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The ACA Marketplace in Texas: Who's Actually Helping Texans Sign Up for Coverage?

*A Look at Brokers, Navigators, Certified Application Counselors, and the
Widening Gaps in ACA Enrollment Help Across Texas*

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Executive Summary

Texas has the second-largest Affordable Care Act (ACA) individual Marketplace in the country, and few enrollees sign up without help. Four in five Texans who select an ACA plan do so through a licensed insurance broker, a share that has grown substantially since the Marketplace's early years and now exceeds that of nearly every other state. Texas Marketplace enrollment has grown more than fivefold since the program began, from roughly 734,000 plan selections in the first open enrollment period in 2014 to approximately 4.17 million in 2026.¹

Enrollment has since declined. After premium subsidies were reduced at the end of 2025, some enrollees did not effectuate coverage and others dropped it, reducing covered lives in Texas to 3.3 million.²

This reliance on brokers changes how access to individual coverage should be assessed. Affordability is one question; the other is whether a family can reach someone, in person or by phone, who can help them choose a suitable plan. The Marketplace is now the largest source of individually purchased health coverage in the state.

This report combines several public datasets (CMS enrollment records, the CMS broker registry, and lists of Navigator and Certified Application Counselor (CAC) sites) to address three questions: where enrollment help exists, where it is thin, and what changes could widen the gaps. Six findings from the data analysis follow.

1. Brokers have become the backbone of Texas Marketplace enrollment.

Broker-assisted enrollment rose from 53% of Texas Marketplace sign-ups in 2020 to 83% in 2026 third-highest share among states using the federally facilitated Marketplace. Over the same period, the number of brokers registered to sell Marketplace plans more than tripled, to over 17,000. In practice, most individual coverage in Texas now runs through this one channel.

2. Rural Texans see similar outcomes with far less enrollment infrastructure.

¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), "Profile of Affordable Care Act Coverage Expansion Enrollment for Medicaid/CHIP and the Health Insurance Marketplace, 10-1-2013 to 3-31-2014: Texas," 2014, <https://www.aspe.hhs.gov/sites/default/files/private/pdf/93801/tx.pdf>; Centers for Medicare & Medicaid Services (CMS), "2026 Marketplace Open Enrollment Period Public Use Files," <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2026-marketplace-open-enrollment-period-public-use-files>; Shao-Chee Sim and Elena M. Marks, "Emerging Trends in Texas ACA Marketplace Enrollment for 2026," Rice University's Baker Institute for Public Policy, April 29, 2026, <https://doi.org/10.25613/FZBA-KD39>.

² Gabby Birenbaum and Dan Keemahill, "Texas' ACA Enrollment Shrinks by 4% After Tax Credit Expiration, New Federal Data Shows," The Texas Tribune, July 9, 2026, <https://www.texastribune.org/2026/07/09/texas-aca-obamacare-health-insurance-effectuation/> (reporting CMS provisional February 2026 effectuated enrollment of 3.28 million Texans).

On a population-weighted basis, rural and urban Texas have nearly identical uninsured rates (17.2% and 17.1%) and similar shares of residents enrolled in a Marketplace plan (13.7% and 14.1%). Rural counties reach those outcomes with about half the broker density (3.21 vs. 6.14 per 10,000 residents) and 7% of the state's registered brokers.

3. Navigators and CACs serve people brokers are not structured to reach, and that safety net is thin.

Unlike brokers, Navigators and CACs are not paid by commission, and Navigators depend on federal grants. Federal Navigator funding has been cut 90% nationally, from \$98 million for the 2024 plan year to \$10 million a year beginning with the 2026 plan year grants issued in late summer 2025.

The CAC network is also concentrated. Texas's 178 CAC sites are run by 51 organizations, and 61 of the 83 counties with any CAC presence rely on a single organization. If one of those organizations withdraws, its county loses its only CAC presence.

4. Federal policy changes are adding friction to the channel Texans now rely on most.

New verification requirements, narrower special enrollment period eligibility, the end of automatic re-enrollment, and a lower bar for terminating a broker's Marketplace agreement are arriving just as Texas has become heavily dependent on brokers. Much of the 2025 regulatory package has since been vacated in federal court and is on appeal. Each change adds paperwork, time, risk, or uncertainty to the broker relationship.

The effects are already visible. One membership organization attributed most of a roughly ten-point drop in its insured rate to the loss of mid-year enrollment opportunities, citing eligible people it could not enroll and premium assistance it could not use. That coverage loss stems from enrollment-period rules, not affordability alone.

5. Help follows population size, not need.

A county's population predicts whether it has any enrollment assistance far better than its uninsured rate does. Assistance is built where enrollment volume justifies the investment, not where need is greatest. That is an expected market outcome, and it identifies where philanthropic or public investment could make a difference.

6. What enrollment practitioners describe

Key informant interviews with enrollment practitioners (brokers and navigators) captured a number of additional observations, comments and opinions which provide additional context and nuance which we include in the report.

Background: Texans Seeking Individual Coverage Rely Heavily on Brokers

Texas Marketplace enrollment has outpaced other states since the program's inception, and two state policy decisions help explain why. First, Texas has not expanded Medicaid, so more low-income adults must look to the Marketplace for coverage. Second, in 2021 the Legislature passed Senate Bill 1296, which adopted a pricing approach known as "silver loading" that maximized federal subsidies and made qualified health plans cheaper for consumers across a wide range of incomes.³

Both decisions pushed more Texans toward the Marketplace. Neither explains how those Texans actually enroll in a state that has more uninsured residents than any other, both in number and as a share of the population.⁴

Enrolling in coverage for the first time is complicated. A typical consumer must compare dozens of plans, check whether their doctors are in network, confirm their prescriptions are covered, and estimate household income closely enough to avoid owing money at tax time. In Harris County, which has more ACA enrollees than any other Texas county, consumers can choose among 119 plans from 7 insurers.⁵ Nationally, roughly half of insured adults report difficulty understanding at least one aspect of their coverage, such as benefits, networks, or out-of-pocket costs⁶. Given that complexity, it is not surprising that brokers have become the main route through which Texans enroll.

Brokers are not the only group certified to help consumers enroll. Navigators and Certified Application Counselors (CACs) play a smaller but important role. All three can legally help a Texan enroll, but each operates under different rules. Table 1 summarizes the differences.

³ Tex. S.B. 1296, 87th Leg., R.S. (2021), <https://capitol.texas.gov/tlodocs/87R/billtext/html/SB01296S.htm>; see also Shao-Chee Sim and Elena M. Marks, "Emerging Trends in Texas ACA Marketplace Enrollment for 2026," Rice University's Baker Institute for Public Policy, April 29, 2026, <https://doi.org/10.25613/FZBA-KD39>.

⁴ U.S. Census Bureau, American Community Survey, 2024 5-Year Estimates, Table S2701, "Selected Characteristics of Health Insurance Coverage in the United States," <https://data.census.gov>; KFF, "Key Facts about the Uninsured Population," <https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/>.

⁵ CMS, Individual Market Medical Qualified Health Plan Landscape File, Plan Year 2026, <https://data.healthcare.gov>.

⁶ Karen Pollitz et al., "KFF Survey of Consumer Experiences with Health Insurance," KFF, June 15, 2023, <https://www.kff.org/affordable-care-act/kff-survey-of-consumer-experiences-with-health-insurance/>.

Three Types of Help, Three Different Rulebooks

	Brokers and agents	Navigators	Certified Application Counselors (CACs)
Compensation	Commission from insurance companies	Federal grants	Not paid directly; hosted by health centers, hospitals, or nonprofits
May recommend specific plans?	Yes; may recommend plans that pay them commission	No; must present all options impartially	No; must act in the consumer's best interest
Training and certification	State insurance license + Marketplace certification	Federal grant program, Marketplace-specific training	Overseen by a CAC Designated Organization
Typical location	Wherever the market supports them; concentrated in cities	Wherever a Navigator grant recipient operates	Health centers, hospitals, and social service agencies

Table 1. How Texas's three enrollment-assistance channels differ.

Navigators, like brokers, help consumers prepare applications and establish eligibility, but they operate under a different standard. They must provide information impartially, may not steer consumers toward a particular plan, and are expected to explain the full range of options. Navigators are funded through federal grants, must complete Marketplace-specific training, and may not have conflicts of interest with any insurer.

CACs fall between the two. Like Navigators, they must act in the best interest of the people they assist; unlike Navigators, they do not receive federal grant funding directly. CACs typically work within hospitals, community health centers, or social service organizations and are overseen by Certified Application Counselor Designated Organizations.

The three channels are not interchangeable, because they tend to serve different populations. Brokers are paid by commission, so their incentives favor high-volume, straightforward enrollments. There is no commission for helping someone in Texas's Medicaid coverage gap (roughly 605 000 adults who earn too little for Marketplace subsidies but too much for Medicaid)⁷, and little additional reward for the time it takes to serve someone who needs translation or lacks reliable internet service. Navigators and CACs exist to serve these

⁷ Sammy Cervantes, Clea Bell, Jennifer Tolbert, and Anthony Damico, "How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible if All States Adopted the Medicaid Expansion?," KFF, July 27, 2026, <https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/>.

consumers, so their presence matters most in the communities where brokers are least equipped or motivated to reach.

