ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

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Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment

KEY POINTS

- In 2020, approximately 30 million U.S. residents lacked health insurance, and the majority were already eligible for some form of federally-subsidized coverage, primarily Medicaid or Marketplace private insurance. Participation rates and outreach are therefore key considerations in policies designed to expand coverage.
- The most common reason cited among uninsured populations for not enrolling in health coverage is cost: In 2020, 7 in 10 uninsured individuals reported that they could not afford monthly premiums above $75. In addition, nearly two in three uninsured individuals had heard "a little" or "nothing" about financial assistance for Marketplace coverage.
- Due to the American Rescue Plan's expanded eligibility and enhanced Marketplace premium tax credits, it is estimated that 73 percent of uninsured individuals can now access a plan for $50 or less per month, and 62 percent of uninsured individuals can access a plan for free.
- Broad public educational campaigns can increase consumer awareness, but evidence suggests that individual assistance and community outreach are necessary supplements to boosting enrollment, particularly among individuals who are uninsured, individuals with limited English proficiency, and people with limited internet access – who are more likely to be older, low-income and living in rural areas.
- For plan year 2022, CMS announced $80 million in grants awarded to Navigators in Federal Marketplaces, the largest funding allocation for Navigator grants to date, which will enable the training and certification of more than 1,500 Navigators.
- Navigators and private health insurance brokers can help consumers to understand basic insurance concepts; however, they serve very different populations. Research indicates that assisters (including Navigators) are 5 times more likely to serve a predominantly uninsured population than are private health insurance brokers.
- Studies also show that some private health insurance brokers frequently offer consumers policies that do not comply with the ACA consumer protections, including short-term limited duration health insurance, in part due to higher commissions from those plans. These findings raise concerns that brokers and outreach by health plan representatives disproportionately lead individuals to enroll in less comprehensive coverage.

Introduction

"The Affordable Care Act (ACA) extended health insurance coverage to millions of Americans - 31 million enrolled as of early 2021[1] - and reduced the uninsured rate among non-elderly individuals from 18.2 percent in 2010 to an all-time low of 10.4 percent in 2016 (roughly 20 million people).[2] However, between 2017 and 2020, the uninsured rate increased. By 2020, two million more Americans were uninsured compared to 2016, leaving 11.1 percent of the U.S. population without health insurance, many of whom have a pathway to subsidized coverage but remain uninsured.[3] Outreach and enrollment assistance play a crucial role in increasing enrollment and retention of consumers seeking health insurance.

This report reviews evidence on factors affecting enrollment in health coverage among uninsured populations, including take-up of Medicaid and subsidized Marketplace plans among eligible individuals. In addition, the report discusses barriers faced by individuals trying to enroll in health coverage and evidence on the impacts of various outreach strategies and consumer assistance on helping uninsured people gain coverage.

The Remaining Uninsured

A 2021 analysis (using 2019 survey data) estimated that of the 30 million remaining uninsured, one-fourth (25 percent) are Medicaid eligible and over one-third (38 percent) are eligible for subsidized coverage purchased through the Marketplace.[4*] ASPE estimates that before the COVID-19 pandemic, 11 million nonelderly Americans were uninsured despite being potentially eligible for free or reduced cost coverage through the Marketplace.[5] In addition, an estimated 3.6 million uninsured individuals are *newly-eligible* for subsidies because of the American Rescue Plan's (ARP) enhanced premium tax credits (See Appendix Table 1).[6]

Uninsured rates vary widely by race, ethnicity, language, education, and other factors, with substantial disparities in coverage. While Hispanic (19 percent) and Black (13 percent) populations represent a smaller share of the total U.S. population, they disproportionately account for 29 percent and 16 percent of the uninsured population, respectively.[7] In some parts of the U.S., large portions of the uninsured population (up to 69 percent) reside in households in which the adults have limited English proficiency (See Appendix Table 2). Of the 11 million uninsured who are eligible for subsidized Marketplace coverage, 30 percent are Hispanic, 86 percent have a high school education or less, and 9 percent do not predominately speak English at home.[8]

Uninsured populations are also disproportionately more likely to be young adults (38 percent aged 19-34), have low incomes (33 percent under 100 percent of the federal poverty level (FPL)) (See Appendix Table 2),[9] or live in a state that hasn't expanded Medicaid to low-income adults (9.1 percent of adults uninsured vs. 17.1 percent of adults uninsured) (See Appendix Figure 1).[10] In 2019, adults aged 19-64[†] were more than twice as likely as children to be uninsured (11.7 percent vs. 5.2 percent)[11] and, although low-income individuals were more likely to be uninsured than those with higher incomes, around 14 percent of the uninsured had incomes of 400 percent FPL or higher.[12] Over half (52 percent) of the uninsured population lived in families of two or more people, and a majority (82 percent) of the remaining uninsured live in families with at least one full time worker. The Congressional Budget Office (CBO) estimated that at any given point in time in 2019, 11 percent of uninsured individuals lacked coverage for less than six months and 80 percent were without coverage for over a year. Children and members of families with higher incomes (above 400 percent FPL) tended to remain

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[*] The remaining uninsured ineligible for Medicaid or Marketplace financial assistance (37 percent of total uninsured) include 4 percent whose income exceed 400 percent of the federal poverty level (FPL), 12 percent who have an offer of employer coverage, and 13 percent who are ineligible due to their citizenship status. Eight percent of the remaining uninsured live in states which haven't adopted the ACA Medicaid expansion and fall in what is often referred to as the "coverage gap," with incomes above the state's Medicaid eligibility level but below 100 percent FPL, the income level qualifying individuals for Marketplace premium tax credits.

[†] Not including undocumented immigrants.

