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Good morning Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the Subcommittee on Health. My name is Peter V. Lee and I serve as the Executive Director of Covered California – California's state-based health insurance marketplace for the individual and small group markets. I am honored to participate in today's hearing. The information and perspectives I will provide are based on six years of experience operating a robust and successful state-based marketplace as well as over twenty years working to make sure the health care better meets the needs of America's consumers. I hope to help inform your deliberations on the measures before you in committee today.

Remarkable Progress Has Been Made Under the Affordable Care Act – But Federal Policy Actions Are Having Significant Negative Impacts on Millions of Consumers in States Across the Nation

Our nation has made historic progress under the Affordable Care Act with millions of Americans across the country gaining access to coverage they can count on through the expansion of Medicaid and health insurance marketplaces since 2014. As a result, rates of uninsured have dramatically decreased and the promise of better access to health care and financial security has been realized by millions of American consumers.

In our state, Covered California has steadily worked to leverage its role in the market to maintain and improve affordability of coverage, promote competition and choice for consumers, and foster improvements in quality and delivery system reform. We have served over 3.5 million California consumers since opening our doors in 2014, by maintaining a very competitive market with 11 contracted health insurance carriers that actively compete based on price and service, developed patient-centered benefit designs that promote value and access to care, and fostered one of the healthiest risk pools in the nation. California's rate of uninsured has been reduced from 17.2 percent in 2013 to an historic low of 7.2 percent in 2017 by using the tools provided under the

Affordable Care Act, including establishing Covered California and the expansion of Medi-Cal, California's Medicaid program. When you count only those currently eligible for coverage — not including individuals who are ineligible for coverage due to their immigration status — California's eligible uninsured rate is roughly 3 percent.

Covered California has also used all of the tools of the Affordable Care Act to build a strong and sustainable individual market that helps keep health care premiums as low as possible. Covered California's 11 contracted qualified health plans (QHPs) vie for consumers based on price and quality. Our significant investments in marketing and outreach have led to strong, steady enrollment and one of the healthiest risk scores in the nation. As a result, individual market health care premiums in California are estimated to be about 20 percent lower than the national average with Covered California's five-year average rate increase below eight percent.

Despite this remarkable progress, we know that there is more work to be done – not only in California, but across the nation. Affordability remains a paramount issue for consumers, especially middle-class Americans who do not qualify for federal financial assistance and must bear the full weight of premiums on their own. These challenges are exacerbated by recent federal policy actions – including the federal elimination of the individual mandate penalty, promotion of short-term, limited duration insurance, and the reduction in marketing and outreach by the federally facilitated marketplace (FFM) – which have chipped away at the integrity of the Affordable Care Act in much of the nation.

These federal actions have contributed to an ongoing decline of enrollment in the FFM. From 2016 to 2018, states served by the FFM experienced a 39 percent decline in new enrollments, decreasing from 4 million to 2.5 million. For the 2019 plan year, the FFM experienced a 16 percent decrease in the number of new enrollees, on top of the 39 percent decrease from the prior years. In contrast, California saw a very modest 9 percent drop in new enrollment between between 2016 to 2018. However, despite maintaining a competitive market, steady enrollment, and a healthy risk mix, California is feeling the effects of these federal policy changes. Earlier this month, Covered California released its "2019 Open Enrollment Early Observations and Analysis," demonstrating that the federal removal of the individual mandate penalty appears to have had a substantial impact in California which experienced a 23.7 percent decrease in new enrollment for the 2019 benefit year.

Additionally, today, Covered California, the Massachusetts Health Connector, and the Washington Health Benefit Exchange released a joint analysis entitled "Exploring the Impact of State and Federal Actions on Enrollment in the Individual Market: A Comparison of the Federal Marketplace and California, Massachusetts, and Washington." This report highlights the stark difference between the experiences of consumers who live in states that have been committed to using the tools of the Affordable Care Act and those who are now relying on the FFM. Since 2014, the cumulative premium increase that consumers in states served by the FFM have risen by 85 percent; while in our three states the increase has been less than half of that increase. Not only does this mean that the federal government is paying literally tens of billions more in premium

support through Advanced Premium Tax Credits than they would have if they'd kept increases to the level of our states — which we estimate to be roughly $35 billion dollars over the past five years — but the biggest impacts are felt by millions of middle class Americans who get no financial help to pay for coverage and have been priced out of coverage due to these federal policies.

