OFFICE OF LEGISLATIVE RESEARCH
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ResearchReport

New England States' Health Insurance Exchanges

By: Tenley Smith, Legislative Analyst II
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Issue

Compare New England states' health insurance exchanges and provide policy considerations for establishing a regional exchange in New England.

Summary

The federal Affordable Care Act (ACA, P.L. 111-148) requires each state and the District of Columbia to have an online health insurance exchange ("marketplace") where consumers, including small business owners and their employees, can compare and purchase private health insurance plans and, in certain cases, connect to public health insurance programs, such as Medicaid.

States may choose to either (1) assume full responsibility for operating their exchange (state-based exchange), (2) give operational responsibility to the federal government (federally funded exchange), or (3) share operational responsibility with the federal government (state-based exchange using the federal platform). Currently, each New England state (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) operates its own exchange, except for New Hampshire, whose exchange is administered by the federal government through Healthcare.gov.

While these exchanges are currently divided by state boundaries, the ACA allows states to establish regional exchanges. However, no states have yet elected to do so. According to federal Centers for Medicare and Medicaid Services (CMS) data, if the New England states created a regional

exchange, they would form the 6th largest exchange pool in the country (see below). Doing so presents several policy considerations. Establishing a regional exchange creates a larger consumer pool, potentially pooling risk and creating more incentives for insurers to offer plans within the marketplace and increase plan competition. This may result in lower premiums for consumers than currently possible with smaller pools. However, a regional exchange may face challenges, such as aligning different requirements and funding sources between state-based and federally facilitated exchanges, standardizing state-specific regulations, and possibly requiring insurers to create new provider networks.

Health Insurance Exchanges

Under the ACA, states must have two types of exchanges, one for individuals and one for small businesses (known as a small business health options program (SHOP exchange)). An individual exchange allows consumers to compare and purchase nongroup insurance for themselves and their families. It also provides financial assistance, such as premium tax credits, which subsidize insurance premiums, to eligible low-income consumers. A SHOP exchange allows small businesses to compare and purchase small-group insurance, as well as apply for small business health insurance tax credits. Small businesses' employees may also enroll in plans offered by their employers on a SHOP exchange.

The ACA sets the exchanges' requirements, including the (1) types of plans they must offer (and annually certify meet federal requirements), (2) data states must share with CMS, and (3) availability of consumer information and assistance with choosing plans (42 U.S.C. § 18031 *et seq.*).

Generally, health insurance plans offered through exchanges must be qualified health plans (QHPs) that meet several federal requirements, such as:

1. offering coverage for 10 broadly defined essential health benefits, including ambulatory patient services, emergency services, hospitalization, and maternity and newborn care, among others (42 U.S.C. § 18022(b)(1));

2. offering at least one silver-level and gold-level plan, which pay for 70% and 80% of covered benefits, respectively (plans are categorized by "metals" that represent cost sharing levels; plans with higher actuarial values generally have lower cost sharing) (42 U.S.C. § 18022(d)(1));

3. sharing certain data with the federal government, including claims payment policies and practices, claims denials, enrollment, cost sharing, and premium rating practices among other things (42 U.S.C. §18031(e)(3) and 45 C.F.R. §§ 155.540 & 156.220); and

4. meeting network adequacy requirements, ensuring that networks have sufficient amounts and types of providers so that service is accessible without unreasonable delay (45 CFR parts 153, 155, and 156).

Exchange Management

Generally, states may choose one of three operational models for administering their exchange:

- *State-Based Exchange (SBE)*: the state assumes full operational responsibility for operating its exchange, including enrollment, benefit information, plan management, and consumer services.
- *Federally Facilitated Exchange (FFE)*: CMS fully operates the state's exchange through Healthcare.gov.
- *State-Based Exchange on the Federal Platform (SBE-FP)*: the state partners with CMS to share operational responsibilities (for example, the state provides consumer services while CMS handles plan management and enrollments).

