

October 2, 2026

The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Subject: Request for Information: Health Coverage That Works for Everyone

Dear Ranking Member Wyden,

Thank you for issuing the Request for Information (RFI): Health Coverage That Works for Everyone. This RFI is particularly timely as health care consumers and stakeholders navigate an increasingly complex and challenging health care environment in which federal policy decisions directly affect whether consumers can obtain coverage and care that is affordable, accessible, and of sufficient value to meet their needs. This RFI provides a valuable opportunity to consider policy approaches that can improve coverage and affordability while preserving the flexibility needed to respond to the needs of different states and populations.

As background, Covered California is the largest state-based health insurance marketplace serving approximately 1.8 million Californians. Since our launch in 2014, we have provided coverage to over 6.3 million Californians – about one in six residents. We are guided by a mission that not only centers on increasing the number of insured Californians, but that extends to improving health care quality, lowering costs, and reducing health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. As such, we are pleased to respond to the RFI and believe we are well-suited to do so based on the direct and practical policy perspectives we have gained through our own marketplace experience, as well as the many federal and state partnerships we have forged to drive positive, consumer-centered change in the health care system as a whole.

We appreciate the nature of this RFI, as it provides the means by which policymakers can deliberate ways to address challenges Americans face that have resulted from

recent federal policy change, as well as a platform to explore what more we can do to advance federal policy to the benefit of health care consumers. To this end, Covered California's comments span a variety of the policy topics outlined in the RFI, and center on key policy considerations in the areas of recent federal actions impacting marketplace consumers, the need to improve affordability and access to coverage and care, the role of marketplaces as drivers of systemic change, program integrity, and concepts to improve access in the commercial market generally. We hope you find our comments useful as you evaluate federal policy changes that will advance the health and wellbeing of Americans in this nation.

I. ADDRESSING FEDERAL POLICIES THAT REDUCE HEALTH COVERAGE ACCESS AND AFFORDABILITY

RESTORE MARKETPLACE ENHANCED PREMIUM TAX CREDIT (RFI Section 1.III)

Covered California's data shows the harmful impacts of the expiration of the federal enhanced premium tax credit. Following the expiration of the enhanced premium tax credit at the end of 2025, Covered California's effectuated enrollment has declined by 9%, with nearly 175,000 fewer consumers enrolled in coverage compared to last year.¹ Substantial disparities exist in termination rates: 27% of middle-income consumers who lost eligibility for financial assistance disenrolled, a much higher rate than prior years, compared to only 8% of lower-income enrollees whose premium assistance was maintained by California's state subsidy program, a similar level to prior years.² Communities of color terminated at disproportionately higher rates, and younger consumers left in higher volumes, increasing premiums for those who remain covered. And, older middle-income enrollees are again facing premiums that can exceed 25% of their household income.³ In addition, many Covered California consumers responded to higher net premiums by moving into Bronze coverage rather than dropping coverage altogether.⁴ Bronze plans typically offer the lowest monthly premiums, but they also expose enrollees to higher deductibles and greater out-of-pocket costs than more generous coverage.⁵

¹ Covered California (2026, August). Many Californians Go Uninsured after Expiration of Federal Enhanced Tax Credits. <https://hbex.coveredca.com/data-research/library/Renewal%20Terminations%20Brief.pdf>

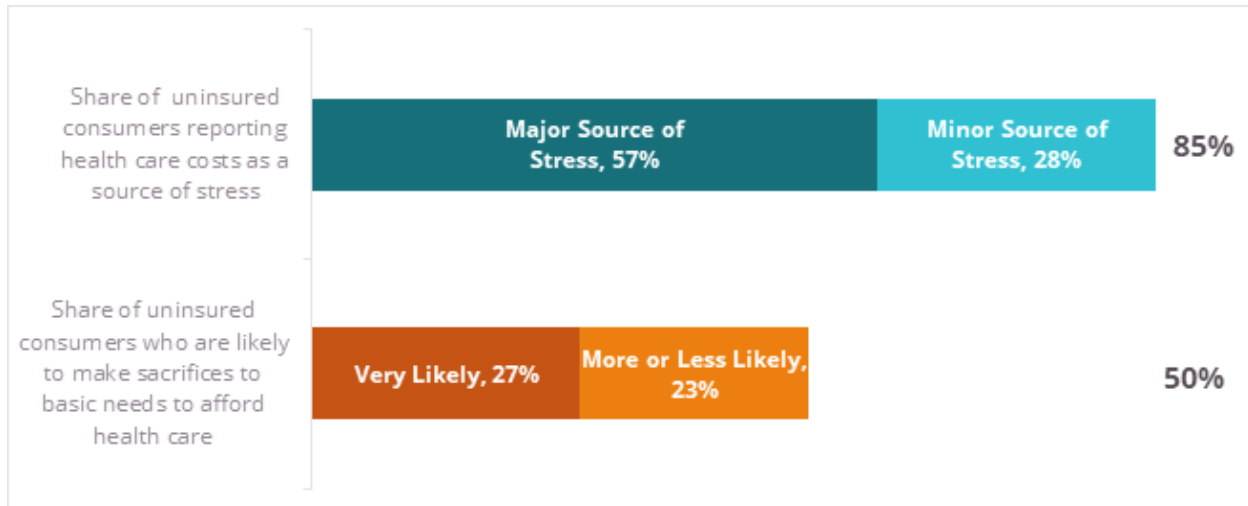
² Covered California (2026, February 20). 2026 California Premium Subsidy Program. https://hbex.coveredca.com/stakeholders/PDFs/2026-02_StatePremiumSub_PolicyExplainer-Final.pdf

