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Private Health Insurance Exchanges: The Latest Evolution in the Health Care Marketplace

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Since the passing of the Affordable Care Act (ACA), the term ''Exchange'' has become ubiquitous in discussions about health care and business. There are many different types of Exchange arrangements, including the public Exchanges (now known as Marketplaces) that were created by the ACA. There has also been significant growth and evolution in employer-sponsored private Exchanges. Although the onset of private Exchanges is not directly related to the ACA, they have created new opportunities for organizations to explore innovative ways to manage their employee benefits packages.

With many options available and different employer needs and goals, all organizations should understand how private Exchanges might help them manage their costs and alleviate their administrative burdens while providing meaningful workforce benefits. Organizations need to research this rapidly evolving market carefully to determine whether a private Exchange should be part of their strategy to provide health and welfare benefits to their employees and/or retirees, either now or in the future.

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Exchange Background

The concept of a health insurance Exchange became mainstream with the advent of the ACA, which mandated the formation of public Exchanges. In its simplest form, an Exchange is an online marketplace through which people can purchase health insurance and evaluate the differences among plan designs and/or insurers. An Exchange is generally delivered as a web-based portal similar to a retail website, except that it sells health insurance coverage instead of consumer goods. It also includes decision-support tools to help users understand the coverage available through the Exchange and to allow them to make informed decisions.

The public Exchanges have been providing coverage since January 2014. Some are run by states, others by the federal government. Individuals can use the public Exchanges to purchase coverage from a variety of insurers. The public Exchanges have largely been a way of providing coverage for lower-income individuals—who may be eligible for a federal premium assistance tax credit in the public Exchange—and those who were previously uninsured. While there is an option for small groups through the Small Business Health Options Program (SHOP) Exchange, these plans will not be offered or available to large groups (more than 100 employees) until 2017 at the earliest.

Private Exchanges

Private Exchanges are very different from public Exchanges. Rather than being operated by the federal or

state governments they are owned and operated by private-sector companies or non-profit organizations that negotiate plan designs with participating insurers to make them available to large employers.

Private Exchanges operate in three main markets, which serve:

- Medicare-eligible individuals;
- Part-time employees, retired pre-65 employees and recipients of continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA); and
- Active employees.

For a detailed look at the three main private exchange markets, see Figure 1 below.

Figure 1: Private Exchange Markets

Medicare-Eligible Individuals	These Exchanges offer a set of predetermined individual insurance products for people who are 65 or older or disabled. Their main function is to provide decision support though call centers and web tools to help people enroll in Medicare products such as Medicare supplemental plans, Medicare Advantage plans and Prescription Drug Plans, products that were available before the Exchanges began. By moving to an Exchange, many plan sponsors that used to offer their Medicare-eligible employees and retirees group coverage no longer do so, replacing this coverage with a defined contribution (through a Health Reimbursement Arrangement) to offset the cost of these individual plans. In many cases, this has been advantageous to both the employer and the retiree, due to the pricing available in the individual Medicare market. The Medicare Exchange market has been in existence the longest and has gained popularity recently due to the savings opportunities that exist.
Part-Time Employees, Retired Pre-65 Employees and COBRA Recipients	These Exchanges leverage coverage available through the public Exchange market. Exchange vendors provide support for members to help decide whether to enroll in individual plans available on or off the public Exchange. This support involves a review of member income levels to determine whether they qualify for tax subsidies created by the ACA weighed against any subsidy that they may be receiving from their employer. The level of support that Exchange vendors are able to provide varies from state to state, depending on the enrollment rules that exist on each public Exchange.
Active Employees	These Exchanges offer employer-sponsored group insurance. It can be fully insured or self-insured, but the employer retains fiduciary responsibility and plans are still covered by ERISA. The employers contract with vendors, who generally have a predetermined suite of plan designs to choose from as well as insurer arrangements, decision-support tools and administrative platforms. These Exchanges vary greatly from vendor to vendor and continue to evolve based on member feedback and competitive pressures.

Source: Sibson Consulting — A BNA Graphic/pen540g5

The rest of this article focuses on private Exchanges for active employees.

History of Private Exchanges

Private Exchanges for active employees have existed for several years. One of the first entries that gained major press coverage was a fully insured insurance model, the Aon Hewitt Corporate Exchange, which debuted in 2013 and was quickly adopted by several large corporations including Sears Holdings and Darden Restaurants.