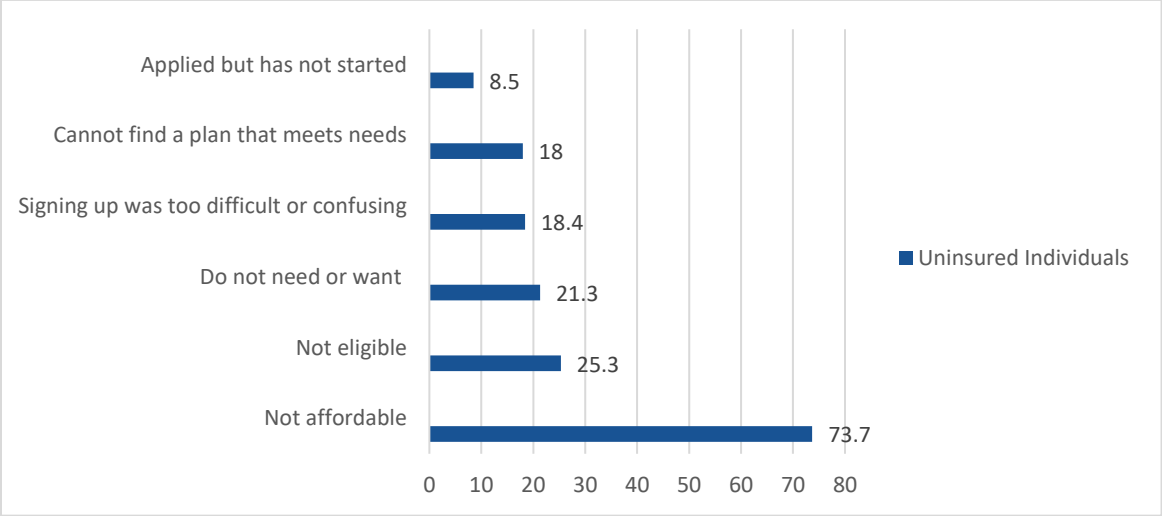
uninsured for shorter periods of time, resulting in "churning," or coverage disruptions and coverage loss.[13] Research has shown that "churning" often leads to periods of uninsurance, delayed care, and less preventive care utilization, as well as higher administrative costs and monthly health care costs.[14]

Various surveys have examined the reasons why people who are uninsured do not have health coverage. By far, the most common answer is cost. A 2020 national survey found that in the past 3 years, 42 percent of uninsured adults looked for individual coverage and did not buy a health insurance plan on their own; most of those individuals said the plan was too expensive (71 percent). Smaller numbers said they found out they were ineligible (6 percent), gained insurance through another source (4 percent), or deductibles or copayments were too high (3 percent).[15] Citing affordability as the main barrier to coverage increased with age, from 67 percent among those 18-29 years of age to 81 percent among those 50-64 years of age. Among uninsured populations, one-fourth (25 percent) reported that they did not think they were eligible for coverage, and Hispanic adults were more likely than their white counterparts to indicate ineligibility as the reason for not being covered (30 percent and 22 percent, respectively).

Lack of information and complexity in the application process are also cited barriers to enrolling in coverage. Thirty-eight percent of uninsured adults who had visited the Marketplaces but did not enroll in a Marketplace plan or Medicaid reported finding the process difficult or confusing.[16] Moreover, many uninsured individuals lack the health literacy to determine their coverage eligibility and navigate the enrollment system, compare their plans options, and use their coverage to access care.[17] For example, one 2021 survey found that more than half of respondents were confused by health insurance and only 20 percent correctly identified all qualified life events, the circumstances that would allow someone to enroll in a new health care plan outside of open enrollment.[18] Factors related to informational barriers are further discussed in this Brief.

As shown in Figure 1, in the 2019 National Health Interview Survey, over one-fifth of the uninsured (21.3 percent) reported they did not need nor want coverage. Reporting that coverage was not wanted or needed was more likely among men (26.8 percent) than women (14.6 percent) and decreased with age. Additional reasons for not having coverage included that "signing up was too difficult or confusing" (18.4 percent), that the consumer "couldn't find a plan that met their needs" (18 percent), or that they had applied but coverage hadn't started (8.5 percent).[19] Note that respondents were able to select more than one reason for not having insurance.

Figure 1. Reasons for Remaining Uninsured Among Non-Elderly Adults



Source: Data from the 2019 National Health Interview Survey

Evidence on Health Coverage Take-Up

Policy Factors

In 2021, ACA-related enrollment reached an all-time high – with over 31 million people enrolled in Marketplace or Medicaid expansion coverage.[20] All states and the District of Columbia have experienced reductions in the uninsured rate since the ACA's implementation in 2013. However, expanding Medicaid in the remaining non-expansion states[‡] would greatly reduce uninsurance rates, with large projected gains in coverage among Black and Hispanic adults.[21] If the remaining states were to expand Medicaid eligibility to adults with incomes up to 138 percent FPL, an estimated four million uninsured non-elderly adults would be newly eligible for Medicaid.

Research shows that states that have developed state-based Marketplaces have experienced increased gains in coverage and lower premium growth compared to states relying on the Federally Facilitated Marketplace (FFM). This is likely due to increased support for coverage, outreach efforts, and state policies that ensure a stable and competitive Marketplace. Between 2012 and 2015, states with state-based Marketplaces saw nearly double the coverage gains compared to FFM states.[22] During the COVID-19 pandemic, all but one state-based Marketplace created a special enrollment period and many have worked to broadcast enrollment opportunities to uninsured populations. For example, many states are collaborating with state labor or employment security departments to provide health insurance enrollment information to individuals filing for unemployment insurance.[23] Moreover, research has found state-based Marketplaces are more likely to engage in targeted outreach to individuals who are more likely to be uninsured, such as Spanish speaking individuals.[24]

Given that cost is the most reported barrier to coverage, it is not surprising that financial assistance plays an important role in increasing coverage among the remaining uninsured. In 2020, 7 in 10 uninsured individuals reported that they could not afford monthly health insurance premiums above $75.[25] States that have both expanded Medicaid and offer additional financial assistance in their Marketplaces generally have lower uninsured rates. For example, Massachusetts has the lowest overall non-elderly uninsured rate in the nation and offers additional subsidies for Marketplace enrollees with incomes below 300 percent FPL.[26] Research has shown that as subsidies decline, insurance take-up falls rapidly, dropping about 25 percent for each $40 increase in monthly enrollee premiums.[27] Studies of Medicaid and the Children's Health Insurance Program (CHIP) have similarly shown that premiums and higher cost-sharing dissuade potential enrollees, while more generous coverage and better provider access lead to higher participation rates.[28,29] However, who is eligible and for what kind of coverage are not the only key policy factors that affect coverage rates. Outreach efforts, enrollment assistance, and other strategies also play important roles, as discussed below.