According to the State Marketplace Network, 20 states (including Connecticut) have SBEs, 27 states have FFEs and three states (Arkansas, Oklahoma, and Oregon) have SBE-FPs. Currently, all New England states have an SBE except for New Hampshire, whose exchange, including enrollment and plan management, is administered by CMS.

New England Individual Exchanges

According to CMS, following the 2026 annual open enrollment period (between November 1, 2025, and January 15, 2026, depending on the state), all individual exchanges nationwide have a total of over 22 million enrollees. State enrollments range from a high of 4.5 million in Florida to 23,380 in Hawaii. Among the New England states, Massachusetts and Connecticut have the largest exchanges and Rhode Island and Vermont the lowest, as shown in Table 1 below.

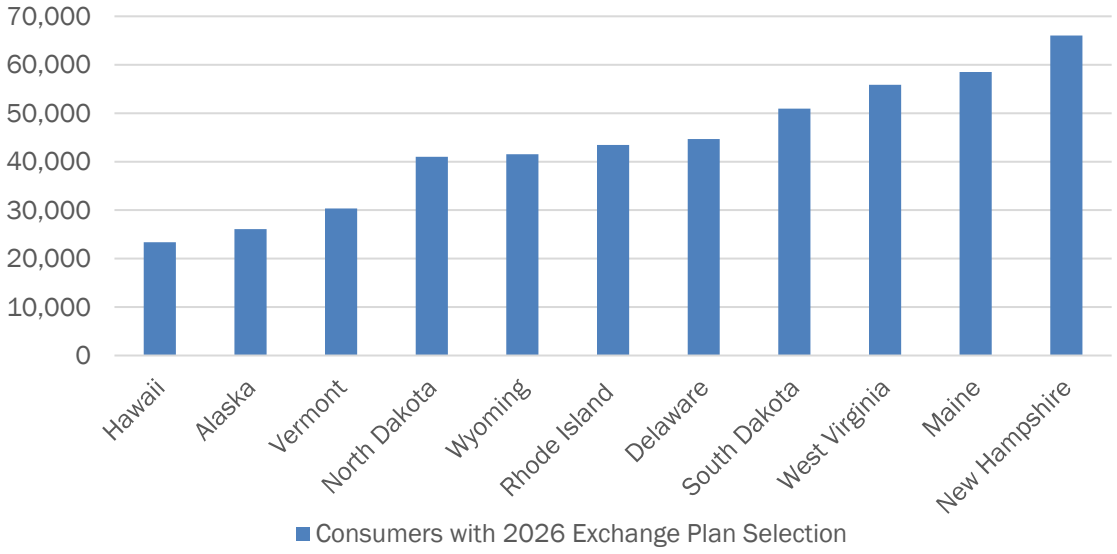
Table 1: Consumers With Exchange Plan Selection by New England State

State	Consumers With an Exchange Plan Selection
Connecticut	156,745
Maine	58,523
Massachusetts	403,624
New Hampshire	66,024
Rhode Island	43,446
Vermont	30,344

Source: CMS 2026 Marketplace Open Enrollment Period Public Use Files, last updated March 27, 2026. (Data is based on 2026 open enrollment period plan selections. Consumers must pay premiums for coverage to take effect.)

Moreover, Rhode Island and Vermont also have among the smallest exchanges in the country, as shown in Figure 1 below.

