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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 since 2014.

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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 since 2014. 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).

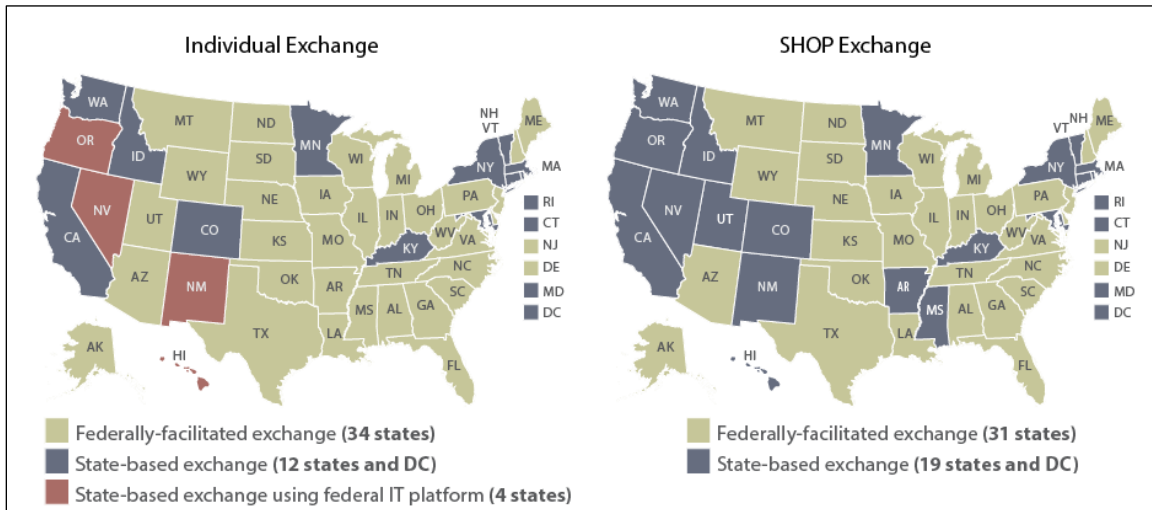
There are varying levels of state involvement in FFEs. In many states with FFEs, the exchange is wholly operated and administered by HHS. In some cases, states may partner with HHS to establish and administer the exchange. For the 2016 coverage year, 34 states have FFEs, 12 states and the District of Columbia (DC) have SBEs, and 4 states have SBEs but use the federal information technology (IT) platform (i.e., HealthCare.gov) (see **Figure 1**).²

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

² As defined by the Department of Health and Human Services (HHS) classification of exchange types. HHS, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, March 11, 2016, at <https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>.

Moreover, HHS may administer the individual exchange while the state administers the SHOP exchange. For the 2016 coverage year, most states have the same entity administer both the individual and SHOP exchanges (see **Figure 1**). However, three states—Arkansas, Mississippi, and Utah—elected to administer their SHOP exchanges while HHS administers their individual exchanges (see **Figure 1**).

Figure 1. Individual and SHOP Exchange Types by State, 2016



Source: CRS illustration of HHS classification of individual and SHOP exchange types.

Note: SHOP is the small business health options program.

Exchange Consumer Assistance

Statute and regulations require that exchanges carry out certain consumer assistance functions. Some functions require that exchanges provide direct support to consumers. For example, exchanges must provide for the operation of a call center that addresses the needs of consumers who have questions about individual exchanges and SHOP exchanges.

Exchanges are also expected to provide indirect support to consumers by implementing consumer assistance personnel programs. Exchanges must establish Navigator programs and certified application counselor programs, and exchanges have the option to implement a program for non-Navigator consumer assistance personnel. Under these programs, individuals are trained to help consumers make informed decisions about their insurance options and help consumers access individual and SHOP exchange coverage. However, consumer assistance personnel may not enroll individuals or small employers in coverage.

Pursuant to state law, exchanges may also allow insurance agents and brokers to help individuals and small employers obtain coverage through exchanges.³ Unlike consumer assistance personnel, agents and brokers may enroll individuals and small employers in coverage through exchanges.

³ For detailed information about how agents and brokers can interact with exchanges, see Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information & Insurance Oversight, “Resources for Agents and Brokers in the Health Insurance Marketplaces,” at <http://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html>.