The American Rescue Plan

Signed into law on March 11, 2021, the ARP expanded eligibility for premium tax credits to households with incomes above 400 percent FPL, and enhanced Marketplace premium tax credits for consumers already eligible for these subsidies. Following passage of the ARP, ASPE estimated that three in four uninsured individuals (73 percent) can now access a plan for $50 or less per month, and 62 percent can access a plan for free.[30] If the ARP enhanced subsidies become permanent, extending beyond 2022, consumer behavior may change. One analysis estimated that subsidized Marketplace enrollment would increase by 5.1 million and the

[‡] The 12 states that have not expanded Medicaid are: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. While Missouri voters expanded Medicaid on August 10, 2021 through a ballot measure, the expansion has not been implemented as the measure lacked a revenue source. The Missouri Supreme Court later ruled that the legislature's budget appropriation authorizes the state to fund expansion coverage.

uninsured population would decline by 4.2 million in 2022, if consumers knew at the time of enrollment that the ARP enhanced subsidies were permanent.[31]

The ARP substantially reduced enrollee premiums during the 2021 COVID-19 Special Enrollment Period (February 15 to August 15), with almost half of HealthCare.gov consumers selecting a new plan having a monthly premium of $10 or less, compared to 25 percent during the same period in 2020. Across HealthCare.gov states, 2.1 million Americans signed up for new health insurance coverage during this time period (See Appendix Table 3).[32]

Demographic Factors

There are a variety of demographic factors that are associated with enrollment in both public health insurance programs like Medicaid and CHIP and private health insurance through the Marketplace. Research findings show that enrollment in public programs such as Medicaid and CHIP is generally higher among children than among adults.[33] Childless adults without disabilities have historically lower Medicaid take-up rates than parents and those with disabilities.[34] Medicaid take-up has been found to be higher among women, Black individuals, unemployed adults, people with less education, and those with worse self-reported health.[35] Among privately insured young adults, predictors of enrollment include having higher socioeconomic status, White race, and attitudinal factors such as perceived need, perceived health, and perceived value.[36]

One survey has found among uninsured adults who had heard only a little or nothing about Marketplace plans or subsidies, more than half were younger than 35 and nearly half were not working. More than a quarter were bilingual or Spanish speaking, more than one in five lacked a high school degree, and more than one in seven lacked home internet access.[37] Some uninsured people are aware of their eligibility for subsidies but may not view health care coverage as worth the cost.[38] Additional evidence suggests that higher financial and health insurance literacy are associated with a greater probability of being insured.[39] Moreover, compared with people who enrolled in a Marketplace or Medicaid plan, those who did not ultimately enroll had much greater difficulty comparing plans based on premium costs, potential out-of-pocket costs, provider network, and benefits covered.[40] Many factors influence Marketplace enrollment, including race, ethnicity, and English proficiency. For instance, studies show that Latino adults, who are significantly more likely than other racial and ethnic groups to be uninsured, have lower awareness of critical provisions of the ACA than other groups.[41] For example, one survey found more than half of all Latinos were unaware of the Marketplace.[42] Research has also highlighted additional barriers related to language, with a California study finding that Spanish speakers were twice as likely to report not knowing how to apply as the main reason for not enrolling in Marketplace coverage.[43]

Challenges & Barriers to Take-up

A majority (60 percent) of Marketplace enrollees reported they faced difficulty applying for coverage in 2020.[44] Consumers have different levels of awareness of their health coverage options and the resources available to assist them in obtaining coverage, which is a key challenge to enrolling eligible populations. A 2020 study found that 29 percent of uninsured adults tried to obtain Medicaid/CHIP coverage[§] and 55 percent looked for information on Marketplace health plans. However, 71 percent did not try to obtain coverage through Medicaid/CHIP, 40 percent of whom did not try because they did not think they would be eligible.[45] Moreover, 45 percent did not look for information on Marketplace plans, and of those, 42 percent did not do so because they believed the cost would be too high. Another 2020 survey of the uninsured found that 65 percent of uninsured adults had little or no knowledge about financial assistance for Marketplace coverage.[46] Moreover,

[§] As indicated by response to the question, "Have you tried to obtain coverage through Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP), or any kind of state or government-sponsored assistance plan based on income or a disability?"

a recent poll found that less than one in five respondents were aware of when the upcoming deadline was to sign up for 2021 coverage through the Marketplace.[47]

While consumers report not looking to enroll in Marketplace plans because they believed cost would be prohibitive, consumers also have little awareness of the financial assistance available to them. Two in three uninsured individuals (65 percent) had heard "nothing" or "a little" about financial assistance for Marketplace coverage and only 11.4 percent of uninsured individuals reported knowing "a lot" about Marketplace financial assistance.[48]

The existing literature highlights the complex nature of health insurance take-up and the shared but also unique needs of various communities in navigating the enrollment process.** Beyond the actual and perceived costs of health insurance, a significant challenge to take-up is health insurance literacy and its correlates. One 2016 study of Asian Americans and Pacific Islanders in California found that new enrollees struggled with informational barriers to accessing care, and that immigrants with limited English proficiency disproportionately experienced challenges with the enrollment process.[49] A study of Latino adults seeking urgent care at a public hospital in California, researchers found that participants experienced challenges with gaining awareness of health insurance benefits and completing the enrollment process; language and fear of authorities also were cited as barriers to take-up.[50] Relatedly, a 2018 cross-sectional study examining underserved Hispanic communities in Texas found that low ACA knowledge was associated with low levels of health insurance literacy and low levels of confidence in choosing and comparing health insurance plans.[51] Other studies in states including Connecticut, Kentucky, and Maryland have found that health insurance terminology was especially confusing to Black and Hispanic enrollees,[52] that difficulty understanding health insurance concepts and mistrust in the health care system are common barriers to enrollment,[53] and that Navigators and In-Person Assisters can help boost enrollment by gaining the trust of patients.[54]

Strategies to Increase Enrollment

Under the ACA, the Centers for Medicare & Medicaid Services (CMS) is responsible for outreach and marketing to consumers enrolling in the federal Marketplace through HealthCare.gov. Research has identified three key enrollment strategies that are effective in helping people enroll in coverage under the ACA: public information campaigns, individual/consumer assistance, and community outreach.[55] Among remaining uninsured Medicaid- or Marketplace- eligible populations, a combination of strategies is likely necessary. Evidence from low-income Medicaid- and CHIP-eligible families shows that consumers have different preferences on where and how they would like to receive information. While broad education and promotion can increase consumer awareness, individual assistance and community outreach are necessary supplements to enroll people who are medically underserved.[56] Recent policy changes regarding Marketplace enrollment, individual assistance, and outreach take this evidence into account, to extend access to coverage for the uninsured and improve health equity. For instance, the CMS payment notice for Plan Year (PY) 2022 lengthens the annual Open Enrollment Period (OEP) by an additional 30 days and creates a new special enrollment period opportunity for certain low-income consumers, providing the opportunity to utilize the ARP's expanded subsidies to access a zero- or low-premium Marketplace plan.[57]