³ Covered California (2025, December). The Inflation Reduction Act Ensures Affordable Coverage for Older Enrollees. <https://hbex.coveredca.com/data-research/library/Brief%203%20IRA%20The%20Inflation%20Reduction%20Act%20Ensures%20Affordable%20Coverage%20for%20Older%20Enrollees%20%202026.pdf>

⁴ Covered California (2026, September). Without Extension of Enhanced Federal Tax Credits in 2026, Renewing Consumers Switched Down to Lower Coverage Bronze Plans and Now Face Higher Out-of-Pocket Costs. <https://hbex.coveredca.com/data-research/library/Bronze-Switchers.pdf>

⁵ Nationally, average deductibles in 2026 were about \$7,476 for Bronze plans, compared with \$5,304 for Silver plans, and annual in-network cost-sharing limits could reach \$10,600 for an individual and \$21,200 for a family.

As expected, the expiration of the federal enhanced premium tax credit is forcing enrollees to make difficult tradeoffs between keeping coverage and paying for basic expenses. The share of disenrolled consumers going uninsured doubled, increasing to 22% in 2026 compared to 11% in 2025. As shown below, nearly all of those who are uninsured report financial stress due to the cost of health care, with most planning to delay care they need while they go without coverage.⁶



Former members of Covered California have shared stories about the sacrifices they are making to cope with higher costs. For example, Amanda shared *“The people who opt out of health insurance are not doing it because they don’t think they need it. They’re doing it because they can’t afford it. I have looked high and low for other options. I have really spent hours searching for health care options that are affordable for my husband and I, and I haven’t been able to find anything.”* Amanda (whose name has been changed here to protect her privacy) is self-employed and lives in Northern California, with her son and husband, who is also self-employed. Her family no longer qualifies for federal premium tax credits, so their monthly premiums rose by \$2,000 compared to 2025. Amanda and her husband opted to purchase health insurance for their son, who has a rare health condition, and go without insurance themselves.

Recommendation: Restore marketplace enhanced premium tax credit to stem coverage losses and address the significant financial stress facing marketplace enrollees.

⁶ Covered California (2026, August). Many Californians Go Uninsured after Expiration of Federal Enhanced Tax Credits. <https://hbex.coveredca.com/data-research/library/Renewal%20Terminations%20Brief.pdf>

REDUCE ELIGIBILITY, ENROLLMENT AND AFFORDABILITY BARRIERS IMPOSED ON MARKETPLACE CONSUMERS BY H.R. 1 (RFI Section 2.IV)

Remove Excessive Red Tape Imposed by Pre-Enrollment Verification Requirements

H.R. 1's requirement of pre-enrollment verification has the potential to cause significant harm to consumers and Marketplaces. Specifically, the requirement introduces new hurdles for consumers to retain coverage, and when combined with income verification provisions, could exacerbate denials of Advanced Premium Tax Credit (APTC) for millions of eligible individuals awaiting paperwork processing. A study in the American Economic Review⁷ found that adding even one extra administrative step reduces enrollment by 33 percent, disproportionately affecting healthy, younger, and low-income individuals. This adverse selection would destabilize the risk pool and raise premiums for unsubsidized enrollees. The pre-enrollment verification requirements also place significant burden on Marketplaces, requiring costly and complex implementation. The Centers for Medicare & Medicaid Services (CMS) estimates that implementing new verification requirements will cost Marketplaces approximately \$198 million annually, diverting resources from other critical priorities that increase coverage and access to high-quality care rather than wrapping consumers in red tape designed to discourage enrollment. As of the date of this letter, CMS has not released draft rules to enable state planning. Finally, allegations of fraud in marketplaces were used to justify pre-enrollment verification requirements. As this letter details below, Covered California and other State-Based Marketplaces have not experienced the fraud publicized on the federal marketplace.

Recommendation: Act swiftly to repeal or delay the burdensome and unnecessary pre-enrollment verification requirement before implementation costs are incurred. Instead, explore mechanisms to ensure accountability of the federal marketplace.

Restore Premium Tax Credit Eligibility to Limited Immigrant Groups

In California alone, an estimated 130,000 lawfully present Covered California enrollees are projected to lose access to APTC and cost-sharing reductions by 2027 as a result of this policy change under H.R. 1.⁸ These individuals—who include those with asylum or pending asylum status, work or student visas, refugees, and survivors of trafficking, domestic violence, and other serious crimes—are lawfully present in the United States

⁷ Mark Shepard & Myles Wagner, [*Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*](#), 115 Am. Econ. Rev. 772, 822 (2025).

⁸ Covered California (2026, April 7). Covered California Member Profile by Immigration Status. [Data set]. [https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fhbex.coveredca.com%2Fdata-research%2Flibrary%2FEnrollment by Immigration Status.xlsx&wdOrigin=BROWSELINK](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fhbex.coveredca.com%2Fdata-research%2Flibrary%2FEnrollment%20by%20Immigration%20Status.xlsx&wdOrigin=BROWSELINK)

and rely on Marketplace coverage to access necessary health care services. When implemented next year, this policy will result in higher uninsured rates, disrupt continuity of care, and impose significant financial hardship on families who can no longer afford coverage. Nearly 80% of lawfully present enrollees who will lose eligibility for premium assistance in 2027 have incomes under 200% of federal poverty level (FPL) (\$31,300 for an individual; \$64,300 for a family of four).⁹ Without financial assistance, lawfully present enrollees from these working families will face average premiums of \$594 per month to maintain coverage. The policy change will also negatively impact the broader health care marketplace by increasing uncompensated care and drive up premiums for all.