The interviews we conducted also identified a structural gap that the maps cannot show. A safety-net organization serving a largely below-poverty caseload does not handle Marketplace enrollment at all, because most of its clients fall below the subsidy threshold in a non-expansion state. Brokers generally handle Marketplace business, not public benefits, and Navigator capacity is increasingly taken up by Medicaid and nutrition-assistance cases. As a result, households under 200 percent of the poverty line that are above safety-net program limits but eligible for subsidies can fall into a gap where no channel is clearly responsible for moving them into coverage.

Finding 1: Brokers Have Become the Backbone of the Texas Marketplace

Texans' reliance on brokers has grown quickly. In the 2020 open enrollment period, 53% of Texas Marketplace enrollees (about 591,000 people) used a broker, already above the national average of 47.8%.⁸ By 2026, the share reached 83%, or roughly 3.46 million of the state's 4.17 million enrollees. Only Florida and Mississippi, both at 86%, rely on brokers more heavily.⁹ Brokers account for a similarly large share of new enrollees and re-enrollees, which indicates they remain involved throughout a consumer's coverage, not only at initial enrollment. Figure 1 shows the growth in broker-assisted enrollment.

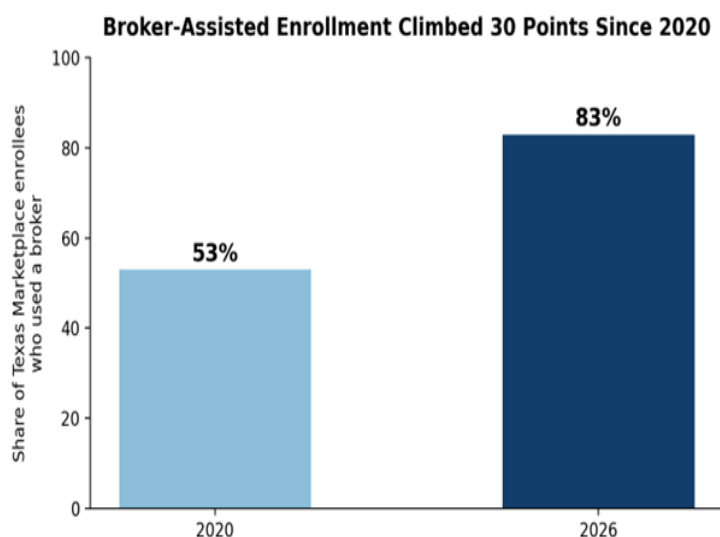


Figure 1. Broker-assisted enrollment share, Texas, 2020 vs. 2026.

The 83% figure should be read with one caveat. Interview respondents from four vantage points (a Navigator, brokers, the enrollment platform, and both issuers) described instances of agent-of-record designations being attached or changed without the consumer initiating a relationship. Issuers reported monitoring agents by National Producer Number and auditing those who drive churn. To the extent this occurs, the broker-assisted share is an upper bound on actual broker assistance.¹⁰

⁸ CMS, "2020 Marketplace Open Enrollment Period Public Use Files," <https://www.cms.gov/data-research/statistics-trends-and-reports/marketplace-products>.

⁹ Centers for Medicare & Medicaid Services (CMS), "2026 Marketplace Open Enrollment Period Public Use Files," <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2026-marketplace-open-enrollment-period-public-use-files> (state-level agent/broker-assisted plan selections); CMS, "Health Insurance Exchanges 2026 Open Enrollment Report," <https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf>.

¹⁰ CMS attributes part of the national decline in agent- and broker-assisted plan selections between the 2024 and 2025 open enrollment periods to system changes that stopped agents and brokers from changing enrollments without

The broker workforce grew with demand. Texas now has 17,152 registered brokers, more than three times the 5,542 registered in 2020.¹¹ Two factors drove this growth. Larger subsidies made selling ACA plans more financially attractive, and online enrollment tools allowed brokers to enroll consumers in minutes rather than through a phone-and-paperwork process. Between 2020 and 2026, broker-assisted enrollment grew by roughly 2.9 million Texans.

The brokers we interviewed described work that enrollment counts do not capture. At larger agencies, enrollment is a small share of the job. These agencies run service operations, separate from sales, that work year-round on premium payments, replacement insurance cards, income and immigration documentation, billing and claims problems, and communication between carriers and the Marketplace. Several stressed that their agents are not seasonal employees. An agent-of-record designation is therefore better understood as an ongoing service relationship than a one-time transaction. Brokers and issuers also told us that clients and new agents are found mainly through referrals within language and immigrant communities, word of mouth, and faith-based and community settings, not advertising. Agents are often recruited from the communities they serve. Figure 2 shows the parallel growth in registered brokers.

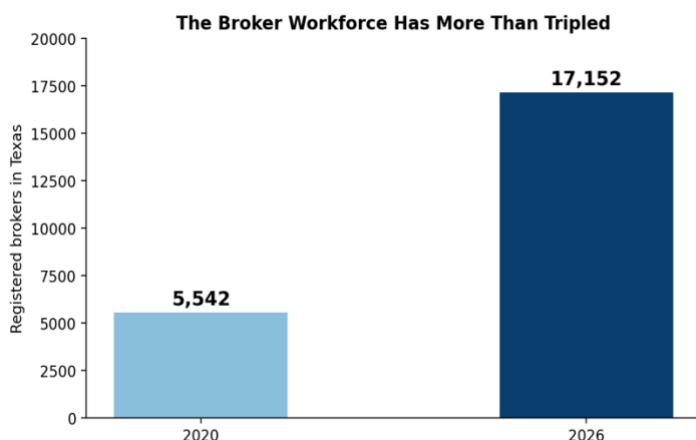


Figure 2. Registered Texas brokers, 2020 vs. 2026.

Additionally, broker registration requires real effort. Brokers must complete Marketplace training, establish a Marketplace Learning Management System profile, maintain an active

consumer engagement. See CMS, “Health Insurance Exchanges 2026 Open Enrollment Report,” <https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf>, 9; CMS, “CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity,” press release, October 17, 2024, <https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity>.

¹¹ CMS, Agent Broker Registration Tracker and Agent and Broker FFM Registration Completion List, data.healthcare.gov (accessed July 20, 2026); see CMS, “Registration and Training for Marketplace Agents and Brokers,” <https://www.cms.gov/marketplace/agents-brokers/registration-training>.

CMS Enterprise Portal account, hold an active license in their state, and have an approved line of authority.¹² That so many have taken on these requirements indicates how central the channel has become to coverage in Texas.

Figure 3 shows total Marketplace enrollment by county, which is concentrated in the major metropolitan areas.

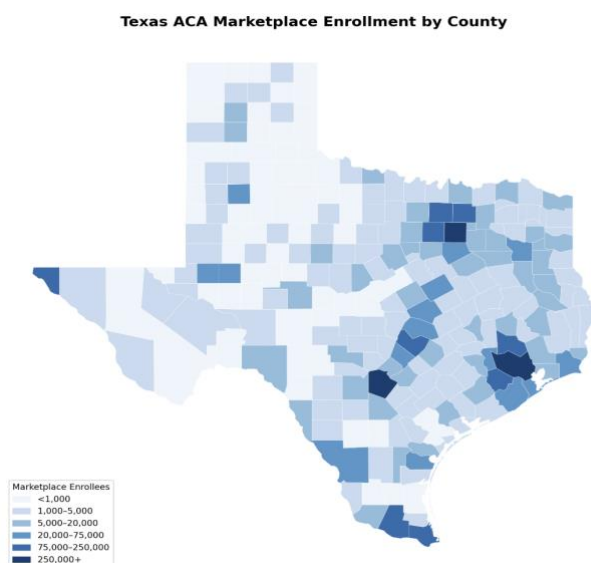


Figure 3. Total Marketplace enrollment by county.

Figure 4 shows the share of enrollees in each county who used a broker. Even in the counties with the lowest reliance, more than half of enrollees used a broker.