The analysis demonstrates the critical role that the federal mandate penalty plays in promoting stability and reducing costs. California and Washington – both of which have used state-specific solutions to build health insurance exchanges that work and maintain very good risk mixes — saw their new enrollment drop significantly in 2019. Conversely, Massachusetts, which has maintained the state-level mandate penalty that they enacted in 2006 and leaned in to expand outreach and promotion for 2019, actually saw increases of over 30 percent in new enrollment for the 2019 benefit year.

In light of the challenges before us, we stand at a time of opportunity. While the Affordable Care Act has provided a staunch framework that has has helped millions of Americans gain access to health coverage and care, American consumers stand to gain from policy efforts to build on the law as it stands today. In his first act as California's governor, Governor Gavin Newsom sent a letter to Congressional leadership that outlined the ways that the Affordable Care Act can and should be improved. States like California, Washington, Massachusetts and many others are working to preserve the gains made and mitigate the impacts of recent federal policy actions in ways that aim to help consumers retain access to affordable, quality coverage.

While Covered California does not take positions on legislation, we do seek to inform the policy discussions with analysis and a real-world perspective informed by our five years of operation. It is in this context that I appreciate the opportunity to provide these comments and welcome a hearing that is looking ahead at how to build on a law that is working well AND needs to be improved.

Woven throughout this testimony are examples of the work states like ours are doing to promote stability and affordability in our marketplaces that can serve as a roadmap for federal policy in both the short- and long-term. In this vein, the legislative proposals before the committee today appear to reflect an effort to build on the Affordable Care Act. Reinsurance, the Navigator program, and the work of state-based marketplaces have each played a vital role in the successful implementation of the Affordable Care Act. I am pleased to provide comment on the policies at the heart of each of these proposals.

A Federal Reinsurance Program Can Effectively Help Stabilize Markets and Lower Premiums for Consumers

One of the most effective ways to help stabilize individual markets throughout the nation is to provide adequate federal funding through reinsurance. By covering a portion of medical costs for enrollees who experience extremely high medical claims, a reinsurance program lowers plan costs thus lowering premiums for all plans sold in the individual market. As a result, reinsurance can have a profound effect on the affordability of coverage, particularly for middle class Americans who do not now

receive federal financial premium assistance because they are above the "cliff" at 400 percent of poverty level and who stand to directly benefit from lowered gross premiums. Additionally, reinsurance gives carriers additional pricing certainty which can help foster carrier participation and more competition in the market.

The Affordable Care Act included a temporary federal Transitional Reinsurance Program for the individual market in years 2014-2016. By providing funding to carriers to offset high cost claims prevalent in a sicker risk mix, the federal reinsurance program fostered carrier participation in the early years of the Affordable Care Act and reduced premiums by more than 10 percent per year (with state and regional variance in the amount of premium reduction experienced). However, the federal Transitional Reinsurance Program expired at the end of the 2016 plan year resulting in higher rates for 2017 in California and other states across the nation. For example, in California the expiration of the federal reinsurance program resulted in a one-time rate increase of approximately 4 to 6 percent as carriers priced for the loss of federal reinsurance funding.

In the absence of a federal reinsurance program, seven states have implemented state-based reinsurance programs to stabilize premium increases in their individual markets using the federal Section 1332 "state innovation" waiver process. Through the 1332 waiver process, states finance the reinsurance program using state funds, with some of the state funding then offset by federal "pass-through" funding based on federal savings generated by premium reductions achieved through reinsurance.

