Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates

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SUMMARY

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Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) required health insurance exchanges to be established in every state and the District of Columbia. 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).* A few states have a *state-based exchange using the federal platform (SBE-FP)*: they administer their exchange but use the federal information technology platform, including the federal exchange website www.HealthCare.gov. SHOP exchanges may be administered as *SB-SHOPs* or *FF-SHOPs*, but there are no *SB-FP-SHOPs.*

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 (also called nongroup) market and small-group market, respectively. Additional requirements apply only to QHPs sold in the exchanges. Exchange insurers also may offer variations of QHPs, such as child-only or catastrophic plans, and they may also offer exchange-certified dental 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* (OEP) 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* (SEP). In general, small businesses may enroll at any time during the year. There are plans available in all individual exchanges, and 20.8 million people were enrolled in health insurance through the individual exchanges as of February 2024. Data available at the time of this report indicate that over 24 million consumers selected a plan during the 2025 OEP. 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 2025, similar to recent years.

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.

Federal government funding for the operation of the exchanges was $2.44 billion for FY2023 (final), $2.47 billion for FY2024 (CR), and was requested to be $2.34 billion for FY2025. 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 overviews of and data on key topics including types and administration of exchanges, eligibility and enrollment, qualified health plan features (benefits, costs, and financial assistance), provider networks, insurer participation, enrollment assistance, and exchange financing. It also includes information about recent statutory and administrative policy changes and current policy issues related to the exchanges and QHPs.

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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 and the District of Columbia.[1] 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).[2] 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 and otherwise monitor the plans that are offered in those marketplaces.

This report provides background on key aspects of the health insurance exchanges and the private health insurance plans sold within the exchanges, which are called qualified health plans (QHPs). It begins with summary information about types and administration of exchanges and an overview of QHPs. Sections on the individual and small business exchanges discuss eligibility and enrollment, plan features (benefits, premiums, cost sharing, and financial assistance available to eligible consumers and small businesses), provider networks, insurer participation, and other topics. The final sections of the report describe types of enrollment assistance available to exchange consumers and provide information on federal funding for the exchanges. Relevant data are provided throughout (e.g., individual exchange enrollment by year). Appendices offer further details, including exchange types by state and federal funding for the exchanges by year.

Throughout the report, there are also updates and insights on recent statutory and regulatory policy changes related to the exchanges and QHPs, and current policy and programmatic issues of interest. This includes discussions of standardized plan requirements, network adequacy requirements, direct enrollment options, special enrollment periods, temporary enhancements to premium tax credits, and requirements on exchange plan agents and brokers.

Although a relatively small proportion of people in the U.S. obtain their coverage through the exchanges,[3] 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.

[1] References to "states" in this report include the District of Columbia, unless otherwise specified.

[2] 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.

[3] For example, an estimated 20.8 million people were enrolled in health insurance through the individual exchanges as of February 2024. This figure is approximately 6.1% of the U.S. population of about 338.7 million people as of February 2024. 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 "U.S. and World Population Clock," accessed March 24, 2025, 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.[4] 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*.[5] These exchanges are part of the nongroup and small-group segments of the private health insurance market, respectively.[6]

- 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.[7] 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.[8]

There are different ways of obtaining coverage on the exchange, including via the exchange website or via agents or brokers or Navigators, as discussed later in this report.[9] Outside of the ACA exchanges, consumers and small businesses can purchase coverage through agents or brokers, or they can purchase it directly from insurers. In addition, there were and still are

[4] The Patient Protection and Affordable Care Act (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.

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

[6] Broadly, private health insurance includes group plans (generally, employer-sponsored insurance) and nongroup plans (which 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. The nongroup market is also called the individual market.

[7] 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. §155.140), but none have done so.

[8] However, health plans are not available in more than half of Small Business Health Options Program (SHOP) exchanges in 2025. See **Table A-1**.

[9] See Individual Exchanges "Eligibility and Enrollment", SHOP Exchanges "Enrollment Processes and Options", and "Navigators and Other Exchange-Based Enrollment Assistance" in this report.

privately operated websites that allow the comparison and purchase of coverage sold by different insurers, broadly similar in concept to the ACA exchanges.[10]

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.[11] 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.

Direct Enrollment Exchange Types

In rulemaking finalized January 19, 2021 (the 2022 Notice of Benefit and Payment Parameters, or *Payment Notice*[12]), 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)."[13] 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

[10] An example of a privately owned website that allows for comparison and purchase of coverage from different insurers is ehealthinsurance.com. 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*.

[11] See Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), *General Guidance on Federally Facilitated Exchanges*, May 16, 2012, 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, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf.

[12] See 2022 Payment Notice, "Part 1," https://www.federalregister.gov/d/2021-01175/p-100, 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.

[13] Ibid. The DE 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."

establishment of these DE exchange type options.[14] Per rulemaking finalized in April 2024, an exchange must "operate a centralized eligibility and enrollment platform" on its website (state exchange website or HealthCare.gov), and exchanges are prohibited from "solely relying on non-Exchange entities" to make eligibility determinations.[15]

Although current regulations do not allow states to adopt a direct enrollment *exchange type* (e.g., FFE-DE), these regulations do not preclude other existing uses of DE approaches and systems in the exchanges, as discussed later in this report. For example, in the individual exchanges, consumers can enroll on their exchange website and there may *also* be DE options for them to enroll directly on an insurer's or web-broker's website.[16] In FF-SHOP and some SB-SHOP exchanges, DE is the only enrollment option.[17]

Exchange Types by State

For PY2025, 28 states have FFEs, 20 states have SBEs, and three states have SBE-FPs.[18] 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 have been in the direction of less federal and more state involvement.[19] From PY2020 to PY2025, nine states transitioned from FFE to SBE-FP and/or from SBE-FP to SBE: Georgia, Illinois, Nevada, New Jersey, Pennsylvania, Maine, Virginia, Kentucky, and New Mexico. In the same time period, no states transitioned to an FFE. See **Appendix A** for more information about current exchange types and transitions over time.

SHOP exchanges may be federally facilitated (FF-SHOP) or state-based (SB-SHOP).[20] Most states' individual and SHOP exchanges are administered in the same way (e.g., both state-based or both federally facilitated). However, in 28 states, no insurers are offering medical plans in the SHOP exchange, meaning there is effectively no SHOP exchange there.[21] For PY2025, there are

[14] 2022 Payment Notice, "Part 3," starting at https://www.federalregister.gov/d/2021-20509/p-197.

[15] 2025 Payment Notice, starting at https://www.federalregister.gov/d/2024-07274/p-589. As discussed in this rule, all exchanges currently do have a centralized eligibility and enrollment platform, and currently perform all eligibility determinations, but these requirements are meant to "codify existing policy and practices and help set clear expectations for existing Exchanges and States that may seek to operate State Exchanges in the future."

[16] See "Brokers, Agents, and Other Third-Party Assistance Entities" in this report.

[17] See "Enrollment Processes and Options" in the SHOP section of this report.

[18] In tallies throughout this report, the District of Columbia is counted as a state. In this report, the terms FFE, SBE, and SBE-FP refer to individual market exchanges unless otherwise specified.

[19] 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, https://www.rwjf.org/en/library/research/2019/10/states-seek-greater-control-cost-savings-by-converting-to-state-based-marketplaces.html.

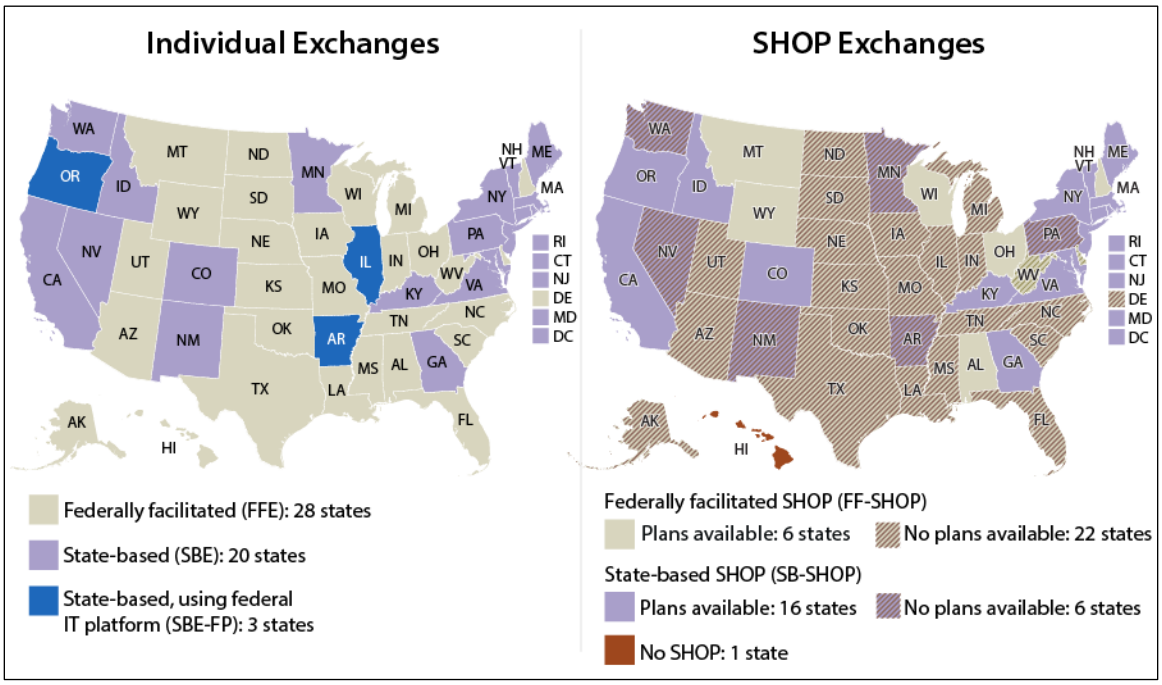
[20] As of June 2018, states could no longer select a state-based SHOP using the federal IT platform (SB-FP-SHOP) approach, except that the two states with that model at that time (Nevada and Kentucky) could maintain it. According to CMS, those states no longer use that model. See "Enrollment Processes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

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

28 FF-SHOPs (6 with medical plans), 22 SB-SHOPs (16 with medical plans), and 1 state exempted from operating a SHOP exchange.[22]

See **Figure 1** for individual and SHOP exchange types by state in PY2025, and see **Table A-1** for additional information, including on state transitions to different exchange types.

Figure 1. Individual and SHOP Exchange Types by State, Plan Year 2025



Source: CRS illustration. See data sources in **Table A-1**.

Notes: IT = information technology; SHOP = Small Business Health Options Program. 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 more than 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.[23]

[22] 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. 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*.

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

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.[24] 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.[25] This includes annually certifying or recertifying plans to be sold in their exchanges as *qualified health plans* (QHPs, discussed below). QHP certification involves a review of various factors, including the plan's benefits, cost-sharing structure, provider network, premiums, marketing practices, and quality improvement activities, to ensure compliance with applicable federal and state standards.[26] 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).[27] A QHP is a health 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.[28] Covering the EHB package means covering 10 broad categories of benefits,[29] complying with limits on consumer cost sharing on the EHB, and meeting certain generosity requirements (in terms of *actuarial value or AV*).[30] As discussed later in this report, an AV is the "percentage paid by a health plan of the percentage of the total allowed costs of benefits."[31] 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.[32]

[24] 42 U.S.C. §18031(b)(1)(A).

[25] 42 U.S.C. §18031(d)(4).

[26] 42 U.S.C. §18031(c)(1); 42 U.S.C. §18031(e). For more information, see CMS, CCIIO, *2025 Final Letter to Issuers in the Federally Facilitated Exchanges*, April 10, 2024, https://www.cms.gov/files/document/2025-letter-issuers.pdf. Hereinafter CMS, *2025 Final Letter to Issuers*. Also see CMS, CCIIO, *2026 Final Letter to Issuers in the Federally-facilitated Exchanges*, January 15, 2025, https://www.cms.gov/files/document/final-2026-letter-issuers.pdf. Hereinafter CMS, *2026 Final Letter to Issuers*.

[27] 42 U.S.C. §18031(d)(2)(B).

[28] 42 U.S.C. §18021(a)(1).

[29] See "Covered Benefits" in this report for more information.

[30] 42 U.S.C. §18022.

[31] 45 C.F.R. §156.20.

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

Following are several key points about QHP requirements, as compared to requirements on other private health insurance plans:[33]

- Requirements on private health insurance plans sold in the nongroup and small-group markets are applicable both in and out of the exchanges.[34] 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 nongroup and small-group plans both in and out of the exchanges.
- There are additional requirements that apply only to QHPs sold in the exchanges.[35] 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. Exchange plans also are subject to certain *network adequacy* requirements, as discussed in the "Provider Networks" section of this report.
- There are multiple data reporting requirements on QHPs, some of which also apply to plans outside the exchanges. Per exchange requirements, QHPs must report data on claims payment policies and practices, claims denials, enrollment, cost sharing, premium rating practices, and other topics.[36] Other private health insurance plans are subject to some of these requirements.[37] Starting in 2026, QHPs in FFEs will be subject to additional reporting requirements regarding prior authorization, including a list of items and services requiring prior authorization and data on prior authorization request approvals, denials, and appeals.[38] These requirements will not apply to other private health insurance plans.
- As of PY2023, QHP issuers in FFEs and SBE-FPs must offer *standardized plan options*, 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. In addition to typical QHPs, certain QHP variations may be available in a given exchange, including child-only plans, catastrophic plans, consumer operated

[33] This is not a comprehensive comparison of requirements on QHPs and other private plans.

[34] 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.

[35] See, for example, 42 U.S.C. §§18021, 18023, and 18031; and 45 C.F.R. §§156.200 et seq. Also see the aforementioned CMS, *2025 Final Letter to Issuers*, https://www.cms.gov/files/document/2025-letter-issuers.pdf and CMS, *2026 Final Letter to Issuers*, https://www.cms.gov/files/document/final-2026-letter-issuers.pdf.

[36] 42 U.S.C. §18031(e)(3), 45 C.F.R. §156.220, and related data collection requirements on exchanges at 45 C.F.R. §155.1040. QHPs must make "accurate and timely disclosure" of the required information to the exchange, the HHS Secretary, the state insurance commissioner, and the public. Other reporting requirements also apply to QHPs, such as 42 U.S.C. §1320b-23, which requires QHPs or their pharmacy benefit managers to report certain prescription drug information to HHS.

[37] 42 U.S.C. §300gg-15a applies the QHP reporting requirements at 42 U.S.C. §18031(e)(3) to most private health insurance plans (i.e., employer-sponsored insurance plans and all nongroup coverage), but as currently implemented, such plans are only required to report certain of the data (not, for example, data on claims denials).