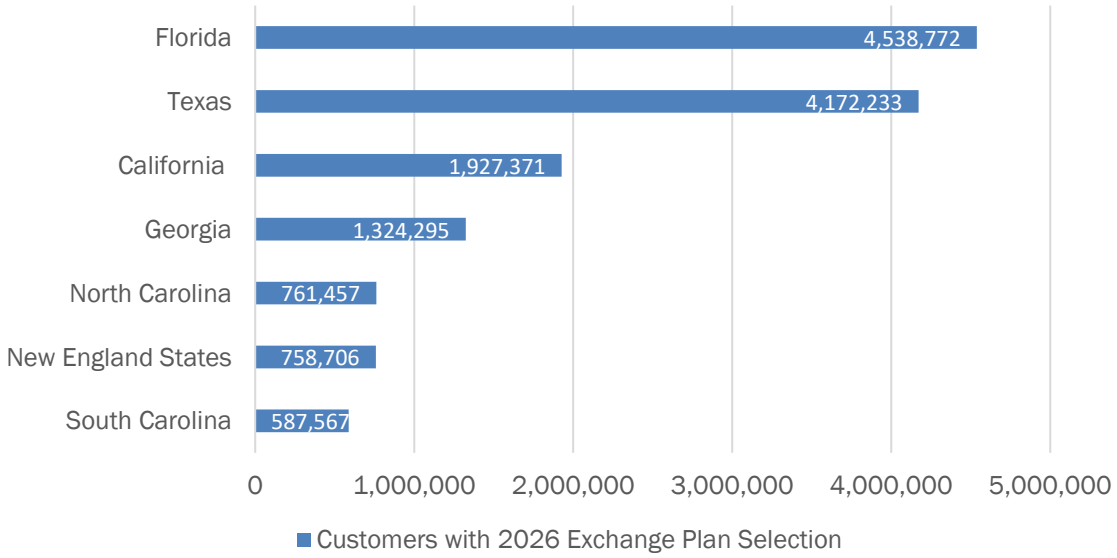
Figure 1: States With Smallest Exchanges



Source: CMS 2026 Marketplace Open Enrollment Period Public Use Files, last updated March 27, 2026

If the New England states formed a regional exchange, it would currently rank as the 6th largest individual exchange in the country, as shown in Figure 2 below.

Figure 2: States With Largest Exchanges



Source: CMS 2026 Marketplace Open Enrollment Period Public Use Files, last updated March 27, 2026

New England Regional Exchange

Under the ACA, states may create (1) regional individual and SHOP exchanges or (2) smaller individual and SHOP exchanges within a single state to serve distinct geographies (for example, northern and southern California) (45 C.F.R. § 155.410). To date, no states have elected to create either these regional or subsidiary exchanges.

Potential Benefits

Creating a regional exchange for New England states has several possible benefits. First, it would create a larger exchange pool with a higher population than the states can create individually, allowing them to pool risk and potentially lower consumer premiums. Risk pooling reduces premiums by spreading higher health care costs incurred by less healthy individuals across a large pool that includes healthier individuals with lower costs. This assumes, however, that the larger population diversifies the pool by including more healthy individuals with less costly health care needs. A larger pool may also reduce costs by creating economies of scale for administrative work, spreading fixed costs for services, such as information technology, across a larger population.

Furthermore, a larger regional exchange market may have greater negotiating power with the private insurance sector and attract increased insurer participation, thereby expanding plan options and competition as well as increasing consumer choice.

Potential Challenges

Creating a regional exchange also presents several operational considerations, including the following:

1. regionalizing certain administrative functions, such as website management (which may limit states' ability to provide information tailored to their specific communities);

2. standardizing funding models between SBEs (which are responsible for funding exchange administration through user fees charged to insurers and additional exchange functions through appropriations) and New England's only FFE (New Hampshire, where CMS is responsible for charging user fees to insurers and funding other functions through federal appropriations);

3. incorporating existing networks into a single plan across states (possibly requiring contract re-negotiations);

4. complying with state-specific regulations (because federal regulations require states to generally specify the benefits covered within the 10 essential benefits categories, required benefits vary, including for example in New England between Connecticut and New Hampshire); and

5. aligning subsidy and program eligibility across various state requirements (exchanges are a 'one-stop shop' to determine consumer eligibility for health program assistance (including premium subsidies, Medicaid and Medicare, and the Children's Health Insurance Program) and state subsidies for these federal programs vary).

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