While state-based reinsurance programs may provide a potential means for some states to stabilize markets and reduce premiums, they are absolutely not a viable strategy for many states. State-based reinsurance programs require a significant financial investment by states, and the amount of federal pass-through funding made available to offset that state investment can vary greatly. In February 2019, State Value Health Strategies released a report entitled "State Reinsurance Programs and 1332 Waivers: Considerations for States," which highlights the significant variance in the amounts of federal pass-through funding received by each of the states with federally approved 1332 waivers. The percentage of the state-based reinsurance program covered by federal pass-through funds ranges from a low of 31 percent in Minnesota to a high of 100 percent in Alaska.

While each state is unique in terms of its own market dynamics and ability to invest state funds into a state-based reinsurance program, not having clear and predictable sense of how much federal pass-through funding may be available can put states at financial risk of having to support a significant proportion of the program with state funds. As such, state-based reinsurance programs at best only provide for a patchwork of premium relief across states and full reliance upon state-based reinsurance does not present either a comprehensive, sustainable or equitable solution to affordability and stability issues throughout the nation.

Fostering and encouraging state-based solutions is vital and states that want to pursue a 1332 waiver for state-based insurance should have that option. However, the reinstitution of a federal reinsurance program would be available to all states, regardless

of whether they have the funding or other capability to support a state-based program. This would ensure that all Americans can benefit from the premium reductions and market stability resulting from reinsurance.

Implementing a new federal reinsurance program with sufficient federal funding could greatly reduce premiums in the individual market, both on- and off-exchange. For a specified nominal amount of funding such as $10 billion for 2020, the net cost to the federal government would likely be only about $3 billion since premium reductions due to reinsurance would reduce federal expenditures on premium subsidies by approximately 70 percent of the reinsurance spend. Additionally, because the federal mechanism for calculating reinsurance payments (referred to as the "EDGE server") remains in place and could likely be "turned on" for reinsurance in a matter of months.

A federal reinsurance program makes sense for the individual market. With recent federal policy changes such as the removal of the individual mandate penalty, a 90 percent reduction in marketing and outreach by the FFM, and the promotion of short-term, limited duration insurance and association health plans, the risk mix of the individual market has deteriorated, contributing to higher premiums, especially for the middle class.

In addition, consideration of federal reinsurance for the individual market is warranted because the individual market is unlike that for employer-sponsored insurance (ESI) for either large or small employers. In contrast to the ESI market, many consumers in the individual market may have some income but are unable to work full-time due to some chronic condition. Based on risk adjustment data published by the Centers for Medicare and Medicaid Services for 2015 through 2017, it appears that enrollees in the individual market are approximately 19 percent higher risk than enrollees in the small group market, and the risk difference increased over the three-year period. This is evidence that a longer-term reinsurance program for the individual market is needed to keep premiums more affordable for consumers who do not have ESI and who do not qualify for other government programs.

Federal policymakers are in a position to help stabilize markets across the country by adopting a federal reinsurance program. Federal reinsurance has been the subject of bipartisan efforts to stabilize markets, and has been proven to be an effective tool to keep coverage affordable and foster carrier participation, and thus competition. The legislation before the committee today, H.R. 1425, would provide, starting in 2020, $10 billion annually to states to either establish a state reinsurance program or provide financial assistance to reduce out-of-pocket costs for individuals buying coverage through the exchange. It also would establish a federal reinsurance program in states that do not apply for federal funding, thus offering a federal reinsurance fallback. While Covered California does not promote or take positions on legislation, as a matter of policy, this proposed legislation appears to provide states with the flexibility and choice to leverage federal funds in a way that would best serve their consumers in the most cost-effective way.