Recommendation: Restore eligibility for financial assistance for lawfully present immigrant groups who will be denied federal financial help under H.R. 1.

Restore and Enhance Protection from Unanticipated Income Changes for Marketplace Enrollees

The Affordable Care Act (ACA) provides a premium tax credit that can be taken in advance during the course of the year or collected at tax time. The vast majority of Covered California enrollees take the ACA premium tax credit in advance to reduce monthly premiums that would otherwise be unaffordable. When taken in advance, the premium tax credit is calculated using projected annual income, and Marketplace enrollees then reconcile the amount they received when they file their federal income taxes. Given the volatility of Marketplace enrollees' employment, self-employment, and gig income, reconciliation commonly results in either a refund or repayment by the individual when they file their federal income tax return. Historically, income-based repayment caps limited the amount lower- and middle-income enrollees had to repay when their income exceeded projections due to unforeseen changes in their lives. H.R. 1 eliminates those caps beginning with coverage year 2026, requiring enrollees to repay all excess premium tax credit regardless of their ability to pay. This change will impose severe financial hardship on consumers experiencing unanticipated income increases and should be reversed. Repayment caps should be reinstated and strengthened, including protections for enrollees with incomes above 400% of the federal poverty level.

Additionally, current Internal Revenue Service (IRS) data sharing limitations prevent State-Based Marketplaces from understanding their applicants' and enrollees' tax reconciliation outcomes for premium tax credits received through marketplace eligibility determinations: the IRS should be directed to share reconciliation outcomes for all enrollees – even after they leave coverage – so that State-Based Marketplaces can continually improve their eligibility policies and procedures for assisting consumers in estimating their incomes and thereby reduce unnecessary tax credit reconciliations.

⁹ Covered California (2026, August). Many of California's Lawfully Present Non-Citizens Will Lose Eligibility for Federal Financial Assistance in 2027. <https://hbex.coveredca.com/data-research/library/LPI-Consumer-Impact-Brief.pdf>

Recommendation: Restore and enhance protection from unanticipated income changes for marketplace enrollees by requiring the IRS to share reconciliation outcomes for all enrollees – even after they leave coverage.

II. IMPROVING AFFORDABILITY BY LOWERING OUT-OF-POCKET COSTS (RFI Section 1.II)

California’s Enhanced Cost-Sharing Reduction Program serves as a model for lowering out-of-pocket costs for marketplace enrollees. Most efforts to address marketplace affordability have focused on increasing premium subsidies, as premiums represent the initial barrier to coverage take-up. However, consumers’ perceptions of plan value include both premium and out-of-pocket costs, with enrollment and utilization decisions reflecting their perceived affordability of both. The ACA requires qualified health plan issuers to reduce out-of-pocket maximums and cost-sharing amounts for consumers with incomes at or below 250 percent of the federal poverty level, which is \$39,125 for an individual and \$80,375 for a family of four in 2026. Marketplace enrollees access these benefits by enrolling in cost-sharing reduction (CSR) plans built on Silver-level coverage. For the lowest-income enrollees, CSR plans provide coverage near or above the Platinum level for highly subsidized Silver premium prices.

The federal cost-sharing program significantly increases the generosity of Silver plans for marketplace enrollees at the lowest income levels, but there is little to no cost-sharing support for those with incomes over 200 percent of the FPL. While individuals with incomes between 200 and 250 percent of the FPL do qualify for Silver 73 cost-sharing reduction plans, these benefit designs are nearly identical to the standard Silver 70 plan and offer little cost-sharing support. In addition, while federally defined maximum out-of-pocket limits provide important financial protection for enrollees who need high-cost care like inpatient hospitalization and specialty drugs, those limits are extremely high as a percentage of income, as shown in Table 1. Individuals and families who hit their maximum out-of-pocket limit could spend up to 30% of their annual income on out-of-pocket expenses. To maximize affordability of out-of-pocket costs, California only allows standard benefit designs and those designs maximize the federally allowable actuarial value of each metal tier. But even with these design features (and availability of the federal enhanced premium tax credit), Covered California’s 2022 data show that nearly 20 percent of Covered California enrollees spent more than 10 percent of their income on premiums and out-of-pocket costs, with some spending far more.¹⁰

Table 1. 2027 Maximum Out-of-Pocket Limits as a Percentage of Annual Household Income

Income Eligibility by Federal Poverty Level	Cost-Sharing Reduction Plan Actuarial Value	Maximum Out-of-Pocket Limit		Maximum Out-of-Pocket Limit as a Percent of Annual Income	
		Individual	Family	Individual	Family of Four
Up to 150%*	Silver 94	\$3,000	\$6,000	13-19%	12-19%

¹⁰ Kohn, E., et al (2025, August). Total cost of coverage for members in California’s marketplace. Health Affairs Scholar. <https://academic.oup.com/healthaffairsscholar/article/3/8/qxaf135/8194569>.

151-200%	Silver 87	\$4,000	\$8,000	13-17%	12-17%
201-250%	Silver 73	\$9,600	\$19,200	25-31%	24-30%

*Range calculated for income at 100 and 150 percent of the federal poverty level.

