HEALTH ACCESS

CALIFORNIA

BOARD OF DIRECTORS

NANCY "NAN" BRASMER
CA Alliance for Retired Americans

CRYSTAL CRAWFORD
CA Black Women's Health Project

LORI EASTERLING
CA Teachers Association

ROMA GUY
CA Women's Agenda

BETSY IMHOLZ
Consumers Union

DAVID KIEFFER
SEIU State Council

PAUL KNEPPRATH
Planned Parenthood Affiliates of CA

KATHY LIM KO
Asian & Pacific Islander American Health Forum

HENRY "HANK" LACAYO
Congress of CA Seniors

TED LEMPERT
Children Now

CHRISTINA LIVINGSTON
Alliance of Californians for Community Empowerment

JOSHUA PECHTHALT
CA Federation of Teachers

WILLIE PELOTE
AFSCME

ART PULASKI
CA Labor Federation

EMILY RUSCH
CALPIRG

THOMAS SAENZ
Mexican American Legal Defense & Education Fund

CARY SANDERS
CA Pan-Ethnic Health Network

REV. RICK SCHLOSSER
CA Council of Churches

RESHMA SHAMASUNDER
CA Immigrant Policy Center

JOAN PIRKLE SMITH
Americans for Democratic Action

HORACE WILLIAMS
CA Black Health Network

ANTHONY WRIGHT
Executive Director

ORGANIZATION LISTED FOR IDENTIFICATION PURPOSES

November 26, 2012

Peter Lee, Executive Director
California Health Benefits Exchange
560 J St.
Sacramento, CA 95814

**Re: Evaluation Planning**

Dear Mr. Lee,

Health Access California, for twenty-five years the health care consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments on the evaluation plan slide show provided by NORC to the Exchange for its review.

### 1. Lower system cost is no guarantee of affordability for consumers

The presentation connects two goals that are related but distinct. Lower system costs are no guarantee of better affordability for consumers. Lower system costs mean lower costs for purchasers. The vast majority of consumers are not direct purchasers, instead the vast majority of consumers are covered by employment-based coverage, public programs and in the future, coverage with advance premium tax credits through the Exchange. For these consumers, lower system cost may or may not be correlated with more affordable coverage.

Lower system costs may translate into lower costs for purchasers. Whether consumers see any benefit from lower system costs is a function of other factors. The Exchange itself lacks the authority to lower consumer cost sharing or premiums if system costs are lower. Other purchasers, including employers and public programs, may choose to capture savings from lower system costs rather than passing these onto consumers.

The logic does not work. Any evaluation should measure these issues separately.

### 2. Increasing health coverage means coverage from all sources

On objective 1, increasing health insurance coverage, in addition to evaluation question 1 on whether the Exchange has met its enrollment goals, a second question should be added about coverage from all sources. The CalSIM model allows the Exchange (and others) to measure whether the predicted impacts on coverage from all sources occur or not. In effect, health reform is a natural experiment: we should be measuring the changes in employment-based coverage, the nonsubsidized share of the individual market and other public programs as well as the Exchange's own enrollment.

**SACRAMENTO:** 1127 11th Street, Suite 234, Sacramento, CA 95814 PH: 916.497.0923, FAX: 916.497.0921
**OAKLAND:** 414 13th Street, Suite 450, Oakland, CA 94612 PH: 510.873.8787, FAX: 510.873.8789
**LOS ANGELES:** 1930 Wilshire Blvd., Suite 916, Los Angeles, CA 90057 PH: 213.413.3587, FAX: 213.413.8631
www.health-access.org

Again, it will be important to measure the Exchange's impact on coverage levels as a whole.

### 3. Wrong goal, wrong metrics: No more fine print gotcha's

Health Access strongly objects to the fourth objective as stated. As constructed, it seems to blame the consumer for a confusing insurance market designed to work for the benefit of insurers and to the detriment of consumers. The problem is not a lack of consumer knowledge. It is benefit designs intended to attract healthy consumers, benefit packages designed to select based on risk rather than price and quality, insurance policies that are full of fine print that include exclusions and exceptions, and rampant confusion that benefits the insurer, not the consumer.

In short, our goal would not be to try to educate consumers about the complexity of health insurance costs and benefits, but to simplify the products themselves. The objective of the Exchange should be to contribute to a more consumer friendly insurer market, not to patronize individual consumers who are inherently amateur purchasers of health coverage. Contrast an individual consumer with a very large employer: a very large employer has a staff that reviews health benefit coverage and attempts to negotiate based on price and quality. An individual consumer is trying to juggle work and family obligations: none of us should expect an individual consumer to have the time or the expertise to "demonstrate knowledge and understanding of the costs and benefits of their health insurance coverage". Most of us are competent to drive a car or operate a smart phone. Few of us are competent to "demonstrate knowledge and understanding" of how a car engine works or how a smart phone does what it does. Instead, today both cars and computers are simpler to operate with less maintenance required than 30 years ago. That should be the objective for the Exchange and health reform more generally.

This is the wrong objective and the wrong metric. The right objective is what has the Exchange done to make health insurance simpler and more consumer friendly? The standard benefit designs should be judged from that perspective, not from a comparison with the existing broken insurance market.

Sincerely,

Anthony Wright
Executive Director