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*.

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;⁴ (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.⁵ 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.

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 2017 exchange coverage, begins November 1, 2016, and ends on January 31, 2017.

Individuals may also be allowed to enroll during a Special Enrollment Period (SEP). Individuals must qualify for enrollment during an SEP. Generally, this is due to a change in personal circumstances, for example, marriage or adoption.⁶

⁴ 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.

⁵ 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.

⁶ HHS may also establish special enrollment periods (SEPs) for other circumstances. For example, in 2014, HHS (continued...)

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.⁷ 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,⁸ 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 an individual's exchange plan.⁹ The second form reduces cost-sharing requirements applicable to an individual's 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 R44425, *Eligibility and Determination of Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*.

Small Businesses

Small businesses that offer health insurance coverage to all of their full-time employees are eligible to use SHOP exchanges. States can define *small* as businesses having either 100 or fewer or 50 or fewer employees.¹⁰ A majority of states define *small* as having 50 or fewer employees, and only a handful of states¹¹ employ the 100 or fewer employee definition. Beginning in 2017, states have the option to allow *large* businesses to use SHOP exchanges.

(...continued)

established an SEP due to technical problems submitting insurance applications through the federal IT platform (i.e., HealthCare.gov). Also, in 2015, HHS established an SEP around tax season for individuals who had not enrolled in 2015 coverage and were subject to the 2014 individual mandate penalty.

⁷ For more information on employer requirements for offering employment-based coverage, see CRS Report R43981, *The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential Employer Penalty*.

⁸ 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 most 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.

⁹ For more information about the annual out-of-pocket limits, see "Cost Sharing" section of this report.

¹⁰ This requirement applies to the small-group market operating outside of SHOP exchanges as well. Prior to the ACA, most states defined *small* as businesses having 50 or fewer employees. Under the ACA, the definition of *small* was set to expand to businesses having 100 or fewer employees beginning 2016. However, President Obama signed into law the Protecting Affordable Coverage for Employees Act (PACE Act; P.L. 114-60) to rescind the ACA's expanded definition of *small* subject to the rules of the small-group market in the state.

¹¹ To date, California, Colorado, New York, and Vermont are the only states that define small businesses as having 100 (continued...)

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.¹² 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. In general, the credit is phased out as the number of FTEs increases from 10 to 25 and as average employee compensation increases.

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*.

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.

(...continued)

or fewer employees.

¹² 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.


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 2014-2017, the HHS Secretary outlined a process where each state identified a single plan, the EHB-benchmark plan, which 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.

For more information on the essential health benefits, see CRS Report R44163, *The Patient Protection and Affordable Care Act’s Essential Health Benefits (EHB)*.

Figure 2. The 10 Essential Health Benefits

	ESSENTIAL HEALTH BENEFITS
	• Ambulatory patient services
	• Emergency services
	• Hospitalization
	• Maternity and newborn care
	• Mental health and substance use disorder services, including behavioral health treatment
	• Prescription drugs
	• Rehabilitative and habilitative services and devices
	• Laboratory services
	• Preventive and wellness services and chronic disease management
	• Pediatric services, including oral and vision care

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.¹³ In 2016, the cost-sharing limit is \$6,850 for an

¹³ 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*.

individual plan and \$13,700 for a family plan.¹⁴ For 2017, the cost-sharing limit is \$7,150 for an individual plan and \$14,300 for a family plan.¹⁵

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.¹⁶ 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.

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).

¹⁴ HHS “Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016,” 80 *Federal Register* 10750-10877, February 27, 2015.

¹⁵ HHS, “Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017,” 81 *Federal Register* 12204-12352, March 8, 2016.

¹⁶ Private health insurance is primarily regulated at the state level. The ACA establishes uniform requirements and additional options for all states.

For more information about the market reform provisions in the ACA, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and 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 a 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.¹⁷

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).¹⁸ 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

¹⁷ For more information about CO-OPs and their current operating status, see CRS Report R44414, *Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions*.

¹⁸ 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.

coverage is available or they have a hardship exemption.¹⁹ 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 are 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 an 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.²⁰

Status of Exchange Implementation

This section provides a brief summary of the implementation and operation of exchanges since 2014.