[38] 45 C.F.R. §156.223, as added by rulemaking finalized in 2024. See summary information and a link to the rule at CMS, "CMS Interoperability and Prior Authorization Final Rule CMS-0057-F," January 17, 2024, https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f.

and oriented plans (CO-OPs), and multistate plans (MSPs). Stand-alone dental plans (SADPs), also sometimes referred to as qualified dental plans (QDPs), are the only non-health plans offered in the exchanges. They are subject to certain modified QHP requirements.[39] See **Table B-1** for more information about types of plans offered in the exchanges.

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 later in this report.

Standardized Plans

In the 2023 Payment Notice, finalized in May 2022, HHS indicated that insurers offering QHPs in most FFEs and SBE-FPs were required to offer "standardized" plans starting in PY2023.[40] The 2024 through 2026 Payment Notices have modified certain requirements for standardized plans and provided limits on the offering of non-standardized plans.[41] These requirements do not apply in SBEs, although in the 2025 Payment Notice, HHS suggested that over half of SBEs have their own standardized plan requirements.[42] The requirements do not apply in SHOP exchanges.

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 regulations and guidance.[43] Standardized plans may still vary in other ways. On HealthCare.gov, standardized plans are identified to consumers as "easy pricing" plan options.

Specifically, HHS designed a standardized plan option for each metal level of plan offered in the exchanges. 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). Examples are shown in **Table 2**, in the cost-sharing section of this report.

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[39] SADPs are dental insurance plans certified to be sold on the exchanges. See 42 U.S.C. §18031(d)(2)(B)(ii), 45 C.F.R. §155.1065, and 45 C.F.R. §155.705. This report does not focus on SADPs but provides some examples of SADP requirements. See the sections on "Covered Benefits" and "Cost Sharing, Actuarial Value Levels, and Maximum Out-of-Pocket Limits" as well as **Table B-1**.

[40] 2023 Payment Notice, starting at https://www.federalregister.gov/d/2022-09438/p-1342. Federal requirements on standardized plans do 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).

[41] 2026 Payment Notice, starting at https://www.federalregister.gov/d/2025-00640/p-893. This discussion also references the relevant sections of the 2023-2025 Payment Notices.

[42] In addition, a Commonwealth Fund analysis includes certain information regarding SBEs and standardized plans: Rachel Schwab et al., "ACA State Marketplace Models and Key Policy Decisions," updated March 14, 2025, https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions. Hereinafter Commonwealth Fund, *2025 State Marketplace Analysis*. For standardized plan information, see the spreadsheet at the "Download the data" link on this page, and the "Simplifying Plan Choice" tab of that spreadsheet.

[43] 45 C.F.R. §156.201 (Standardized Plan Options) and 45 C.F.R. §156.202 (Non-standardized Plan Option Limits). Specific cost-sharing requirements for standardized plans are listed in the relevant Payment Notice's preamble (e.g., in the 2025 Payment Notice for plan year 2025, https://www.federalregister.gov/d/2024-07274/p-1472). Also see the aforementioned CMS, *2025 Final Letter to Issuers*, https://www.cms.gov/files/document/2025-letter-issuers.pdf, and CMS, *2026 Final Letter to Issuers*, https://www.cms.gov/files/document/final-2026-letter-issuers.pdf.

In general, FFE and SBE-FP QHP issuers are required to "offer in the individual market at least one standardized plan "at every product network type ..., at every metal level, and throughout every service area that it also offers non-standardized QHP options, including, for silver plans, for the income-based cost-sharing reduction plan variations."[44] 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.[45] As of PY2024, QHP issuers are not required to offer standardized plans at the "non-expanded bronze" metal level, and as of PY2026, QHP issuers that offer "multiple standardized plan options within the same product network type, metal level, and service area must meaningfully differentiate these plans," as specified.[46]

As of PY2025, issuers are generally limited to offering two non-standardized plan options per product network type and per metal level, although there are exceptions as specified in regulations (e.g., "if issuers demonstrate that these additional non-standardized plans have specific design features that will substantially benefit consumers with chronic and high-cost conditions").[47] Variations are also allowed with regard to inclusion of adult dental, pediatric dental, and adult vision benefit coverage.

According to an HHS issue brief, standardized plan requirements (and limits on non-standardized plans) are intended to help consumers understand their plan options and reduce "choice overload." This brief and other resources provide further background on standardized plans, including prior federal rulemaking and certain state approaches.[48]

Individual Exchanges

Eligibility and Enrollment

Qualified individuals may purchase health insurance plans for themselves and their families in their state's individual exchange.[49] Consumers are qualified individuals—i.e., eligible for exchange coverage—as long as they (1) meet state residency requirements;[50] (2) are not incarcerated, except individuals in custody pending the disposition of charges; and (3) are U.S.

[44] 45 C.F.R. §156.201. The standardized plan requirements refer to the definition of *product* at 45 C.F.R. §144.103: "a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area." 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," accessed March 24, 2025, https://www.healthcare.gov/glossary/service-area/. Also see 45 C.F.R. §155.1055.

[45] CMS, "HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet," April 28, 2022, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet.

[46] 45 C.F.R. §156.201(b) and (c).

[47] 2025 Payment Notice, starting at https://www.federalregister.gov/d/2024-07274/p-1502.

[48] HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces,* December 28, 2021, https://aspe.hhs.gov/reports/standardized-plans-health-insurance-marketplaces. Also see, for example, Katie Keith, "Final 2023 Payment Rule, Part 2: Standard Plans And Other Exchange Provisions," *Health Affairs Forefront,* April 30, 2022, https://www.healthaffairs.org/content/forefront/final-2023-payment-rule-part-2-standard-plans-and-other-exchange-provisions, and Center on Budget and Policy Priorities, "Easy Pricing Plans (Standardized Plans)," July 2024, https://www.healthreformbeyondthebasics.org/easy-pricing-plans-standardized-plans/.

[49] 42 U.S.C. §18032(a) and (f) and 45 C.F.R. §155.305.

[50] 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.

citizens, U.S. nationals, or "lawfully present" residents.[51] 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."[52] 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.[53] 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).[54]

Interaction with Medicaid, CHIP, and Medicare

In conjunction with the streamlined application mentioned above, exchanges must have "screen and enroll" 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.[55]

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.[56] 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.

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[51] Examples of *lawfully present* immigrants include lawful permanent residents, refugees, asylees, and nonimmigrants (e.g., students and temporary workers). For a full list, see CRS Report R47351, *Noncitizens' Access to Health Care*. For more information (including regarding Deferred Action for Childhood Arrivals (DACA) recipients), see HealthCare.gov, "Immigration status to qualify for the Marketplace," accessed March 24, 2025, https://www.healthcare.gov/immigrants/immigration-status/.

[52] 42 U.S.C. §18083, 45 C.F.R. §155.405.

[53] 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 three states: Minnesota, New York, and Oregon.

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

[55] 45 C.F.R. Part 155, Subpart D, including §155.302. Regarding FFE and SBE-FP states, also see Section 2.2.5 of CMS, CCIIO, *Federally-facilitated Exchange (FFE) Enrollment Manual*, August 19, 2024, https://www.cms.gov/files/document/ffe-enrollment-manual-2024-5cr-082024.pdf. Hereinafter CMS, *FFE Enrollment Manual (2024)*.

[56] Social Security Act §1882(d)(3)(A)(i). Medicare is a federal program that pays for covered health care services for (continued...)

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).[57] 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 in effect.

The annual federal OEP is November 1 to January 15, for FFE and SBE-FP states.[58] This means, for example, that the OEP for PY2025 was November 1, 2024, to January 15, 2025.[59] This is also the default OEP for SBEs, but states with SBEs may extend or otherwise modify their OEPs, subject to federal regulations.[60]

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.[61] 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.[62]

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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 September 10, 2024, https://www.cms.gov/marketplace/about/medicare. Also see Section 3.4.8 of CMS, *FFE Enrollment Manual (2024)*, linked in the prior footnote. Information for consumers is at Medicare.gov, "Medicare & the Marketplace," accessed March 24, 2025, https://www.medicare.gov/basics/get-started-with-medicare/other-paths/medicare-marketplace.

[57] 45 C.F.R. §155.410.

[58] These annual OEP dates were updated via rulemaking, in effect as of the PY2022 OEP (in fall 2021). See the 2022 Payment Notice, "Part 3," starting at https://www.federalregister.gov/d/2021-20509/p-248. See prior year OEPs at 45 C.F.R. §155.410(b) and (e). Annual payment notices are cited in **Table D-1**.

[59] 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.

[60] 45 C.F.R. §155.410(e)(4)(ii) and (iii). For PY2025 SBE OEPs, see CMS, *State Exchange OE Chart PY 2025*, October 14, 2024, at https://www.cms.gov/files/document/state-exchange-oe-chart-py-2025.pdf. For PY2024 and prior year SBE OEP information, see the CMS/CCIIO pages of "Marketplace Open Enrollment Period Public Use Files" (PUFs) at https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files. Hereinafter CMS, "Marketplace OEP PUFs."

[61] See Section 3.2.5 of the aforementioned CMS, *FFE Enrollment Manual (2024)*, at https://www.cms.gov/files/document/ffe-enrollment-manual-2024-5cr-082024.pdf. Also see the most recent CMS guidance to nongroup market issuers on providing notices of coverage renewal or discontinuation, June 2023, at https://www.cms.gov/files/document/updated-federal-standard-notices-and-enforcement-safe-harbor-discontinuation-notices-py-2024.pdf. There, see "Instructions for Attachment 2," item 31.

[62] 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 the aforementioned CMS, *FFE Enrollment Manual (2024)* at https://www.cms.gov/files/document/ffe-enrollment-manual-2024-5cr-082024.pdf. Although this manual describes processes for HealthCare.gov states, SBEs also have processes for automatic reenrollment.

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*.[63] This includes, for example:

- **Loss of *qualifying coverage*,** which includes most types of comprehensive coverage (e.g., Medicaid, and group and nongroup private insurance).[64] 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.[65]
- **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.[66] Regarding dependents, birth and adoption (and other specified scenarios) are QLEs that trigger SEPs, but generally not pregnancy.[67]
- **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.[68]
- **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.[69]
- **Certain other situations,** including errors or misrepresentations made by exchanges and/or plans,[70] and other exceptional or complex circumstances.[71]

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).[72]

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[63] In addition to the examples and their regulatory citations shown here, see HealthCare.gov, "Special enrollment opportunities," accessed March 24, 2025, https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ and HealthCare.gov, "Special Enrollment Periods for complex issues," accessed March 24, 2025, https://www.healthcare.gov/sep-list/. Also see 45 C.F.R. §147.104 regarding SEPs applicable to the nongroup and group markets overall.

[64] 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.

[65] 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.

[66] 45 C.F.R. §155.420(d)(2).

[67] There is no federal SEP based on pregnancy, but per CRS review (in November 2024) of the websites of the 20 SBEs for PY2025, there are pregnancy-related SEPs in at least nine SBEs: Colorado, Connecticut, Kentucky, Maine, Maryland, New Jersey, New York, Vermont, and Washington, DC. SBE websites are linked in **Table A-1**. 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.

[68] 45 C.F.R. §155.420(d)(3, 6).

[69] 45 C.F.R. §155.420(d)(7). Note that "moving only for medical treatment or staying somewhere for vacation doesn't qualify you for a Special Enrollment Period." HealthCare.gov, "Special enrollment opportunities," accessed March 24, 2025, https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/.

[70] 45 C.F.R. §155.420(d)(4, 5, 12).

[71] 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, gaining access to an Individual Coverage Health Reimbursement Account (ICHRA), the cessation of employer contributions toward COBRA continuation coverage, and more.

[72] Statutory requirements for exchange SEPs are at 42 U.S.C. §18031(c)(6), and Secretarial authority to establish (continued...)

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.[73]

CMS later announced another temporary SEP for eligible consumers who lost Medicaid or CHIP coverage due to the end of the Medicaid continuous enrollment requirement that was in place during the pandemic.[74] The SEP was available if consumers applied for coverage or updated their applications between March 31, 2023, and November 30, 2024, and attested to an end of Medicaid or CHIP coverage during that period.[75] While there is already an SEP based on loss of qualifying coverage, this "Unwinding SEP" temporarily provided additional time for affected individuals to enroll in an exchange plan. In the 2024 Payment Notice, CMS permanently provided a longer SEP for individuals losing Medicaid or CHIP coverage (generally 90 days, as compared to the 60-day SEP applicable to most other QLEs).[76]

Federal SEPs apply to FFEs, SBE-FPs, and generally to SBEs. However, SBEs have flexibility regarding implementation of some SEPs.[77] 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.[78]

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.

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, https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization.

[73] 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, 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, https://www.cms.gov/newsroom/fact-sheets/extended-access-opportunity-enroll-more-affordable-coverage-through-healthcaregov.

[74] At the start of the pandemic, Congress enacted the Families First Coronavirus Response Act (FFCRA; P.L. 116-127), which included a requirement that Medicaid programs keep individuals continuously enrolled from January 1, 2020, through the end of the COVID-19 public health emergency (PHE), in exchange for enhanced federal funding. As part of the Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-164), Congress delinked the continuous enrollment provision from the COVID-19 PHE period, ending continuous enrollment on March 31, 2023.

[75] This SEP was initially set to end on July 31, 2024, and was later extended to November 30, 2024. See CMS, *Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition Operations for Plan Year 2024*, March 28, 2024, https://www.medicaid.gov/resources-for-states/downloads/extn-sep-cnsmrs-lsg-chip-cvrg-adndm-faq.pdf. This cites the initial announcement.

[76] 45 C.F.R. §155.420(c)(6).

[77] 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, https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf. In addition, the aforementioned Commonwealth Fund, *2025 State Marketplace Analysis* includes information on SBEs and certain special enrollment periods. Specifically, see the spreadsheet at the "Download the data" link at https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions, and the "Reducing Enrollment Barriers" tab of that spreadsheet.

[78] For more information about SEPs, see Section 5 of the aforementioned CMS, *FFE Enrollment Manual (2024)*, https://www.cms.gov/files/document/ffe-enrollment-manual-2024-5cr-082024.pdf.

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 March 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 in September 2021, through the 2022 Payment Notice, Part 3.[79] 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). Initially, this SEP allowed such individuals to newly enroll or switch plans once a month, only 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 were based on the ARPA enhancements to the PTC. Although this SEP was not required by ARPA and was not exclusive to ARPA, it would have been effective only during times when PTC enhancements are available, such as those in ARPA and the IRA.

In the 2025 Payment Notice, finalized April 2024, this SEP was made permanent, with a modification.[80] The SEP is still for consumers who are eligible for the PTC and have expected household incomes up to 150% of FPL, but the limitation regarding $0 premiums was removed.

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.[81] The enrollment options and adverse selection concerns are also summarized in a *Health Affairs* article on the September 2021 rule.[82]

This SEP is available in all FFE and SBE-FP states, and it is optional for SBEs.[83] Insurers are not required to offer this SEP outside of the exchanges.[84] HHS also clarified that this SEP and its related enrollment options do not change eligibility for, or enrollment options for, any other exchange SEP.