While H.R. 1425 would not require a Section 1332 Waiver for implementation by states, I would like to add, however, that to the general extent funding to states is based on the use of the Section 1332 Waivers, there are structural improvements that could be made to that waiver process to truly foster state innovation and allow states to meet their consumers' needs in alignment with the goals of the Affordable Care Act. Under current law, the structure of the waiver requires "budget neutrality" for the federal government over a 10-year period – meaning that total funding under a waiver cannot exceed total funding projected to be spent in the absence of a waiver. This limits the potential for innovation under the waiver. Changes to budget neutrality requirements under Section 1332 that would allow states to use per-member federal costs as a basis for waiver funding would mean that rather than having coverage expansions count "against" state efforts that lower the per-person costs of subsidies as they currently do under the existing budget neutrality construct, budget neutrality would be calculated on a per enrollee basis, not total spending. Given that the work in our state through Covered California has resulted in lower per-member costs to the federal government, and thus significant federal savings, making a change such as this would enable states like California to better innovate and enact policies that would meet the goals of the Affordable Care Act to expand coverage in a cost-effective way.

State-Based Exchanges are Proving Grounds for Marketplaces Done Right

Today, the Committee will deliberate on H.R. 1385 which would provide states with $200 million in federal funds to establish state-based marketplaces. Given that Covered California is a well-established state-based marketplace, this proposal would not impact our state. However, I would like to take this opportunity to highlight the valuable and innovative role that state-based marketplaces can play in helping reduce the rate of uninsured, fostering competition, maintaining a healthy risk mix, helping make premiums more affordable, and driving improvements in quality and delivery system reform.

I'll begin with an oft-stated adage that bears repeating: "all health care is local." State-based marketplaces have the advantage of knowing and understanding their markets and consumers in ways that can optimize performance and lead to good outcomes with regard to enrollment, affordability, and risk mix. Covered California, as well as many other state-based marketplaces, have leveraged the tools of the Affordable Care Act to build strong and sustainable individual markets that have helped drive down health care premiums. In California alone, the result is a competitive marketplace in which a stable group of carriers vie for consumers based on price and quality. Covered California's significant investments in marketing and outreach — which equate to about 1.1 percent of the on-exchange premium and is funded out of our assessment on health plans — have led to more than one million actively enrolled consumers and one of the lowest risk scores in the nation. As a result, individual market health care premiums in California are about 20 percent lower than the national average.

In addition to California, other state-based marketplaces have set models for how successful exchanges work. State-based exchanges have lower risk scores on average than the FFM. [1] As outlined in our comparative analysis of California, Massachusetts and Washington exchanges to the FFM, each of our three states has used state-specific solutions to build health insurance exchanges that work, including:

- Active outreach and marketing.
- State policies that ensure a stable and competitive individual marketplace.
- To varying extents, playing active roles in the certification of QHPs to ensure quality and affordable products.
- Having common patient-centered benefit designs and improved choice architecture to simplify the purchase experience and have consumers focus on price and quality.

The result has been that these three states have been successful at restraining growth in the average benchmark premium, holding average annual increases to less than 7 percent since opening in 2014. During the same period, the FFM average benchmark premiums have grown at an average rate of over 13 percent.[2] In 2019, average benchmark premiums in the FFM are now 85 percent higher than they were in 2014, while the weighted average increase across the three states was 39 percent. Had the FFM experienced the lower premium growth seen in California, Massachusetts, and Washington, the federal government could have seen saved as much as $14 billion in 2018, or cumulative savings of approximately $35 billion, based on reduced expenditures on federal premium subsidies. Additionally, lowered premiums through the FFM could have provided direct savings to millions of Americans who do not receive any subsidies making them less likely to have been priced out of coverage.

