Health Coverage Options for the Uninsured

This job aid provides information and guidance for Navigators, Certified Application Counselors (CACs), and Enrollment Assistance Personnel (EAPs) (collectively, assisters) when working with underinsured and uninsured consumers, including options for health insurance and free or low-cost health care.

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Version 1.0. August 2024. This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator assistance personnel in a Federally-facilitated Marketplace. The terms "Federally-facilitated Marketplace" and "FFM," as used in this document, include FFMs where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

Overview

The Affordable Care Act (ACA) has reduced the number of uninsured Americans dramatically. Of those Americans who are insured, over half are provided health insurance through their employers.[i] Others may be covered through Medicaid, Medicare, health insurance offered through the Health Insurance Marketplace®[ii], or the Department of Veterans Affairs. However, many consumers remain uninsured. Some uninsured consumers may be eligible for no- or low-cost health insurance through Medicaid or subsidized health insurance through the Marketplace but may be unaware of those options. Others may be uninsured because the coverage available to them is unaffordable even with Marketplace subsidies, or they may be ineligible for coverage due to immigration status.

Consumers who are underinsured have coverage, but because of high premiums or out-of-pocket costs are unable to meet their share of costs and may skip necessary care. Others may be underinsured because their plans do not cover the extent of services they need. The uninsured rate in 2023 reached an all-time low of 7.7 percent among all U.S. residents, indicating that 6.3 million people have gained health insurance coverage since 2020. An estimated 11.4 percent of adults ages 18-64 and 3.4 percent of children under age 18 were uninsured in Q3 2023. Data from the fourth quarter of 2023 indicates no statistically significant change in the uninsured rate from the previous three quarters of 2023 and a continued steady decline in uninsurance since 2020[iii].Compared to Q1 2020, the uninsured rates for adults and children have decreased by 2.5 and 1.4 percentage points, respectively.[iv]

Coverage Options

Uninsured and underinsured consumers may have different health insurance coverage options to consider. In fact, about half of all uninsured consumers are eligible for but not enrolled in either Medicaid or health insurance coverage through the Health Insurance Marketplace® with financial assistance. As an assister, you should explore these options with consumers.

The Health Insurance Marketplace®

The ACA created the Health Insurance Marketplace® where consumers can shop for and enroll in private health insurance coverage. Most Marketplace consumers are eligible for help paying the cost of their Marketplace plan. Depending on their household income, Marketplace consumers may be eligible for premium tax credits (PTCs) to help pay the costs of their monthly premiums and cost-sharing reductions (CSRs) for help paying their out-of-pocket health care costs like deductibles, coinsurance, and copayments.

Under the ACA, individuals with household incomes between 100 percent and 400 percent of the federal poverty level (FPL) may be eligible for PTCs. The American Rescue Plan Act of 2021 (ARP) and the Inflation Reduction Act of 2022 (IRA) expanded the availability of PTCs to consumers with household incomes above 400 percent of the FPL and capped the amount of a household's income they will pay for a benchmark plan at 8.5 percent.

According to the Health Insurance Marketplaces 2023 Open Enrollment Report, nationwide, 4.6 million more consumers received advance payments of the premium tax credit (APTC) in 2023 compared to 2021. Additionally, 1.4 million consumers reported household incomes over 400 percent of the FPL during the 2023 Open Enrollment Period (OEP). These consumers would not have been eligible for APTC without the expanded subsidies made available through the ARP and the IRA. The average monthly premium after APTC fell by 21 percent, from $164 in 2021 to $129 in 2023, and 35 percent of consumers selected a plan for $10 or less per month after APTC during the 2023 OEP.[v]

In 2022, a new Special Enrollment Period (SEP) became available to lower-income consumers allowing them to enroll in Marketplace coverage or change their Marketplace coverage once per month if they so choose. Consumers who are APTC-eligible and have an estimated annual household income at or below 150 percent of the FPL in their state are eligible for this SEP.

In the 2025 Payment Notice, CMS made this SEP permanent. Previously, it was only available when eligible individuals were expected to contribute zero percent of their household income toward premiums. This SEP is available to consumers with a projected household income at or below 150 percent of the FPL, without regard to the consumer's expected premium contribution. To get this SEP, consumers can submit a new application or update an existing application online, or they may call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

Some consumers may be eligible for even more savings. Individuals with household income between 100 percent and 250 percent of the FPL may be eligible for CSRs for help paying their out-of-pocket health care costs, like deductibles, coinsurance, and copayments. For more information, refer to APTC and CSR Basics.