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[79] 45 C.F.R. §155.420(d)(16), as added by the 2022 Payment Notice, "Part 3," starting at https://www.federalregister.gov/d/2021-20509/p-272 .

[80] 2025 Payment Notice, starting at https://www.federalregister.gov/d/2024-07274/p-1087.

[81] 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, Actuarial Value Levels, and Maximum Out-of-Pocket Limits" in this report.

[82] Katie Keith, "Biden Administration Finalizes First Marketplace Rule, Including New Low-Income Special Enrollment Period," *Health Affairs Forefront,* September 20, 2021, https://www.healthaffairs.org/content/forefront/biden-administration-finalizes-first-marketplace-rule-including-new-low-income-special. The 2025 Payment Notice also addresses certain adverse selection concerns regarding this SEP, https://www.federalregister.gov/d/2024-07274/p-1096.

[83] See the aforementioned Commonwealth Fund, *2025 State Marketplace Analysis,* regarding SBEs and certain SEPs including the low-income SEP. Specifically, see the spreadsheet at the "Download the data" link at https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions, and the "Reducing Enrollment Barriers" tab of that spreadsheet.

[84] 45 C.F.R. §147.104(b)(2)(i)(G), as added by the 2022 Payment Notice, "Part 3," https://www.federalregister.gov/d/2021-20509/p-899.

Enrollment Data

Nationwide individual exchange enrollment by year is 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 data are released during, and soon after, an annual open enrollment period. For example, in March 2024, CMS reported that 21.4 million consumers signed up for a plan (or were automatically reenrolled) in the individual exchanges nationwide during the 2024 open enrollment period (November 1, 2023-January 16, 2024 in most states).[85] In an early 2025 enrollment "snapshot," CMS reported that 24.2 million consumers had selected a plan during the 2025 OEP as of January 15, 2025.[86] Additional pre-effectuated enrollment data will likely be released in spring 2025.

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 data generally are point-in-time and enrollment numbers 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. In July 2024, CMS reported that 20.8 million consumers, or 97% of the OEP 2024 individual exchange enrollees, had effectuated their enrollment as of February 2024.[87]

CMS also releases data on average effectuated enrollment 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 of Statistics*, for HHS reports and resources detailing various enrollment data.

[85] CMS, *HEALTH INSURANCE MARKETPLACES 2024 OPEN ENROLLMENT REPORT,* March 2024, https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf. Hereinafter *CMS, 2024 OEP Report*.

[86] CMS, "Marketplace 2025 Open Enrollment Period Report: National Snapshot," January 17, 2025, https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-2.

[87] CMS, *Effectuated Enrollment: Early 2024 Snapshot and Full Year 2023 Average*, July 2024, https://www.cms.gov/files/document/early-2024-and-full-year-2023-effectuated-enrollment-report.pdf.

Table 1. Nationwide Individual Exchange Enrollment, by Plan Year

(in millions)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
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**	**16.4**	**21.4**
Effectuated, early in PY (point-in-time as of date shown)[b]	NA[c]	**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	**15.7,** Feb. 2023	**20.8,** Feb. 2024
Effectuated, late in PY (point-in-time or average for month shown)[d]	**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	**13.5,** Dec. 2022	**17.4,** Dec. 2023	NA[e]

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 of Statistics*, in report sections specified in table notes below.

Notes: OEP = open enrollment period; PY = plan year. In the individual exchanges, a PY 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 data typically are released following an OEP and include any broadly applicable OEP extensions or longer state-based exchange OEPs. For these data sources by year, see the "Pre-effectuated Enrollment Data" section of the report mentioned above. For example, the 2021 amount 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 data for a point in time early in the plan year and may release additional point-in-time data during the year. Data sources by year are in the "Point-in-Time Effectuated Enrollment Data" section of the report. For example, the 2020 amount is from Centers for Medicare and Medicaid Services (CMS), *Early 2020 Effectuated Enrollment Snapshot,* July 2020.

c. Early-year effectuated enrollment estimate not found for PY2014.

d. Some effectuated enrollment data reflect an average over a specified time period. For PY2016 and on, average monthly enrollment data are provided. Average monthly enrollment data were not provided for PY2014 and PY2015, but quarterly point-in-time data were released in those years. Although point-in-time and average monthly enrollment are not the same, they are provided here to show late-year enrollment 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 2022 amount is from Table 7 in CMS, *Early 2023 Snapshot and Fully Year 2022 Average,* August 2023).

e. Late-year effectuated enrollment data for PY2024 are expected in summer 2025.

Enrollment Trends

As shown in **Table 1**, early year effectuated enrollment was around 10-11 million each year until 2021, but it has increased sharply since then. February 2024 enrollment (20.8 million) is 32.5% higher than February 2023 (15.7 million), and 94.4% higher than February 2020 (10.7 million). Changes in exchange enrollment have varied by state.

Year-over-year changes in the other types of exchange enrollment data (e.g., pre-effectuated enrollment) generally followed the same pattern. However, when comparing enrollment rates within a given year, it is evident that there were greater shifts in exchange enrollment rates in the

early years of the exchanges than there have been in recent years. For example, from 2014 through 2019, there was more than a 20% decrease in each year's late year effectuated enrollment as compared to that year's pre-effectuated enrollment. The greatest changes were in 2016 and 2017, with decreases of 28.3% and 27%, respectively. The changes have varied since 2020, ranging from a 13.2% decrease in 2020 to a 6.1% increase in 2023. See **Table 1**. Increases or decreases in enrollment within a given year are the net of disenrollments (and those who did not effectuate their initial plan selections) as well as new enrollments throughout the year (e.g., through special enrollment periods).

Increases or decreases in exchange enrollment—including changes over time and within a given year—may be due to numerous factors, including federal and state policy changes as well as market and demographic effects. For example, exchange enrollment increases during and after the COVID-19 pandemic may be attributable, at least in part, to new eligibility for subsidized exchange coverage (discussed later in this report), new special enrollment periods, and changes in income and/or access to other forms of health coverage. Other factors that may affect enrollment include marketing and outreach efforts, plan choices and costs on and off the exchanges, enrollment processes and available assistance, and consumer preferences. It would be difficult to isolate the effects of any particular variable (policy or otherwise) on enrollment, given their interacting effects.[88]

Covered Benefits

In and out of the exchanges, covered benefits may differ by private health insurance plan, subject to applicable federal and state requirements.

As stated earlier,[89] private health insurance plans sold in the individual exchanges (i.e., QHPs) are subject to the same federal requirements on benefit coverage as private health insurance plans sold in the nongroup market outside the exchanges. This includes, for example, coverage of 10 categories of essential health benefits (EHB).[90] Per current federal regulations, states generally specify the benefits to be covered within the 10 categories, so particular EHB benefits vary by state. Other federal requirements that apply both on and off the exchanges include coverage of certain preventive services without cost sharing, mental health parity, and a prohibition on benefit coverage exclusions based on an enrollee's preexisting health conditions.[91] States also may impose requirements on the types of plans they regulate, including those sold on the exchanges.

[88] However, a number of government and stakeholder resources provide analysis and data on enrollment trends, including the federal reports linked in the "Additional Exchange Statistics" section of CRS Report R46638, *Health Insurance Exchanges: Sources of Statistics*. Also see, for example, Terry Burke et al., "9 Trends Driving Historic ACA Enrollment Growth," Oliver Wyman, January 2024, https://www.oliverwyman.com/our-expertise/perspectives/health/2024/jan/9-trends-driving-historic-aca-enrollment-growth.html; and Cynthia Cox and Jared Ortaliza, "Where ACA Marketplace Enrollment is Growing the Fastest, and Why," KFF, May 16, 2024, https://www.kff.org/policy-watch/where-aca-marketplace-enrollment-is-growing-the-fastest-and-why/.

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

[90] The 10 categories of EHB are 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; and pediatric services, including oral and vision care. For more information on EHB requirements and state specification of their EHB, see the CRS report in the following footnote, and see CMS, CCIIO, "Information on Essential Health Benefits (EHB) Benchmark Plans," updated January 14, 2025, https://www.cms.gov/cciio/resources/data-resources/ehb.

[91] These and other federal requirements on private health insurance plans, applicable to the nongroup market and otherwise, are discussed in CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

One distinction regarding QHPs (as compared to plans sold off the exchanges) is related to dental coverage. While EHB coverage includes the category "pediatric services, including oral and vision care," QHPs are exempt from covering pediatric dental benefits if a stand-alone dental plan (SADP) is also available in that exchange. In turn, one requirement on SADPs is that they must cover pediatric dental in accordance with relevant EHB standards.[92]

Certain ACA provisions address QHP coverage and financing of abortion. The ACA specifies that states may elect to require or prohibit coverage of abortion by QHPs (and other private plans regulated by states).[93] If QHPs do cover elective abortion, there are payment segregation requirements, including that a plan cannot use any funds attributable to premium tax credits (discussed below) to pay for such services.[94]

CMS public use files (PUFs) on plans offered in the federal and state exchanges include data on certain benefits covered by QHPs, including benefits covered as EHB.[95]

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) and associated administrative expenses (including taxes and fees).[96]

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, and insurers are subject to annual state and federal review of their premium rates.[97] In addition, insurers that want to offer plans in the exchanges must submit their proposed premiums to the exchanges as part of the QHP certification process each year.[98] Data on exchange premiums are in **Table 3** at the end of this section.

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[92] Regarding the pediatric dental exception for QHPs and requirements on SADPs, see 42 U.S.C. §18022(b)(4)(F), 42 U.S.C. §18031(d)(2)(B)(ii), and 45 C.F.R. §155.1065(d). See Appendix **Table B-1** for more information on SADPs.

[93] 42 U.S.C. §18023(a) and (c). For more information, including on states requiring or prohibiting abortion coverage, see "Does Federal Law Require Private Health Insurance Coverage of Abortions or Abortion Counseling?" in CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions*.

[94] Ibid. See "Can Federal Funds Be Used to Pay for Abortion in Private Health Insurance Plans?"

[95] Public Use Files (PUFs) that primarily include data on plans in the FFEs and SBE-FPs, by year, are available at CMS, CCIIO, "Health Insurance Exchange Public Use Files (Exchange PUFs)," updated December 18, 2024, https://www.cms.gov/marketplace/resources/data/public-use-files. See, for example, the PY2025 "Benefits and Cost Sharing PUF" at that page. A separate webpage includes similar exchange PUFs for plans in each SBE by year: CMS, CCIIO, "Health Insurance State-based Exchange Public Use Files," updated September 10, 2024, https://www.cms.gov/marketplace/resources/data/state-based-public-use-files. Hereinafter CMS, "Exchange PUFs" and CMS, "SBE PUFs," respectively. Note that these are different than the Marketplace OEP PUFs cited elsewhere in this report, which primarily provide data on OEP enrollment.

[96] See CRS Report R47507, *Private Health Insurance: A Primer* for further background on private health insurance premiums.

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

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

Because a premium is the price for coverage, the premium amount generally reflects plan features (e.g., covered benefits, cost-sharing requirements). As the majority of premium revenue pays for medical claims, the relationship of plan features to potential claims costs may directly affect a given premium. For example, a plan that covers many benefits—which has the potential to lead to numerous medical claims—can have higher premiums than a plan that covers few benefits, all else equal.

Changes in premiums may be related to numerous factors, including changes in plan features (e.g., more or fewer benefits covered), changes in the prices insurers pay for covered benefits (e.g., higher or lower provider payments), or changes in enrollee demand for healthcare (e.g., more or fewer number of claims filed). These changes can be affected by federal or state requirements or market dynamics, and they can vary geographically and by plan type.

One analysis suggests that rising health care prices are a key driver of increases in exchange plan premiums for PY2025.[99] It also points to increased utilization of costly prescription drugs as a factor affecting premiums. Another analysis of 2025 health insurance premium drivers in the nongroup and small group markets (not specific to the exchanges) similarly highlights prescription drug spending as a driver of premium increases.[100] These resources also discuss various recent and ongoing policy changes (e.g., the temporarily enhanced premium subsidies discussed below in this report), and the extent to which there are any indications of their effects on premiums.

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

As enrollees receive benefits covered by their 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 deductibles, coinsurance, and co-payments, up to an annual limit on consumer out-of-pocket spending.[101] Consumer cost-sharing requirements on covered benefits may vary by QHP, subject to applicable federal requirements as discussed here, and any applicable state requirements.

Actuarial Value and the "Metal Levels"

Most health plans sold through the exchanges (and non-grandfathered plans sold in the nongroup and small-group markets off-exchange[102]) must provide coverage in compliance with one of four levels of *actuarial value* (AV), which correspond to a precious metal designation.[103] AV is the

[99] Jared Ortaliza et al., "How Much and Why ACA Marketplace Premiums Are Going Up in 2025," Peterson-KFF Health System Tracker, August 2, 2024, https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2025/.

[100] American Academy of Actuaries, *Drivers of 2025 Health Insurance Premium Changes*, August 2024, https://www.actuary.org/sites/default/files/2024-08/health-brief-2025-premium-changes.pdf.

[101] 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.

[102] *Grandfathered plans* are nongroup 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 HealthCare.gov, "Grandfathered health insurance plans," accessed March 24, 2025, https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/.

[103] 42 U.S.C. §18022(d).

"percentage paid by a health plan of the percentage of the total allowed costs of benefits."[104] In other words, a plan's AV indicates the average share of the medical costs that it will pay for covered benefits. Given that plans and enrollees collectively pay total costs, AV is the plan counterpart to enrollee cost-sharing expenses.

The four AV levels are 90% for platinum, 80% for gold, 70% for silver, and 60% for bronze.[105] 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.[106]

CMS reports on pre-effectuated enrollment include data on enrollment by metal level. During the PY2024 open enrollment period, 31% of individual exchange consumers nationwide selected bronze plans, 54% silver, 13% gold, 1% platinum, and less than 1% catastrophic plans.[107]

Maximum Out-of-Pocket Limits

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.[108] The maximum OOP limits are updated each year through HHS rulemaking and/or guidance. See **Figure 2** for the generally applicable maximum limits by year. For example, the PY2025 maximum OOP limit for self-only coverage is $9,200; the limit is doubled for coverage other than self-only. Plans may set their OOP limits lower than these applicable maximums.

QHP issuers also must offer plan variations with reduced OOP limits for certain standardized plan options and for consumers who qualify for cost-sharing reductions, as discussed below in this section. SADPs are subject to modified OOP limits.[109]

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[104] 45 C.F.R. §156.20.

[105] 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).

[106] 45 C.F.R. §156.200(c)(1).