Since then, many other organizations—including major benefits consulting firms and brokers such as Towers Watson, Mercer, Buck Consultants, Willis and Gallagher—have introduced private Exchanges, developing different models that provide various versions of how an Exchange operates. Many are self-insured. Plan designs and administrative platforms differ. Some provide multiple insurers by geographic location while others fix the insurer by location. Most include voluntary benefits (e.g., life, disability, accident, critical illness) in addition to traditional health and welfare benefits. As they gain experience, vendors are modifying their approaches based on client and participant feedback.

It is important to understand that the private Exchanges have a profit motive. Some make money largely based on commissions, either on all benefits or on voluntary benefits. Some charge administrative service fees that vary from vendor to vendor. Some charge employee-per-month fees. Fees can be negotiated downward as an organization's plan grows. Organiza-

ISSN

tions should thoroughly understand the fees prior to contracting with an Exchange, as the profit motive may influence what an Exchange is promoting or endorsing.

The Future of Private Exchanges

In its short period of existence, the private Exchange market has rapidly evolved. Many of the technology platforms (e.g., bswift, Liazon, Bloom Health) have changed hands. Some have been purchased by consulting firms while others have been purchased by insurers, which are increasingly eager to join the Exchange market. This has created interesting interconnections. For example, some consulting firms use the Liazon platform, which is now owned by Towers Watson, for their Exchange. Mercer has increased its investment in Benefit Focus, the administration platform powering their Exchange. Some insurers were using bswift technology, which was recently purchased by Aetna. As more insurers get involved, it is likely that there will be further acquisitions. In addition, further consolidation in the insurer and the consulting market place, as seen with the mergers between Anthem and CIGNA and Willis and Towers Watson, could affect the level of choice both within and among the available Exchange offerings.

Possible future scenarios include further consolidation and a converging of solutions. Although the consultant-owned Exchanges have been gaining traction, more insurers are entering the market, making it more competitive.

Although most of the Exchanges started with large provider networks, many are experimenting with narrow (high-performance) networks and accountable care organizations. These options are gaining popularity in Exchanges that offer group insurance and in the public Exchanges. Organizations that have implemented narrow networks have found they can generate savings and limit employee pushback by continuing to offer choice between these plans and traditional plans with broader networks.

Many Exchanges tie their insurance offerings to their administrative portal and services, which makes administration and benefits difficult to separate. Over time, the Exchanges may be required to split these functions because employers want to pursue more cost-effective benefit choices while maintaining satisfaction with the Exchange's administrative services.

Questions to Ask

For some employers, private Exchanges may offer advantages (See the sidebar ''What's Driving Employers to Explore the Exchange Market?'') and growing costs and administrative burdens have made them very popular, but there are significant differences among the offerings.

Organizations need to carefully research this rapidly evolving market to determine whether an Exchange-based platform should be part of their long-term strategy to provide health and welfare benefits to their employees. There are a number of ways to determine how a private Exchange would affect the organization's costs, administrative processes and employees.

As part of the evaluation process, an organization should ask the following questions:

What's Driving Employers to Explore the Exchange Market?

Private Exchanges may offer some organizations a variety of advantages. Joining a private Exchange can:

- Potentially reduce the organization's health insurance costs due to improved discounts by leveraging the best insurer in each market, the "buy-down" effect in coverage selection and improved fees through bundling,
- Shift the administrative burden of many functions associated with managing an organization's health benefits from Human Resources to the Exchange,
- Provide employees with more plan and/or insurer choices,
- Allow the organization to efficiently offer voluntary benefits, and
- Promote health care consumerism.

Source: Sibson Consulting — A BNA Graphic/pen540g6

■ **What role does the organization want to play in health care delivery?** Many employers play a very active role in managing their employees' health benefits. This includes developing wellness and disease-management programs, choosing every facet of the health plan's design and helping employees with claims problems and insurer relationships. In an Exchange model, the organization may need to cede some of this control to an Exchange partner.

■ **What are the organization's long-term strategy and its Employee Value Proposition (EVP) as it relates to retention and employee relations?** It is important to know if health care benefits play a major role in employee attraction, retention and engagement. The organization then needs to determine how its employees would view moving to an Exchange, based on their overall rewards package and any perceived employer commitments.

■ **What impact would a move to an Exchange have on the organization's contribution approach?** The move to an Exchange is often coupled with a shift in an organization's employee contribution formula to a defined contribution approach in which employees are provided a defined amount of employer funds to use toward the purchase of a medical plan. Employers need to know the requirements and restrictions that an Exchange may put on their ability to manage their contribution strategy as they wish. Some Exchange vendors will include regional pricing, which could result in a more complicated discussion about managing a familiar contribution approach. The communications available to explain the potential changes should be reviewed in detail.

