Breakout Group Exercise

Designing a Blueprint of a Successful Affordable Health Insurance Exchange

Decision Point 1
Market Structure: *Open vs. Restricted*

States have a range of options for how the Exchange operates from an "active purchaser" model, in which the Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an "open marketplace" model, in which the Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings. In both cases, consumers will end up with options, and States will provide comparison shopping tools that promote choice based on price and quality and enable consumers to narrow plan options based on their preferences.

Industry: The "Open Marketplace" model enhances competition and provides the same advantages available to large employer groups by organizing the private insurance market, including a more stable risk pool, greater purchasing power, more competition among insurers and detailed information regarding about the price, quality, and service of health coverage.

Consumer: The "Active Purchaser" model limits the market to those accredited insurance companies based on the premise that these insurers will differentiate themselves not just by price, but rather by loyalty and accountability to the consumer shifting the burden of risk from the consumer to the insurer.

States can use other methods to support quality and efficiency goals including:

- providing information to consumers that promotes choice of plans that achieve high performance on cost and quality metrics;
- encouraging plan investments in primary care and better coordinated care such as medical homes and other delivery system reforms; and
- recruiting new insurance carriers, possibly even Medicaid carriers, particularly in states with highly concentrated markets.

For this decision point, your group must select how it will operate the Exchange within the market structure. You have the option to create either an "Open Marketplace" or an "Active Purchaser."

You will need to discuss the benefits of both models before agreeing to your selection. You should consider how the market structure will impact both the insurer and the consumer, and provide a brief statement on how you reached this selection.

Decision Point 2
Balancing Coverage and Cost: ***Minimum vs. Maximum Essential Health Benefits***

Essential health benefits (EHB) must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these benefits in order to be certified and offered in Exchanges. Insurers may provide benefits in addition to the EHB and states may require plans subject to their regulation to provide additional benefits. For states that require "qualified health plans" to cover benefits in addition to the EHB, the state must pay the cost of additional benefits.

Industry: The "Minimum EHB" package remains affordable, maximizes the number of people with insurance, promotes better care, and ensures stewardship of limited financial resources by focusing on high value services of proven effectiveness.

Consumer: The "Maximum EHB" package goes beyond the statutory requirement and allows for additional health care-related services, even if they are not deemed medical necessities, which promotes prevention, holistic therapeutics, and biomedical innovation rather than just treating the patient's current ailment(s).

- **Q: Will the EHB cover any service I want/need to get?**
    - **A:** The EHB will set a minimum set of standard benefits to include in health insurance plans offered initially to individuals and small businesses. Just as in current health insurance practice, plans developed with the EHB will not pay for anything the consumer wants, unless it is a covered benefit and it is medically appropriate for that particular patient. Plans may add benefits beyond those in the EHB package, and consumers could choose to purchase a plan with additional benefits if that best suits their needs, although purchasing additional benefits could mean a higher premium.
- **Q: Will the EHB provide access to any provider I want to see?**
    - **A:** The ACA does not change current practice; which providers the consumers may see will depend on the health insurance they buy. Insurers now offer a variety of options for consumer plans and choices of the network of providers.

For this decision point, your group must select how it will apply the federal definition of Essential Health Benefits while determining what insurance companies must cover to operate in your exchange. You have the option to require either the minimum EHB based upon the federal mandate, or add upon the minimum to include additional medical treatments or services.

You will need to discuss the benefits of both models before agreeing to your selection. You should consider how this will impact both the insurer and the consumer, and provide a brief statement on how you reached this selection.