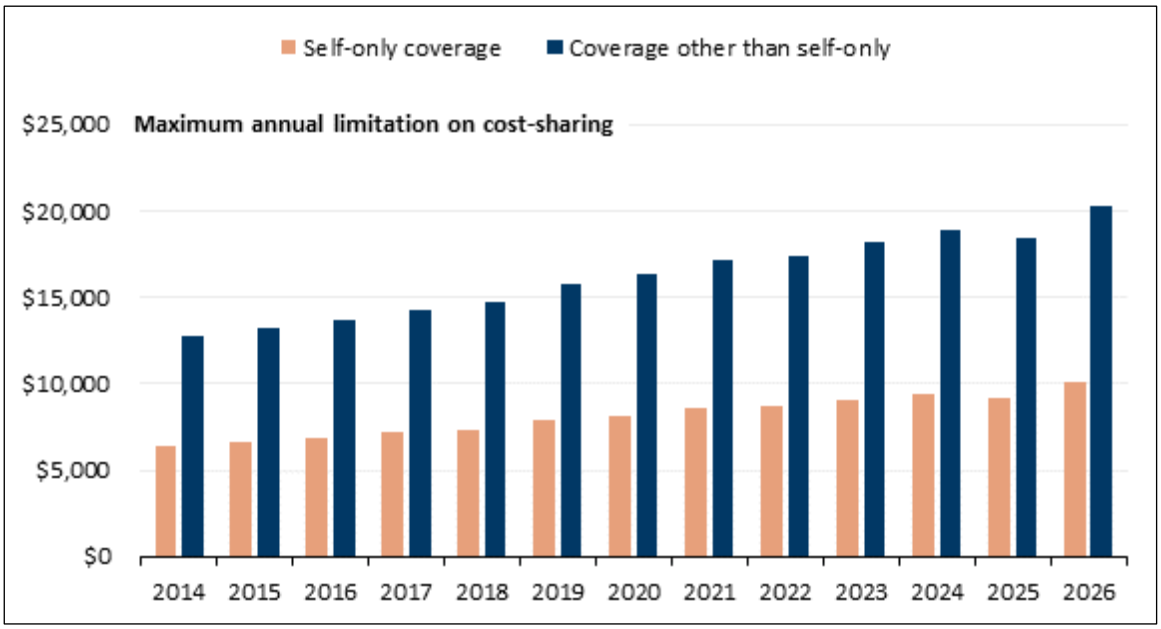
[107] See Table 5 in the aforementioned CMS, *2024 OEP Report,* https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf. For more data, including state-level estimates, see the aforementioned CMS, "Marketplace OEP PUFs," https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files. See "Enrollment " in this report for more information on effectuated and pre-effectuated enrollment.

[108] 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 **Figure 2** of this report.

[109] For example, per the aforementioned CMS, *2025 Final Letter to Issuers,* SADPs are subject to a 2025 OOP limit specific to their EHB pediatric dental coverage: $425 for one covered child and $850 for two or more children. See https://www.cms.gov/files/document/2025-letter-issuers.pdf. Also see "Qualified Health Plans" in this report regarding SADPs, and "Covered Benefits" in the Individual Exchanges section of this report regarding EHB requirements and SADPs.

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

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



Source: CRS analysis of relevant federal rulemaking and guidance 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. Annual payment notices are cited in **Table D-1**. Starting with PY2023, these OOP limits and certain other payment parameters are published in guidance instead of Payment Notices. For PY2025 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 2025 Benefit Year*, November 15, 2023, https://www.cms.gov/files/document/2025-papi-parameters-guidance-2023-11-15.pdf. See the similarly titled guidance on PY2026 amounts, issued October 8, 2024, https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf.

Notes: Once an enrollee's cost sharing (including deductibles, coinsurance, and co-payments) meets 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. 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.

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 also may set their OOP limits lower than the applicable maximums.

Cost-Sharing Limits for Standardized Plans

As discussed earlier in this report, QHP issuers in FFEs and SBE-FPs are generally required to offer *standardized* QHPs—with certain cost-sharing limits designed by HHS—in addition to any non-standardized QHPs they offer. Specifically, HHS designed a standardized plan option for each metal level of plan offered in the exchanges. 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). Examples of such cost-sharing amounts set for PY2025 standardized plans are shown in **Table 2** below. The 2025 maximum OOP limit for the standardized expanded bronze plan is the same as the 2025 maximum OOP limit generally applicable to non-standardized plans, as shown in **Figure 2** above.

Table 2. Examples of Standardized Plan Requirements for QHP Issuers in Most FFE and SBE-FP States, Plan Year 2025

Selected Requirements[a]	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	63.81%	70.01%	73.09%	87.33%	94.14%	78.06%	88.04%
Deductible	$7,500	$5,000	$3,000	$500	$0	$1,500	$0
Maximum OOP Limit	$9,200	$8,000	$6,400	$3,000	$2,000	$7,800	$4,300
ER Services	50%	40%	40%	30%	25%, ND	25%	$100, ND
Inpatient Hospital Services (including MH/SUD)	50%	40%	40%	30%	25%, ND	25%	$350, ND
Primary Care Visit (including MH/SUD Outpatient Office Visits)[b]	$50, ND	$40, ND	$40, ND	$20, ND	$0, ND	$30, ND	$10, ND
Specialist Visit	$100, ND	$80, ND	$80, ND	$40, ND	$10, ND	$60, ND	$20, ND
Generic Drugs	$25, ND	$20, ND	$20, ND	$10, ND	$0, ND	$15, ND	$5, ND
Specialty Drugs	$500	$350	$350	$250	$150, ND	$250, ND	$150, ND

Source: 2025 Payment Notice, Table 11, https://www.federalregister.gov/d/2024-07274/p-1472. Also see Table 12 at that link. These requirements do 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). Annual payment notices are cited in **Table D-1**.

Notes: The Department of Health and Human Services designed a standardized plan option for each metal level of plan offered in the exchanges. The metal level plan designations correspond to the plan's actuarial value (AV), which is the "percentage paid by a health plan of the percentage of the total allowed costs of benefits," as defined at 45 C.F.R. §156.20. In general, the four AV levels are 90% for platinum, 80% for gold, 70% for silver, and 60% for bronze. For standardized plans, "expanded bronze" (with a higher AV) is used instead of the typical bronze. There are also standardized plan options for the silver plan cost-sharing reduction (CSR) plan variations, which are available to eligible consumers based on income and other factors. See the following section of this report regarding CSRs.

For specified benefit categories, there are co-payments (flat dollar amounts) or coinsurance (percentages). ER = emergency room; FFE = federally facilitated exchange; MH/SUD = mental health and substance use disorder; ND = the benefit category is not subject to the plan deductible; OOP = Out-of-pocket costs; QHP = qualified health plan; SBE-FP = state-based exchange using the federal information technology (IT) platform.

a. Illustrative examples of standardized plan cost-sharing limits are excerpted here; see source table (2025 Payment Notice, Table 11) for additional rows (e.g., laboratory services, speech therapy, preferred and non-preferred brand drugs).

b. In the source table, there is a separate row for "mental health & substance use disorder outpatient office visits," but those limits are the same as provided for primary care visits, so they are combined in this table. The source table included inpatient MH/SUD in the inpatient hospital row.

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).[110]

[110] For more information about these forms of consumer financial assistance, including applicable eligibility criteria (continued...)

As temporarily enhanced (through the end of 2025; see text box), the PTC generally is available to consumers with household incomes at or 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 (or family'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.

Individuals who receive PTCs also may be eligible for subsidies that reduce cost-sharing expenses.[111] 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 certain 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 credits (APTCs),[112] and CSRs by year, as available in relevant HHS reports on effectuated enrollment in the individual

and illustrative examples, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[111] 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, https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

[112] Consumers may choose to receive the premium tax 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.

exchanges.[113] The average premium and APTC amounts shown in the table are provided for general reference, but they 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 (e.g., age). In addition, the APTC data in the table are typically not 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 PY2025.[114]

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)

Plan Year	Average Total Premium per Month[a]	Average APTC per Month[b]	Percentage of Enrollees Receiving APTC[c]	Percentage of Enrollees Receiving CSR[d]	Data as of
2014[e]	Not available	$276	86%	58%	Dec. 2014
2015[f]	Not available	$272	85%	57%	Mar. 2015
2016[f]	Not available	$291	85%	57%	Mar. 2016
2017[g]	$470.52	$373.06	84%	57%	PY2017
2018[h]	$597.20	$519.89	87%	53%	Feb. 2018
2019	$594.17	$514.01	87%	52%	Feb. 2019
2020	$576.16	$491.53	86%	50%	Feb. 2020
2021	$574.59	$485.67	86%	48%	Feb. 2021
2022	$586.56	$508.26	90%	49%	Feb. 2022
2023	$604.78	$527.07	91%	48%	Feb. 2023
2024	$603.04	$535.91	93%	50%	Feb. 2024

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 these table notes and cited at CRS Report R46638, *Health Insurance Exchanges: Sources of Statistics* in the "Point-in-Time Effectuated Enrollment Data" section. These PY2024 estimates, for example, are point in time for February 2024, per CMS, *Effectuated Enrollment: Early 2024 Snapshot and Full Year 2023 Average,* July 2024, https://www.cms.gov/files/document/early-2024-and-full-year-2023-effectuated-enrollment-report.pdf.

Notes: 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 in the table obscure**

[113] In the HHS reports cited in **Table 3**, certain of these data are also available at the state level. In such reports, and in other HHS reports (e.g., on pre-effectuated enrollment) some data are also available on demographics and/or metal levels of plans. For more information, see CRS Report R46638, *Health Insurance Exchanges: Sources of Statistics*.

[114] For example, regarding premiums and cost sharing on plans offered in FFEs and SBE-FPs in PY2025, see CMS, CCIIO, *Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces,* October 2024, https://www.cms.gov/marketplace/resources/data/qualified-health-plan-choice-premiums-healthcaregov-states. Hereinafter "CMS, *QHP Choice, PY2025*. Also see KFF, "Average Marketplace Premiums by Metal Tier, 2018-2025," accessed March 24, 2025, https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/; and KFF, "Deductibles in ACA Marketplace Plans, 2014-2024," December 22, 2023, https://www.kff.org/private-insurance/issue-brief/deductibles-in-aca-marketplace-plans/.

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 (e.g., age; see "Premiums, Cost Sharing, and Subsidies" in this report). **In addition, the APTC data in the table typically are not 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. 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."

b. 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."

c. 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."

d. 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."

e. 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.

f. 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.

g. 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.

h. See *Early 2018 Effectuated Enrollment Snapshot,* July 2018. Subsequent year data in this table are from similar subsequent year reports.

Provider Networks

Most plans—in and out of the exchanges—have a provider network, which refers to a set of health care providers and facilities that the insurer has contracted with to furnish covered benefits to plan enrollees at specified prices. In general, insurers can make various decisions about their provider networks, including whether to include out-of-state providers in their networks and whether to provide coverage for benefits furnished by out-of-network providers.

There are no federal requirements generally related to provider network composition that apply to private health insurance plans outside the exchanges,[115] but there are certain *network adequacy* requirements that apply to QHPs in the exchanges.[116]

Per current regulations on exchange network adequacy requirements, QHP issuers must use provider networks and must ensure their networks are "sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder

[115] However, some federal requirements (e.g., mental health parity) may have implications for plans' provider networks. Other federal requirements (e.g., continuity of care) are related to plan interactions and consumer interactions with providers. See CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[116] QHP network adequacy requirements are at 42 U.S.C. §18031(c)(1)(B) and 45 C.F.R. §156.230.

services, to ensure that all services will be accessible without unreasonable delay."[117] This is further defined in terms of the following standards:

- As of PY2023, QHP issuers in FFEs generally must meet "time and distance" network adequacy standards set by HHS.[118] Plans must provide access to at least one provider in each category listed in guidance, within set time and distance parameters (which vary by provider type and by geography), for at least 90% of enrollees. "For example, for endocrinology in a large metro county, at least 90 percent of enrollees would be required to have reasonable access to at least one provider within 15 miles and 30 minutes." [119]
- As of PY2025, QHP issuers in FFEs generally also must meet "appointment wait time" network adequacy standards. For example, enrollees seeking an appointment for routine primary care must be able to schedule an appointment within 15 business days, at least 90% of the time.[120]

These network adequacy requirements also apply in some or all exchanges:

- QHP issuers in all exchanges must include *essential community providers* (ECPs) in their provider networks, namely a "a sufficient number and geographic distribution of [ECPs], where available, to ensure reasonable and timely access" for low-income and medically underserved individuals.[121] QHP issuers in FFEs are subject to specific ECP standards—for example, that they must offer a contract to at least one ECP in each of eight categories of providers (e.g., federally qualified health centers, mental health facilities, and family planning providers) in each county in the plan's service area and all available Indian Health Care providers in the plan's service area.
- QHP issuers in all exchanges "must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients" and other information as specified, "in a manner that is easily accessible."[122]

Exchange Provider Network Data

CMS PUFs on plans offered in the federal and state exchanges include certain data on QHPs' provider networks—for example, plans' provider network URLs and indications of whether a plan has a nationwide network—but the files do not appear to measure network composition.[123]

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[117] 45 C.F.R. §156.230(a)(1)(ii). Prior regulations on network adequacy requirements applied only to QHPs that used provider networks. As of PY2024, all QHPs are required to use provider networks and to comply with network adequacy requirements. See the 2024 Payment Notice, starting at https://www.federalregister.gov/d/2023-08368/p-1358.

[118] 45 C.F.R. §156.230(a)(2)(i)(A).

[119] See the CMS *2023 Final Letter to Issuers in the Federally-facilitated Exchanges*, April 2022, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf. The aforementioned CMS, *2025 Final Letter to Issuers* and *2026 Final Letter to Issuers* generally refer to the CMS, *2023 Final Letter to Issuers* regarding network adequacy requirements. See https://www.cms.gov/files/document/2025-letter-issuers.pdf and https://www.cms.gov/files/document/final-2026-letter-issuers.pdf.

[120] 45 C.F.R. §156.230(a)(2)(i)(B). Also see CMS, *2025 Final Letter to Issuers*, linked in the prior footnote.

[121] 45 C.F.R. §156.235(a)(1). Also see 42 U.S.C. §18031(c)(1)(C).

[122] 45 C.F.R. §156.230(b).

[123] See the aforementioned CMS, "Exchange PUFs" page (primarily on plans in the FFEs and SBE-FPs), (continued...)

There have been some analyses of QHP provider networks, including estimates of plans' network composition relative to available providers in the area. For example, an August 2024 KFF report estimated the following, regarding the individual exchanges nationwide in 2021:

> On average, Marketplace enrollees had access to 40% of the doctors near their home through their plan's network, with considerable variation around the average. Twenty-three percent of Marketplace enrollees were in a plan with a network that included a quarter or fewer of the doctors in their area, while only 4% were in a plan that included more than three-quarters of the area doctors in their network.[124]

These analyses also address some factors that insurers may consider when establishing their networks (e.g., provider availability, market dynamics between insurers and providers, costs and their effect on premiums, consumer preferences regarding access and costs, and applicable federal and state requirements).