Public Information Campaigns

Public information and advertising campaigns, including health education and promotion efforts, can disseminate materials about health insurance choices and the enrollment process. This strategy may be used

** In addition to the communities highlighted here, ASPE has published briefs on the unique needs and challenges in accessing care faced by LGBTQ+ (https://www.aspe.hhs.gov/sites/default/files/2021-07/lgbt-health-ib.pdf) and rural communities (https://aspe.hhs.gov/sites/default/files/2021-07/rural-health-rr.pdf).

by various entities, including private organizations, media, and government agencies. States can also use specially allocated ACA funding for such local outreach and enrollment supports.[58]

These campaigns can be effective at increasing enrollment among a large population.[59] For example, in 2016 CMS determined that of the 9.6 million enrolled in coverage, 1.8 million had enrolled due to advertising. By 2017, advertising drove 37 percent of enrollments.[60] At the state-level, California, which operates its own Marketplace, has found outreach to result in a more than three-to-one return on investment by increasing enrollment and retention of healthy individuals. Covered California asserts their marketing and outreach expenses in 2015 and 2016 likely lowered premiums by 6 to 8 percent by enrolling healthier consumers, with an estimated combined savings to consumers and the federal government between "$853 million to a high of $1.3 billion" in 2015 and 2016.[61] In Kentucky, researchers concluded that almost 40 percent of unique visitors and web-based applications to the Kentucky Health Benefit Exchange were associated with state-sponsored television advertising.[62] Another study estimates that, between 2013 and 2016, one-fifth of the decline in the uninsured rate in individuals above 400 percent FPL was due to outreach and advertising efforts.[63] Advertisements are one approach to health education, and research has found that the volume and source of advertisements under the ACA were associated with increased coverage. Specifically, government-sponsored advertisements were associated with insurance gains, whereas privately-sponsored advertisements were not similarly associated with increases in coverage.[64]

Public information campaigns can be particularly impactful among certain subpopulations, such as for uninsured individuals, who may need multiple points of contact and exposure to information about health plans and enrollment deadlines before they will enroll.[65] As found in a 2018 GAO study, some stakeholders emphasized how outreach and advertising are particularly important for increasing new enrollment, especially among younger, healthier individuals. Research shows that a higher percentage of adults with low literacy receive their information about health issues from radio and television than through written sources, the internet, or social contacts.[66] Alternatively, research has found that individuals seeking information and online help when making a health insurance plan decision may more likely be higher income.[67] The economic recession has shown that affected families have turned first to community-based organizations for help with linking them to public assistance programs.[68]

Other outreach efforts can include direct-to-consumer materials such as emails, letters, postcards, or automated telephone calls. Such "nudging" efforts are relatively low-cost and can help overcome inertia in coverage take-up. For example, Oregon found that postcards, mailings, and automated telephone outreach increased enrollment among Medicaid-eligible populations.[69] Similarly, Oregon found that generic reminders sent through mail and e-mail increased Marketplace plan shopping by 23 percent.[70] For Marketplace-eligible populations, California experimentally varied enrollment deadline reminders mailed to households with typically low take-up. The effort cost $0.69 per letter but raised enrollment by 1.3 percentage points and increased the average consumer's willingness to pay for insurance by at least $25 per month.[71] A second study in California found that personalized phone calls to individuals who had applied but not selected a Marketplace plan increased enrollment by nearly 3 percentage points and was particularly effective for low-income and elderly individuals, Spanish-speaking individuals, and enrollees transitioning from Medicaid.[72] Researchers in Massachusetts examining the impact of personalized letters found that letters that included a simplified enrollment option ("check-the-box") increased enrollment by 11 percent overall and by 23 percent for individuals below 150 percent FPL.[73] These efforts have also shown to be effective in reducing plan choice errors, which occur when a low-income household enrolls in a gold or platinum plan despite being eligible for cost-sharing reduction (CSR) silver plans with lower premiums and higher actuarial values. Consumers who received a postal message and email increased switching to CSR plans by 11 percent, which saved an average of $84 in premiums and $56 in out-of-pocket expenses per month.[74]

At the federal level, in 2017, the Internal Revenue Service mailed informational letters to 3.9 million households who paid the tax penalty for lacking health insurance, comparing them to a randomized comparison group that did not receive those notices. The uninsured individuals who received letters were 1.1 percentage points more likely to enroll in coverage in the following two years than those in the control group, with the increase in coverage being driven primarily by Marketplace enrollment. Researchers concluded the initiative increased coverage and reduced short-term mortality among the population over the subsequent two years.[75] These results suggest that outreach efforts not only increase coverage but lead to substantial health benefits among those targeted.

Individual/Consumer Assistance

Consumer assistance is effective at helping uninsured individuals make informed decisions during the health coverage selection process, including helping such individuals understand their coverage options and apply for financial assistance. Individual assistance involves educating consumers about their coverage options, helping to screen for eligibility, and supporting them throughout the application process. In this section, we review the following types of individual and consumer assistance: Navigators, Certified Application Counselors (CACs), Community Health Workers (CHWs), and enrollment workers.[76]

Federal rules require Marketplaces to develop and operate Navigator programs funded by federal grants overseen by the CMS.[77] Navigators are required to provide free and unbiased services to consumers, small businesses, and employees as they look for health insurance coverage on the Marketplace.[78] The ACA defines Navigator duties to include the following tasks: performing public education activities to raise awareness of the availability of qualified health plans (QHPs), distributing fair and impartial information regarding enrollment in QHPs and the availability of federal financial assistance, facilitating enrollment in QHPs, providing referrals to appropriate agencies for grievances or complaints, and providing all information in a manner that is linguistically and culturally appropriate for the consumer.[79] Navigators contract directly with the state-based Marketplace or FFM, and a variety of organizations may serve as Navigators. As part of HHS' funding agreement with Navigator organizations in the FFMs, Navigators are tasked with providing impartial information about health insurance options to traditionally underserved populations, including assisting those with limited English proficiency or complex enrollment and financial circumstances.[80] In addition, CACs, who serve a similar function and role as Navigators, operate in the FFMs.[81] However, unlike Navigators, CACs operating in the FFMs are not federally funded. In 2021, CMS awarded 60 organizations Navigator Cooperative Agreement awards for PY 2022 in 30 states with an FFM. These Navigator grants include United Way of Anchorage, the Arizona Alliance for Community Health Centers, and the Illinois Primary Health Care Association.[82] In addition to federal funding, community based training in health insurance, health care resources, and outreach supported at the state- or community-level has also been effective in increasing competencies among a diverse set of Navigators.[83] Of note, CACs and Navigators are not allowed to receive any payment or other consideration directly or indirectly from health insurance issuers in connection with the enrollment of any consumer in a QHP or non-QHP.[84] CMS is also expanding services provided by FFM Navigators and is re-launching a partnership program with local organizations that are active in providing outreach and education about the Marketplace and how consumers can enroll in coverage through HealthCare.gov, Medicaid, or CHIP.