American Indians and Alaska Natives (AI/ANs) who are members of federally recognized tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders may be eligible for zero or limited cost sharing plan variations. People enrolled in a:

- Zero cost sharing plan:
  - Have income between 100 percent and 300 percent of the FPL.
  - Don't pay copayments, deductibles, or coinsurance when getting care from an Indian health care provider or when getting essential health benefits (EHB) covered by their Marketplace plan.
  - Can get zero cost sharing with a plan at any metal level in the Marketplace.
  - Must agree to have their income verified to enroll.

- Limited cost sharing plan:
  - Have income below 100 percent or above 300 percent of the FPL.
  - Don't pay copayments, deductibles, or coinsurance when getting care from an Indian health care provider.

For more information on zero and limited cost sharing plan variations, visit HealthCare.gov: Health coverage for American Indians & Alaska Natives.

As an assister, you should help consumers determine if they may be eligible for help paying the costs of their Marketplace plan and health care.

Noncitizens who are lawfully present in the United States (U.S.) and meet other basic eligibility requirements may be eligible for coverage through the Marketplace. If they meet the eligibility requirements, they may also be eligible to receive financial assistance through the Marketplace. For more information on helping consumers who are noncitizens, refer to the Assister Guide to the Immigration Section of the Online Marketplace Application.

Easy Pricing Plans Offered through the Marketplace

Within health plan categories (metal levels), some plans are considered "easy pricing" plans, and are identified by a green price tag icon on HealthCare.gov. These plans are also known as standardized plan options. These plans have the same out-of-pocket costs within their health plan category for deductibles, out-of-pocket maximums, copayments, and coinsurance rates for a key set of EHB. They also include a range of benefits before a consumer reaches their deductible. For these easy pricing plans, consumers will only need to pay a copayment for services like primary care visits, urgent care visits, mental health and substance use disorder outpatient office visits, specialist visits, physical therapy, occupational therapy, speech therapy, and generic and preferred drugs – without first needing to meet the deductible.

Catastrophic Coverage Offered through the Marketplace

Catastrophic health insurance plans available through the Marketplace generally have low monthly premiums and high deductibles, but consumers are not eligible for subsidies. Only consumers who are under the age of 30 or who are of any age with a hardship or affordability exemption are eligible to purchase Catastrophic coverage. Catastrophic plans cover:

- The same essential health benefits (EHB) as other Marketplace plans, subject to certain limitations.
- Like other plans, certain preventive services at no cost.
- At least three primary care visits per year before consumers meet their deductible.

For more information on Catastrophic health insurance plans, visit HealthCare.gov: Catastrophic health plans. For more information on how consumers can apply for exemptions through the Marketplace, visit HealthCare.gov: Health Coverage Exemptions.

Short-term, Limited-duration Insurance and COBRA

Short-term, limited-duration insurance (STLDI) is a type of health insurance coverage that is designed to fill temporary gaps in coverage when a consumer is between jobs. These plans are generally less expensive than traditional individual health insurance coverage because they are exempt from requirements for individual market plans under the ACA and, on average, provide less coverage.

What Assisters Need to Know When Discussing STLDI with Consumers

- STLDI plans are offered by many of the same issuers that offer qualified health plans (QHPs) through the Marketplace, although the STLDI plans are not sold in the Marketplace, and consumers are not eligible for financial assistance through the Marketplace for help paying the cost of the coverage.

- STLDI plans are not subject to federal individual market consumer protections and requirements for comprehensive coverage. For example, under federal law, STLDI issuers and plans can deny coverage due to a pre-existing condition or health status and may include annual limits on the amount an insurer will pay for essential health benefits. Assisters should recommend consumers read STLDI plan documents to fully understand what is covered.

- On March 28, 2024, the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) amended the federal definition of STLDI to limit the length of the initial contract term to no more than three months and the maximum coverage period to no more than four months, taking into account any renewals or extensions.

- The revised definition of STLDI realigns the federal definition of STLDI with its traditional role of serving as temporary coverage, helps ensure that consumers can clearly distinguish STLDI from comprehensive coverage, and ultimately reduces the financial and health risks to consumers who would otherwise enroll in this limited coverage as a long-term alternative to comprehensive coverage.

- Consumers who lose their STLDI coverage will not qualify for the loss of coverage SEP to enroll in Marketplace coverage.