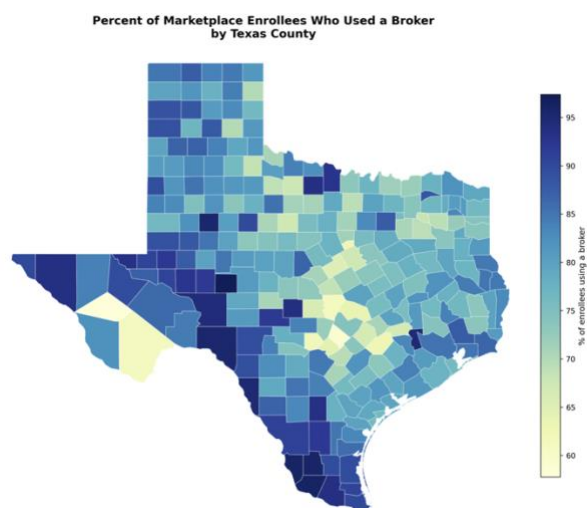


Figure 4. Percent of Marketplace enrollees who used a broker, by county

¹² CMS, "Registration and Training for Marketplace Agents and Brokers," <https://www.cms.gov/marketplace/agents-brokers/registration-training>; CMS, "New Agents' and Brokers' Guide to Plan Year 2026 Marketplace Registration and Training," <https://www.cms.gov/marketplace/agents-brokers/registration-training>

The Field Market Organization (FMO) layer: how brokers reach carriers

Increasingly, another intermediary that enrollment data does not capture sits between the broker and the insurer: the field marketing organization (FMO). An FMO is a licensed insurance distribution entity that contracts with multiple carriers and subcontracts independent agents and brokers under those agreements. Rather than contracting with each carrier separately, an agent contracts once with an FMO, which provides access to many carriers along with compliance support, training, enrollment technology, and marketing tools. Base commissions are broadly comparable to direct contracting, at roughly \$20 to \$30 dollars per member per month, but FMOs add bonuses and agency overrides that direct appointments do not.

The two FMOs we interviewed said this layer has become a primary entry point into the individual market for much of the broker workforce. One, based in Texas, contracts roughly 1,200 independent agents nationally under this model; the other contracts about 300. FMOs therefore sit upstream of the broker-assisted enrollment model described above, shaping which carriers an agent can offer and how quickly a new agent can begin selling.

For plan year 2026, most carriers can be reached through FMOs, and newer market entrants, have used them to build a broker force quickly. Several of these carriers also appoint agents directly or through General Agent and Managing General Agent arrangements, so FMOs operate alongside direct contracting rather than replacing it. The carrier landscape continues to change, and this description reflects 2026.

The national broker and call-center broker channel

Not every broker in the broker-assisted share is a local agent with an office. A substantial share of broker-facilitated enrollment nationally flows through large national brokerages and call centers that reach consumers by phone and online. The enrollment platform we interviewed, which supplies technology many of these brokers use, reported handling roughly two-thirds of broker-facilitated enrollment nationally. One broker described a business model built around providing agents such a platform and connecting them to carriers that do not outreach to agents directly.

An expert broker identified national broker and call-center operations, along with local agents, as a main way enrollment assistance reaches rural Texas. The FMOs we interviewed said call centers are especially common in the Rio Grande Valley and can be effective when they correctly identify a consumer's needs, though they argued that local agents should play a larger role.

Respondents distinguished legitimate national brokers from the fraudulent operations that drew federal enforcement. One expert broker attributed the fraud of recent years (mass, repeated enrollments and misleading advertising, concentrated among call centers targeting Spanish-speaking consumers in markets such as Tampa and Miami) to a specific set of bad actors. She did not attribute it to the established national platforms, several of which are

publicly traded and, in her view, have too much to lose. When federal verification requirements tightened and the year-round enrollment opportunity narrowed, the call-center agents who had exploited it largely moved to other lines of business.

An FMO we interviewed expected the new rules to burden call-center operations more than local brokers. If so, the broker channel may shift toward local, relationship-based agents over the next few years, even as the overall broker-assisted share stays high.

Finding 2: Rural Texans See Similar Outcomes with Far Less Enrollment Infrastructure

Registered brokers (those licensed by the Texas Department of Insurance and registered with CMS to sell Marketplace coverage, which requires annual training and an executed Marketplace agreement) are unevenly distributed across Texas. Five counties (Harris, Dallas, Bexar, Tarrant, and Hidalgo) hold 49% of the state's brokers, and the top 10 counties hold **71.6%**. Harris County alone has 3,726 brokers (*Figure 5*).

Texas Registered Marketplace Brokers by County

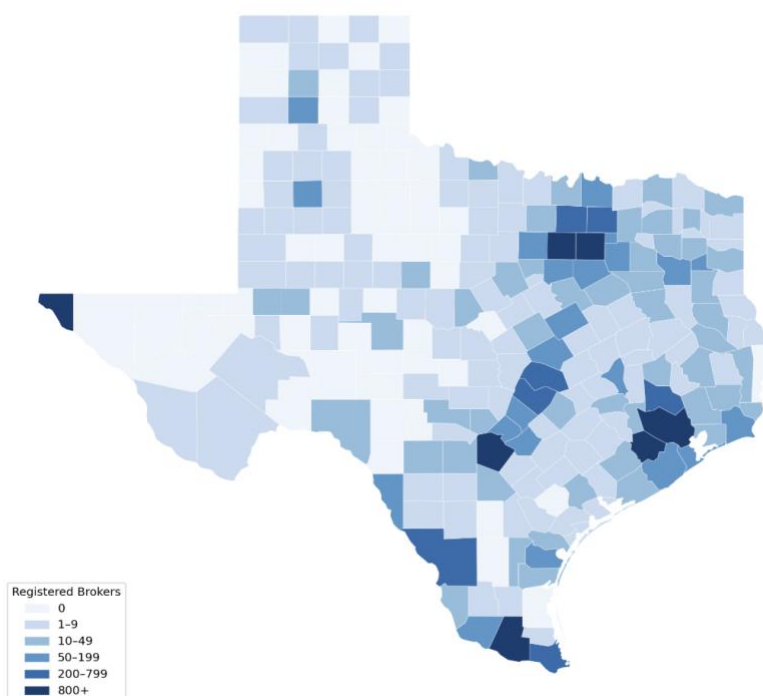


Figure 5. Registered brokers by county.

In less populated counties or rural areas, 30 counties have one registered broker, and **59 of Texas's 254 counties have none. Nearly** a quarter of counties therefore have no locally based broker, although residents can still be served remotely by brokers located elsewhere.

By metropolitan region, brokers are distributed as follows:

Houston and Dallas–Fort Worth together hold nearly 59% of the state's brokers, while more than half of Texas counties share about a tenth. Most brokers are located along the Houston–Dallas/Fort Worth corridor and the I-35 corridor through Austin and San Antonio to the Rio

Grande Valley. West Texas and the Panhandle are almost uniformly pale on the map, consistent with the 59 counties that have no registered broker.

Several counties have among the lowest broker reliance. These include Hays (58.9%), Burnet (61.2%), and Kendall (61.9%) in the Hill Country near Austin, and Jeff Davis (57.8%) and Brewster (61.1%) in far West Texas. One possible explanation is that these faster-growing, higher-income, and more highly educated counties have higher rates of employer-based coverage or direct enrollment.

Region	Share
Houston metro	33.0%
Dallas–Fort Worth	25.8%
Rio Grande Valley	10.0%
San Antonio	8.4%
Austin / El Paso	~5% ea.
151 rural counties	10.5%

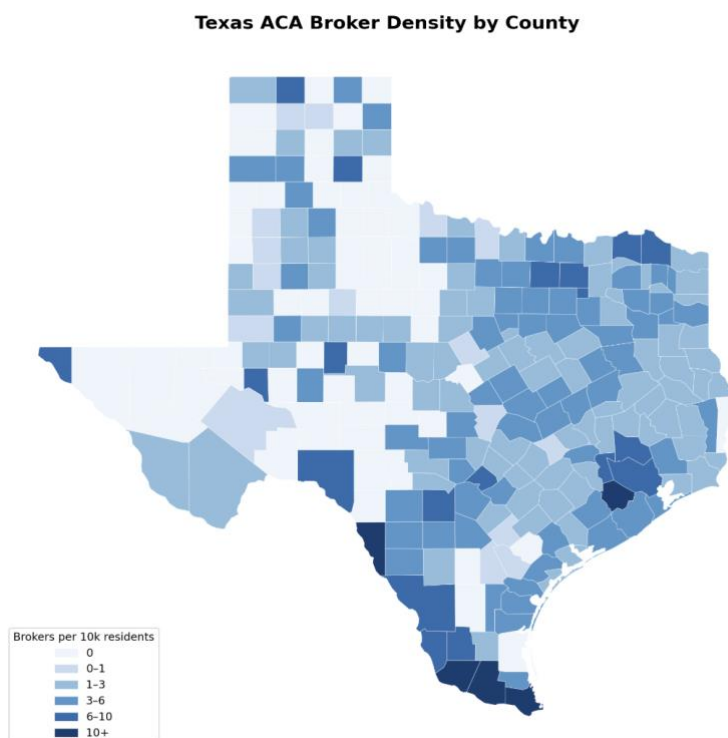


Figure 6. Registered brokers per 10,000 residents, by county.

Statewide, Texas has 5.78 brokers per 10,000 residents. The border region stands out (Figure 6). The 14 Texas–Mexico border counties have 10.99 brokers per 10,000 residents, compared with 5.27 in the rest of the state. They also average 88.7% broker-assisted enrollment, compared with 79.4% elsewhere, and reliance is higher still in Zapata, Starr, Jim Hogg, and Val Verde counties.