Studies show that consumer assistance can be highly effective in enrolling people in coverage. Nearly 20 percent of consumers[††] who looked for coverage or actively renewed their coverage received consumer assistance in the past year. Forty percent of those who used assistance think it is unlikely they would have the same coverage if not for the help they received.[85] A 2015 study found that in-person assistance increased

[††] Answering "Yes" to the following question, "At any time in the past 12 months, did you get help with shopping, applying, or renewing health insurance or Medicaid from anyone other than a family or friend?" Source: Kaiser Family Foundation Consumer Assistance Survey (March 28 – April 14, 2020)

successful enrollment among lower income populations from 84.9 percent to 93.1 percent.[86] Among those who didn't receive assistance, two-thirds (66 percent) said they would seek consumer assistance if it were available.[87] Consumers cited several reasons for using assistance: they didn't understand their health coverage options (62 percent), the process was too complicated to complete on their own (52 percent), they did not have internet at home (18 percent), they had technical problems with the website (18 percent), or they needed help in another language (15 percent). In a nationally representative survey of assisters, the majority identified similar problems that they work to help consumers address: understanding important financial and nonfinancial considerations beyond premiums, assistance for consumers unable or unwilling to afford plan options, and overcoming limitations for consumers who lack sufficient insurance literacy.[88] Additionally, research has found that recent immigrants or predominantly Spanish speaking individuals, who are among the most likely to be uninsured, tend to prefer to interact directly with a person (e.g., a Navigator) for health information or when enrolling in programs.[89]

Minnesota's state-based Marketplace, MNSure, trained Navigators and CACs and utilized those assisters to conduct additional community outreach, holding regular assistance hours at community centers and places of worship, and also used paper and social media campaigns. In a follow-up evaluation, researchers found that 76 percent of uninsured individuals exposed to the state's outreach activities sought more information about health insurance, and those who gained coverage were almost 7 times more likely to have received in-person assistance during the enrollment process.[90]

From its inception until 2017, the Navigator program had received federal funding in the amount of at least $60 million annually to cover enrollment, outreach, and public education activities in FFM states.[91] Between 2017 and 2020, however, funding for outreach and Navigators was reduced significantly.[92] In 2017, CMS awarded $36.2 million for Navigator grants for PY 2018, which was further reduced to $10 million in the 2019 and 2020 PYs. During this time period, funding for outreach outside of the Navigator programs also decreased by 90 percent.[93] This amounted to $1 spent on advertising per enrollee in 2018, compared to about $11 for 2017 and $5 for 2016.[94] The dramatically reduced investment in federal outreach and enrollment strategies coincided with drops in enrollment. In 2020, 11.4 million people enrolled in Marketplace coverage, a decrease of 1.27 million people from 2016, the year before federal funding cuts.[95] However, this downward trend in outreach spending has been reversed this year, and for the 2022 PY, CMS has made $80 million in grant funding available in grants to Navigators in FFMs.[96] Through the grant awards, 60 Navigator awardee organizations will be able to train and certify more than 1,500 Navigators, quadrupling the number of Navigators in the states using an FFM.[97] In the previously mentioned 2018 GAO study, stakeholders cited Navigator organizations as a factor affecting enrollment and pointed out that the HHS funding reductions in 2018 limited the availability of some Navigator organizations to conduct outreach and assist with enrollment, particularly in rural areas and for consumers with complex circumstances.[98]

Some states have imposed restrictions on Navigators which limit their ability to help certain consumers. For Americans living in states with an FFM, where consumer outreach efforts have been modest to begin with, this chilling effect only makes it harder to learn about the health law and enroll in coverage. For example, 12 states restrict the advice Navigators can offer consumers. Four states bar them from giving advice about the benefits, terms, and features of a particular health plan, despite the fact that federal rules require Navigators to clarify distinctions among plans and assist people in making informed decisions about what coverage to choose. In some instances, state restrictions have led Navigator organizations to withdraw from the program.[99]

Community Outreach

Outreach at the community level includes individual/consumer-level assistance but also focuses on using trusted messengers with a localized message. Partnerships are formed among community organizations, federally qualified health centers, local health centers, hospitals and social workers, faith-based places, and

other trusted local resources who can organize community events.[100] Community Action Agencies' (CAAs) are private and public nonprofit organizations that receive federal funding with roots in their communities and access to vulnerable populations that can help them effectively find and serve the uninsured. CAAs can leverage diverse public and private funding sources to extend outreach and enrollment efforts, providing a holistic approach that combines human services programs with health insurance enrollment.[101]

Community outreach is effective in engaging specific segments of the population with lower rates of coverage. This strategy uses local agencies' existing connections and credibility in the community (including with clients already receiving other public services) to increase access to quality health coverage among populations with low take-up.[102] In a study on different outreach approaches for public health insurance in California between 2001 and 2007, non-technology-based approaches, including media campaigns, provider in-reach, and school-linked approaches such as using school nurses and counselors, yielded a 12 percent increase in new enrollment.[103] More recent research on California has demonstrated the importance of community outreach for diverse populations. A statewide network of Community-Based Outreach, Enrollment, Utilization and Retention in California supports individuals and families in navigating the health insurance system. Organizations in this network often work with low-income populations, mixed status families, and communities of color to support the access, utilization, and maintenance of health coverage. Additionally, enrollers assist individuals with troubleshooting errors and post-application follow-up activities. Enrollers often come from the communities they serve and may be employed as a CAA, Certified Enrollment Counselor (CEC), Navigator, and CAC, at a community-based organization, clinic, or hospital. They also can linguistically support the communities they serve by using Spanish, English, and a number of Asian languages, as Latinos and Asians represent substantial shares of California's Medicaid-eligible and subsidy-eligible population.[104]