- The final rules amended the federal notice standard to help consumers better distinguish between comprehensive coverage and STLDI and get information on their health coverage standards. The revised notice provisions for STLDI apply with respect to coverage periods (including renewals and extensions) beginning on or after September 1, 2024.

COBRA

Another short-term coverage option for employees is Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage, which allows consumers who lose their job-based coverage to keep it, generally at a higher cost, for a period of up to 18 months following a qualifying event, such as termination of employment or reduction in hours.[vi] Assisters should be prepared to help consumers understand their rights or options under COBRA; more information is available at DOL.gov: COBRA Continuation Coverage. Be aware, however, that losing qualifying coverage, like coverage through a job, qualifies consumers for an SEP to purchase a plan in the Marketplace, and you should be prepared to discuss that option with consumers.

COBRA is a federal law that may let a consumer stay on their employee health insurance for a limited time after their job ends. It is generally more expensive than the share the consumer was paying while employed because the consumer is most often responsible for paying the full amount of the premium, including the employer's share as well as their own. If a consumer is eligible for COBRA continuation coverage, they will have an election period of 60 days to enroll. Consumers may only drop COBRA and enroll in a Marketplace plan during Open Enrollment or if they qualify for an SEP.

Medicaid and the Children's Health Insurance Program (CHIP)

Medicaid and CHIP provide free or low-cost health coverage to millions of Americans, including low-income adults, families and children, pregnant individuals, older adults, and people with disabilities. Federal and state governments run both programs jointly, and eligibility requirements and covered benefits vary between states.

Medicaid

To participate in Medicaid, federal law requires states to cover certain groups of individuals. Low-income parents and caretaker relatives, pregnant individuals, children and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups. For a complete list of mandatory eligibility groups, visit Medicaid.gov: List of Medicaid Eligibility Groups.

States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services whose financial eligibility is determined as if they were in an institution, and children in foster care who are not otherwise eligible.

Medicaid eligibility depends partly on whether a state has expanded its program to cover low-income adults.

- All states: A person can qualify for Medicaid based on income, household size, disability, family status, and other factors. Eligibility rules differ between states.

- In states that have expanded Medicaid coverage: A person can qualify based on being a low-income adult. Federal law makes additional federal funding available to states to expand their Medicaid programs to cover certain adults younger than 65 with income up to 133 percent of the FPL (because of the way this threshold is calculated, it is effectively 138 percent of the FPL). Forty states and the District of Columbia have elected to expand Medicaid to cover the adult group. This means that in states that have expanded Medicaid to adults, free or low-cost health coverage is available to individuals with incomes below a certain level regardless of disability, financial resources, and other factors that are sometimes considered in Medicaid eligibility determinations.

- In states that have not expanded Medicaid coverage: If a state hasn't expanded Medicaid, a person's income is below the federal poverty level, and they don't qualify for Medicaid under their state's current rules, they fall into a coverage gap and won't qualify for either Medicaid coverage or savings on a private health plan bought through the Marketplace.

Individuals can apply for Medicaid coverage through their state's Medicaid office or through the Marketplace application. To find Medicaid information for your state, visit Medicaid.gov: Where Can People Get Help With Medicaid & CHIP?. For more information on Medicaid and the Marketplace, visit HealthCare.gov: Medicaid & CHIP coverage and refer to the Medicaid and CHIP Overview assister job aid.

CHIP

CHIP is a joint federal and state program that provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private coverage.

States have the flexibility to adopt their own coverage standards, but they must adhere to certain conditions. A child must be:

- Under 19 years of age;

- Uninsured (determined ineligible for Medicaid and not covered through a group health plan or creditable health insurance);

- A U.S. citizen, U.S. national, or have satisfactory immigration status;

- A resident of the state; and

- Eligible within the state's CHIP income range based on family income and any other state-specified rules.

States also have the option to provide coverage, such as prenatal, delivery, and postpartum care, to uninsured targeted low-income pregnant individuals under the CHIP state plan.

Extended Postpartum Coverage in Medicaid and CHIP

Medicaid and CHIP require that pregnant individuals who were eligible for and enrolled in Medicaid or CHIP (on the basis of pregnancy in CHIP) continue to receive coverage from the last day of their pregnancy through the last day of the month in which the 60-day postpartum period ends.[vii] Medicaid coverage is maintained regardless of any changes in income that would otherwise result in a loss of eligibility. States have the option to extend continuous Medicaid and CHIP eligibility for pregnant individuals from 60 days to 12 months postpartum. As of May 2024, 46 states, the District of Columbia and the US Virgin Islands have elected postpartum extension to 12 months.