The border appears to be a distinct, relationship-driven market, shaped by established broker networks, bilingual service, and community trust more than by the number of brokers present. Broker reliance along the border stays high regardless of how many brokers in a county. The interviews support this conclusion. Brokers described building their books of business through referrals within English as a second language communities, word of mouth, and messaging-

app groups rather than paid advertising, and agents are often recruited from the communities they serve. Both national issuers independently identified the Rio Grande Valley and Spanish-speaking communities as areas of concentrated broker activity.

One caveat applies throughout this section; registration shows that a broker is authorized to sell Marketplace coverage, but not necessarily that this is what occurs. A registered broker may have no Marketplace business in any given year, and one interviewee described an agency that stopped selling individual coverage entirely while its agents remained licensed. County broker counts, which range from 0 in 59 counties to 3,726 in Harris County, should be read as broker capacity, not production.

On its face, the map suggests a serious access problem. The enrollment data are more reassuring; counties with no local broker still have broker-assisted enrollment rates close to those of well-supplied counties. The likely explanation is that brokers serve clients remotely, by phone and online, well beyond the county where they are registered. A rural resident with no local broker can be served by one working from the nearest metropolitan area. Registered-broker maps show where brokers have offices, not whether consumers can reach one.

The interviews generally support this conclusion, with two qualifications. A Navigator closed its rural offices after funding cuts and cited that poor internet connectivity and low trust limit how well virtual appointments may replace local presence and assistance. An expert broker noted that rural provider adequacy limits which plans can be sold in some counties. Remote service works, but not without friction.

Geographic Patterns: Rural and Urban Differences in Broker-assisted Enrollment

Brokers drive most Marketplace enrollment in both rural and urban Texas, but the underlying dynamics differ in ways that matter for access. Urban counties hold 87.6% of Texas's population but 93.1% of registered brokers (15,973 of 17,152). Urban and rural are defined here by a population threshold rather than by any single federal standard as described in the report Appendix.

Rural brokers carry nearly twice the caseload of urban brokers. Urban counties have 191 broker-assisted enrollees per broker, compared with 347 in rural counties. The small rural broker pool is not underused; each rural broker serves about 1.8 times as many clients as an urban broker. The constraint in rural Texas is broker supply, not demand; rural residents rely on brokers as heavily as urban residents but have fewer to turn to.

The interviews independently confirmed this level of reliance. Both national issuers we spoke with estimated the broker share of their Texas business at roughly 80 percent, close to the enrollment data. Table 2 presents the full urban and rural comparison, and Figure 7 plots coverage gaps against broker density.

Rural Texas has 12.4% of the population but only 6.9% of brokers, so urban Texans have roughly twice the broker supply per capita (6.14 vs. 3.21 per 10,000 residents). The rural uninsured rate is roughly 17%, similar to the statewide rate and about double the national rate of 8.6%.¹³ In rural counties, 81.4% of Marketplace enrollees used an agent or broker, ranging from 58% in Jeff Davis County to 97% in Irion County. About 13.7% of the rural population is enrolled in a Marketplace plan. In urban counties, 83% of Marketplace enrollees used an agent or broker, ranging from 59% in Hays County to 94% in Hidalgo County. About 14.1% of the urban population is enrolled in a Marketplace plan.

Despite these differences in density and volume, urban and rural broker-assisted enrollment shares are within a few points of each other overall (83.1% vs. 81.4%), for new consumers (81.7% vs. 77.6%), and for automatic re-enrollment (87.2% vs. 84.5%). Rural Marketplace enrollees are nearly as likely as urban enrollees to use a broker, which supports the conclusion that brokers serve clients across county lines and that the channel remains accessible in rural areas.

The most consequential difference may be in new-consumer enrollment. Brokers enroll 81.7% of new urban consumers but 77.6% of new rural consumers, a difference of about four points. Because new-consumer enrollment is most directly tied to reducing the uninsured rate, this suggests brokers are somewhat less present, or less effective, in reaching first-time enrollees in rural Texas, even though they remain the dominant channel for rural re-enrollment.

Measure	Urban Counties (50)	Rural Counties (204)
Total population	26,027,326	3,669,435
Registered brokers	15,973 (93%)	1,179 (7%)
Overall broker-assisted enrollment share	83.1%	81.4%
New-consumer enrollment via broker	81.7%	77.6%
Auto re-enrollment via broker	87.2%	84.5%
Share of population enrolled in a Marketplace plan	14.1%	13.7%
Uninsured rate	17.1%	17.2%
Broker density per 10,000 residents	6.14	3.21

Table 2. Urban vs. rural comparison across broker-related measures, Texas, 2026.

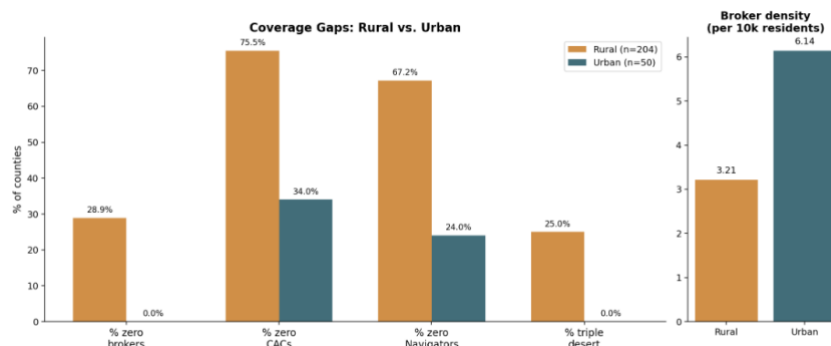


Figure 7. Coverage gaps and broker density, rural vs. urban counties.

¹³ U.S. Census Bureau, American Community Survey, 2024 5-Year Estimates, Table S2701.

Finding 3: Navigators and CACs Fill a Role Brokers Cannot, and This Safety Net Is Fragile

In February 2025, CMS announced that federal Navigator funding would fall 90% nationally, from \$98 million for the 2024 plan year to \$10 million a year beginning with the 2026 plan year. From plan year 2017 through the 2020 open enrollment period, the average broker enrolled between 24 and 35 more consumers than the average Navigator, and Navigator cost-effectiveness appeared to decline over time.¹⁴

A Navigator grantee we interviewed described the effect of the cuts: lost sub-grantee partners, reduced staffing and outreach, withdrawal from rural counties, and a reduction of bilingual assisters to a single Spanish-speaking staff member supplemented by a telephone interpretation line.

Opponents of the cuts argued that, despite their smaller share of enrollment, Navigators and CACs provide services the broker channel does not duplicate, and that the cuts disproportionately harm the uninsured, legal resident immigrants, rural communities, people with disabilities, and people with limited English proficiency. These groups rely on impartial Navigators, who also conduct public education and outreach that falls outside a typical broker's commission-based practice¹⁵.

A funding formula based on enrollment volume and cost-efficiency will favor the channel that specializes in high-volume, low-friction enrollments. That channel is not necessarily best positioned to reach the populations Navigators and CACs are designed to serve. As broker-assisted enrollment grows, it is important to track which vulnerable groups may be further marginalized and how those communities are affected.

The Texas data support this distinction: CAC placement does track need. A statistical model of where CAC sites are located shows that both county population and the local uninsured rate matter, whereas broker presence tracks population alone. This is consistent with CACs typically being hosted by community health centers and hospitals with safety-net missions. Figure 8 maps CAC sites by county.

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

¹⁵ Karen Pollitz et al., "2022 Survey of ACA Marketplace Assister Programs and Brokers," KFF, October 17, 2022, <https://www.kff.org/affordable-care-act/2022-survey-of-aca-marketplace-assister-programs-and-brokers/>.

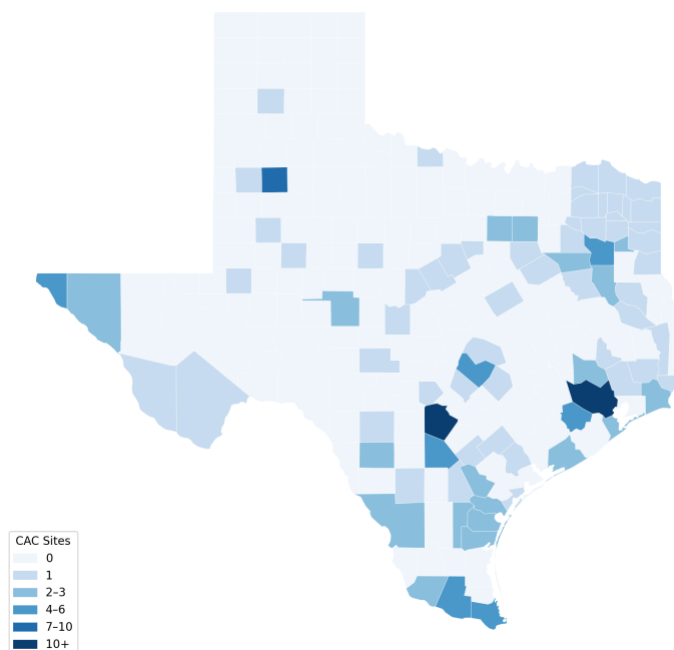
Certified Application Counselor (CAC) Sites by County


Figure 8. Certified Application Counselor (CAC) sites by county.