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. Also as stated earlier (see "Individual and SHOP Exchanges"), insurers offering QHPs—also called QHP issuers—may offer plans that cover the whole state or only certain areas within a state, such as one or more counties.

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.[125]

See **Figure 3** for CMS projections of insurer participation in all individual exchanges (including SBEs) in PY2025. It shows that 18% of counties have one or two QHP issuers, 49% of counties have three or four QHP issuers, and 32% of counties have five or more QHP issuers.[126]

According to a CMS report on the 31 FFE and SBE-FP states in PY25, eight states have more QHP issuers in PY25 than PY24 (Florida, Iowa, Michigan, Nebraska, New Hampshire, Ohio, Texas, and Wyoming) and three states have fewer QHP issuers in PY25 than PY24 (Illinois, Kansas, and Utah).[127] Additional data on issuer participation and plan availability are provided at the end of this section.

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https://www.cms.gov/marketplace/resources/data/public-use-files. For example, the PY2025 "Plan Attributes" PUF indicates whether plans have a national network, and the "Network" PUF on such plans includes links to plans' network details. Also see similar files on plans in the SBEs in the aforementioned CMS, "SBE PUFs" page, https://www.cms.gov/marketplace/resources/data/state-based-public-use-files.

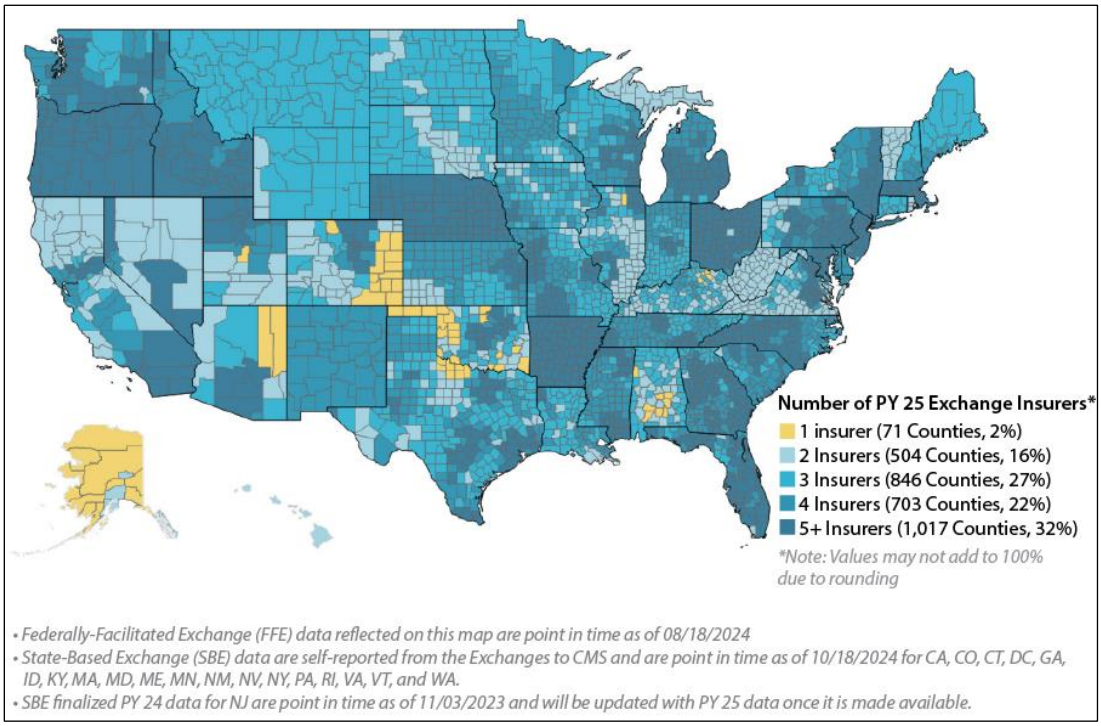
[124] Matthew Rae et al., "How Narrow or Broad Are ACA Marketplace Physician Networks?," KFF, August 26, 2024, https://www.kff.org/private-insurance/report/how-narrow-or-broad-are-aca-marketplace-physician-networks/. Also see Terry Burke et al., "Understanding Why Narrow Networks Dominate the ACA Exchange," Oliver Wyman, March 2024, https://www.oliverwyman.com/our-expertise/perspectives/health/2024/march/understanding-why-narrow-networks-dominate-the-aca-exchange.html.

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

[126] As stated in **Figure 3**, values may not add to 100% due to rounding.

[127] See the aforementioned CMS, *QHP Choice, PY2025*, https://www.cms.gov/marketplace/resources/data/qualified-health-plan-choice-premiums-healthcaregov-states. See Figure 1 in that resource, as well as Figure 2 in that resource for changes in issuer participation at the county level.

Figure 3. Plan Year 2025 Insurer Participation in the Individual Exchanges, by County



Source: CRS adapted from Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), "County by County Plan Year 2025 Insurer Participation in Health Insurance Exchanges," October 25, 2024, https://www.cms.gov/marketplace/about/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.[128] 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;[129]
- the consumer financial assistance available only in the exchanges;[130]

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

[129] 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.

[130] See "Premium Tax Credits and Cost-Sharing Reductions" in this report for background on these topics. One of the factors cited in the aforementioned GAO, *Issuer Participation* report, January 2019, as affecting insurers' participation was "federal funding changes," including the ending of federal payments for cost-sharing reduction subsidies in October 2017. See https://www.gao.gov/products/GAO-19-215.

- the three ACA programs—risk corridors, reinsurance, and risk adjustment—meant to mitigate insurers' financial risk in the nongroup and small-group markets, including in the exchanges;[131]
- federal policy changes in the years since the enactment of the ACA;[132] 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).

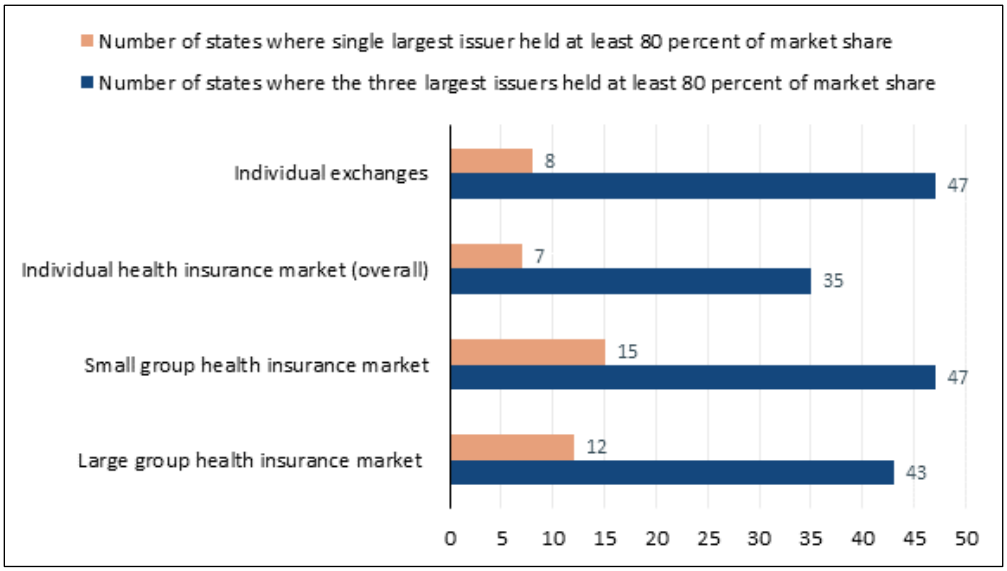
The GAO also reports biannually on private health insurance market concentration, including in the individual exchanges. In its November 2024 and prior such reports, the GAO defines a concentrated market (in a state or otherwise) as one where "three or fewer issuers held at least 80 percent of the market share of enrollment among consumers."[133] The GAO finds that market concentration generally has increased in the nongroup market (the individual market overall, including the exchanges), from 2011 through 2022. Focusing on the exchanges, market concentration increased from 2015 through 2020, when all 51 individual exchange markets were concentrated, per the definition above. This number has decreased slightly since then, and as of 2022, 47 individual exchange markets were concentrated. As shown in **Figure 4**, other private health insurance markets were also concentrated in 2022 (i.e., the large group market in 43 states, the small group in 47 states, and the individual market overall in 35 states). Factors affecting market concentration are discussed below.

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

[132] See Figure 1 in the aforementioned GAO, *Issuer Participation* report, January 2019, https://www.gao.gov/products/GAO-19-215.

[133] GAO, *Private Health Insurance: Market Concentration Generally Increased from 2011 through 2022,* November 2024, https://www.gao.gov/products/gao-25-107194.

Figure 4. Private Health Insurance Market Concentration in the Individual Exchanges and Other Markets, 2022



Source: CRS illustration of data from the Government Accountability Office (GAO), *Private Health Insurance: Market Concentration Generally Increased from 2011 Through 2022,* November 2024, at https://www.gao.gov/products/gao-25-107194. See Table 1 in this GAO report for these 2022 as well as prior year data.

Notes: Counts include the 50 states and the District of Columbia. The individual health insurance market (nongroup market) includes the individual exchanges. And per GAO, "Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year." See GAO report for methodology, additional details, and prior year data.

Market *concentration* is affected by insurer entrances and exits in a given market, and the related factors discussed earlier in this section. It is also affected by market *consolidation*, including when one insurance company merges with or purchases another insurance company.[134] Health insurance market concentration and consolidation may have implications for insurers (e.g., in terms of their contract negotiating power with healthcare providers) and implications for consumers (e.g., in terms of plan choices and costs). However, insurer-provider interactions and health insurance premiums are also affected by numerous other factors. [135]

There are several ways to measure the health insurance options that consumers have. As discussed above in this section, there are counts of *insurer participation* (how many insurers are offering plans) and *insurer concentration* (insurers' market share of enrollment). There are also counts of the number of *plans* available in a market, because a given insurer might offer one or multiple plan options. Per the aforementioned CMS analysis of the 31 FFE and SBE-FP

[134] Insurance company merges and acquisitions are an example of horizontal market consolidation. Insurers can also engage in vertical integration (e.g., mergers and acquisitions between insurers and other types of entities such as healthcare providers or pharmacy companies). This expands their operations outside of strictly insurance functions, but can still affect their activities as an insurer.

[135] For example, insurer-provider interactions are also affected by providers' market power, which can be affected by provider concentration and consolidation dynamics. Full discussion of these issues is beyond the scope of this report. Regarding other factors affecting premiums, see "Premiums" in the Individual Exchanges section in this report.

exchanges in PY2025, there are an average of 7.3 QHP issuers—and an average of 100 QHPs—available to exchange consumers per county.[136]

Agency concerns about "choice overload" have contributed to recent regulatory requirements regarding "standardized plans" and limitations on non-standardized plans, discussed earlier in this report.[137]

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.[138] States also may define *small employer* as having not more than 100 employees–four states do.[139] As of 2017, all states have the option to allow *large employers* to use SHOP exchanges, as well, but no states have done so.[140]

SHOP eligibility also depends on an employer having at least at least one *common-law employee*.[141] 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.[142] The business may, but is not required to, offer coverage to part-time or other employees, and/or to the spouses and dependents of any employees offered

[136] See the aforementioned CMS, *QHP Choice, PY2025*, https://www.cms.gov/marketplace/resources/data/qualified-health-plan-choice-premiums-healthcaregov-states. See Table 1 in that report, as well as the appendix file linked within that report, which includes issuer and plan availability data by HealthCare.gov state, and for selected counties, by year. According to the report methodology, the counts exclude catastrophic, child-only, SADP, and SHOP plans. Certain metrics in the report (e.g., average premiums) are weighted by enrollee plan selections (and PY2025 data are weighted by PY2025 plan selections because this report was published before PY2025 enrollment began), but it is not clear if state and county averages of insurer participation and plan availability are similarly weighted.

[137] See "Standardized Plans" in this report for an overview of these plans. Regarding "choice overload," see footnote 48 for a December 2021 ASPE report and an April 2022 *Health Affairs* article.

[138] 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.

[139] 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 September 10, 2024, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating. Also see **Table A-1**.

[140] 42 U.S.C. §18032(f)(2)(B).

[141] 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* 18310**,** https://www.federalregister.gov/d/2012-6125/p-1139. Hereinafter HHS, "Exchange Establishment" Final Rule, 2012.

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

coverage.[143] Employees and their enrolling family members must meet the same 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.[144] 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.[145] 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.[146]

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.[147] 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 determine their SHOP eligibility and can browse plan options on HealthCare.gov, but they need to work directly with a SHOP-registered agent, broker, or insurer to purchase coverage.[148] This is sometimes called SHOP *direct enrollment*, and it has been the only option in such states since plan years beginning in 2018. Previously, employers and employees could purchase SHOP coverage on HealthCare.gov or via direct enrollment. HHS finalized this change in the 2019 Payment Notice, citing generally low employer participation in the SHOP exchanges and decreasing insurer participation (both further discussed below in this section).[149]

[143] 45 C.F.R. §155.710(e).

[144] 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, HealthCare.gov, "Find out if your small business qualifies for SHOP," accessed March 24, 2025, https://www.healthcare.gov/small-businesses/choose-and-enroll/qualify-for-shop-marketplace/.

[145] 45 C.F.R. §155.726(b).

[146] 45 C.F.R. §155.726(c).

[147] 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 & businesses," accessed March 24, 2025, https://www.healthcare.gov/small-businesses/provide-shop-coverage/business-in-more-than-one-state/.

[148] HealthCare.gov, "Overview of SHOP: Health insurance for small businesses," accessed March 6, 2025, https://www.healthcare.gov/small-businesses/choose-and-enroll/shop-marketplace-overview/.

[149] 2019 Payment Notice, starting at https://www.federalregister.gov/d/2018-07355/p-654. In that rule, HHS also confirmed 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 (continued...)

- **States administering their own SB-SHOPs** initially were allowed to use a SHOP direct enrollment approach, due to early difficulties some states had in getting their SHOP exchange websites online.[150] As of April 2016, HHS indicated SB-SHOPs would need to implement online portals in time for plan years beginning in 2019.[151] However, 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 PY2025, of the 16 SB-SHOP states with medical plans offered, 11 are using SHOP direct enrollment approaches only.[152]

Besides SHOP 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 PY2025, there are no insurers offering medical plans in SHOP exchanges in more than half of states.[153] 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 Data

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.[154] CMS

(discussed in "State-Based and Federally Facilitated Exchanges" in this report). The two 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. See https://www.federalregister.gov/d/2018-07355/p-442. They have since transitioned to SB-SHOPs (see **Table A-1**).

[150] 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, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/1332-and-SHOP-Guidance-508-FINAL.PDF.

[151] 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*.