Assisters should check with their state Medicaid and CHIP agency to learn whether the state they operate in has extended postpartum coverage for pregnant Medicaid and CHIP beneficiaries and can check this resource for the list of states that have elected to provide this extended postpartum coverage. In states that have extended postpartum coverage, let consumers know that pregnant individuals who are eligible for and enrolled in Medicaid (including during a period of retroactive eligibility) or CHIP remain continuously eligible through the end of their 12-month postpartum period. States that do not elect the extended postpartum coverage option must continue to provide coverage for pregnant individuals in Medicaid or targeted low-income pregnant women in CHIP through the 60-day postpartum period as currently required.

Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Individuals

States may elect to cover children under age 21 (under age 19 for CHIP) and/or pregnant individuals (including during their postpartum period) in Medicaid or CHIP who are lawfully residing in the U.S., including qualified noncitizens that have not yet met the five-year waiting period. Individuals who are eligible for Medicaid or CHIP under this option receive full Medicaid or CHIP coverage. Thirty-eight states, three territories, and D.C. provide Medicaid or CHIP coverage to lawfully residing children and/or pregnant individuals.[viii]

Medicaid Coverage Limited to Treatment of an Emergency Medical Condition

Certain noncitizens, including individuals whose citizenship or immigration status has not been verified, are not eligible to purchase coverage through the Marketplace, even at full cost. Individuals who do not have a satisfactory immigration status or who are qualified noncitizens but have not yet met the five-year waiting period, if applicable, and meet all other eligibility criteria for Medicaid in the state plan are eligible for limited Medicaid coverage to pay for the treatment of an emergency medical condition.

Medicaid and CHIP Unwinding

In March 2020, the Families First Coronavirus Response Act (FFCRA) continuous enrollment condition ensured Medicaid enrollees remained enrolled during much of the COVID-19 pandemic. After the continuous enrollment condition ended on March 31, 2023, states began to resume regular Medicaid and CHIP eligibility renewals, including terminations of coverage for people who are no longer eligible. Those people who are no longer eligible for Medicaid or CHIP coverage, will need to transition to other coverage, such as Marketplace coverage. Therefore, CMS provided additional flexibilities for states and Marketplaces during the unwinding period to help beneficiaries maintain continuity of coverage as they transition off Medicaid or CHIP coverage and into a Marketplace qualified heath plan (QHP). CMS announced a Marketplace Special Enrollment Period (SEP) for qualified individuals and their families who lose Medicaid or CHIP coverage due to the end of the continuous enrollment condition. The Unwinding SEP allows individuals and families in states with Marketplaces served by the HealthCare.gov platform to enroll in Marketplace coverage. Marketplace-eligible consumers who submit a new application or update an existing HealthCare.gov application between March 31, 2023, and November 30, 2024, and attest that they have lost Medicaid or CHIP coverage between the same time period will be eligible for the Unwinding SEP. For more information, please visit Temporary SEP for Consumers Losing Medicaid or CHIP Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition.

For more general information, visit CMS.gov: Moving Forward after the COVID-19 Public Health Emergency.

Free or Low-cost Health Care Options

For individuals who are ineligible for Medicaid or are ineligible for or unable to afford private health insurance coverage, there are government, community, and non-profit options.

Community-based Health Care

- Federally Qualified Health Centers (FQHCs) cover an underserved area or population and offer primary care and additional health services on a sliding fee scale based on a patient's income. They accept private insurance but are required to offer services regardless of a patient's ability to pay. For more information on FQHCs, visit CMS.gov: Federally Qualified Health Centers (FQHC) Center. For a list of FQHC preventive services, visit CMS.gov: Federally Qualified Health Center (FQHC) Preventive Services Chart.
    - Migrant Health Centers (MHCs) are a type of FQHC that provide health care to farmworkers and their families on a sliding fee scale. For more information, visit NCFH.org: Migrant Heath Program.
    - Public Housing Primary Care (PHPC), a type of FQHC, is a program that provides health care services to public housing residents, either on the premises of a housing complex or at another location. For more information, visit NCHPH.org:

Public Housing Primary Care Program. For a list of locations, visit HRSA.gov: Find a Health Center or NACHC.org: Directory of PCAS and HCCNS

- Health Care for the Homeless Program (HCHP), a type of FQHC, is a project that provides health care to people experiencing homelessness. For more information, visit NHCHC.org. To find HCH grantees in your state, visit NHCHC.org: HCH Grantee Directory.