Recent changes to federal policy appear to have impacted new enrollment in our three State-based marketplaces. While the FFM has seen new enrollments drop considerably from 2016 to 2018 – a 40 percent drop from 4.0 million to 2.5 million – our marketplaces held steady given the state-based efforts that have driven new enrollment and kept markets stable despite changing policies at the federal level. However, for the 2019 open enrollment, it appears that the loss of the individual mandate penalty has been a significant driver of lower numbers of new enrollment for California and Washington. Both states with healthy risk mixes - saw their new sign-ups drop off significantly, 24 percent and and 50 percent, respectively. The FFM also experienced a 16 percent decline on top of the 40 percent cumulative decline from 2016 to 2018. In contrast, Massachusetts saw a 31 percent *increase* in the number of new sign-ups. A major distinction between Massachusetts and California, Washington, and the FFM is that it had in place since 2006 its own state individual mandate penalty and also adds

[1] Health Affairs (July 2018). National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success.
https://www.healthaffairs.org/do/10.1377/hblog20180710.459445/full/

[2] Analysis of enrollment weighted average benchmark premiums reported by Kaiser Family Foundation (2014-2019): https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/

additional states subsidies for enrollees. The state of Massachusetts invested more in outreach and marketing for the 2019 plan year and — building on a "culture of coverage" where residents know they need to get coverage — residents of the state are the winners.

In California, Governor Newsom and the California State Legislature are actively considering taking action to protect the Affordable Care Act from erosion by federal action by proposing to implement a state-level individual mandate penalty. At the same time, they are also showing notable leadership by proposing additional subsidies to low- and middle-income Californians – including groundbreaking proposals to provide financial assistance to individuals with household incomes up to 600 percent of the federal poverty level. If enacted, this policy would make California the first in the nation to address the subsidy "cliff" by providing financial help to those members of the all-too-often forgotten middle class who currently bear the full cost of coverage all on their own.

Covered California has helped inform these state policy efforts by developing policy options that can improve affordability and expand upon the progress we have made in our state. On February 1, 2019, Covered California released a report entitled, "Options to Improve Affordability in California's Individual Health Insurance Market," which outlined modeling and analysis of the impacts of various state-based policies to improve affordability including a state individual mandate penalty, premium and cost-sharing subsidies, and reinsurance. I will note that while California and other states are charting a path forward with these efforts, in many instances these types of policies are better done at the federal level — as reflected in Governor Newsom's letter to Congress. When we completed this report for the Governor and California's legislature, we also sent it via a letter to Congressional leadership sharing our work with the hope that it may serve as a roadmap for federal policymakers to the extent Congress presses forward on health care policy in both the short- and long-term for the benefit of all Americans.

Finally, in light of your consideration of the policy merits of H.R. 1385, I'd like to take this opportunity to share some of the core elements specific to Covered California that serve as examples of a marketplace done right:

- ***Curating a competitive marketplace that promotes affordability and value for consumers***
  Covered California actively negotiates with its contracted QHPs in an effort to keep premiums affordable, ensure access to care by consumers, and promote competition among carriers that fosters choice and value for consumers. Covered California's patient-centered benefit designs, which are designed to encourage access to care – including access to outpatient services outside of deductibles – promote enrollment and retention, and result in Covered California QHPs competing on price, provider networks, and service, all to the benefit of consumers.

- ***Advancing improvements in quality and delivery system reform***
  Since its inception, Covered California has set forth standards and requirements for quality improvement and delivery system reform in its contracts with its qualified health plans with the goal of lowering costs and making sure consumers

get the right care, at the right time and in the right setting. These requirements, which exceed those set by the Affordable Care Act, aim to address underlying costs of health care and promote better quality. For example, our qualified health plans are required to work toward improving health outcomes and patient safety, prevent hospital readmissions and reduce medical errors and health disparities. Covered California is currently in the process of revising its quality improvement and delivery system requirements for QHPs. We recently issued a report entitled, "Covered California's Efforts to Lower Costs While Ensuring Consumers Get the Right Care at the Right Time," which provides an early look at the results of Covered California's work to improve care and promote better quality while reducing costs. I would be happy to provide a copy to the committee which could help inform congressional discussions about how to address rising costs of health care and delivery system reform.