Beginning in 2024, California took action to address high out-of-pocket costs in Marketplace plans. State funds were appropriated to enhance the value of CSR benefits among those eligible for federal CSR Silver plans. By eliminating deductibles, lowering maximum out-of-pocket amounts, and reducing copays for many services, California's enhanced CSR program lowered the AV for all three Silver CSR plans: Silver 73 plans increased to 80% AV, Silver 87 plans increased to 90%, and Silver 94 plans increased to 95%. In 2025, California expanded eligibility for CSR benefits to individuals with incomes above 250% FPL, allowing all middle-income consumers to enroll in Silver plans with no deductibles and an average 80% AV – on par with the marketplace Gold coverage tier and employer-sponsored coverage.¹¹ Table 2 shows the value of eliminating deductibles in Covered California's Silver plans. Emphasis was also placed on lowering both copays for common services as well as maximum out-of-pocket amounts so that all consumers could benefit from the program whether they used care infrequently or regularly for a chronic condition.

Table 2. Deductible Changes in Covered California Silver Plans, 2023 through 2025

		Reduced member cost with California Enhanced CSR Program	
Silver Plan Variant by Income as a Percent of FPL (2026 FPL values shown)	2023	2024	2025
Silver 94 for enrollees up to 150% FPL <i>about \$22,590 for a single person and \$46,800 for a family of four</i>	\$75 inpatient \$0 pharmacy	\$0	\$0
Silver 87 for enrollees up to 200% FPL <i>about \$30,120 for a single person and \$62,400 for a family of four</i>	\$800 inpatient \$25 pharmacy	\$0	\$0
Silver 73 for enrollees up to 250% FPL <i>about \$37,650 for a single person and \$78,000 for a family of four</i>	\$4,750 inpatient \$30 pharmacy	\$0	\$0
Silver 70 for enrollees above 250% FPL <i>starting at about \$37,650 for a single person and \$78,000 for a family of four</i>	\$4,750 inpatient \$85 pharmacy	\$5,400 inpatient \$150 pharmacy	\$0

¹¹ Actuarial Research Corporation (2024, September 27). Employer Sponsored Insurance Actuarial Values and Sensitivity Analysis. <https://www.dol.gov/sites/dolgov/files/ebsa/researchers/analysis/health-and-welfare/employer-sponsored-insurance-actuarial-values-and-sensitivity-analysis.pdf>

California's enhanced cost-sharing reduction program dramatically increased enrollment in the Silver tier of coverage, especially for consumers above 250 percent FPL who newly qualified for cost-sharing support. Among this group, Gold enrollment dropped significantly and Bronze enrollment dropped but to a smaller extent. Consumers who chose Silver instead of Gold were able to save on both out-of-pocket costs and premiums, by accessing a plan with a zero-dollar deductible, lower copays and lower monthly premiums. In addition to the significant shift in enrollment by metal tier, Covered California is also analyzing internal data to understand how lower costs under the state enhanced cost sharing program impacted overall program enrollment and utilization of care.

California's enhanced cost sharing program was structured similarly to the ACA's original cost-sharing reduction program. Qualified health plans received a monthly prospective payment based on enrollment and expenditures were reconciled at year-end based on actual claims costs. California's 2025 program budget for the enhanced cost-sharing reduction program was \$165 million. This augmented approximately \$10 billion in federal premium assistance received by Covered California enrollees in 2025. When the federal enhanced premium tax credit expired at the end of 2025, Covered California enrollees lost an estimated \$2.6 billion in premium support. To mitigate this loss of premium affordability, Covered California sunsetted the enhanced cost-sharing reduction program and implemented a premium subsidy program in its place for 2026. While California's cost-sharing reduction program is no longer operational, it provided an efficient path to reduce consumer costs and raise the value of coverage to a Gold level while keeping premium subsidies tied to the lower-cost Silver tier.

Recommendation: Consider California's Enhanced Cost-Sharing Reduction Program as an efficient and viable model for reducing out-of-pocket costs for Marketplace enrollees.

III. MARKETPLACES CAN SERVE AS A CENTRAL HUB FOR CONNECTING ELIGIBLE INDIVIDUALS TO COVERAGE (RFI SECTION 1.1)

Covered California's experience demonstrates that marketplaces can do more than wait for consumers to initiate an application. When marketplaces are connected to timely information from Medicaid and other authorized public and private sources, they can identify people experiencing—or likely to experience—a loss of coverage and help them move to affordable coverage with minimal disruption.

California's integrated Medicaid and Marketplace eligibility infrastructure provides a practical example. Under California state law, Covered California automatically selects the lowest-cost Silver plan for eligible consumers who lose Medicaid eligibility due to an increase in income.¹² Consumers receive customized notices and a tailored online experience, retain a special enrollment period to change plans, and can obtain help from Agents, Navigators, and carriers. This model combines data sharing with

¹² Covered California (2026, May 29). Medi-Cal to Covered California Enrollment Program. https://hbex.coveredca.com/stakeholders/PDFs/2026_SB260_PolicyExplainer--Final.pdf

consumer choice, outreach, and an affirmative step to effectuate coverage. In the first year of program operations, nearly two-thirds of individuals without another source of coverage after losing Medicaid opted into a Covered California plan.¹³ Similar approaches can be used to reach people before a coverage loss occurs or among people who are likely eligible but have not applied. California law supports sharing data from state departments and health insurance issuers for outreach and enrollment assistance.¹⁴

Proactive outreach and enrollment assistance could be explored as a broader Marketplace function nationwide: examples could include requiring data sharing from other federal departments or other public or private entities who serve Americans likely to be marketplace eligible so that marketplaces can conduct outreach, eligibility, and enrollment activities. Based on our own experiences in California, example entities could include the Internal Revenue Service or the Social Security Administration, health plans who have disenrolled consumers or retain consumers in COBRA plans, providers such as non-profit hospitals who receive tax write offs for charity care to the uninsured, or other recipients of federal funds who serve seasonal, unemployed, or displaced workers. To encourage innovation, federal policy could authorize State-Based Marketplaces to receive data directly from federal or state and local entities. Additionally, to achieve efficiency, CMS could leverage the federal data services hub to act as a central data asset by identifying Americans likely in need of coverage and sharing that data with states through the existing secure infrastructure.