- Rural Health Clinics (RHCs) serve patients in rural areas (13 percent of rural Americans are uninsured; refer to the Assisting Rural Consumers job aid for further information on supporting their health care needs). While RHCs are not required to provide care to the uninsured, many will provide care to the uninsured on a sliding fee scale. For more information on RHCs, visit CMS.gov: Rural Health Clinics Center. For more information on services provided at RHCs, visit CMS.gov: Information for Rural Health Clinics.

- Local volunteer or free clinics exist in many areas to fill gaps in health service provision. These clinics are often free and run by volunteers. They are independent of insurance coverage, and they predominantly serve the uninsured or underinsured. Services provided at different locations may vary. To find a clinic in your area, visit NAFCClinics.org: Find a Clinic.

- Local homeless shelters may also provide free medical services for residents.

- School-based health centers typically provide a full range of age-appropriate health care services and often are operated as a partnership between the school and a community health organization, such as a community health center, hospital, or local health department. For more information, visit BPHC.hrsa.gov: School-Based Service Expansion (SBSE) Frequently Asked Questions.

What Assisters Need to Know When Discussing Community-based Health Care Options

- These options are mostly administered at a state or local level and may have different requirements or qualifications that need to be met for individuals seeking health care services to receive care.

- Some of these community-based health care facilities accept insurance, some charge based on what an individual can pay, and some offer free services.

- Some of these community-based health care facilities increased their use of telehealth support during the COVID-19 pandemic and may still offer consumer access to video conferencing software to use their services.

Prescription Medication Discounts

Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients. This makes vital medications available at reduced costs to vulnerable populations through participating organizations such as:

- Community health centers, such as FQHCs.
- Ryan White HIV/AIDS Program grantees.
- The Hill-Burton Program, which are health care facilities nationwide that provide free or reduced-cost care to those who qualify. A list of facilities participating in the program can be found at HRSA.gov: Hill-Burton Free and Reduced-Cost Health Care.
- Children's hospitals.
- Hemophilia treatment centers.
- Critical Access Hospitals serving rural areas. For more information, visit CMS.gov: Rural Health Clinics and CMS.gov: Critical Access Hospitals.
- Sole Community Hospitals serving geographically isolated regions. For more information, visit Rural Health Information Hub: Sole Community Hospitals.
- Rural Referral Centers (RRCs), high-volume, acute-care rural hospitals treating a large number of complicated cases. For more information on RRCs, visit HRSA.gov: Rural Referral Centers. For a list of RRCs by state, visit NARHC.org: State Rural Health Organizations.

Non-governmental resources for reduced pharmaceutical prices include[ix]:

- NeedyMeds: Lists programs that may provide patients with financial assistance for prescription drugs.
- GoodRx: Compare drug prices, print coupons, and save on prescription medications.
- Medical Assistance Tool: Finds patient assistance programs for prescription assistance.

Generic drugs are generally cheaper than name-brand drugs. Consumers can research to find out if a generic is available for a prescription they need.

If a prescription is only available from a specific drug manufacturer, the manufacturer may offer a manufacturer coupon or Patient Assistance Program (PAP). These are often available to low-income, uninsured, or underinsured consumers.

Additional Health Care Resources

- Retail-based health care clinics can be found at certain chain retail stores across the country. Retail health clinics do not require insurance and charge a flat, upfront fee for services. Services may include primary care, acute care, lab tests, immunizations, preventive care, and physicals.

- Urgent Care clinics have similar upfront costs but are for emergency situations. They are generally less expensive than emergency departments; however, they are not obligated to provide services to patients, even if their condition is life-threatening.

- The Emergency Medical Treatment and Labor Act (EMTALA) requires emergency departments to provide an appropriate medical screening examination to every patient who presents to the emergency room and requests examination or treatment of a medical condition. If the hospital determines that the individual has an emergency medical condition, then the hospital must provide treatment within the hospital's capabilities to stabilize the medical condition. The hospital must treat the patient with an emergency medical condition regardless of health insurance or ability to pay. Hospitals may still bill patients for care provided under EMTALA. For more information, visit CMS.gov: Emergency Medical Treatment & Labor Act (EMTALA).