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

[153] The number of states with no insurers offering plans in SHOP exchanges in 2025 is based on CRS analysis of the 2025 "Business Rules" public use file at the aforementioned CMS, "Exchange PUFs" page, https://www.cms.gov/marketplace/resources/data/public-use-files, as well as information available on HealthCare.gov and state exchange websites at **Table A-1**. 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 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, https://www.gao.gov/products/gao-19-306. Hereinafter GAO, *Issuer Concentration* report, March 2019.

[154] 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, archived at https://web.archive.org/web/20170517142657/https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SHOP-Marketplace-Enrollment-Data.pdf.

previously estimated 10,700 active small employers and 85,000 employees in the SHOP exchanges as of May 2015.[155]

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.[156]

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 designated staff 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.[157] This includes designated staff working in a Member's home state.[158] As implemented, they purchase coverage through the District of Columbia's SHOP exchange, DC Health Link.

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").

Benefits, Premiums, and Cost Sharing

The information earlier in this report on certain federal requirements that apply to benefits, premiums, and cost sharing in the individual exchanges (e.g., coverage of the EHB, minimum AV levels), generally applies in the SHOP exchanges, as well.[159] See CRS Report R45146, *Federal*

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

[156] See page 24 and Appendix III of GAO, *Issuer Concentration* report, March 2019, https://www.gao.gov/products/gao-19-306.

[157] 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/Staff," accessed March 24, 2025, https://www.opm.gov/healthcare-insurance/changes-in-health-coverage/eligibility-enrollment/#url=Members-of-CongressStaff.

[158] See the OPM list of frequently asked questions regarding health coverage for Members of Congress and staff, including the question, "If I do not live in Washington, DC, am I still eligible to sign up for coverage in the DC Health Link?," accessed March 24, 2025, https://www.opm.gov/healthcare-insurance/insurance-faqs/.

[159] For example, the aforementioned *CMS, 2025 Final Letter to Issuers* describes various requirements for QHP certification in the HealthCare.gov exchanges, and notes that unless otherwise specified, its references to QHP requirements in the FFEs also include QHPs in the FF-SHOPs. See https://www.cms.gov/files/document/2025-letter-issuers.pdf. One difference between the individual and SHOP exchanges is that QHP issuers in the SHOP exchanges are not subject to standardized plan requirements, as discussed earlier in this report.

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 plan features specific to the SHOP exchanges, but certain CMS PUFs on the federal and state exchanges include data on SHOP plans.[160]

Small Business Health Care Tax Credit

Certain small businesses are eligible for the small business health care tax credit (SBTC).[161] In general, this credit is available only to small employers with 25 or fewer full-time-equivalent (FTE) employees that purchase coverage through SHOP exchanges and contribute at least 50% of premium costs for their full-time employees.[162] 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.[163]

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.[164]

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 $33,300 or less for taxable years beginning in 2025.[165] 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.[166]

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[160] See the aforementioned CMS, "Exchange PUFs" page (primarily on plans in the FFEs and SBE-FPs), https://www.cms.gov/marketplace/resources/data/public-use-files. For example, the PY2025 "Plan Attributes" PUF includes SHOP plans, and that file can be linked to the PY2025 "Benefits and Cost Sharing" PUF for more information. Also see similar files on plans in the SBEs in the aforementioned CMS, "SBE PUFs" page, https://www.cms.gov/marketplace/resources/data/state-based-public-use-files.

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

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

[163] Regarding SHOP eligibility, see 26 U.S.C. §4980H, 26 C.F.R. §54.4980H-1(a)(21), and 45 C.F.R. §155.20. Also see the SHOP "Eligibility and Enrollment" section of this report. Regarding the SBTC, see 26 U.S.C. §45R.

[164] Internal Revenue Service (IRS), *Small Business Health Care Tax Credit Questions and Answers: Who Gets the Tax Credit,* Question 6D, updated September 13, 2024, https://www.irs.gov/newsroom/small-business-health-care-tax-credit-questions-and-answers-who-gets-the-tax-credit.

[165] Section 2.10 of IRS, Rev. Proc. 2024-40, October 22, 2024, https://www.irs.gov/pub/irs-drop/rp-24-40.pdf, referring to 26 U.S.C. §45R(d)(3)(B).

[166] 26 U.S.C. §45R(d)(1)(B).

The SBTC is different than the business expense deduction that employers can claim for the costs of the health insurance premiums they subsidize. If an employer qualifies for the SBTC, they can claim the deduction for the premiums that exceed the credit amount. If an employer doesn't qualify for the SBTC, they can claim the deduction.

Employees who enroll in a SHOP plan do not receive the SBTC, 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.[167] For 2016, the IRS indicates that 6,952 employers claimed the SBTC.[168]

Provider Networks

Exchange requirements related to network adequacy and essential community providers apply in the SHOP exchanges as in the individual exchanges.[169]

Also as for the individual exchanges, certain CMS PUFs include limited data on SHOP QHPs' provider networks—for example, plans' provider network URLs and indications of whether a plan has a nationwide network.[170]

Insurer Participation

As stated above, there are no insurers offering SHOP medical plans in more than half of states. Some of the factors affecting insurer participation in the individual exchanges also may affect insurer participation in the SHOP exchanges.[171] 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 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 rulemaking, 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.[172] 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

[167] IRS, *SOI Tax Stats - Affordable Care Act (ACA) Statistics: Credit for small employer health insurance premiums*, updated November 8, 2024, https://www.irs.gov/statistics/soi-tax-stats-affordable-care-act-aca-statistics-credit-for-small-employer-health-insurance-premiums. See excel file, "Small Business Health Care Tax Credits Filed in Tax Years 2010–2016," linked on this web page.

[168] Ibid. CRS is not aware of more recent data than this.

[169] See "Provider Networks" in the Individual Exchanges section of this report.

[170] See the aforementioned CMS, "Exchange PUFs" page (primarily on plans in the FFEs and SBE-FPs), https://www.cms.gov/marketplace/resources/data/public-use-files. For example, the PY2025 "Plan Attributes" PUF indicates whether plans have a national network, and the "Network" PUF on such plans includes links to plans' network details. These files include SHOP plans. Also see similar files on plans in the SBEs in the aforementioned CMS, "SBE PUFs" page, https://www.cms.gov/marketplace/resources/data/state-based-public-use-files.

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

[172] 2018 Payment Notice, starting at https://www.federalregister.gov/d/2016-30433/p-884.

when the SHOPs were being established, and the limited duration and administrative complexity of the small business tax credit.[173]

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.[174]

Each exchange must have a *Navigator* program.[175] 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."[176]

Navigators are funded by the exchanges, via grants (federal or state, depending on exchange type) provided to qualifying organizations. There is no specific appropriation or statutorily required funding level for the Navigator program, and HHS funding for the Navigators in FFEs has varied over the years.[177] States with SBEs and SBE-FPs fund their own Navigator programs.

In August 2024, HHS announced $100 million per year in grants to 44 Navigator organizations in the 28 FFE states as of PY2025. Per this funding announcement, this is "part of a commitment of up to $500 million over five years" (August 2024-August 2029).[178] This is longer than prior Navigator grant periods, which have ranged from one to three years. In February 2025, CMS announced a reduction in this funding to $10 million per year, as of the 2026 grant period that

[173] See GAO, *Small Business Health Insurance Exchanges: Low Initial Enrollment Likely due to Multiple, Evolving Factors*, November 2014, https://www.gao.gov/products/gao-15-58; and GAO, *Issuer Concentration* report, March 2019. Also see Timothy Jost, "CMS Announces Plans To Effectively End The SHOP Exchange," *Health Affairs Blog*, May 15, 2017, https://www.healthaffairs.org/content/forefront/cms-announces-plans-effectively-end-shop-exchange.

[174] 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.

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

[176] 45 C.F.R. §155.210(c)(1)(iii).

[177] See "Ongoing Federal Funding for Exchange Operations" and **Table C-2** in this report for more information.

[178] CMS, "Biden-Harris Administration Awards $100 Million to Navigators Who Will Help Millions of Americans—Especially in Underserved Communities—Sign Up for Health Coverage," August 26, 2024, https://www.cms.gov/newsroom/press-releases/biden-harris-administration-awards-100-million-navigators-who-will-help-millions-americans.

starts in August 2025.[179] More information on current and prior year Navigator grants in FFE states is available on the CMS website.[180]

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).[181] 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.[182] Other Navigator program changes have been made via rulemaking over time.[183]

Exchanges also must have a *Certified Application Counselor* (CAC) program.[184] 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, assisters may not advise consumers on which plan to select, or complete the enrollment application for consumers. Once a consumer chooses a plan, the assisters may help as the consumer enrolls in coverage (including educating them about the enrollment process).[185] Neither Navigators nor CACs may be health insurers or take compensation for selling health policies from insurers or consumers.[186]

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.[187] Exchanges also provide consumer information and outreach via mail, radio or television ads, and/or other methods. Overall, exchanges' consumer outreach efforts and materials

[179] CMS, "CMS Announcement on Federal Navigator Program Funding," February 14, 2025, https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.

[180] CMS, "In-Person Assistance in the Health Insurance Marketplaces," updated February 18, 2025, "Navigators" section, https://www.cms.gov/marketplace/in-person-assisters/programs-procedures/in-person-assistance#Navigators. CRS is not aware of a compilation of information about Navigator grants in states that fund and administer these programs (those with SBEs and SBE-FPs).

[181] 2019 Payment Notice starting at https://www.federalregister.gov/d/2018-07355/p-473; 2020 Payment Notice starting at https://www.federalregister.gov/d/2019-08017/p-550. Payment Notice citations are in **Table D-1**.

[182] 2022 Payment Notice, Part 3, starting at https://www.federalregister.gov/d/2021-20509/p-156.

[183] For example, in the 2024 Payment Notice, HHS removed a prohibition on Navigators going door-to-door to conduct consumer outreach and enrollment assistance. See https://www.federalregister.gov/d/2023-08368/p-590. No Navigator program changes were made in the 2025 or 2026 Payment Notices.

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

[185] Per a CMS training document for Navigators, assisters must not "log into the consumer's online Marketplace account, fill out the Marketplace application, or select a plan for the consumer." See page 29 of CMS, "Course 1 – Training Overview," linked at CMS, "Navigator and Certified Application Counselor Training Courses," updated February 19, 2025, https://www.cms.gov/marketplace/technical-assistance-resources/training-materials/certified-application-counselor-training-courses.

[186] 42 U.S.C. §18031(i)(4). Also see 45 C.F.R. §155.215.

[187] 45 C.F.R. §155.205.

must meet certain standards regarding accessibility for individuals with disabilities or with limited English proficiency.[188]

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.[189] These entities are not funded by the exchanges; they are compensated by the health plans that they help sell.

According to the National Association of Insurance Commissioners (NAIC), individuals who want to "sell, solicit or negotiate insurance in the United States must be licensed as a 'producer'" in the state in which they do business.[190] The term *producer* includes insurance agents and brokers. *Agents* may sell plans for one insurance company or they may represent more than one company, and they may receive salary and/or commission income. *Brokers* "work on behalf of the customer and are not restricted to selling policies for a specific company but commissions are paid by the company with which the sale was made."[191] Because brokers do not represent insurers, they must work through an agent or other insurance company representative to purchase a policy for a customer. In federal exchange regulations, the term "agent or broker" is defined as "a person or entity licensed by the State as an agent, broker, or insurance producer."[192]

As permitted by states, and after meeting exchange requirements, agents and brokers may assist consumers in comparing and enrolling in an exchange QHP.[193] It is not apparent that any states have disallowed agents and brokers from participating in their exchange.

In all exchange types, agents and brokers may help consumers enroll via the "Marketplace pathway" as shown here. In the FFEs and SBE-FPs (and in SBEs if available), agents and brokers may also help consumers via of the other following pathways:

- **Marketplace Pathway:** Completing an eligibility application, comparing plans, and enrolling in a plan via HealthCare.gov or the SBE website.
- **Direct Enrollment [DE] or "Classic Direct Enrollment" Pathway:** Completing an eligibility application via HealthCare.gov, then redirecting to an approved DE website to compare plans and enroll in an exchange plan.
- **"Enhanced Direct Enrollment" [EDE] Pathway:** Completing all steps, including eligibility application, plan comparison, and enrollment, directly on the approved EDE website without needing to be redirected to HealthCare.gov (in most cases).[194]

[188] See, for example, 45 C.F.R. §155.205.

[189] 45 C.F.R. §155.220.

[190] National Association of Insurance Commissioners (NAIC), "Producer Licensing," updated February 10, 2025, https://content.naic.org/insurance-topics/producer-licensing.

[191] NAIC, "Glossary of Insurance Terms," accessed March 24, 2025, https://content.naic.org/consumer_glossary. The NAIC states that its glossary represents a "common or general use of the term," as "based on various insurance references."

[192] 45 C.F.R. §155.20.

[193] See, for example, 45 C.F.R. §155.220(a) and (d).

[194] For more information, see CMS, "Direct Enrollment and Enhanced Direct Enrollment," updated March 10, 2025, https://www.cms.gov/programs-and-initiatives/health-insurance-marketplaces/direct-enrollment-and-enhanced-direct-enrollment. Although CMS offers the DE and EDE "pathways" for FFE and SBE-FP states only, SBEs may also choose to offer their own DE and EDE options, which would interface with their exchange websites rather than (continued...)

Agents or brokers using the DE or EDE pathways may use their own approved websites or contract with approved *web-brokers,* including *direct enrollment technology providers* that operate exchange DE and EDE websites.[195] In some cases, health insurance issuers and web-brokers may also offer DE or EDE to consumers without the assistance of agents or brokers.

If certified to sell exchange plans, these entities (e.g., agents, brokers, and web-brokers) must follow rules related to plan marketing, display of plan information, and enrollment assistance, among other things. This includes providing consumers "with correct information, without omission of material fact," regarding the exchanges, QHPs, and subsidies, and "refrain[ing] from marketing or conduct" that is misleading, coercive, or discriminatory, as specified.[196] In addition, web-broker websites must provide consumers information and access to all QHPs that would be available to them on the exchange website, and comply with rules about whether and how to promote certain QHPs over others.[197] 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, subject to rules about displaying non-exchange plans separately from QHPs, displaying a disclaimer provided by HHS, and limiting the marketing of non-QHPs during exchange open enrollment periods.[198]

The regulatory requirements for exchange agents, brokers, and web-brokers have previously applied primarily in the FFEs, with some extended to the SBE-FPs. The 2025 Payment Notice also applied certain of these requirements in the SBEs.[199]

Insurers that offer QHPs are also subject to certain requirements related to marketing and plan display. Regulations also specify that a QHP issuer is responsible for its own compliance and the compliance of any "delegated or downstream entities" with all applicable federal exchange standards.[200] The relevant definitions of delegated and downstream entities include agents and brokers.

Issuers of nongroup plans, including QHPs, are also required to disclose to enrollees any direct or indirect compensation provided to agents or brokers associated with enrolling individuals in such coverage.[201] Insurers must annually report similar information to HHS.