The CAC network, however, is thin and fragile. Texas has 178 CAC sites, run by 51 organizations and located in 83 of 254 counties, leaving 171 counties with none. Coverage in the remaining counties depends on a few organizations: 61 of the 83 counties rely on a single organization for their only CAC presence. CHRISTUS Health Ark-La-Tex, for example, runs 24 sites across 24 East Texas counties and is the sole CAC provider in 19 of them. If that one health system were to leave the program, roughly a quarter of the counties that currently have CAC access would lose it.

The two channels should be considered separately. CACs are certified rather than federally funded, so the Navigator funding cuts do not affect them directly, and hospital, FQHC, and community organization staff do carry a meaningful share of this work. Our interviews suggest, however, that they are not simply absorbing the gap left by Navigators.

One community organization stopped providing Marketplace assistance after a partner organization's grant lapsed and now refers people elsewhere rather than enrolling them. This type of withdrawal is how a county served by a single organization becomes an unserved county. Interviewees also consistently described weaker ties between channels. Collaboration between Navigators and brokers has largely dissipated, and Navigators and community organizations now generally direct consumers to the federal website rather than to specific brokers.

The strongest case for Navigators came from outside the Navigator program. The enrollment platform and both issuers said Navigators remain necessary for complex cases involving

multiple eligibility questions, particularly where broker economics do not support a local presence.

The expert broker described the difference between the channels as one of scope rather than skill. In her view, Navigators can enroll a consumer in a Marketplace plan but do not attend carrier product rollouts, know carrier representatives, or sell the supplemental products (hospital indemnity, dental, and vision) that make a low-premium, high-deductible plan usable. Their clients may therefore be enrolled but underinsured. Brokers assemble a complete package, while Navigators complete an application. Both perspectives may be accurate, and each channel may be necessary for the populations it serves best.

A ‘triple desert’ has emerged across parts of rural Texas. 51 counties have no Navigator, CAC, or broker coverage at all. Home to about 193,000 Texans, these counties are concentrated in West Texas, the Panhandle, and the Trans Pecos region of the state where populations have not been large enough to attract sustainable assistance infrastructure. (Figure 9).

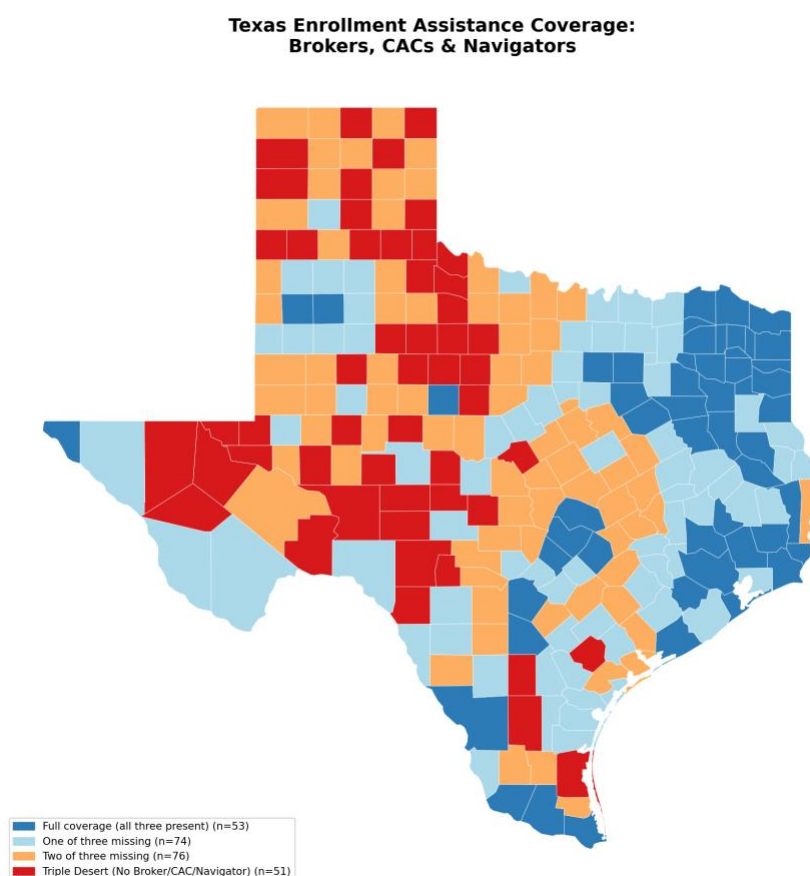


Figure 9. Counties with no broker, CAC, or Navigator presence (“triple deserts”).

Finding 4: As Texas Relies More on the Broker Channel, New Federal Rules Add Friction

Significant federal actions are changing how brokers work. HR 1, the reconciliation bill signed in July 2025 made large rescissions to the Medicaid program over the next decade (approximately \$900 billion) and the current Administration's phasing out of the enhanced premium tax subsidies available to ACA enrollees. The Congressional Budget Office projects that the bill's health provisions will cause 11.8 million Americans to lose coverage by 2034, with 4.2 million of that number tied to the expiration of enhanced premium tax credits that ended December 2025.¹⁶

Separately, the 2025 Marketplace Integrity and Affordability Rule, finalized by CMS in June 2025, directly changed how Marketplace enrollment works. HR 1 writes several similar policies into statute. The distinction is important. Although litigation has blocked or overturned significant portions of the CMS rule, those court decisions do not eliminate similar requirements that Congress separately enacted into federal law through HR 1.¹⁷ The rule is not settled law, and the gap between what it says and what is in force now defines the regulatory environment for brokers. In *City of Columbus v. Kennedy*, No. 1:25-cv-2114 (D. Md.), a coalition of cities, physicians, and small-business groups challenged ten provisions of the rule. On August 22, 2025, three days before those provisions were due to take effect, the court stayed seven of them nationwide, and on September 18, 2025, the Fourth Circuit declined to disturb the stay.¹⁸

In February 2026, Health and Human Services (HHS) itself asked the court to resolve the case so insurers could price their 2027 bids. The court vacated eight provisions on June 12, 2026, in an order amended four days later. The government appealed to the Fourth Circuit on July 16, 2026, and the appeal is pending as of this report's publication. On the same day, in a second case brought by substantially the same plaintiffs, the court stayed provisions of

¹⁶ An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No. 119-21, 139 Stat. 72 (2025); Congressional Budget Office (CBO), "Estimated Budgetary Effects of Public Law 119-21," July 21, 2025, <https://www.cbo.gov>; CBO, Supplemental Cost Estimate, P.L. 119-21, Title VII, Subtitle B, Chapter 1, October 2025, https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_O.pdf; Georgetown University Center for Children and Families, "New CBO Health Coverage Estimates of Budget Reconciliation Law," August 14, 2025, <https://ccf.georgetown.edu/2025/08/14/new-cbo-health-coverage-estimates-of-budget-reconciliation-law/> (noting that CBO's 4.2 million estimate for expiration of the enhanced premium tax credits is separate from its estimate for the law). The enhanced premium tax credits were enacted in the American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9661, and extended through 2025 by the Inflation Reduction Act of 2022, Pub. L. No. 117-169, § 12001.

¹⁷ Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27074 (June 25, 2025), <https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>; An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No. 119-21, 139 Stat. 72 (2025).

¹⁸ *City of Columbus v. Kennedy*, No. 1:25-cv-02114-BAH (D. Md. Aug. 22, 2025) (memorandum opinion granting in part plaintiffs' motion for a stay under 5 U.S.C. § 705), <https://www.courtlistener.com/docket/70684987/city-of-columbus-v-kennedy/>; *City of Columbus v. Kennedy*, No. 25-2012 (4th Cir.); CMS, "RE: *City of Columbus v. Kennedy*, No. 25-cv-2114," <https://www.cms.gov/files/document/info-re-city-columbus.pdf>.

the 2027 Notice of Benefit and Payment Parameters. A parallel challenge in the District of Massachusetts has produced separate rulings, including vacatur of the essential health benefits provision on August 14, 2026.¹⁹

Table 3 summarizes the status of each provision. requirements.