- Note: The No Surprises Act and implementing regulations require a "good-faith estimate" of medical items or services for uninsured (or self-paying) individuals and establish a patient-provider dispute resolution process for uninsured (or self-paying) individuals, among other provisions. For more information, refer to the No Surprises Act Overview for Assisters, Agents, and Brokers assister webinar and visit Emergency Room Rights and the No Surprises Act Consumer Advocate Toolkit at CMS.gov.

- Charity Care is a program of free or reduced prices for low-income people who are uninsured or underinsured that hospitals or health systems are often required to provide by law. Applications for Charity Care are specific to each health center and are available through financial assistance/billing departments. Charity Care is particularly useful for specialty services that are not available at primary care offices.
- Local and state health departments may provide free or reduced-price screenings and services including:
    - Screening for breast and cervical cancer for age-appropriate low-income, uninsured, and underinsured women.
    - Vaccines for low-income and uninsured children.
    - Colorectal cancer screening for age-appropriate low-income, uninsured, and underinsured men and women.
    - Free sexually transmitted disease (STD) testing and flu vaccines.

- Private organizations may provide copay, coinsurance, or deductible assistance for consumers with financial need. Many of these options exist at the state and local levels. It is worthwhile to search online for local or state organizations that provide additional assistance for underinsured individuals.

- The Health Resources and Services Administration (HRSA) will cover the costs of administering COVID-19 vaccines to underinsured individuals and to uninsured individuals. For more information, visit HRSA.gov: COVID-19 Claims Reimbursement for the Uninsured and HRSA.gov: Provider Relief.

Protections for Uninsured and Self-pay Consumers

The No Surprises Act protects uninsured (or self-pay) individuals from unexpected medical bills. Starting January 1, 2022, a provider or facility has to give an uninsured (or self-pay) individual a good faith estimate of expected charges after an item or service is scheduled or upon request. The good faith estimate will include expected charges for the primary item or service the individual is receiving, as well as for any other items or services that would reasonably be expected to be provided as part of the same scheduled or requested items/services.

Consumers may use a new dispute resolution process if they are uninsured (or self-pay) and get a bill for an item/service that's substantially greater than the expected charges in the good faith estimate.

For more information on these protections, refer to:

- The No Surprises Act webinar
- Understanding the Good Faith Estimate and Patient-provider Dispute Resolution Process assister webinar
- CMS.gov: Ending Surprise Medical Bills
- No Surprises Act Consumer Advocate Toolkit

How Assisters Can Share Information with Consumers

Stay informed. Feel free to pass along new information to other assisters and consumers consistently.

- You can research local clinics, discount programs, and area-specific resources to complement the national programs presented here.
- You can establish relationships with local organizations and departments that provide services to the uninsured.
- You can compile a list of resources to give to consumers you assist.

- Remember that a number of these options have specific requirements that must be met by a consumer in order to receive services.
- Some populations experience eligibility and enrollment barriers including limited choice and access to care, affordability, and barriers to communication. The Serving Vulnerable and Underserved Populations assister training course provides further background on these populations.

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[i] Keisler-Starkey, K., and Bunch, L. "Health Insurance Coverage in the United States: 2020." United States Census Bureau. September 202120212021. Available at Census.gov/library/publications/2020/demo/p60-271.html

[ii] Health Insurance Marketplace® is a registered service mark of the Department of Health & Human Services

[iii] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE). "National Uninsured Rate Q4.'available at ASPE.HHS.gov/sites/default/files/documents/8fc1b15be1d96a55592c62aa35f3a4d0/nhis-q4-2023-data-point.pdf

[iv] Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE). "National Uninsured Rate Q3.' Available at ASPE.HHS.gov/sites/default/files/documents/e497c623e5a0216b31291cd37063df1d/NHIS-Q3-2023-Data-Point-FINAL.pdf

[v] Centers for Medicare and Medicaid Services. "Health Insurance Marketplaces 2023 Open Enrollment Report." Available online at CMS.gov/files/document/health-insurance-exchanges-2023-open-enrollment-report-final.pdf

[vi] Up to 36 months for a dependent following a second qualifying event, such as death or divorce of the covered employee.

[vii] Pregnant and postpartum individuals may also be eligible for Medicaid on another basis, for example, as a parent or caretaker relative or on the basis of disability status

[viii] Centers for Medicare and Medicaid Services. "Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women." Available online at Medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-women

[ix] Note: this is not an exhaustive list of websites and does not constitute a CMS endorsement of any of the listed websites.