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,

¹⁹ 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*.

²⁰ HHS, "Health Care," at <http://www.hhs.gov/healthcare/index.html>.

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 an SEP (through April 19, 2014), the pre-effectuated enrollment²¹ for the individual exchanges in all states and DC was approximately 8.0 million individuals.²² On October 15, 2014, the effectuated enrollment in the individual exchanges was approximately 6.7 million individuals.²³ An estimate for nationwide enrollment in the SHOP exchanges in 2014 was never released.

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 15, 2014. Overall, the exchanges had fewer operational difficulties in 2015, particularly with respect to IT infrastructure. This was 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 an SEP (through February 22, 2015), the pre-effectuated enrollment for the individual exchanges in all states and DC was approximately 11.7 million individuals.²⁴ On December 31, 2015, the effectuated enrollment in the individual exchanges was approximately 8.8 million individuals.²⁵ As of May 2015, enrollment in the SHOP exchanges was approximately 85,000 individuals.²⁶

The exchanges experienced different challenges in 2015. For SBEs, one of those challenges was obtaining funds to sustain operations. As noted earlier in this report, exchanges were expected to be self-sustaining and could 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 projected funding shortfalls for their exchanges and sought ways to secure more funding and reduce operating costs.²⁷

²¹ For a discussion about the differences between pre-effectuated and effectuated enrollment, see “Exchange Enrollment” section of this report.

²² HHS, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*, May 1, 2014, at http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf.

²³ HHS, *How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period*, November 10, 2014, at http://aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf.

²⁴ HHS, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*, March 10, 2015, at https://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf.

²⁵ Centers for Medicare & Medicaid Services, *December 31, 2015 Effectuated Enrollment Snapshot*, March 11, 2016, at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html>.

²⁶ This estimate excludes Vermont and Idaho; these states had not reported 2015 enrollment data to CMS. CMS, *Update on SHOP Marketplaces for Small Businesses*, July 2, at https://blog.cms.gov/2015/07/02/update-on-shop-marketplaces-for-small-businesses/#_ftn1.

²⁷ Lena H. Sun and Niraj Chokshi, “Almost Half of Obamacare Exchanges Face Financial Struggles in the Future,” (continued...)

2016 Coverage Year

Between 2015 and 2016, the only state to change its exchange type was Hawaii, which went from a state-based exchange to a state-based exchange using the federal IT platform (i.e., HealthCare.gov).

By the end of the 2015 OEP (November 1, 2015, through January 31, 2016) the pre-effectuated enrollment for the individual exchanges in all states and DC was approximately 12.7 million individuals.²⁸ As of March 31, 2016, the effectuated enrollment in the individual exchanges was approximately 11.1 million individuals.²⁹ Updated SHOP enrollment estimates have not yet been released.

In 2016, SBEs continue to explore avenues to become self-sustaining. Discussion among states continues about the type of exchange platform they utilize, particularly the advantages and disadvantages of an SBE, an SBE using the federal IT platform, and an FFE. Given the costs associated with developing and maintaining an eligibility and enrollment platform, the use of the existing federal IT platform may be an option for SBEs with limited resources. States that have the resources, political support, and desire to remain autonomous, however, may decide to employ their own IT platforms, which are often considered to be more responsive to specific state needs and to have more flexibility compared to states using the federal IT platform.³⁰

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 Patient Protection and 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 R44425, <i>Eligibility and Determination of Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief</i> .

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Washington Post, May 1, 2015.

²⁸ HHS, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, March 11, 2016, at <https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>.

²⁹ Centers for Medicare & Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot*, June 30, 2016, at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>.

³⁰ Justin Guivannelli and Ken Lucia, “The Experiences of State-Run Insurance Marketplaces That Use HealthCare.gov,” *The Commonwealth Fund*, September 2015, at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/sep/1840_giovannelli_experiences_states_use_healthcaregov_rb_v2.pdf.

Topic	Report
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 R44438, <i>The Individual Mandate for Health Insurance Coverage: In Brief.</i>
Employer Mandate	CRS Report R43981, <i>The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential Employer Penalty.</i>
Essential Health Benefits	CRS Report R44163, <i>The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB).</i>

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