable Care Act (ACA): Employer Shared Responsibility Determinations and Potential Penalties</i> .
Exchange Enrollment	CRS Report IN10282, <i>Maps of 2015 Individual Exchange Enrollment by Zip Code</i> .
<i>King v. Burwell</i>	CRS Report R43833, <i>Premium Tax Credits and Federal Health Insurance Exchanges: Questions and Answers</i> .

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