Provision	Source	Status as of August 27, 2026	Applies
Pre-enrollment verification for special enrollment periods	2025 Rule	Stayed Aug 22, 2025; vacated June 12, 2026. Never took effect. On appeal (filed July 16, 2026).	—
Income documentation when attested income conflicts with data sources	2025 Rule	Stayed Aug 22, 2025; vacated June 12, 2026. Never took effect. On appeal.	—
Income-inconsistency window cut from 150 to 90 days	2025 Rule	Took effect Aug 25, 2025; the only provision of the rule that operated in PY2026. Vacated June 12, 2026; CMS reinstated the 60-day extension July 27, 2026. On appeal.	Aug 2025 – June 2026
\$5 monthly charge on fully subsidized auto-re-enrollees	2025 Rule	Stayed Aug 22, 2025; vacated June 12, 2026. Never took effect. On appeal.	—
Issuers may require past-due premiums before new coverage	2025 Rule	Stayed Aug 22, 2025; vacated June 12, 2026. Never took effect. On appeal.	—
Standardized open enrollment period (FFM would have run Nov 1 – Dec 15)	2025 Rule	Vacated June 12, 2026. CMS announced July 27, 2026 that PY2027 FFM open enrollment runs Nov 1, 2026 – Jan 15, 2027.	—
Monthly SEP for those at or below 150% FPL paused	2025 Rule	In effect since Aug 25, 2025. Not challenged. Applies to PY2026 only; CMS also barred income-based SEPs as an exceptional circumstance.	Aug 2025 – Dec 2026
Preponderance-of-the-evidence standard for broker termination (§ 155.220(g)(2))	2025 Rule	In effect since Aug 25, 2025. Never challenged in the litigation, so not affected by the vacatur or the appeal.	Aug 2025 onward
One-year failure-to-file-and-reconcile policy	2025 Rule	Vacated June 12, 2026. Related 2027 Payment Notice provision stayed July 16, 2026; CMS states its prior two-year FTR guidance is no longer valid. Returns under H.R. 1 for PY2028.	—
End of automatic re-enrollment; pre-enrollment verification	H.R. 1 §71303	Statute. Not affected by the litigation.	Plan year 2028
End of eligibility for APTC while verification is pending	H.R. 1 §71303	Statute. Not affected by the litigation.	Plan year 2028
Enhanced premium tax credits	ARPA / IRA	Expired Dec 31, 2025.	Expired
Re-adopted provisions in the 2027 Payment Notice	2027 NBPP	Challenged June 3, 2026 in a second suit (No. 1:26-cv-2215); certain provisions stayed July 16, 2026. Litigation ongoing.	Pending

Table 3. Status of federal Marketplace policy changes affecting brokers, as of August 27, 2026.

¹⁹ City of Columbus v. Kennedy, No. 1:25-cv-02114-BAH (D. Md. June 12, 2026) (order on cross-motions for summary judgment), <https://www.courtlistener.com/docket/70684987/city-of-columbus-v-kennedy/>; Kansas Health Institute, “Hill to the Heartland: What’s Changing and What Hasn’t Changed on the ACA Marketplace, Part 2,” 2026, <https://www.khi.org/articles/whats-changing-and-what-hasnt-changed-on-the-aca-marketplace-part-2/>; Georgetown University Law Center, Health Care Litigation Tracker, “City of Columbus et al. v. Kennedy et al. (Columbus I),” <https://litigationtracker.law.georgetown.edu/litigation/city-of-columbus-et-al-v-kennedy-et-al-columbus-i/>; City of Columbus v. Kennedy, No. 1:26-cv-02215 (D. Md. July 16, 2026) (order granting stay); Katie Keith, “Court Stays Major 2027 Marketplace Changes,” Health Affairs Forefront, July 24, 2026, <https://www.healthaffairs.org/content/forefront/court-stays-major-2027-marketplace-changes>; State of California v. Kennedy, No. 1:25-cv-12019-NMG (D. Mass. Aug. 14, 2026) (memorandum and order), <https://www.mass.gov/doc/aca-gac-win/download>.

As a result, several of the changes described in Table 3 never took effect, one regulation operated for roughly ten months before it was vacated, and others are scheduled to be implemented several years from now.

The following changes directly affect brokers:²⁰

- **Verification before enrollment:** Five special enrollment categories (marriage, adoption, moving, loss of other coverage, and Medicaid/CHIP denial), along with at least 75% of all new special enrollment period sign-ups, would have required verification before coverage could take effect. An enrollment that can now be completed in one sitting would have taken several days. This requirement was stayed before it took effect and was vacated in June 2026.
- **Low-income monthly enrollment window paused through 2026:** The rule paused, through plan year 2026 only, the monthly special enrollment period (SEP) for people with incomes under 150% of the poverty line, which had been one of the more accessible year-round entry points for low-income consumers. This SEP was widely blamed for many of the fraudulent enrollments that followed its creation. CMS also clarified that a change in income does not qualify as an exceptional circumstance, closing an alternative route Marketplaces might have used to offer an income-based SEP. This is one of the few provisions on this list that took effect and remains in force, although it lapses at the end of 2026 unless re-adopted.
- **More income documentation:** Marketplaces would have had to request documentation whenever a consumer's reported income did not match outside data sources. This requirement was stayed in August 2025 and vacated in June 2026.
- **Less time to resolve income-verification issues:** The rule shortened the window to resolve income-verification issues from 150 days to 90, a change CMS itself estimated could cost roughly 140,000 federal-marketplace enrollees their premium tax credit.²¹ Unlike the provisions above, this one was not stayed. It took effect on August 25, 2025, and was the only provision of the rule that actually took effect for plan year 2026. It operated for roughly ten months before it was vacated in June 2026. On July 27, 2026, CMS reinstated the automatic 60-day extension, so the pre-rule 150-day window applies again.²²

²⁰ Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27074 (June 25, 2025), <https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>; CMS, “2025 Marketplace Integrity and Affordability Final Rule,” fact sheet, June 20, 2025, <https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-final-rule>; Pub. L. No. 119-21, § 71303.

²¹ 90 Fed. Reg. 27074 (regulatory impact analysis).

²² CMS, Center for Consumer Information and Insurance Oversight, “Updated Statement Regarding the Failure to File and Reconcile Requirement for Plan Years 2026–2027,” July 27, 2026, <https://www.cms.gov/files/document/fttr-requirement-py26-27-statement.pdf>.

- Lower bar for terminating brokers: CMS lowered the evidentiary standard for terminating a broker's Marketplace agreement, which raises the stakes of every enrollment a broker completes. This provision, at 45 C.F.R. § 155.220(g)(2), took effect on August 25, 2025, and was not challenged in the litigation. It has applied to Texas brokers continuously since then, making it the most durable of the regulatory changes described here.²³
- End of automatic re-enrollment: Beginning in plan year 2028 (and first affecting the open enrollment period in fall 2027), H.R. 1 requires annual re-verification for anyone receiving premium tax credits and ends the practice of granting eligibility while verification is pending. Nationally, about 11 million people, more than half of all returning enrollees, were automatically re-enrolled in 2025.²⁴ Because re-enrollees make up 81.7% of Texas's Marketplace population, a large group that previously renewed passively will need to re-enroll actively each year.²⁵ This change is in statute rather than regulation, so it is the one item here that the litigation does not affect.

The open enrollment period is the clearest example of this confusion. Enrollment professionals we interviewed within days of each other gave conflicting accounts of how long the coming open enrollment period would last. An expert broker said the field still did not know what was changing, because the required consent and authorization forms had not been released even though mass consumer outreach needed to begin.

One broker described the instability directly. Asked when open enrollment ends this year, she answered, "January 15th, for now," and explained that the date had been December 15th until about two weeks earlier. She was not yet sharing the dates with agents in her downline "because we don't have anything" firm to communicate. That an experienced broker who follows the litigation closely could not state the date with confidence shows how much uncertainty the current environment places on the channel.

The same interview also complicates the view that the new rules are simply bad for brokers. The expert broker supported the return of eligibility and income verification as a fraud control, noting that a person "can't just sign up for ACA because they got diagnosed with cancer yesterday." Her objections were to the compressed timelines and to requirements issued too late, and without the necessary forms, to implement well. The burden practitioners describe is less the existence of verification than its timing and administration.

²³ 45 C.F.R. § 155.220(g)(2), as amended by 90 Fed. Reg. 27074, <https://www.ecfr.gov/current/title-45/section-155.220>.

²⁴ CMS, "Health Insurance Exchanges 2025 Open Enrollment Report," <https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf> (10.8 million automatic re-enrollees, 54 percent of returning consumers).

²⁵ Shao-Chee Sim and Elena M. Marks, "Emerging Trends in Texas ACA Marketplace Enrollment for 2026," Rice University's Baker Institute for Public Policy, April 29, 2026, <https://doi.org/10.25613/FZBA-KD39> (approximately 3.41 million returning enrollees, or 82 percent of Texas plan selections, in the 2026 open enrollment period); Centers for Medicare & Medicaid Services (CMS), "2026 Marketplace Open Enrollment Period Public Use Files," <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2026-marketplace-open-enrollment-period-public-use-files>.

Beginning with plan year 2027, the 2025 rule would have shortened open enrollment in the federally facilitated Marketplace to November 1 through December 15, removing roughly a month from the busiest part of a broker's year. The rule would have required every Exchange to open no later than November 1, close no later than December 31, and run no longer than nine calendar weeks; for HealthCare.gov states, that meant November 1 through December 15. The provision was vacated in June 2026. On July 27, 2026, CMS announced that open enrollment for plan year 2027 will run from November 1, 2026, through January 15, 2027, in HealthCare.gov states, including Texas.²⁶

In a state where brokers complete four in five enrollments, a widely misunderstood deadline is a direct risk to coverage. The risk is greatest in rural counties where a single broker or CAC site is the only source of accurate information.