Recommendation: Pursue policies to allow Marketplaces to proactively provide outreach and enrollment assistance to uninsured Americans.

IV. SUPPORTING AND PROMOTING THE ROLE OF MARKETPLACES AS “ACTIVE PURCHASERS” (RFI Sections 1.I, 2.I)

As an “active purchaser,” Covered California uses its authority and leverage as a purchaser to ensure a competitive marketplace that offers choice and value to consumers. For Covered California, this means:

- **Selective contracting with carriers:** Covered California does not accept all plans that simply meet federal and state requirements. Rather, we selectively contract with health insurance carriers to determine which Qualified Health Plans will bring an optimal balance of affordability, access, quality, competition, and choice to consumers. Through this process, we are also able to determine which plans are best suited to meet our contractual requirements related to rates, benefit designs, quality, delivery-system reform, and health disparities reduction.
- **Negotiating for value:** Covered California negotiates with insurers on premium rates, provider networks, quality, and how care is delivered.

¹³ Hagen, R., et al (2026, August 3). ACA Marketplace Take Was High After Facilitated Enrollment in California; Disparities Remained. Health Affairs.
<https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01585>

¹⁴ Covered California (2024, February 15). Covered California Executive Director’s Report to the Board. Slide 44. https://board.coveredca.com/meetings/2024/February%2015,%202024/ED_Report.pdf

- **Holding plans accountable:** A major tenet of active purchasing is holding plans accountable to consumer-centered contract requirements and evaluating and publicly reporting on plan performance, including quality, cost, and disparities in care.

Promoting Standard Benefit Designs

Standardized Benefit Designs promote a more consumer-friendly marketplace by simplifying consumer decision-making, allowing consumers to make apples-to-apples comparisons between health plans rather than having to navigate complex and confusing benefit structures. Every Individual Market Qualified Health Plan offered through Covered California offers a standard benefit design, empowering consumers to compare their plans based on cost, provider network, and the quality of service provided by the carrier. Standardization also helps protect the value of coverage, as non-standardized plans may rely on lower actuarial values, higher deductibles, or alternative cost-sharing structures to shift out of pocket costs to consumers without clear visibility about whether this is reflected in premiums. Comparatively, all of Covered California's standardized benefit designs maximize the actuarial value to the top of the allowed range.

Covered California refreshes and refines its standardized benefit designs through an annual stakeholder-engagement process that includes health plans, consumer advocates, providers, regulators, and other interested parties. Rather than carrier-designed products that maximize enrollee out of pocket costs, our benefit designs maximize consumer value through low copays and no deductible for high value services, such as primary care visits and generic drugs in all tiers. Platinum and Gold plans have no deductibles, and the medical deductible only applies to inpatient stays in the Silver plans. Further, Covered California's 2026 Silver 70 plan has a medical deductible of \$5,200 as compared to the national benchmark average of \$5,304. In the Expanded Bronze Plan, the deductible is selectively applied to maintain access to care. These cost sharing structures work to improve enrollee health outcomes while controlling premiums by reducing preventable hospital utilization.

Recommendation: The Federally-facilitated Marketplace (FFM) should permanently expand the availability of standard benefit designs offered through Healthcare.gov, eliminate or reduce the number of non-standardized plans per metal tier, and clearly identify and feature standardized plans throughout the shopping experience. This will enable consumers to readily recognize, evaluate, and compare their options.

Cross-purchaser Alignment Benefits Consumers, Providers, and Health Plans

Covered California, the largest State-Based Marketplace, the California Public Employees' Retirement System (CalPERS), and the California Department of Health Care Services (DHCS) collectively represent over 45 percent of all Californians and have chosen to use their joint market power selectively and strategically. Across several areas of focus, California's public purchasers have worked together to align contracting, payment policy, and public reporting for over a decade.

Several examples of cross purchaser alignment span the domains of quality, equity, and advancing primary care and ensure that requirements are implemented in such a way that they reach Californians.

California public purchasers have long recognized the value of aligning quality measures across lines of business and across purchasers as a means of reducing administrative burden both for plans and providers, while preserving accountability. Aligning with a focused, shared measure set reduces fragmentation and duplicative reporting for plans while still allowing purchasers to hold them accountable for the outcomes that matter most. Providers also note a reduction in data collection and quality measure reporting burden when they contract with multiple plans across multiple lines of business.

Additionally, California's public purchasers have turned primary care policy into action through health plan contract requirements, financial incentives, and public reporting since 2023.¹⁵ In 2026, California's public purchasers jointly outlined how to continue to align and advance primary care across the state.¹⁶ This strong, public, aligned approach sends a significant market signal that can shift the landscape of health care across broad covered populations.