Direct Enrollment

Another strategy for Marketplace enrollment in HealthCare.gov states is the Direct Enrollment (DE) program, which allows QHP issuers and web-brokers to enroll consumers in individual health insurance coverage offered through the Marketplace, directly from the QHP issuer or web-broker website.[105] There are two pathways in the DE Program, Classic DE and Enhanced Direct Enrollment (EDE). In Classic DE, consumers start on the QHP issuer or web-broker website and are redirected to HealthCare.gov to complete the application. In EDE, consumers complete the entire enrollment process on the QHP issuer or web-broker website. During the 2021 OEP, the Center for Consumer Information and Insurance Oversight (CCIIO) reported that 37 percent of all plan selections in HealthCare.gov states were made through Classic DE or EDE.[106]

While Classic DE has been an option since the initial 2014 OEP, EDE has only been available since late 2018 when CCIIO began approving entities to use the EDE pathway, which allows QHP issuers and web-brokers to handle the entire Marketplace application process on their respective websites. EDE is intended to provide a comprehensive consumer experience, in which the enrollment is fully completed on the EDE website, using secure data transfers to the federal Marketplace for determinations of a consumer's eligibility for the Marketplace and Medicaid/CHIP, including the calculation of subsidies (if otherwise eligible).[107]

As of August of 2021, CMS lists 43 approved EDE entities, 9 of which are hosting an EDE platform.[108] In the 2021 OEP, 20 percent of plan selections in HealthCare.gov states used the Classic DE pathway, and 17 percent used the EDE pathway. Among new consumers, plan selections in HealthCare.gov states through non-DE channels dropped by about 21 percent during the 2021 OEP, and enrollment through the DE program represented 46 percent of new consumer enrollments on the FFM. [109]

DE is intended to increase ease of enrollment. However, several concerns exist around the ability of the program to protect consumers. While some entities, including one of the largest EDEs, only enroll people in Marketplace plans,[110] other DE entities may expose consumers to additional risks by directing them towards

health plans not subject to the ACA consumer protections. These alternative coverage options that DE entities may offer can impose lifetime and annual benefit limits, require cost-sharing of any amount, leave out ACA essential health benefits, and reject applicants or charge higher premiums based on age, gender, and pre-existing conditions.[111] For example, short-term limited duration insurance (STLDI) plans may charge lower premiums, but are not required to cover pre-existing health conditions, meet minimum medical loss ratios requirements, or cover essential health benefits, and they are not prohibited from discriminating in rating based on gender and health.[112] DE entities may also provide secondary products like vision or accident coverage.[113] Additionally, some DE entities often display products differently than HealthCare.gov and some web-brokers have not displayed premiums and certain other plan details historically. While web-brokers are required to display all plans, they have been permitted to exclude the display of premiums and deductibles and instead can post a standardized disclaimer directing consumers to HealthCare.gov for more information.[114] This practice will no longer be permissible beginning with the PY 2022 OEP; web-broker websites will be required to display QHP comparative information aligned with the information displayed on HealthCare.gov. In addition, QHP issuers are only required to display QHPs they offer in the consumer's area.

By allowing consumers to navigate a single centralized website to view all plans eligible for financial assistance and access tools to compare and enroll in all available plans, HealthCare.gov simplifies the complex application process for Marketplace, Medicaid, and CHIP coverage, as well as assist with Marketplace plan selection. Though some have argued that a decentralized platform and increased choice of enrollment pathways could benefit the consumer, research does not support this assertion.[115] For instance, a study of Medicare Part D plans found that while having fewer than 15 options raised enrollment, having 15 to 30 options did not, and more than 30 options resulted in decreased enrollment.[116] HealthCare.gov also more reliably ensures that those consumers eligible for Medicaid are informed of that fact and directed appropriately. During the 2021 Special Enrollment Period, HealthCare.gov identified nearly 400,000 applicants who were found to be eligible for Medicaid.[117] In contrast to HealthCare.gov, DE entities typically begin the user experience on their websites with a pre-application screening process. Not all DE websites consider and communicate possible Medicaid eligibility. As a result, some consumers eligible for Medicaid that use DE websites may not proceed to completing the eligibility application and therefore may not become aware of their Medicaid eligibility. Most enrollments from DE channels also do not come from consumers visiting websites/web-brokers themselves but come from those assisted by agents and brokers.

Insurance Agents & Brokers

Health insurance agents and brokers are professionals licensed by their state to sell private health insurance to individuals and businesses.[118] According to a CCIIO report, nearly half (approximately 4 million) of all Marketplace enrollees using HealthCare.gov for PY 2020 were assisted by an agent or broker, an increase of 3 percent from PY 2019 and continuing a steady increase from PY 2017.[119] Brokers, similar to assisters or Navigators, can help answer individuals' questions about the Marketplace and financial assistance. Both brokers (53 percent) and assister programs (37 percent) said most clients had questions that were not answered by information on HealthCare.gov.[120]

While both Navigators and brokers can help consumers understand basic insurance concepts, in practice, they have different incentives and often serve different populations. In 2016, 42 percent of assister programs[‡‡] reported most or nearly all clients were uninsured, compared to 8 percent of brokers. Fifty-six percent of assister programs say that most or nearly all clients had income low enough to qualify for Medicaid compared to 30 percent of brokers, and 89 percent of assister programs reported helping individuals eligible for

[‡‡] Assister Programs included: Navigators (those identified by Marketplace officials contracted with and received grant funding directly from the Marketplace), Federal Enrollment Assistance Program (contractors that operate in certain FFM states and that otherwise act as Navigators), Federally Qualified Health Centers (those that received grant funding from HRSA to provide enrollment assistance), and CACs (all other Assister Programs certified to provide assistance in Marketplaces)

Medicaid/CHIP compared to 47 percent of brokers.[121] In addition, only 40 percent of brokers engage in outreach and public education activities compared to 76 percent of assister programs.[122] Brokers were also significantly less likely than Navigators to help individuals who were uninsured, had limited English proficiency, or who lacked internet at home.[123] A quarter of Marketplace assisters with most or all of their clients lacking internet access report that the average individual takes two or more hours to assist and usually require multiple contacts.[124]

Unlike Navigators, brokers are not supported by federal funding. Instead, they earn a commission through private insurance companies for each plan initial enrollment and renewal. Some brokers may only be able to sell plans from specific health insurers. Unlike individual assisters, brokers are not required to remain unbiased and may make a specific plan recommendation to a client, including but not limited to QHPs, such as plans not subject to the ACA consumer protections such as STLDIs and fixed indemnity plans.[125] Per HHS guidance, the standards of conduct for agents, brokers, and web-brokers assisting consumers in HealthCare.gov states include providing consumers with correct information, without omission of material fact, regarding the Marketplace, QHPs, and insurance affordability programs. These standards also include requirements that the agent, broker, or web-broker refrain from misleading, coercive, or discriminatory conduct; provide the Marketplace with correct information; and obtain consumer consent prior to offering assistance.[126]