- ***Investing in marketing and outreach***
  While the federal government has significantly reduced its marketing investments, Covered California has continuously made major investments in marketing and outreach leading to steady enrollment, one of the healthiest risk mixes in the country, and lower premiums. In its landmark report, "Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," Covered California outlines that selling health insurance is uniquely challenging and that while sick people are motivated to buy health insurance, healthier people need to be reminded, nudged and encouraged. Marketing is necessary to overcome innate biases that discourage consumers from purchasing something that does not provide immediate returns. A recent analysis, "National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success," cites Covered California's high marketing and outreach spending and efforts as being associated with its better risk scores and a contributing factor to its success in stabilizing the individual market both on- and off-exchange.

While there are many opportunities for the FFM to use existing evidence and itself implement these policies, there is evidence indicating that state-based exchanges perform well when they leverage tools and resources in innovative ways to reach and serve consumers. The state-based marketplaces that are in existence today benefited from receiving federal "establishment funds" to help start up in the early years of ACA implementation. Federal establishment funds expired, and today no state-based marketplace receives federal funds in order to operate. However, it is not clear that states would have made the early investments required to create the new state-based marketplaces that have taken shape over the past eight years, had it not been for early federal support.

Many states may be very interested in receiving federal support to inform their decisions about whether or not to establish their own state-based marketplaces that would serve in the best interest of their residents and leverage their own innovations to provide affordable and sustainable options for health care. In addition, the bill gives states until 2024 to implement a self-sustaining state-based marketplace — essentially allowing

them the opportunity to build from lessons learned from other states. To the extent that the federal government can continue to foster the laboratory of the states through state-based marketplaces, providing states with support that gives them the latitude to develop and establish their own state-based marketplace has the potential of going a long way in boosting consumer enrollment in the health insurance marketplace.

Navigator Funding and Program Requirements

As the committee deliberates H.R. 1386 which would fund the Navigator program for the FFM $100 million per year, among other provisions, I would refer back to California's experience which shows that a stable individual insurance market does not just happen on its own – investments in marketing, outreach, and enrollment assistance play a vital role in maintaining enrollment and attracting healthy risk which in turn can lower premiums, encourage carrier participation, and foster stable markets. Under the Affordable Care Act, Navigator programs provide outreach, education, and enrollment assistance to consumers eligible for marketplace coverage and are funded by marketplaces. Navigator grantees play an important role in the constellation of service channels facilitating marketplace enrollment, particularly among traditionally "underserved" populations.

In 2017, CMS reduced funding for Navigator programs serving states in the FFM by 43 percent, from $63 million awarded in 2016 to $36.1 million for 2017. On a state-by-state basis, the funding reduction ranged from 0 percent to 96 percent from the amounts Navigator grantees were expecting for the 2017-18 program year.[3] CMS also reduced all other marketing expenditures by 90 percent, from $100 million in advertising in 2017 to $10 million for 2018. On September 12, 2018, CMS released funding awards for Navigators serving consumers in the FFM which reduced funding to $10 million. Compared to 2016, federal Navigator funding for the 2018-19 program year reflects an 84 percent reduction. The number of Navigator grantees serving the FFM states was 104 in 2016 compared to 40 for the 2018-19 year.

In California, we have a Navigator program that complements and supplements the work of over 12,000 certified licensed agents. Our competitive grant program for Navigators has selected organizations rooted in communities throughout the state serving distinct and diverse populations, many of which require one-on-one assistance delivered in culturally and linguistically appropriate ways. As such, Covered California's investments in the Navigator program have generally held steady between 2016 to today. In 2016, funding for the Navigator program in California was $7.1 million. For 2018-19, Covered California allocates approximately $6.5 million (reflecting approximately 0.08 percent of the premium dollar) to 102 grantees (42 lead Navigator entities and 60 subcontractors). In 2018, approximately 2.5 percent of Covered California enrollees, roughly 40,000 consumers, were enrolled in Covered California through Navigators, with about 3.5 percent (about 60,000) being enrolled through our uncompensated but supported Certified Application Entities.