V. ADVANCING CONSUMER EXPERIENCE AND VALUE THROUGH STATE-BASED MARKETPLACE AUTHORITY (RFI Sections 1.I, 2.IV)

Covered California provides an example of how State-Based Marketplaces can use public purchasing authority to advance consumer value and market accountability. Over more than a decade, Covered California has developed an active-purchasing infrastructure that includes standardized benefit designs, selective plan certification, claims and quality data, public reporting, and a detailed Qualified Health Plan contract. These tools support the Exchange's ability to evaluate, compare, and actively oversee participating health plans across the dimensions that matter most to consumers and

¹⁵ California Health Care Foundation (2023, May). California Public Purchaser Contract Provisions on Primary Care: Multi-Payer Alignment Drives Investment. <https://www.chcf.org/wp-content/uploads/2022/04/CAPublicPurchaserContractProvisionsPCMMultiPayerAlignment.pdf>

¹⁶ California Health Care Foundation (2026, May 29). How California's Public Purchasers Are Joining Forces to Strengthen Primary Care. <https://www.chcf.org/resource/how-californias-public-purchasers-are-joining-forces-strengthen-primary-care/>

public purchasers. For example, the Exchange can use both market level data and plan-specific data to assess medical and pharmacy spend, member cost-sharing, and overall affordability; compare quality measures such as preventive-care rates, chronic-condition management, member experience, and disparities in outcomes; and monitor operational performance, including call-center responsiveness, grievances and appeals, and continuity of care. With the visibility afforded by the data, Covered California has required plans to improve cancer screenings year over year, close disparities in behavioral health utilization, and address outlier prescriber patterns.

The California experience demonstrates the importance of allowing State-Based Marketplaces to tailor enrollment and eligibility operations to state systems, use established data sources, coordinate with Medicaid and CHIP, and implement consumer-focused approaches. Coordination with other public purchasers can further reinforce shared priorities, reduce administrative fragmentation, and strengthen accountability across lines of business.

Recommendation: We recommend that federal policy preserve and strengthen these authorities while establishing appropriate baseline requirements for consumer protection and interoperability. Federal policy should also provide State-Based Marketplaces with adequate resources, technical assistance, meaningful consultation, and sufficient implementation time to operationalize new requirements effectively. Taken together, these policies would enable State-Based Marketplaces to apply their data, contracting, and purchasing capabilities in support of affordable, high-quality coverage.

VI. PREVENTING FRAUD: TAKING A COMMON-SENSE APPROACH TO PROGRAM INTEGRITY (RFI Section 2.IV)

Covered California's experience is distinct from the challenges that have been identified in the FFM and demonstrates that targeted, risk-based, front-end safeguards can protect program integrity without imposing broad verification requirements that delay coverage or burden eligible consumers. The same approach can be applied in the FFM by adopting proven safeguards that address risk at enrollment while maintaining an accessible and affordable consumer experience.

Covered California supports targeted, risk-based safeguards that protect program integrity without creating unnecessary barriers to coverage. Covered California focuses on front-end controls that address risk in enrollment pathways and intermediary activity before coverage is effectuated. This approach is more effective and less disruptive than relying on post-enrollment recovery and avoids broad requirements that can delay coverage or burden eligible consumers.

To safeguard consumers and ensure that enrollments reflect their informed choices, Covered California requires consumer consent before an enrollment partner can access a case or enroll a consumer in a health plan. An enroller must obtain delegation before

accessing information or making changes. Consumers can manage delegates through their online account, by calling the Consumer Service Center, through a three-way call with the enroller, or through a delegation tool that sends a one-time passcode directly to the consumer. The enroller cannot complete the delegation without entering the passcode. These safeguards prevent unauthorized access or changes by agents or brokers.

Covered California's Agent Agreement and Code of Conduct require accurate consumer information and prohibit unauthorized or misleading activity. Covered California monitors complaint trends, enrollment activity, and agent marketing practices, including website branding and disclaimers. Misconduct may result in coaching, correction, warning notices, suspension, termination, decertification, or referral to the California Department of Insurance or law enforcement. This graduated enforcement allows Covered California to respond proportionately to misconduct.

Covered California also uses risk-based identity and eligibility verification. Its AI-driven remote identity-proofing solution replaced a credit-based process that caused approximately 34 percent of applicants to abandon their applications. Approximately 85 percent of applicants can now be verified passively without additional steps. Higher-risk cases are routed to secure selfie-and-document review rather than blocked outright. Overall, approximately 95 to 98 percent of applicants successfully complete remote identity proofing, while the system detects nearly 100 percent of fraudulent identity attempts. Covered California also uses Intelligent Document Processing to validate more than 25 document types and prioritize enhanced review for higher-risk cases.

Covered California monitors and resolves duplicate enrollment; duplicate coverage involving financial assistance represents less than one percent of enrollment. When a consumer has more than one subsidized enrollment, Covered California provides 30 days to act before correcting the cases to retain one active subsidized enrollment. When a consumer has both Covered California financial assistance and Medi-Cal coverage (California's Medicaid program overseen by the California Department of Health Care Services), Covered California coordinates with the Department of Health Care Services and gives the consumer an opportunity to clarify the correct coverage and income information. When only one of two plans receives financial assistance, Covered California notifies the consumer but does not require corrective action unless the consumer requests a change. These processes distinguish consumer confusion from intentional misuse and avoid punitive action when it is not warranted.

Covered California's centralized Fraud Management team receives complaints, researches suspicious activity, monitors trends, and coordinates with internal and external partners, including California's state Medicaid agency, state health insurance regulators, health and dental plans, and law-enforcement partners. Covered California has received no complaints in recent years from consumers enrolled without their knowledge, and only one agent has been decertified for misconduct in the past two years.

Of note, the federal Government Accountability Office (GAO) recently issued a report¹⁷ outlining findings and recommendations on how CMS can strengthen agent and broker controls to stop fraudulent or unauthorized actions. Covered California was one of three State-Based Marketplaces interviewed by the GAO for this report. The report cites safeguards we have in place that prevent fraudulent activity and could serve as a model for the federal government to follow.