In SHOPs in which small businesses cannot purchase SHOP plans via the exchange website, or in states where there are no insurers offering SHOP plans, the SHOP exchange websites direct employers to agents, brokers, or insurers who can help them enroll in SHOP plans and/or small-group plans available off-exchange.[202] These options may be referenced as "SHOP direct

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HealthCare.gov. The 2025 Payment Notice, which clarifies that exchanges must operate a centralized eligibility and enrollment platform, emphasizes that this does not preclude the use of DE and EDE options, including for state exchanges. See https://www.federalregister.gov/d/2024-07274/p-616.

[195] Ibid. At 45 C.F.R. §155.20, "web-broker" is defined as "an individual agent or broker, group of agents or brokers, or business entity registered with an Exchange under §155.220(d)(1) that develops and hosts a non-Exchange website that interfaces with an Exchange to assist consumers with direct enrollment in QHPs offered through the Exchange as described in §155.220(c)(3) or §155.221. The term also includes an agent or broker direct enrollment technology provider." Several types of direct enrollment entities are also defined at 45 C.F.R. §155.20.

[196] See this and other "standards of conduct" at 45 C.F.R. §155.220(j)(2).

[197] 45 C.F.R. §155.220(c)(3).

[198] 45 C.F.R. §155.221(b).

[199] See 45 C.F.R. §155.220(n) and §155.221(j).

[200] 45 C.F.R. §156.340 and definitions at 45 C.F.R. §156.20.

[201] 42 U.S.C. §300gg-46.

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

enrollment" but such enrollment processes may be different than the DE and EDE pathways described above.

CMS Updates on Certain Unauthorized Agent and Broker Marketplace Activities

In 2024, the Centers for Medicare & Medicaid Services (CMS) released several statements regarding "reports of consumers in HealthCare.gov states whose coverage was switched by agents and brokers without their knowledge."

The CMS statements included data on these consumer complaints and updates on CMS responses. As of October 2024, CMS announced the suspension of 850 agents' and brokers' "Marketplace agreements" (approvals to offer coverage via the exchanges), for "reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or unauthorized plan switches." CMS also addressed these issues in the 2026 Payment Notice (finalized in January 2025), including by expanding its authority at 45 C.F.R. §155.220(k)(3) to suspend agents' and brokers' ability to conduct exchange enrollments "if HHS discovers circumstances that pose unacceptable risk" to the exchange or enrollees, as specified.

Resources:

Centers for Medicare & Medicaid Services, "CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity" October 17, 2024, https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity. This article also links to prior CMS updates on this issue.

CMS, "HHS Notice of Benefit and Payment Parameters for 2026 Final Rule," January 13, 2025, at https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2026-final-rule. Also see the 2026 Payment Notice at https://www.federalregister.gov/d/2025-00640/p-147, cited in **Table D-1**.

Exchange 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.[203] 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.[204]

Ongoing Federal Funding for Exchange Operations

Information on prior and proposed federal funding for exchange operations can be found in the annual President's budget requests. For example, the FY2025 President's budget request provided federal funding amounts for FY2023 and FY2024, as well as the proposed FY2025 amounts.

A given budget request typically provides an update on the amount that was enacted for the prior year, but temporary funding under a "continuing resolution" (CR) was in effect at the time that the FY2025 budget request was being formulated.[205] Thus, the amount listed for FY2024 was based on an annualized estimate under that temporary funding and not the amount that was ultimately enacted for FY2024. Federal government funding for the operation of the exchanges

[203] 42 U.S.C. §18031(a).

[204] 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.

[205] For further information, see pp. 5-6 of CRS Report R48060, *Department of Health and Human Services: FY2025 Budget Request*.

was $2.44 billion for FY2023 (final), $2.47 billion for FY2024 (CR), and requested to be $2.34 billion for FY2025.[206] See **Appendix C**, which includes these funding levels by source, as well as estimated and prior year federal funding for the exchanges by activity (e.g., information technology, Navigator grants), as provided by CMS in recent annual budget justifications to Congress.

Much of this federal funding is specific to FFEs. For example, the federal government funds the Navigator program only in states with FFEs. Some of the federal funding, 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)" and "ensuring proper payment of financial assistance" for eligible consumers.[207]

The premiums of the plans purchased through the exchanges are covered by enrollees' premium contributions and, in some cases, are subsidized by the federal government (i.e., via PTCs). The PTCs are financed through a permanent appropriation.[208] These tax expenditures 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.[209]

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. For example, the user fee rates in PY2025 are 1.5% of total monthly premiums for issuers in FFEs and 1.2% of total monthly premiums for issuers in SBE-FPs. See **Figure 5** below.

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).[210] 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-1**. Other

[206] CMS, *Justification of Estimates for Appropriations Committees, Fiscal Year 2025*, March 15, 2024, https://www.cms.gov/about-cms/performance-budget/prior. See "Federal Marketplace Programs" table and narrative, pages 200-205. Hereinafter CMS Budget Justification, FY2025."

[207] Page 202 of the aforementioned CMS Budget Justification, FY2025, https://www.cms.gov/about-cms/performance-budget/prior.

[208] 31 U.S.C. §1324(b). The permanent appropriation provides indefinite budget authority for PTC/APTC disbursements.

[209] 42 U.S.C. §18031(d)(5)(A). Also see 45 C.F.R. §156.50.

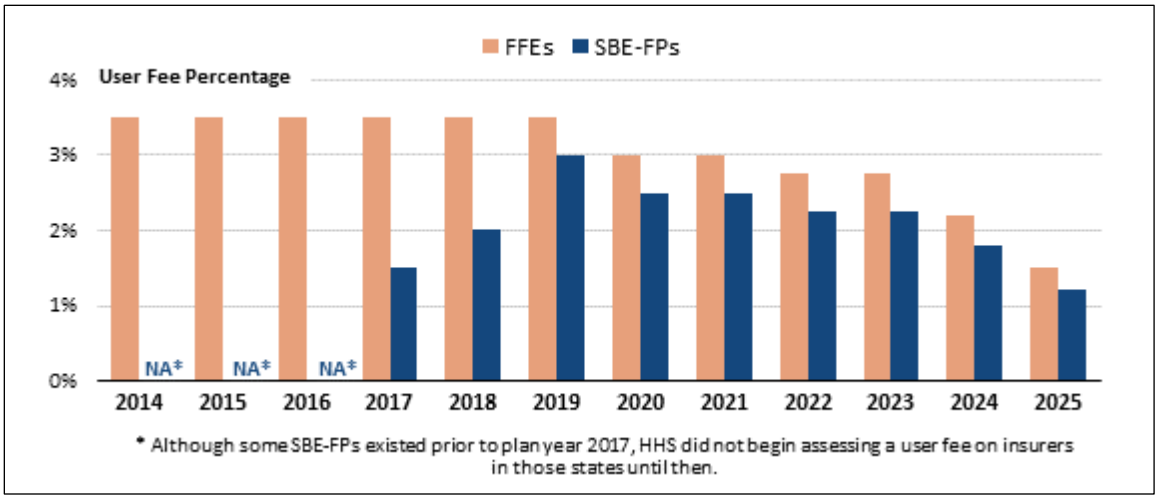
[210] For further discussion, see the 2025 Payment Notice (cited in **Table D-1**), starting at https://www.federalregister.gov/d/2024-07274/p-1240. Also see discussion of CMS activities conducted on behalf of certain exchanges versus all exchanges at CMS Budget Justification, FY2025, page 202, https://www.cms.gov/about-cms/performance-budget/prior.

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 SB-FP-SHOPs, due to the reduced functionality of the federal SHOP website also announced in that rule.[211]

Figure 5. 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: Congressional Research Service 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, https://www.irs.gov/pub/irs-drop/rp-13-25.pdf. For example, the Plan Year (PY) 2025 user fees were finalized in the 2025 Payment Notice, April 2024, starting at https://www.federalregister.gov/d/2024-07274/p-1240.

Notes: FFE = federally facilitated exchange; PTC = premium tax credit; SBE = state-based exchange; SBE-FP = state-based exchange using the federal information technology (IT) platform. See "Types and Administration of Exchanges" for discussion of exchange types. See "Premium Tax Credits and Cost-Sharing Reductions" for information about the temporarily enhanced PTCs.
SBEs' assessment of user fees, if any, varies, as discussed below in this report.
The 2026 Payment Notice, finalized January 15, 2025, established two possible sets of user fee rates for PY2026: first, 2.5% for FFE issuers and 2.0% for SBE-FP issuers if the temporarily enhanced PTCs expire at the end of 2025, as provided by current law. Alternately, if the enhanced PTCs are extended through PY2026 at current or higher levels by July 31, 2025, the 2026 user fees will be 2.2% for FFE issuers and 1.8% for SBE-FP issuers. The rule did not specifically address the user fee with regard to potential extensions of the enhanced PTC that may occur after July 31, 2025. See https://www.federalregister.gov/d/2025-00640/page-4487.

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. Within these appropriations (e.g., for CMS Program Management), Congress has not required any particular level of spending on the exchanges. There is also a risk-adjustment user fee, related to the risk-

[211] 2019 Payment Notice, https://www.federalregister.gov/d/2018-07355/p-769. Regarding the reduced functionality of the federal SHOP website, see "Enrollment Processes and Options" in the SHOP Exchanges section of this report.

mitigation program briefly mentioned earlier in this report.[212] There is currently no mandatory HHS appropriation for exchange activities.[213] An overview of recent and currently proposed federal funding sources for exchange operations is in **Table C-1**.

State Financing of the Exchanges

States with SBEs finance their own exchange administration. States with SBE-FPs also finance the costs associated with the exchange functions they administer (whereas the federal user fee is assessed on insurers in FFE/SBE-FP states to finance federally run functions such as the IT platform, as discussed above in this section).

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 comprehensive estimates of total or state-level spending on SBE and SBE-FP exchanges, but one stakeholder group analysis includes information on these exchanges' user fees and other financing mechanisms.[214]

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.[215]

See "Premium Tax Credits and Cost-Sharing Reductions" regarding other ARPA provisions relevant to the exchanges and the plans sold in them.[216]

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

[213] According to the "Federal Exchanges" table in the FY2020 CMS budget justification, 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 budget justification does not show this for FY2019, and it is also not shown in subsequent budget justifications. See **Table C-1** for citations.

[214] See the aforementioned Commonwealth Fund, *2025 State Marketplace Analysis*: Select the spreadsheet at the "Download the data" link at https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions and see the "Marketplace Governance" tab of that spreadsheet.

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

[216] 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) 2025, there are 28 FFEs, 20 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).[217] For PY2025, there are 28 FF-SHOPs and 22 SB-SHOPs. One state (Hawaii) is exempted from operating a SHOP exchange. However, in more than half of all states, no insurers are offering medical plans in the SHOP exchange, meaning there is effectively no SHOP exchange there.

For PY2025, 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 (Arkansas, Hawaii, Illinois, and Oregon) 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 2025

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:** 28 **SBE:** 20 **SBE-FP:** 3 (plans and online enrollment available in all counties, all states)	**FF-SHOP (28)**: 6 with plans (all DE only); 22 without plans **SB-SHOP (22)**: 16 with plans (11 are DE only); 6 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]

[217] 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)
Connecticut	Access Health CT	SBE	SB-SHOP
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	Georgia Access	SBE as of PY25 (initially FFE, then SBE-FP for PY24)[e]	SB-SHOP, DE only[h]
Hawaii	HealthCare.gov	FFE as of PY17[i] (initially SBE, then SBE-FP for PY16)[e]	No SHOP exchange per waiver[j]
Idaho	Your Health Idaho	SBE as of PY15 (initially SBE-FP)[e]	SB-SHOP, DE only[h]
Illinois	Get Covered Illinois; HealthCare.gov	SBE-FP as of PY25 (initially FFE);[e] transitioning to SBE for future PY[k]	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, but no medical plans[f]
New York	New York State of Health	SBE	SB-SHOP, DE only[h] (up to 100 employees)[g]

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)
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]
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	Virginia's Insurance Marketplace	SBE as of PY24 (initially FFE, then SBE-FP as of PY21)[e]	SB-SHOP, DE only[h]
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: FFE = federally facilitated exchange; FF-SHOP = federally facilitated SHOP exchange; SBE = state-based exchange; SBE-FP = state-based exchange using the federal information technology (IT) platforms; SB-SHOP = state-based SHOP exchange; SHOP = Small Business Health Options Program.
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 2025 exchange types by state in map form.

a. **2025 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" (PY2025, PDF), https://www.cms.gov/files/document/exchange-pufs-geninfofacts-py25.pdf; at the CMS "Exchange PUFs" page, updated December 18, 2024, https://www.cms.gov/marketplace/resources/data/public-use-files.

b. **2025 SHOP exchange types:** See footnotes cited in the CMS/CCIIO "General Information" resource at table note (a). Also see HealthCare.gov, "Offer SHOP Insurance to Your Employees," accessed March 24, 2025, https://www.healthcare.gov/small-businesses/employers/. At the "Pick state" list on that page, if a selected state has an SB-SHOP, users are directed to the state's exchange site. Otherwise, the selected state has an FF-SHOP.

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," accessed March 24, 2025, 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 the PY2025 "Business Rules" PUF at the CMS Exchange PUFs 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. See HealthCare.gov, "2025 health insurance plans and prices," accessed March 24, 2025, https://www.healthcare.gov/see-plans/#/small-business, and input a zip code from one of the states with FF-SHOPs without medical plans in the table above, such as 85001 (Maricopa County, AZ).

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, 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. PY2017-2024: CMS, "Open Enrollment Period Public Use Files" pages at https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files. See PUFs and/or PUF FAQs for each year.

f. **No insurers are currently offering SHOP medical plans in these SB-SHOP states**, per CRS review of those sites as of January 2025**.** 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 General Information resource at table note (a).

j. Hawaii received a Section 1332 waiver exempting it from having SHOP exchange, initially for PY2017-PY2021 then extended through PY2026. This is related to the state's pre-existing program and requirements related to employment-based coverage. 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*.

k. Regarding Illinois' ongoing transition to a state-based exchange, see CMS, "State-based Exchanges," updated October 8, 2024, at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/state-marketplaces.

Appendix B. Types of Plans Offered Through the Exchanges

In general, health insurance plans offered through exchanges must be qualified health plans (QHPs).[218] 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 general QHPs, certain QHP variations are also (or may be) available in a given exchange, including standardized plans, child-only plans, catastrophic plans, consumer operated and oriented plans (CO-OPs), and multistate plans (MSPs). Stand-alone dental plans (SADPs) are the only non-health plans that are offered in the exchanges.

[218] 42 U.S.C. §18031(d)(2)(B).