Brokers earn commissions that differ by plan type and plan premium, and they may be financially incentivized to steer consumers towards specific plans. Brokers have no monetary incentive to redirect eligible consumers to Medicaid/CHIP (which does not pay a commission), and commissions in the Marketplace have declined among QHPs, while health plans not subject to the ACA consumer protections continue to pay a higher commission.[127] In a 2020 report, brokers reported earning a commission of 15 to 20 percent on STLDI plans compared to a 3 to 5 percent commission on ACA plans.[128] In 2020, roughly 1 in 5 Marketplace enrollees who were helped by a broker or commercial health plan representative were offered an alternative health plan not subject to the ACA consumer protections, and one-quarter were offered other policies to buy as a supplement to Marketplace coverage.[129] Moreover, covert testing has highlighted deceptive practices at times used by brokers, such as incorrectly claiming a pre-existing condition or a specific treatment was covered by a STLDI plan.[130,131]

Finally, in contrast to the evidence reviewed earlier on the effectiveness of assisters in boosting coverage rates among eligible populations, the overall impact of private brokers on coverage rates is unclear in terms of the current literature, particularly given that they are less likely to serve people who are medically underserved. However, brokers and agents vary widely in their practices, and these general patterns do not necessarily apply to all of these entities.

Conclusion

Many uninsured individuals are not aware of their coverage options and cite cost and difficulty with the enrollment process as barriers to enroll in coverage. The evidence demonstrates that enrollment strategies such as public information campaigns, individual assistance, and community outreach efforts can be effective at reaching targeted populations, improving consumers' understanding of plans, and increasing enrollment. Research shows that Navigators and consumer assisters can effectively boost enrollment among high need consumers such as low-income individuals, those with limited English proficiency, and individuals lacking internet access. Evidence is weaker on the effectiveness of decentralized approaches, such as the Classic DE and EDE pathways and the use of private brokers, and current financial incentives for these entities may lead consumers to less generous plans that are not subject to the ACA consumer protections. Expanding support for enrollment strategies proven to increase access and take-up of comprehensive coverage can help inform individuals' health insurance choices and reduce the nation's uninsured rate.

APPENDIX

Appendix Table 1. Zero- and Low-Premium Plan Availability for Uninsured QHP-Eligible Non-Elderly Adults by HealthCare.gov State, Pre- and Post-American Rescue Plan of 2021

State	Study Population	$0 Available – Any Metal, %			$50 or Less Per Month Available – Any Metal, %		
		Pre-APR, %	Post-ARP*, %	Percentage Point Difference**	Pre-ARP, %	Post-ARP*, %	Percentage Point Difference**
All HealthCare.gov States	**11,103,000**	**42.5%**	**61.7%**	**+19.2%**	**56.8%**	**73.3%**	**+16.5%**
Alabama	229,000	67.7%	79.7%	**+12.0%**	74.3%	84.8%	**+10.6%**
Alaska	37,000	0.0%	0.0%	**0.0%**	60.4%	77.4%	**+17.0%**
Arizona	389,000	24.7%	53.3%	**+28.6%**	42.1%	65.1%	**+23.0%**
Arkansas	124,000	22.9%	58.0%	**+35.1%**	46.1%	69.7%	**+23.6%**
Delaware	33,000	43.2%	61.4%	**+18.2%**	53.7%	68.8%	**+15.1%**
Florida	1,560,000	46.1%	66.2%	**+20.1%**	58.0%	74.1%	**+16.1%**
Georgia	737,000	46.0%	66.8%	**+20.9%**	59.5%	75.9%	**+16.4%**
Hawaii	22,000	0.0%	0.0%	**0.0%**	42.1%	56.7%	**+14.6%**
Illinois	463,000	0.0%	0.0%	**0.0%**	37.5%	59.5%	**+22.1%**
Indiana	267,000	16.0%	48.6%	**+32.6%**	36.4%	61.5%	**+25.1%**
Iowa	80,000	55.8%	73.5%	**+17.7%**	61.8%	80.8%	**+19.0%**
Kansas	144,000	49.7%	68.5%	**+18.8%**	60.3%	76.2%	**+15.9%**
Kentucky	137,000	39.8%	65.0%	**+25.1%**	55.7%	73.6%	**+17.9%**
Louisiana	193,000	39.6%	60.3%	**+20.7%**	51.2%	69.4%	**+18.2%**
Maine	58,000	0.0%	0.0%	**0.0%**	34.6%	58.7%	**+24.1%**
Michigan	286,000	25.0%	54.1%	**+29.1%**	42.7%	64.4%	**+21.7%**
Mississippi	172,000	28.1%	58.5%	**+30.4%**	48.0%	69.4%	**+21.4%**
Missouri	254,000	45.9%	65.5%	**+19.5%**	58.5%	74.2%	**+15.6%**
Montana	50,000	40.5%	55.8%	**+15.3%**	49.5%	64.3%	**+14.8%**
Nebraska	66,000	64.4%	83.6%	**+19.1%**	73.2%	90.5%	**+17.3%**
New Hampshire	54,000	16.3%	39.1%	**+22.8%**	29.1%	52.8%	**+23.7%**
New Mexico	95,000	33.6%	57.1%	**+23.5%**	48.4%	66.6%	**+18.3%**
North Carolina	643,000	59.1%	76.4%	**+17.3%**	69.0%	81.9%	**+12.9%**
North Dakota	24,000	53.0%	67.0%	**+14.0%**	55.5%	82.2%	**+26.7%**
Ohio	384,000	23.2%	52.7%	**+29.5%**	41.3%	65.3%	**+24.1%**
Oklahoma	238,000	55.7%	73.0%	**+17.4%**	64.7%	78.9%	**+14.3%**
Oregon	166,000	0.0%	0.0%	**0.0%**	43.8%	63.1%	**+19.3%**
South Carolina	285,000	53.7%	71.4%	**+17.6%**	65.5%	77.1%	**+11.6%**
South Dakota	45,000	63.8%	76.9%	**+13.1%**	73.0%	84.6%	**+11.6%**
Tennessee	369,000	50.7%	69.4%	**+18.7%**	62.2%	76.7%	**+14.5%**
Texas	2,730,000	52.8%	69.7%	**+17.0%**	63.1%	76.3%	**+13.2%**
Utah	135,000	52.9%	72.2%	**+19.3%**	66.5%	79.1%	**+12.6%**
Virginia	322,000	36.9%	63.1%	**+26.2%**	54.0%	70.6%	**+16.6%**
West Virginia	56,000	5.7%	34.7%	**+29.0%**	27.3%	56.4%	**+29.1%**
Wisconsin	212,000	40.5%	60.6%	**+20.2%**	52.5%	69.0%	**+16.5%**
Wyoming	42,000	67.4%	81.7%	**+14.3%**	70.0%	86.7%	**+16.8%**

