Creating a Competitive Marketplace

How the Corporate Exchange Can Help Employers Break Away from the Health Care Trend
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Executive Summary

Employers offering health coverage today find themselves at a crossroads, where major trends are converging to create both new burdens and new opportunities.

First, annual health care cost increases have compounded to a level that places significant pressures on businesses’ ability to remain competitive and still be profitable, on the wages and other benefits that employers provide to their employees, on the share of employees’ personal spend on health care, and on shareholder value. An increasingly unhealthy population makes it both more critical and more difficult to control health risks and costs.

Second, the Patient Protection and Affordable Care Act (PPACA) is changing the health care landscape as we have known it.

In January 2014, large employers will face new responsibilities for the health coverage they offer their employees, as well as financial penalties if they fail to meet those responsibilities. In that same time frame, new state health care exchanges established under the PPACA will launch new health insurance marketplaces to individuals and small businesses, where coverage can be purchased with no medical underwriting or pre-existing condition exclusions. And if an individual has no other coverage and qualifies on the basis of family income, federal assistance will be available to help pay for premiums.

Large employers cannot purchase health coverage for their employees through the public exchanges until at least until 2017, when each state exchange will be given the discretion to admit employers with more than 100 employees.

As these dynamics unfold, employers now need to move beyond just compliance with the health reform law, and begin to focus on determining the role they want to play in providing employee health coverage in the future—and the strategies to realize that vision.

The old approaches are failing. What employers need—and are searching for—are new and innovative ones.

New Choices

Health reform offers one new approach: It gives employers the option to stop offering health insurance coverage by paying “free rider” penalties while their employees obtain individual coverage through the state exchanges. While appealing to some organizations, this approach is a step too far and too disruptive for most. A survey conducted in 2011 found that nearly all employers (94%) are committed to continuing to offer health benefits coverage.1

Those employers that continue to offer health coverage can engage in annual plan design reevaluation and vendor negotiation to try to lower their future cost trend to a modest degree. They will also look for ways to reduce the demand for health care services. For example, employers can put a greater emphasis on health screening and wellness activities to improve and maintain the health of employees and their families—with premium reductions or other incentives.

Another solution attracting a great deal of employer interest is the concept of offering health coverage through an innovative private Corporate Exchange. The exchange allows employers to join forces to create a competitive marketplace for health insurance based on consumer choice, which will encourage insurance companies to drive the system toward greater efficiency.

The Corporate Health Care Exchange

A health care exchange is a marketplace that connects insurance companies with individuals or employees wishing to purchase health insurance. The more exchange participants, the greater the economies of scale that increase carriers’ ability to offer competitive prices. In this insurance marketplace, as in every consumer market, the element of competition will ultimately reduce prices.

While there are different configurations of exchanges, the Aon Hewitt Corporate Exchange is a first-of-its-kind private-sector approach that uses a multi-carrier model to maximize competition among insurers on the basis of consumer choice. This dynamic will enable employers to establish a health care spending model comparable to an annual salary increase, as opposed to the common annual health care trend increase of 7% to 10%—and without necessarily shifting more costs to employees.

A company that participates in Corporate Exchange no longer designs and manages its health care plan—that function falls to the exchange. The employer determines how much of the cost of coverage it is willing to subsidize. Employees use this subsidy to select both the plan design and the insurance provider that best fit their needs. Thus, the exchange gives employers a greater ability to predict their costs.

In addition, the employer subsidy is no longer “hidden”—employees can now see the employer’s full monthly or annual subsidy.

Employers choosing this approach move from a self-insured plan to an insured group health plan, thereby transferring risk and cost accountability to the insurers. This increases predictability, minimizes volatility, and eases the employer’s administrative burden.

The employer health benefits contribution, or subsidy, is transparent.
How It Works

Employers choose the level of fixed subsidy they make available to employees for the purchase of coverage through the Corporate Exchange. Employees choose among an array of benefit levels. For each of these benefit levels, insurers offer rates to each employer based solely on the employer’s group experience; there is no pooling of risk among employers. Insurers then compete for the enrollment of employees on the basis of price, provider network, performance, and other value-added features. Benefit designs are standardized, and a risk adjustment mechanism compensates insurers for taking on enrollees with greater health risks from insurers that enroll a better-than-average risk.

Under this model, the Corporate Exchange can use competitive forces to limit future trend increases to the benefit of both employers and employees. Employees also have a wider choice of options and carriers.