[3] Kaiser Family Foundation. September 2018. *Data Note: Further Reductions for Navigator Funding in Marketplace States.* https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/

Navigators are part of a comprehensive investment by marketplaces and others in consumer acquisition. In addition to Navigator programs, Covered California makes significant investments in marketing and advertising; digital advertising and engagement; earned media, quality customer service through our Service Centers; support for licensed and certified agents and brokers; patient-centered benefit designs that provide value; and many efforts to provide a positive consumer experience. In addition, Covered California's QHPs make investments to attract and retain enrollment through competitive pricing, marketing, agent commissions and others.

As the committee evaluates the goals and merits of increased Navigator funding, it should consider the valuable role Navigators play in providing outreach, education and enrollment assistance to consumers in need. The committee should also consider how the Navigator program fits with within the comprehensive efforts across marketplaces, agents and brokers, carriers, and others promoting coverage and providing enrollment assistance as it determines the level of federal funds for the program.

Additionally, the proposed legislation would impose new requirements related to Navigators, both those serving the FFM states as well as state-based marketplaces. One such proposed provision would prohibit the U.S. Department of Health and Human Services (HHS) from taking into account a Navigator entity's capacity to provide information related to association health plans or short-term, limited duration insurance in awarding grants. In California, a new law[4] taking effect this year bans the sale of short-term, limited duration insurance in the state, so our Navigator grantees would not be allowed to enroll individuals into such plans. However, with federal policies promoting the sale of short-term, limited duration insurance and association health plans as cheaper alternatives to the comprehensive coverage consumers can purchase through the marketplace, this provision appears to be timely and relevant to others states throughout the nation.

Short-term, limited duration insurance does not need to comply with the consumer protections of the Affordable Care Act, allowing these policies to deny coverage based on pre-existing conditions or other factors. Additionally, contrary to the comprehensive coverage guaranteed to be issued under the Affordable Care Act, this type of insurance generally covers a limited set of services and can include annual and benefit limits. The promotion of this type of coverage can not only leave consumers who purchase it vulnerable to health and financial risk when they need care, it can also have negative impacts to individual markets where they are sold. These products lead to the siphoning of healthy individuals out of the marketplace as they may take the risk of buying cheaper coverage with limited benefits. This will leave sicker enrollees who need the protection of comprehensive coverage in the marketplace, which creates adverse selection and can drive up premiums for everyone.

While it is unclear to what degree Navigator entities would promote short-term, limited duration insurance or association health plans given their general commitment to the

[4] Senate Bill 910 (Hernandez, Chapter 687, Statutes of 2018), commencing January 1, 2019, prohibits a health insurer from issuing, selling, renewing, or offering a short-term limited duration health insurance policy, as defined, for health care coverage in California.
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB910

goals of the Affordable Care Act, this issue merits consideration as you deliberate on this legislation.

Conclusion

I will close my testimony by stating that, as a nation, we are at a pivotal time in health care. This subcommittee and all members of Congress will be faced with challenging decisions that will have real and significant impacts on the lives of Americans throughout the country. Having served as the only Executive Director for Covered California, I have been witness to both the remarkable achievements made thus far, as well as challenges overcome as our state-based marketplace moved from being start-up to now being a robust, financially solid, successful exchange serving millions. Despite some of the contentions around the passage of the Affordable Care Act, it is fair to say that the Affordable Care Act is the most significant health care-related legislation since the establishment of Medicare and Medicaid in 1965. Like Medicare, the Affordable Care Act was not perfect upon enactment. Also like Medicare — which has been revised many times — it can and should be reviewed, revised and improved. To the extent that federal policy discussions can shift toward building on the progress of the Affordable Care Act, we are hopeful that the work of Covered California and other state-based marketplaces can serve as a roadmap for the nation.

Again, I would like to thank the committee for inviting me to testify on this set of timely and relevant proposals. I am honored to represent Covered California, and always aim to help inform the health policy dialogue at both state and federal levels. To that end, I encourage you to use Covered California as a resource, and do not hesitate to reach out to us if we may provide you with any information or lessons learned that can assist you as you consider health care proposals that come before you in Congress.

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