These themes are also reflected in Covered California's March 30, 2026 comment letter¹⁸ responding to CMS' Request for Information on Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH). In that letter, Covered California described how affirmative consumer consent, risk-based identity verification, duplicate-enrollment monitoring, centralized fraud management, and graduated enforcement can prevent fraud at the point of enrollment without creating unnecessary barriers for eligible consumers. The letter also emphasized that the GAO findings were limited to the FFM and should not be treated as evidence that identical interventions are necessary for State-Based Marketplaces with demonstrated safeguards.

Recommendation: Covered California's experience supports federal policies that prioritize practical, targeted capabilities rather than blanket verification requirements. The federal government can adopt similar policies within the FFM, and support adoption among more State-Based Marketplaces, that prevent fraud while ensuring consumers are not subjected to unnecessary burdens that could deter enrollment.

VII. COMMERCIAL AND EMPLOYER MARKET POLICY CONSIDERATIONS

EXPANDING ACCESS TO HIGH-VALUE COVERAGE: RETHINKING THE EMPLOYER-SPONSORED COVERAGE FIREWALL (RFI Section 1.III)

Depending on what an American family qualifies for, health care costs range from free to simply beyond financial reach. For example, a family of three earning around \$36,000 per year that qualifies for Medicaid will face little to no cost for coverage. If a member of that family gets a small raise that puts them just over the qualifying income for Marketplace coverage (e.g. \$38,000 per year), they will pay about \$100 per month for the whole family to be covered by a 2026 Marketplace benchmark Silver plan. That Silver plan will likely come with a small deductible averaging around \$80 for an individual for the year. If that same family gets an offer of employer-sponsored coverage without also getting a pay raise, the average monthly premium the family will have to pay for the job-based plan will jump to \$571 per month and they will face an average deductible of about \$1,663 for an individual for the year.¹⁹

¹⁷ U.S. Government Accountability Office (2026, July 13). Health Insurance Marketplaces: CMS Needs Stronger Controls to Prevent Unauthorized Actions by Agents and Brokers. [GAO-26-108297](#).

¹⁸ Covered California (2026, March 30).

https://hbex.coveredca.com/regulations/PDFs/CMS_CRUSH_RFI_2026.03.30.pdf

¹⁹ Sources: Marketplace [premium](#) and [benefit design](#) information from KFF. ESI premium and benefit design information from [KFF 2025 Employer Health Benefits Survey](#).

The different realities of affordability across major coverage sources including Medicaid, Marketplace and employer coverage create financial inequity for Americans depending on how they make a living. The ACA firewall, which bars people from accessing often more affordable Marketplace coverage if they have access to an employer plan that meets an arbitrary affordability test, should be removed to mitigate the inequity in the current coverage system. This would allow employees to choose coverage through Marketplaces when the existing Marketplace premium and cost-sharing subsidies would be more affordable than their employer offer.

If the firewall cannot be eliminated entirely, it could be modified to allow low-income working Americans to take advantage of Marketplace subsidies that are likely to be more affordable than their employer offer (eliminating the firewall for anyone below a certain percent of the federal poverty level). This would give workers access to the income-adjusted premium contributions available in Marketplaces. In the example above, the family of three would pay 3.14 percent of their income for a Marketplace benchmark plan but could not access subsidized Marketplace coverage under today's rules unless they were asked to pay **more than three times** that amount, or 9.96 percent of their income, for their employer plan.²⁰

Consideration should also be given to the affordability ceilings across the federal premium tax credit program and employer-sponsored coverage. The enhanced premium tax credit provided by the American Rescue Plan and Inflation Reduction Act capped the premium contribution for a benchmark plan at 8.5 percent of income for individuals at or above 400 percent of the federal poverty level. If the enhanced premium tax credit is reinstated and made permanent, in the absence of changes to the firewall, the affordability test for employer-sponsored coverage should be realigned with the premium tax credit contribution limits.

Recommendation: Remove or modify the ACA firewall.

BETTER INFORMING COMMERCIAL MARKET POLICY (RFI Section 1.III)

Covered California's experience demonstrates the importance of pairing data and expertise with accountability and action-orientation. Through the Medicare Payment Advisory Commission (MedPAC), and the Medicaid and CHIP Payment and Access Commission (MACPAC), the Medicare and Medicaid programs benefit from dedicated institutions that develop reliable data, conduct independent analysis, and inform policy. However, the commercial markets lack a comparable source of truth and it can be difficult to make accurate comparisons not only across markets but also between different types of commercial coverage (individual, small group, and large group). A Commercial MedPAC/MACPAC could close this double standard by grounding commercial-market policy in evidence rather than assumptions.

²⁰ [IRS Revenue Procedure 25-26](#)

To be effective, the commission must be more than a research and reporting entity:

- It should have a clear statutory mission focused on affordability, access, quality and consumer protection.
- It must have authority to obtain standardized data from issuers, public purchasers, self-funded plans, and third-party administrators.
- It should produce an integrated view across purchaser types because policies affecting one market often shift costs, enrollment, access, or risk into another - the health care equivalent of squeezing a balloon.
- The commission should maintain a formal policy feedback loop requiring agencies and Congress to respond to recommendations or explain why they are not adopted.
- A purchaser and state implementation arm should serve as a learning collaborative, offering technical assistance and translating findings into practical tools for contracting and oversight. The State Transformation Collaboratives within the Health Care Payment Learning and Action Network were an example of an effective CMS-led learning collaborative that shared data, best practices and provided technical assistance. Its practical value was in helping participants pressure-test approaches, learn from other similar organizations, and provide access to subject matter experts and academics.