The Value Proposition: Win, Win, Win

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Sometime after 2014, if and when there is a viable individual market, the Corporate Exchange may evolve in the direction of individual policies with employer subsidies that provide full portability of coverage if the employee leaves the company. This portability does not exist today with employer-sponsored health insurance except in the limited COBRA window, and the employer still retains the claims liability. A functioning individual market enabled by an exchange would replace the need for COBRA coverage and eliminate the “hidden subsidy” between COBRA rates and actual claims experience.

For many employers now looking toward the future, the Corporate Exchange is an idea whose time has come. The multi-carrier Corporate Exchange model creates a competitive marketplace unlike anything that exists today, while offering employees greater choice, control, and a superior user experience.

In a world of health care fraught with uncertainty, Corporate Exchanges can help provide employers with more predictability and less volatility.
A New Paradigm and New Choices

Employer-sponsored health care coverage, the source of health coverage for nearly 170 million individuals\(^2\) in the U.S., is at a crossroads.

In a little over a year, for the first time employers with 50 or more employees will have to begin paying a $2,000 penalty for each employee if: 1) the employer does not offer all full-time employees a health plan that provides what the law calls “minimum essential coverage”; and 2) even one employee becomes eligible for federal assistance in paying premiums (“premium credits”). A $3,000 penalty applies for each employee if the minimum essential coverage is offered but is considered “unaffordable” and an employee qualifies for federal premium assistance through one of the state exchanges.

In the same time frame, new opportunities to purchase coverage will emerge. New marketplaces will become available in every state, with either the state creating its own health insurance exchange or leveraging the federal government exchange option. State and federally based health exchanges are intended to offer an efficient marketplace for individuals and small businesses to purchase coverage from private insurers, with federal subsidies available to assist low-income individuals without other coverage. Health coverage is guaranteed in these exchanges, and premiums cannot be based on an individual’s health status or any pre-existing medical condition. Individuals who fail to purchase health coverage will pay a penalty that starts at $95 or 1% of income in 2014 and gradually rises over time.

Large employers cannot purchase health coverage for their employees through these state exchanges until 2017 or after, at which time each state exchange will be given the discretion to widen eligibility to larger employers.

Many leading organizations are studying the implications of the PPACA and developing strategies to address what their organization’s health care program should look like when the law’s major changes take effect in 2014. They are asking:

- Does our organization believe that health benefits are a core element of the employment deal with employees?
- Is there a direct connection between health benefits and employee attraction, engagement, retention, and productivity?
- Should our firm pay employees for their talent and performance, and simply provide access to competitive and tax-efficient health insurance options that employees then purchase on their own?

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If the employer seeks to stop providing health care benefits completely, there is one option:

Terminate the plan, pay the “free rider” penalty, and send employees shopping in the state and federal exchanges. Aon Hewitt’s recent survey of 562 employers indicates very few large employers are seriously considering this strategy. Many believe there would be far-reaching labor and employee relations consequences and that a weakening of the employer-sponsored system would likely trigger a legislated rise in the employer “free rider” penalty that would change the economics of such a decision.

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If the employer plans to continue to sponsor health insurance coverage, there are three options:

1. Manage the cost of the benefit on an annual basis by trying to close the gap between top-line health care cost trends and what the business can afford—by changing plan design, increasing employee contributions, and managing vendor contracts.

2. Require employees to take greater responsibility for their health and well-being in order to receive a comprehensive health plan. This “house money, house rules” strategy could, for example, require a health risk questionnaire, biometric screening, and/or ongoing health coaching in order to be eligible for the richest plan or the highest employer subsidy. About half of large employers Aon Hewitt surveyed indicate that this more requiring path will likely be part of their long-term strategy.

3. Continue to offer health coverage, but do so through a Corporate Exchange. This option is increasingly attractive to employers looking for new alternatives to lowering future cost trends, and who wish to lessen some of the administrative burden associated with sponsoring a health plan. In an Aon Hewitt survey of large employers, 44% said a Corporate Exchange will be their preferred approach to providing health care in the next three to five years.