CMS presents these changes as fraud prevention. That framing places much of the compliance burden on the broker channel rather than on people who enroll without help, even though brokers now handle most Texas Marketplace enrollment. With much of the rule vacated and on appeal, the main burden on Texas brokers over the past year has been advising consumers under rules whose status keeps changing, more than any single requirement.

Brokers we interviewed widely believe that fraud by a small percentage of brokers has made it harder than necessary for brokers, and more importantly for enrollees, to obtain and keep coverage. All interviewees (brokers, Navigators, and issuers) support reducing fraud, waste, and abuse, particularly fraudulent enrollments by brokers. Brokers and issuers support working with CMS to develop workable rules to reduce fraud.

²⁶ 90 Fed. Reg. 27074; CMS, Center for Consumer Information and Insurance Oversight, "Updated Statement Regarding the Failure to File and Reconcile Requirement for Plan Years 2026–2027," July 27, 2026, <https://www.cms.gov/files/document/ftf-requirement-py26-27-statement.pdf>.

Finding 5: Help Follows Population, Not Need

The clearest pattern in the data may also be the most addressable. Whether a Texas county has enrollment assistance is explained largely by its population, not by how many of its residents are uninsured and in need of assistance.

Assistance infrastructure in Texas is being built where enrollment volume makes it financially viable, not where need is greatest. This is a rational outcome for a market-based system. Brokers go where the commissions are, and even grant-funded programs tend to concentrate where caseloads justify the investment. It also means the gaps are predictable and therefore addressable. Targeted investments could extend assistance to places where enrollment volume alone will not sustain it. For example, investments could be made to subsidize virtual-broker services, CAC grants targeted to triple-desert counties, or Navigator contracts that give greater weight to geographic need rather than enrollment volume alone.

The interviews explain the mechanism. One agency left the individual market entirely because group business was more financially beneficial and more stable. Brokers and an FMO described commissions that have held flat at roughly \$20 - \$25 per member per month for years, a decline in real terms. Both issuers expected the loss of enhanced subsidies to lead brokers to reconsider whether the market is worth their time. Assistance follows commission potential, and when the economics deteriorate, agencies exit rather than absorb the loss.

Finding 6: What Enrollment Professionals Describe

Alongside the enrollment and registration data, we conducted key informant interviews with brokers, Navigator grantees, community enrollment organizations, field marketing organizations and health plans.

Brokers describe a year-round service relationship, not a point of sale

Broker respondents described enrollment as a small share of their work. As noted in Finding 1, separate from sales, larger agencies maintain service operations, to support people already enrolled. Recurring tasks include following up on premium payments, replacing identification cards, submitting income and eligibility documentation, and escalating disputes with carriers and the Marketplace. One agency reported that its agents also help consumers with needs outside the individual market, including nutrition assistance, housing vouchers, utility assistance, and hospital charity care applications.

Acquisition runs through community networks rather than advertising

Brokers described finding both consumers and new agents through referrals within specific diverse communities, word of mouth, and messaging-app groups rather than paid marketing. Agents are often recruited from the communities they serve and speak the community's language. An assister described the same dynamic less favorably, reporting that consumers are sometimes recruited to purchase an ACA product with incentives such as gift cards and do not always understand what they have agreed to.

Both accounts describe the same structure. The Texas individual market operates through dense, community-based referral networks better than office locations alone, which explain the geographic patterns in Finding 2. This also suggests that language capacity among brokers may now exceed that of Navigators or CACs where one respondent described capacity reduced to a single Spanish-speaking staff member supported by a telephone interpretation service.

The subsidy change moved people between plans, and moved some out of coverage entirely

After the enhanced premium tax credits expired, respondents reported different outcomes depending on whom they served. One large commercial book saw less disenrollment than expected; instead, its plan mix shifted from roughly ninety percent silver to a roughly even split across bronze, silver, and gold.

Respondents serving lower-income populations through non-commissioned channels described a different result. Consumers moved down a metal level to bronze plans, and in some cases, dropped coverage entirely as monthly premiums rose from roughly \$50 per month to \$150 monthly. One membership organization that enrolls members on-site reported that its insured rate fell from approximately 95% to 85% over the year. It attributed most of

that drop not solely to affordability but also resulting from the narrowed enrollment window, which left eligible people disenrolled due to missed enrollment deadlines and premium-assistance funds it could not use. This pattern is consistent with Finding 2; aggregate outcomes can look similar while the infrastructure behind them differs, and coverage losses appear concentrated where assistance capacity is thinnest.

Assistance is segmented by income eligibility, and the handoff belongs to no one

The clearest structural finding concerns households with incomes below 200% of the federal poverty level (\$31,920 for an individual, \$66,000 for a family of four in 2026). A community organization serving a mostly below-poverty population devotes more than half of its application volume to county indigent care coverage and does not assist with Marketplace enrollment at all, because most of its clients fall below the subsidy threshold in a state that has not expanded Medicaid. Its earlier partnership with an organization that *did* provide Marketplace assistance lapsed. The same respondent observed that brokers generally handle Marketplace business rather than public benefits, and that Navigator capacity is increasingly taken up by Medicaid and nutrition assistance cases.

The result is a population that falls between enrollment systems due to financial status; their incomes are too high for the programs that many community organizations are funded to support, yet they are not consistently connected to assistance with Marketplace coverage. This is the functional counterpart to the geographic desert analysis in Finding 3. Assistance may exist within a county, but no organization may be responsible for helping a household move from a Medicaid or other safety-net program denial to subsidized Marketplace coverage.

Commission economics determine who serves the market at all

One respondent described why they exited the market. The respondent described the individual market as volatile, low-margin, and not worth the time and effort. The agency previously wrote individual Marketplace business but moved the responsible staff member to employer-sponsored benefits because group business produces better revenue and more stable client relationships. The same respondent rarely encounters Marketplace-certified brokers in general business networking settings, which suggests that individual-market brokers and group-benefits brokers are largely separate professional groups working different channels. This account is consistent with the pattern described in Finding 5.

Respondents on both sides report unauthorized changes to consumer records

An assister reported an increase in cases in which consumer information was altered, plans were switched, accounts were created without the consumer's knowledge, or assister identifiers were removed from consumer records and replaced. Consumers with limited English proficiency were particularly affected. A broker discussed fraud in the channel openly

and supported, and was already working toward, mandatory authorization requirements, while cautioning that anti-fraud rules could become operationally burdensome.

That respondents with opposing interests raised the same practice independently lends the account weight.

The relationship between channels has deteriorated, but can be improved

Respondents described collaboration between Navigators and brokers that existed in earlier years but has since dissipated. Assistants no longer refer consumers to specific brokers and instead direct them to the federal website. One broker raised concerns about Navigators' knowledge and competency. A third respondent works with brokers on complex individual cases but confirmed this is not standard practice.

Respondents did identify one constructive model. Community organizations and Navigators already screen for eligibility across multiple programs. Under the proposal, they would perform initial triage and refer Marketplace-eligible households to specialized enrollment resources, rather than each channel attempting the full scope of work. Respondents on both sides responded positively to versions of this idea.

Separately, one respondent proposed a nonprofit insurance agency, which would hold agent appointments and earn commission revenue while employing agents with no personal financial incentive tied to enrollment volume or plan selection. The rationale is sustainability: commission revenue continues across political cycles in a way discretionary grant funding does not.

Regulatory uncertainty is already visible in the field

Finding 4 argues that regulatory instability is itself a burden on the assistance channel, and the interviews provide direct evidence. Two enrollment assistance professionals, interviewed within days of each other, gave conflicting accounts of the length of the coming open enrollment period. One correctly stated that the litigation had preserved the November through January window; the other described a much shorter period.

Respondents also described enrollment-period restrictions as a current cause of coverage loss, not a future one. One organization attributed most of the ten-percent decline in its insured rate to the loss of mid-year enrollment opportunities. As a result, eligible individuals remained uninsured, and the organization was unable to use several hundred thousand dollars in available premium assistance to help them obtain coverage.

In anticipation of the end of automatic re-enrollment, a large agency reported that it is training its agents to shift from passive renewal to better insulate its book of business from the change. It acknowledged broader market exposure, suggesting the requirement will be uneven: agencies with established renewal processes may adapt more quickly and be less affected, whereas enrollees who receive little assistance may face greater risk of losing coverage.

Where the Interviews and the Data Converge

The quantitative analysis and the interviews were conducted independently, with one using public datasets and the other drawing on experiences of people working in the enrollment system environment. Comparing the two provides an opportunity to identify where independent sources of evidence arrive at similar findings and therefore provide greater confidence in the conclusions. The tables below indicate where the two methods' evidence converge, where they differ, and where interviews provided information not captured through data review and analysis. To preserve confidentiality, respondents are described by roles and not by name or organization.