Without these features, a commercially focused commission risks becoming another source of reports; with them, it could provide the institutional infrastructure needed for more transparent, evidence-based, and coordinated commercial-market policy.

To the extent that the creation of a commission like this is not feasible, policymakers should, at minimum, evaluate potential policies that promote greater cost transparency in the commercial market. Improving transparency would help with the availability, consistency, and comparability of information about premiums, provider pricing, utilization, administration spending, and other factors that drive commercial-market costs and could help support ongoing efforts to improve affordability, competition, access, and value to consumers.

Recommendation: Ground commercial-market policy in evidence through a commercial MedPAC/MACPAC.

ADVANCE COST CONTAINMENT AND PURCHASER ALIGNMENT

California's experience demonstrates that cost containment must remain a sustained priority. California's Office of Health Care Affordability (OHCA) is working to hold health plans, providers, and other participants in the health care system accountable for meeting statewide cost targets. This work complements Covered California's commitment to tackling cost as an active purchaser: analyzing claims and encounter data to understand the drivers of premium growth, releasing data and cost dashboards for public transparency, and then aligning expectations across public purchasers. Covered California's internal analysis has determined that the primary cost drivers on the individual market are unit cost at the provider level with outliers by regions and service categories and prescription drugs, specifically high-cost specialty drugs. Enhanced federal policy could support the Exchange's ability to oversee carriers, advance affordability and value, and promote greater consistency across the commercial market. Explicit federal guidance should encourage data sharing agreements among state purchasers, the establishment of common definitions and standards reports to allow comparability, and partnership on model contract language that could be leveraged for health plans or TPAs. The federal government could also facilitate regular coordination among public purchasers, state employee health plans and employer purchasers to share best practices and cross-pollinate. These steps would give states and employers practical tools to identify outliers, align expectations across purchasers, and hold carriers accountable for measurable progress toward affordability and value across the commercial market.

Recommendation: Convene state, public, and employer purchasers and support shared data standards and model contract language to advance affordability.

PRESCRIPTION DRUG POLICY REQUIRES STRONGER FEDERAL ACTION

Prescription drug policy is an area of persistent challenge for states and state purchasers. Many of the consequential tools for addressing prescription drug prices - including the authority to negotiate prices with manufacturers - are established at the federal level. To maximize state purchasing power, expanded authority would improve the ability to achieve affordability and value. Covered California supports the RFI's consideration of policies that would advance and strengthen prescription drug price negotiation, along with other federal approaches to lowering prescription drug costs. The federal government should build on these efforts and provide additional tools that enable large state purchasers such as Covered California to participate meaningfully in securing better prices and value for consumers.

Options include:

- Extend Medicare Maximum Fair Prices (MFPs) to marketplaces and other commercial purchasers.

- When selecting drugs to be negotiated, utilize available APCD data which includes commercial data.
- Extend inflationary rebate protections to marketplaces and other commercial coverage.
- Release national standards for drug reporting that include NDC, HCPCS and J-code crosswalks, physician-administered drugs, units, applicable rebates, and member cost sharing in those fields.
- Support the use of independent value assessments to inform launch prices and reimbursement.
- Require PBM and “middleman” disclosure along with purchaser audit rights.

Recommendation: Expand federal prescription drug price-negotiation and affordability tools, including policies that give large state purchasers meaningful leverage to secure lower prices and better value.

STATE AUTHORITY OVER SELF-FUNDED PLANS (RFI Section 2.III)

We strongly agree that employer-sponsored insurance market reforms are needed. California is already demonstrating what is possible through the close partnership between Covered California and the California Public Employees’ Retirement System (CalPERS), which together serve approximately 3.5 million people. This is more than coordination: the purchasers align health plan contract requirements around improving health outcomes, correcting misaligned financial incentives in the delivery system, and advancing affordability. The approach is producing measurable progress, including stronger performance on core quality measures and greater attention to quality among health plan leaders. The partnership also includes joint implementation efforts including recurring convenings of health plan leaders to address difficult challenges, including hospital quality, primary care investment, and low-value specialty care.

Together, these efforts send a more cohesive market signal to health plans, providers, and the broader delivery system, reducing fragmentation and reinforcing shared expectations for better outcomes. While we recognize the needs of national employers to think holistically about benefits for their employees, we encourage Congress to examine ways that self-funded plans could be included in high-priority state efforts to improve health care. Many of these efforts, such as initiatives to reduce costs or improve health outcomes, would benefit these very same employers and their employees. California’s experience demonstrates that broad purchaser alignment drives change faster and more effectively than siloed efforts, and we believe the ability to include self-funded plans would prove transformative. At a minimum, Congress should

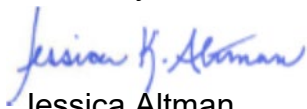
review national standards applied to self-funded plans to ensure all Americans are offered coverage that provides a foundational level of access, affordability, and quality and equitable care regardless of the source of coverage.

Recommendation: Encourage Congress to examine ways that self-funded plans could be included in high-priority state efforts to improve health care. At a minimum, Congress should review national standards applied to self-funded plans to ensure all Americans are offered coverage that provides a foundational level of access, affordability, and quality and equitable care regardless of source of coverage.

Conclusion

Covered California appreciates your consideration of these comments and the opportunity to inform future policy development. We look forward to continued collaboration to share best practices and health coverage that works for everyone. Please do not hesitate to contact me or Kelly Green, Director of External Affairs and Community Engagement, at kelly.green@covered.ca.gov or 916-539-5097 if you have questions or would like more information.

Sincerely,



Jessica Altman
Executive Director