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

	Summary	PTC and CSR Eligible?[a]	Can Be Offered Outside Exchanges?
Qualified Health Plan (QHP)[b]	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. Subject to applicable requirements, QHP features may vary (e.g., coverage and cost sharing for particular benefits). General QHPs may be referenced as "non-standardized," as compared to the standardized plans (also QHPs) discussed below.	Yes	Yes
QHP Variations			
Standardized Plan[c]	A plan that meets parameters designed by the Department of Health and Human Services, particularly regarding cost-sharing requirements (for certain categories of benefits and overall). QHP issuers in certain individual exchanges must offer standardized plans as specified in regulations.	Yes	Yes
Child-Only Health Insurance Plan[d]	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[e]	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 SHOP exchanges. Consumer eligibility requirements apply.	No	Yes
Consumer Operated and Oriented Plan (CO-OP)[f]	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.	Yes	Yes
Multistate Plan (MSP)[g]	A plan sold in the exchanges under contract with the federal Office of Personnel Management (OPM).	Yes	No
Non-Health Plans			
Stand-Alone Dental Plan (SADP)[h]	Coverage for dental care; subject to certain modified QHP requirements. May be offered either "as a stand-alone dental 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 cited below. Annual payment notices are cited in **Table D-1**.

Notes: CSR = cost-sharing reduction; FFE = federally facilitated exchange; HHS = Department of Health and Human Services; PTC = premium tax credit; SBE = state-based exchange; SBE-FP = state-based exchange using the federal information technology (IT) platform; SHOP = Small Business Health Options Program.

a. **Premium tax credits and cost-sharing reductions:** 26 U.S.C. §36B(c)(3)(A), 42 U.S.C. §18071(f)(1).

b. **Qualified health plan definition:** 42 U.S.C. §18021.

c. **Standardized plans:** 45 C.F.R. §156.201, 45 C.F.R. §156.202. Insurers offering QHPs in the FFEs and SBE-FPs are required to offer a standardized plan at every product network type, at every actuarial level, and throughout every service area that they offer non-standardized QHP options. 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. Insurers are also subject to limitations on offering non-standardized plan variations. In FFE and SBE-FP states, these requirements also apply in the nongroup market outside the exchanges, but these requirements do not apply in SBEs, nor in the SHOP exchanges or otherwise in the small group market. See the 2023 Payment Notice at https://www.federalregister.gov/d/2022-09438/p-1406, and see "Standardized Plans" in this report.

d. **Child-only plans:** 42 U.S.C. §18022(f).

e. **Catastrophic plans:** 42 U.S.C. §18022(e). 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*.

f. **CO-OPs:** 42 U.S.C. §18021, 42 U.S.C. §18042. The Secretary of Health and Human Services (HHS) 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. The Centers for Medicare & Medicaid Services (CMS) initially awarded loans to 24 CO-OPs, but one was dropped from the program prior to offering health plans. See archived 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 offered health plans at one time but have shut down or were in various stages of shutting down. As of November 2024, the three CO-OPs are offering plans for 2025 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.

g. **Multistate plans:** 42 U.S.C. §18021, 42 U.S.C. §18054. The 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 *multistate 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 multistate plans available.

h. **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. In the "Exchange Establishment" Final Rule, 2012, HHS interpreted the statutory requirement on offering SADPs "either separately or in conjunction with a qualified health plan ... to mean that the Exchange must allow stand-alone dental plans to be offered either independently from a QHP or as a subcontractor of a QHP issuer, but cannot limit participation of stand-alone dental products in the Exchange to only one of these options" (see https://www.federalregister.gov/d/2012-6125/p-1320). Per HealthCare.gov, "Dental coverage in the marketplace," FFE or SBE-FP dental plan shoppers may purchase a health plan that includes dental, or they may purchase a health plan and separate dental coverage, but they may not *solely* purchase an exchange SADP (see https://www.healthcare.gov/coverage/dental-coverage/, accessed March 24, 2025). CRS is not aware of statutory language requiring or prohibiting this approach. SBEs appear to take varied approaches regarding allowing the purchase of dental coverage without also purchasing health coverage.

Appendix C. Exchange 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 budget request, 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 funding. For example, per the FY2025 CMS budget justification, federal funding for the operation of the exchanges was $2.44 billion for FY2023 (final), $2.47 billion for FY2024 (continuing resolution, or CR), and requested to be $2.34 billion for FY2025. See **Table C-1**.

The exchanges are largely funded by user fees assessed on the insurers that offer plans in federally facilitated exchanges (FFEs) and state-based exchanges using the federal platform (SBE-FPs). 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 (HCFAC) account, among other sources. Within these annual appropriations, Congress has not required any particular level of spending on the exchanges. **Table C-1** displays federal exchange funding by source, by year.

Provisions in annual appropriations acts require CMS to provide, in its budget justification for each fiscal year, "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]."[219] In its annual budget justifications, CMS generally has provided a "Health Insurance Marketplaces Transparency Table" that tracks federal funding for multiple exchange activities, but such a table was not included in the FY2025 CMS budget justification. This may be because temporary funding under a CR, rather than a full-year appropriation, was in effect at the time that the FY2025 budget request was being formulated.[220] However, each CMS budget justification—including for FY2025—also includes narrative information about federal funding for the same or similar activities. See **Table C-2** for federal exchange funding by activity, by year.

See "Exchange 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.

[219] See, for example, the Further Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-47), Division D, Title II, §220. See also the Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), Division H, Title II, §220.

[220] The CMS Budget Justification, FY2025, was released on March 15, 2024. The CAA 2024, which included the requirement for an FY2025 Marketplace Transparency Table, was enacted on March 23, 2024. For further information, see pp. 5-6 of CRS Report R48060, *Department of Health and Human Services: FY2025 Budget Request*.

Table C-1. CMS Funding for the Exchanges, by Source, by Year

($ in thousands)

Treasury Account[a]	FY2018 Actual	FY2019 Final	FY2020 Final	FY2021 Final	FY2022 Final	FY2023 Final	FY2024 CR	FY2025 PB
Program Management	$1,944,190	$1,636,111	$1,618,091	$1,939,603	$2,066,898	$2,412,472	$2,433,889	$2,306,495
Discretionary Appropriation	$618,164	$263,895	$261,226	$142,455	$143,977	$119,243	$121,052	$125,945
Program Operations (non-add)	*$580,886*	*$229,384*	*$226,035*	*$119,520*	*$119,685*	*$119,243*	*$121,052*	*$125,945*
Federal Administration (non-add)[b]	*$37,278*	*$34,511*	*$35,191*	*$22,936*	*$24,292*	*N/A*	*N/A*	*N/A*
Offsetting Collections	$1,304,280	$1,351,893	$1,335,768	$1,776,028	$1,899,955	$2,293,229	$2,266,405	$2,154,216
[FFE] User Fee (non-add)[c]	*$1,272,168*	*$1,304,458*	*$1,310,948*	*$1,729,249*	*$1,853,605*	*$2,237,915*	*$2,205,463*	*$2,087,100*
Risk Adjustment User Fee (non-add)	*$32,112*	*$47,435*	*$24,820*	*$46,778*	*$46,350*	*$55,314*	*$60,942*	*$67,116*
Other[d]	$21,746	$20,323	$21,097	$21,120	$22,966	$0	$46,432	$26,334
Penalty Mail	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*$0*	*$35,359*	*$26,334*
Health Insurance Reform Implementation Fund	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*$0*	*$11,073*	*$0*
Health Care Fraud and Abuse Control	$4,629	$19,256	$47,684	$24,143	$18,446	$28,274	$31,121	$33,705
Discretionary Appropriation	$0	$19,256	$47,684	$24,143	$18,446	$28,274	$31,121	$33,705
Mandatory Appropriation[e]	$4,629	N/A	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	$2,440,746	$2,465,010	$2,340,200
FFE User Fee Amounts as a Percentage of Program Level Funding Sources[f]	65.3%	78.8%	78.7%	88.1%	88.9%	91.7%	89.5%	89.2%

Sources: Unless otherwise specified, compiled by CRS from Centers for Medicare & Medicaid Services (CMS) annual budget justifications as indicated below, available at CMS, "Performance and Budget," updated March 28, 2025, https://www.cms.gov/about-cms/performance-budget/current. Comparable data were not found in prior years' budget justifications.

FY2023-2025 in this table: HHS, CMS, *Justification of Estimates for Appropriations Committees, Fiscal Year 2025* (CMS Budget Justification FY2025), March 15, 2024. See

"Federal Marketplace Programs" table, page 201.
FY2022: CMS Budget Justification, FY2024, March 31, 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: CR = continuing resolution; FY = fiscal year; FFE = federally facilitated exchange; N/A = not available; PB = President's budget (proposed). 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. This row is not included in the Federal Marketplace Programs table in the CMS Budget Justification, FY2025.

c. Per communication with CMS, this row is inclusive of both federally facilitated exchange (FFE) and state-based exchange using the federal information technology platform (SBE-FP) federal user fees.

d. The two subcategories "Penalty Mail" and "Health Insurance Reform Implementation Fund" are newly listed in the Federal Marketplace Programs table as of the CMS Budget Justification, FY2025, along with the following note: "The FY2023 Final level excludes Penalty Mail as the associated funding sources were not available for obligation. Beginning in FY2024, Penalty Mail will be obligated through other expired sources." The Federal Marketplace narrative section does not otherwise address these funding sources.

e. 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."

f. Calculated by CRS.

Table C-2. CMS Funding for the Exchanges, by Activity, by Year

($ in thousands)

Activity	FY2018 Actual[a]	FY2019 Actual	FY2020 Actual	FY2021 Actual	FY2022 Actual	FY2023 Enacted[b]	FY2024 PB[c]	FY2025 PB[d]
Health Plan Bid Review, Management and Oversight	$37,910	$45,797	$45,480	$38,841	$54,255	$56,219	$53,319	$63,500
Payment and Financial Management	$45,141	$50,220	$39,178	$49,821	$47,780	$57,600	$57,600	$63,100
Eligibility and Enrollment	$392,660	$348,488	$371,802	$350,482	$391,341	$391,627	$417,907	$423,700
Consumer Information and Outreach	$591,948	$579,088	$503,271	$843,729	$903,220	$1,090,299	$975,981	$938,100
Call Center (non-add)	$525,326	$499,053	$440,000	$477,247	$535,219	$504,500	$489,500	Not specified
Navigators Grants & Enrollment Assisters (non-add)	$12,720	$19,499	$19,689	$91,233	$133,293	$141,747	$141,200	Not specified
Consumer Education and Outreach (non-add)	$10,744	$11,231	$14,082	$245,749	$211,592	$382,250	$280,750	Not specified
Information Technology	$767,413	$504,283	$549,369	$515,388	$511,706	$552,830	$561,713	$645,300
Quality	$7,240	$7,334	$7,063	$6,391	$6,706	$7,777	$8,282	$6,900
SHOP and Employer Activities	$4,418	$2,117	$200	$197	$195	$195	$195	$200
Other Marketplace	$31,196	$40,290	$63,579	$38,827	$35,400	$62,267	$63,644	$60,000[e]
Federal Payroll and Other Administrative Activities	$70,892	$77,750	$85,833	$120,071	$134,741	$164,170	$168,924	$139,400
Total	$1,948,818	$1,655,367	$1,665,775	$1,963,746	$2,085,344	$2,382,984	$2,307,565	$2,340,200

Source: CRS analysis of FY2025 and FY2024 Centers for Medicare & Medicaid Services (CMS) budget justifications, particularly the Health Insurance Marketplaces Transparency Table and/or the Federal Marketplace Programs narratives, as indicated in the notes below. See table notes (b) and (c) regarding the FY2023 and FY2024 total amounts in this table, as compared to such totals in **Table C-1**, above, in this report.

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.

a. **FY18-24 in the table:** HHS, CMS, *Justification of Estimates for Appropriations Committees, Fiscal Year 2024*, March 31, 2023, at https://www.cms.gov/about-cms/performance-budget/prior. See "Health Insurance Marketplaces Transparency Table," pages 237-238, including for these data for FY2010-FY2017 and for CMS notes on these data. Discussion of the categories is at "Federal Marketplace Programs" narrative, pages 199-204.

b. Updated FY2023 "Actual" or "Final" amounts for each activity were generally not found in the CMS Budget Justification, FY2025. The FY2023 total funding level and activity funding details in this table are from the FY2024 Transparency Table. However, the FY2025 Federal Marketplace Programs narrative did provide an updated FY2023 "final" total funding amount for the exchanges of $2.441 billion, and relevant updates on FY2023 funding by source, which is reflected in **Table C-1**, above.

c. Updated FY2024 "Enacted" amounts for each activity in this table were generally not found in the CMS *Budget Justification*, FY2025. The FY2024 total funding level and activity funding details in this table are from the FY2024 Transparency Table. However, the FY2025 Federal Marketplace Programs narrative did provide an updated FY2024 "CR" total funding amount for the exchanges of $2.465 billion, and relevant updates on FY2024 funding by source, which is reflected in **Table C-1**, above.

d. **FY25 in the table:** HHS, CMS, *Justification of Estimates for Appropriations Committees, Fiscal Year 2025,* March 15, 2024, at https://www.cms.gov/about-cms/performance-budget/prior. See "Federal Marketplace Programs" narrative, pages 201-205. Because the CMS Budget Justification, FY2025, did not include a "Health Insurance Marketplaces Transparency Table" as in prior years, relevant FY25 budget narrative information is provided in this table instead.

e. This "Other Marketplace" amount for FY2025 includes $33.7 million for Program Integrity and $26.3 million for Planning and Performance, per the Federal Marketplace Programs narrative in the CMS Budget Justification, FY2025. In the CMS Budget Justification, FY2024, such narrative indicated $43.8 million for Program Integrity and $19.8 million for Planning and Performance, which total $63.6 million, the "Other Marketplace" amount in the FY2024 Transparency Table.

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
2026	Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; Basic Health Program	90 *Federal Register* 4424	January 15, 2025
2025	Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program	89 *Federal Register* 26218	April 15, 2024
2024	Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024	88 *Federal Register* 25740	April 27, 2023
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

For Plan Year	Title	Citation	Publication Date
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 first 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 additional resources are listed below.

Table D-2. Selected Federal Resources on the Exchanges

Resource	Summary
CMS, "Health Insurance Marketplaces"	Links to agency FAQs, letters, and other resources on the exchanges
CMS, "Qualified Health Plan Certification Information and Guidance"	Resources for health insurance issuers seeking QHP certification
CMS, "Health Insurance Exchange Public Use Files (Exchange PUFs)"	Data on QHPs (primarily in the FFEs and SBE-FPs), by year
CMS, "Health Insurance State-based Exchange Public Use Files"	Data on QHPs in the SBEs, by year
CRS Report R46638, *Health Insurance Exchanges: Sources of Statistics*	Compilation of HHS resources on exchange enrollment and other exchange data

Source: CRS compilation of selected resources.

Notes: CMS = Centers for Medicare & Medicaid Services; FFE = federally facilitated exchange; HHS = Department of Health and Human Services; SBE = state-based exchange; SBE-FP = state-based exchange using the federal information technology (IT) platform.

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