Data Sources: ASPE analysis of American Community Survey, 2019; Marketplace Plan Files for Coverage in 2021
https://www.aspe.hhs.gov/reports/access-marketplace-plans-low-premiums-uninsured-american-rescue-plan

Notes: Catastrophic plans excluded from all analyses; *Rounded to the nearest thousand, and "study population" refers to uninsured QHP-eligible nonelderly adults in HealthCare.gov states; **Rounding may result in slight deviation in listed percentage point difference and the difference in pre-ARP and April 2021 ISSUE BRIEF 8 post-ARP values calculated from the rounded values in the table; # "Post-ARP" only refers to the two subsidy provisions from the ARP examined in this analysis: lowering of max applicable percent of income toward benchmark premiums and extension of APTC to those above 400 percent FPL.

Appendix Table 2. Total Uninsured Population in the United States, Excluding Undocumented Immigrants (2019): Select Demographics and Totals

	U.S. Total
Uninsured (% of population)	26,086,500 (10%)
Age	
Age 0-18	4,032,700 (15%)
Age 19-34	9,946,200 (38%)
Age 35-49	6,904,800 (26%)
Age 50-64	5,202,900 (20%
Income	
<100% FPL	8,684,000 (33%)
100-138% FPL	2,482,800 (10%)
139-249% FPL	6,786,800 (26%)
250-400% FPL	4,492,100 (17%)
400%+ FPL	3,640,100 (14%)
Race/Ethnicity	
Spanish / Hispanic / Latino Origin	7,461,000 (29%)
White Non-Latino	12,291,100 (47%)
Black Non-Latino	4,220,400 (16%)
Asian / Native-Hawaiian / Pacific Islander	986,200 (4%)
American Indian / Alaska Native	434,700 (2%)
Multi-racial or Other	693,100 (3%)
Language in Household (HH)	
No English Speaking Adults	2,242,300 (9%)
English Spoken in HH	22,816,000 (87%)
Spanish Spoken in HH	2,445,600 (9%)
Chinese Spoken in HH	111,900 (0%)
Korean Spoken in HH	51,900 (0%)
Vietnamese Spoken in HH	59,900 (0%)
Tagalog Spoken in HH	20,000 (0%)
Russian Spoken in HH	28,800 (0%)
Other Language Spoken in HH	552,300 (2%)

Source: ASPE analysis of the ACS, https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features

NOTES: Household language columns do not add to 100% because ACS asks respondents whether English was spoken at home and whether a non-English language was spoken at home. Income categorization is done based on the 'health insurance unit" (HIU), which includes adults, their spouses and their dependent children (ages 0-18, plus full-time students under the age of 23.) Estimates are nonelderly population excluding undocumented individuals. Foreign languages in HH (Spanish, Chinese, Korean, Vietnamese, Tagalog, Russian, Other) only apply to people who don't have an English proficient HH member.

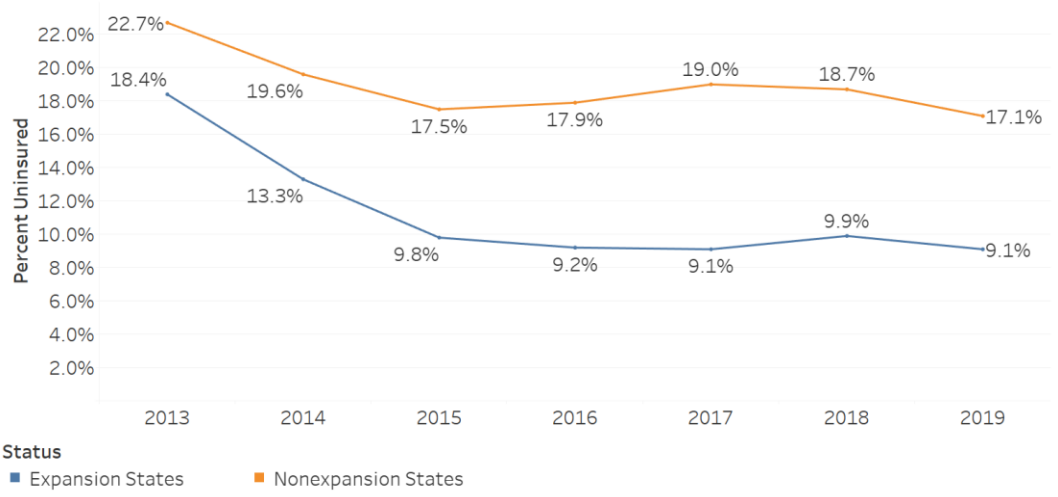
Source: *ASPE analysis of ACS*.

Appendix Table 3. New SEP Plan Selections by HealthCare.gov State, February 15 – August 15

State	2021	2020	2019
All HealthCare.gov States	2,069,596	751,835	554,385
Alaska	4,069	1,460	1,421
Alabama	42,094	13,084	9,243
Arkansas	19,390	6,175	6,107
Arizona	40,827	13,678	13,060
Delaware	5,882	2,583	2,036
Florida	542,067	222,588	152,295
Georgia	147,463	41,138	25,656
Hawaii	4,130	3,014	1,949
Iowa	15,246	6,644	5,875
Illinois	54,432	25,272	22,958
Indiana	27,984	11,810	11,375
Kansas	21,220	7,693	6,124

Source: CMS (2021, Sept.) *2021 Final Marketplace Special Enrollment Period Report.* Accessed at: https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf

Appendix Figure 1. Percentage of adults aged 18–64 who were uninsured at the time of interview, by year and state Medicaid expansion status, 2013–2019



Sources: 2010-2019: Cohen RA, Terlizzi EP, Martinez ME. Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2018. National Center for Health Statistics. May 2019. Available from: https://www.cdc.gov/nchs/nhis/releases.htm.
Notes: For 2013 and 2014, there were 26 Medicaid expansion states including District of Columbia. For 2015, there were 29 Medicaid expansion states. For 2016–2018, there were 32 Medicaid expansion states.

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