Where both methods agree

Finding	In the interviews	In the data
Brokers are the default enrollment channel	All respondents treat brokers as the default route to enrollment; both issuers put the broker share of their own books near 80%.	83% of 2026 Texas enrollment was broker-assisted, up from 53% in 2020.
Assistance follows commission, not need	An agency exited for better-paying group business; commissions flat for years; issuers expect brokers to reassess the market.	County population predicts assistance presence (pseudo- $R^2 = 0.42$); the uninsured rate adds almost nothing.
Border enrollment is relationship-driven	Bilingual agents embedded in Valley and Spanish-speaking communities; both issuers name the same areas.	14 border counties average 10.99 brokers per 10,000 vs 5.27 elsewhere; 88.7% broker usage vs 79.4%.
The safety net is fragile	A Navigator lost rural offices and language capacity after funding cuts; a community organization dropped Marketplace help when a partner lapsed.	178 CAC sites, 51 organizations, present in 83 of 254 counties; 61 of those depend on one organization.
Subsidy loss moved people between plans, and some out	Commercial books traded down metal levels; lower-income books saw outright coverage loss and some migration to non-ACA products.	Texas open enrollment plan selections held near 4.17 million while national enrollment fell; the interviews supply the mechanism.

Where they pull against each other

Question	The tension	How we read it
Are Navigators still needed?	Brokers call the program wasteful; the platform and both issuers call Navigators necessary for complex, eligibility-intersecting cases.	The neutral parties side with need. CAC placement tracks the uninsured rate; broker placement does not.
Does remote service erase the rural gap?	Rural outcomes nearly match urban, yet a rural Navigator reports connectivity and trust limits on virtual service.	The conclusion holds, with a qualifier; the real gap is in new-consumer reach (77.6% rural vs 81.7% urban).

Question	The tension	How we read it
Does the 83% measure genuine broker relationships?	Four vantage points describe agent-of-record designations changing without consumer action; issuers audit it by NPN.	Read 83% as an upper bound on genuine broker assistance, not a precise measure.

Findings only the interviews can show

Finding	Why the data cannot show it
An enrollment-platform layer carries much of broker enrollment and supplies data the federal site does not; estimates of its size diverge sharply.	No public dataset records which platform an enrollment passed through.
Brokers run year-round service operations (payments, cards, documentation, claims, translation) that extend well beyond enrollment.	CMS publishes plan selections, not post-enrollment servicing.
Households below 200% of poverty can fall into a handoff gap that no channel owns.	The data can locate assisters but not observe what happens to a denied safety-net applicant.
Enforcement of broker misconduct is fragmented between CMS and state regulators, with no consistent process.	Regulatory structure is not visible in enrollment data.
The call-center broker model is a distinct channel likely to shrink under HR1's new verification rules.	No dataset separates call-center brokers from local agents, or tracks how rules shift the mix.

Taken together, the interviews serve three purposes: 1) They independently corroborate the central quantitative findings, most notably that assistance is concentrated where the economics reward it. 2) They provide important context to two conclusions that the data alone cannot fully explain, the reach and efficacy of remote rural enrollment assistance and the share of broker-assistance in practice. And 3) They highlight parts of the enrollment system that the datasets cannot capture, field market organizations, technology platforms that support enrollment at scale, year-round service work by brokers, and the gaps in the handoff between eligibility programs.

Conclusions

Four in five Texas Marketplace enrollments now occur through a broker, a share that has risen substantially. At that level, the strengths and vulnerabilities of the broker channel have significant implications for Marketplace enrollment overall. Marketplace coverage has been firmly integrated into the same distribution system brokers use to sell most health insurance in Texas, and Marketplace business is now a meaningful source of brokers' business portfolio. Navigators and CACs continue to serve populations where enrollment volume, commissions, or other market conditions do not provide sufficient incentives for brokers to participate.

On a population-weighted basis, rural and urban counties have nearly identical uninsured rates and Marketplace participation. The difference is in the infrastructure behind those outcomes. Rural counties have roughly half the broker density of urban counties and reduced likelihood of hosting a CAC site. One in four rural counties has no enrollment assistance at all, which is not the case in any urban county. The brokers who serve rural Texas already carry nearly twice the caseload of their urban counterparts. Yet, rural communities are achieving comparable ACA enrollment outcomes with a system that has much less capacity to absorb a disruption.

The distribution of brokers and assisters in Texas is not accidental. The most consistent pattern in the data is that enrollment assistance follows population size and commission potential, not need; a county's population predicts the presence of assistance far more reliably than its uninsured rate does. That is the expected behavior of an enrollment system that optimizes for volume and efficiency.

The coming years will test this system more than any period since the Marketplace began. New verification requirements, stricter special enrollment eligibility, the end of automatic re-enrollment, and a lower threshold for broker termination are arriving as enhanced subsidies have expired and H.R. 1's Medicaid provisions begin to take effect. Each adds friction to the enrollment channels that now handle most of the state's Marketplace enrollment, despite many of the regulatory provisions being struck down, delayed, or required to be implemented several years later.

Safety-net respondents placed the greatest vulnerability not in any single policy change but in how assistance is funded: grant-dependent Navigator capacity declines sharply with each political cycle. However, some solutions to address reduced capacity but increased need of assistance by consumers. Two proposals came up repeatedly in the research: a triage-and-refer model linking community screening to specialized enrollment, and a nonprofit "broker agency" model that would earn commission revenue. Both aim to build assistance that can withstand funding swings by generating revenue independent of a grant cycle.

Recommendations for the Episcopal Health Foundation

Enrollment assistance in Texas follows market economics rather than need, and the safety net meant to offset that is fragile and shrinking. Four recommendations follow, from most immediate and most structural.

Fund the handoff no channel owns. The clearest structural gap involves lower-income households (under 200 percent of poverty), who may be ineligible for Medicaid or other safety-net programs. CACs and navigators may assist families eligible for Medicaid but if these applicants are denied, they are not consistently assisted for Marketplace enrollment. lack the capacity and incentive to refer them to a broker. EHF could pilot a triage-and-refer model in which community organizations screen for eligibility and refer Marketplace-eligible households to specialized enrollment resources. This collaborative proposal was supported by brokers, Navigators, and community organizations.

Invest in assistance that survives the funding cycle. Enrollment professionals identified funding models, not any single policy change, as the greatest vulnerability for consistent assistance and sustainability. Grant-dependent Navigator capacity diminishes with each political cycle, while the commission-funded broker channel is durable although it follows revenue rather than need. EHF could fund the design and testing of models that combine the two, such as a nonprofit “broker agency” that earns commission revenue with every successful enrollment.

Use EHF’s convening power to reconnect the channels. Collaboration between brokers and Navigators has dissipated; the two now rarely refer consumers to each other, and some community organizations will not work with commission-paid agents at all. A neutral, trusted convener can help rebuild these connections in ways neither channel can on its own. EHF could bring brokers, Navigators, CACs, issuers, and community organizations together around a shared, noncompetitive goal such as designing a process to enroll households that currently fall through the income eligibility gaps.

Work with broker-aligned associations and advocacy organizations. EHF could strengthen ties with the broker community through the National Association of Benefits and Insurance Professionals (NABIP), its Texas affiliate NABIP-TX, and Health Agents for America. These organizations have significant influence on state and federal policy regulations specific to the Marketplace and other insurance coverage. EHF and others key stakeholders could work with them to reduce fraud while limiting the harm to enrollees, including those losing ACA coverage.

Appendix: Methodology Notes

County population and uninsured rate figures come from the U.S. Census Bureau's American Community Survey (ACS) 2024 5-year estimates. These are somewhat less current than newer Census releases but more reliable, particularly for small rural counties.

Broker-assisted enrollment figures come from the CMS Marketplace Open Enrollment Period Public Use File for 2026. Beginning in 2026, state- and county-level public use files include agent/broker-assisted plan selection data for states using HealthCare.gov.

Broker registration counts by geography come from the CMS Agent Broker Registration Tracker (data.healthcare.gov), accessed July 20, 2026.

Navigator county coverage was derived from CMS's "2025–2026 Navigator Awardee Summaries" (U.S. Department of Health and Human Services, August 25, 2025).

Rural/urban classification follows a population-based standard: the 50 most populous Texas counties (population greater than roughly 70,000) are classified urban, and the remaining 204 counties are classified rural. Because there is no single federal or state definition of "rural," and the appropriate classification varies by policy area and agency, this report applies a consistent population threshold throughout.

CAC site data were compiled from CMS's public directory of Certified Application Counselor Designated Organizations and geocoded to the county level. Two limitations apply to these counts. Broker registration indicates authorization to sell Marketplace coverage, not active sales in a given year. In addition, no public data source captures enrollment assistance provided by hospital, clinic, or community organization staff who are not certified as CACs. As a result, the counts likely understate some forms of assistance and overstate others.

Federal policy and litigation status is current as of August 27, 2026. It reflects the June 12, 2026, vacatur order in *City of Columbus v. Kennedy*, No. 1:25-cv-2114 (D. Md.), as amended June 16, 2026; the government's July 16, 2026, notice of appeal to the Fourth Circuit; the July 16, 2026, stay affecting the 2027 Notice of Benefit and Payment Parameters; and CMS and HHS guidance issued in connection with the litigation, including guidance issued in early August 2026. Because the appeal is pending, and a parallel challenge remains before the District of Massachusetts, several provisions described in Finding 4 could be reinstated or further narrowed.

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