■ **What is the Exchange's underwriting model and who assumes the claims risk?** The organization needs to understand fully its ongoing fiduciary and claims liabilities under each Exchange model. Organizations

must decide whether they will be fully insured or self-insured and how this will be managed among the multiple insurers and contracts the Exchange may require. An Exchange is not an insurance captive, and Exchanges generally do not pool risk among employer groups.

■ **How involved would the organization be in insurer administration?** Although joining an Exchange may reduce vendor administration, it will not eliminate it. The way the organization communicates with its insurer(s) may also change. It is important to understand how these new relationships will work, including how the Exchange will manage the insurers and the new points of contact, as well as which responsibilities will remain with the employer and their employees.

■ **Will joining a private Exchange affect the organization's access to high-quality health plans?** With a private Exchange, employers typically offer a menu of insurance vendors, which can help organizations that are geographically diverse. In addition, employers should compare their current plan offerings with those available in the Exchange to determine if the benefits and networks they currently offer are similar to those being offered through the Exchange.

Once the organization has answered all these questions, it will have a much better understanding of whether an Exchange-based model is appropriate. It can then consider which Exchange provider would be the right partner.

Choosing an Exchange Partner

When choosing an Exchange partner, consider the following criteria:

■ **The Variety of Plans and Insurers in the Areas Where the Organization's Employees Live.** Does the Exchange offer a good selection of medical and prescription drug plans in these areas? How much do these plans cost, how do they vary by insurer, and how do they compare to the organization's current plan?

■ **Customer-Service Capabilities.** What customer-service support does the Exchange provide, and how much does it depend on web-based interactions? The transition to the Exchange model can be strenuous for employees, and call center personnel and decision-support tools should be capable of assisting employees during the transition process and during each new open enrollment period.

■ **Communications Support.** What materials and support are available to inform employees of the new program and transition process? How customizable are those materials? Additionally, will the Exchange administer the distribution of required notices (e.g., under HIPAA and the ACA)?

■ **Consulting Services.** As part of their offering, many Exchanges will include consulting services as part of the product. Employers should consider the level of services that are being provided and the cost associated with them, as well as whether they offer unbiased and independent advice.

■ **Administrative Requirements.** Some Exchanges require (or strongly prefer) that their employers use the Exchange's outsourcing platform to seamlessly administer the benefits they offer. This raises several issues (see the sidebar ''Using the Exchange's Outsourcing Platform).

Using the Exchange's Outsourcing Platform

It is important to know that:

- This relationship tightly couples the health plan with the administration provider and a change in one could likely require a change in the other.
- The model for the costs of administration (how administrative fees are derived) are different based on the model that the Exchange provider has implemented.
- Existing investments in benefits administration services or technologies could be disrupted. These could currently be provided by another outsourcing organization or internally with an existing human resources enterprise resource planning system (ERP).
- During a move to an Exchange provider, it is quite possible that current health and welfare benefits service providers would change, which would generate implementation costs and new integration needs.
- Employees will likely gain access to more consumer-friendly decision support tools.

While some organizations may see some of the above items as challenges, others may view them as an opportunity to upgrade their technology.

Source: Sibson Consulting A BNA Graphic/pen540g7

Best Practices

When selecting an Exchange provider, organizations should follow these best practices:

■ **Talk to everyone.** This is a relatively new marketplace with a lot of media attention. It is easy to get caught up in the hype surrounding a specific Exchange model and the promise of offering employees greater choice while mitigating costs and administrative burdens. But, there are key differences among the platforms, and one may be a better fit than others.

■ **Identify employee ''winners'' and ''losers.''** There will be ''winners'' if the company subsidy is fair. But, there will also be ''losers'' based on changes in contribution strategy, geographic differences in offerings, provider networks and other factors, depending on which plans the employees elect.

■ **Ask about year two.** With a rapidly changing marketplace and products, it is important to understand what the employees and the organization can expect to experience after a year in the program, when it is time for renewal, including any guarantees that can be made regarding the insurer choice and costs going forward.

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Conclusion

On the surface, private insurance Exchanges can be seen as a way to control costs and shift much of the administrative burdens to a third party. However, the differences among Exchanges, which continue to evolve, can be extensive, and these differences can have a major impact on the organization. As a result, employers need to carefully evaluate their options and the implications to their workforce before making the leap to adopting a private Exchange approach to health benefits.