Employers will be more likely to join a health care exchange if they:

- Are philosophically aligned with “monetizing” their commitment in the form of a defined contribution or subsidy
- Are willing to shift from self-insured to insured arrangements
- Want to avoid managing annual plan design changes and negotiating vendor relationships (but are willing to retain responsibility for wellness and health promotion)
- Believe that health benefit plan design is not a key or differentiating component of the organization’s total rewards program
- Desire to move toward a compensation-like rate of cost growth for health benefits while avoiding cost shifting to employees
- Are comfortable with employees accessing information and support from a third party (in this case, the exchange)

44% of employers surveyed say a Corporate Exchange will be the preferred approach in the next 3 to 5 years.\(^4\)

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The Competitive Marketplace of a Corporate Exchange

A health care exchange is a marketplace that connects insurance companies with individuals or employees wishing to purchase insurance. The more participants, the greater the economies of scale, and the more likely it is that carriers’ prices will reflect competitive dynamics. The added dimension of consumer choice introduces additional competition across the carriers.

Private health care exchanges are designed differently and have distinct attributes. For example, some insurers are creating exchanges that offer their products only. This provides employees choices of different plan options, but not a choice among different carriers.

By contrast, the Corporate Exchange Aon Hewitt is launching in January 2013 is a multi-carrier exchange. This model creates the framework for more competition among insurance carriers, driven by employee choices. The goal of this Corporate Exchange is to create a competitive market in health care benefits at a retail/consumer level, driving efficiency and mitigating cost trend through competitive forces.

To enable true market competition, the Aon Hewitt Corporate Exchange will offer five different levels of coverage, similar to the metallic levels of coverage to be offered through the state exchanges. The Corporate Exchange will offer Bronze, Bronze Plus, Silver, Gold, and Platinum levels of coverage, with actuarial values ranging from 66% for the Bronze plan to 92% for the Platinum plan. The benefit package for each of these metallic levels is standardized across carriers, and there are only four moving pieces between the metallic levels—deductible, coinsurance percentage, out-of-pocket maximum, and pharmacy coverage. All other design provisions have been equalized to make it easier for employees to understand and to prevent insurers from “cherry-picking” based on risk. The use of fixed employer subsidies encourages employees to choose the level of coverage that best suits their needs, recognizing they will pay more for higher-level coverage and less for lower-level coverage.
Competition Among Carriers

Carriers will compete for the individual employee’s enrollment on the basis of price, provider networks, performance, and customer service. It is this competition for market share that will drive greater efficiency overall and help reduce the future cost trend. If one carrier raises rates too much for the same standard benefit offered by other carriers in the exchange, that carrier risks losing market share. As carriers look for ways to contain costs to remain competitive, they will be strongly motivated to increase operational efficiency, eliminate programs that have little return on investment, and look for opportunities to reduce top-line cost. In addition, the Aon Hewitt Corporate Exchange uses 21 discrete regional rating bands to enable carriers to innovate, and think “best in market.” For example, a carrier may decide to use a network of high-performing health providers in a particular market, which will lead to more competitive rates for consumers and cost savings for the employer and carrier.

To protect carriers from adverse selection, risk adjustment mechanisms will provide offsetting payments to reflect the higher risk of their enrollees.

How the Corporate Exchange Works

In the Aon Hewitt Corporate Exchange model, the employer continues to offer a group health plan, fully compliant with the PPACA. On behalf of each company wishing to join the exchange, Aon Hewitt solicits employer-specific insured rates from both national and regional insured health plans that have contracted to provide coverage through the exchange. The employer then decides how much subsidy or “credit” to provide employees to purchase coverage. This credit most likely differs based on the employee’s family status, with higher credits given to employees wishing to purchase family coverage (similar to today’s model).

Employers with health improvement/wellness strategies may want to reward healthy activities with additional credits toward the purchase of health coverage. Similar to current approaches that reduce the price of health insurance to reward healthy behaviors, this approach has the advantage of greater transparency to employees as the wellness credits will be clearly communicated.

The employee then takes these credits and enters the exchange through a centralized portal with both web and phone support. Using a diverse set of robust decision support tools, the employee evaluates various plan options expressed in the metallic levels noted above. Bronze is the least expensive plan, followed by Bronze Plus, Silver, Gold, and Platinum options, each representing richer levels of coverage with increasing prices. While the Bronze plan from one insurer offers the same coverage as the Bronze plan from another insurer, their prices may be different—reflecting insurers’ own competitive positioning, network size, provider discounts, or assumed care management program effectiveness. The employee chooses the metallic level and insurer that best meet his or her health insurance needs and personal budget. If the employee has a credit of $300 per month, for example, and chooses a plan that costs $400 per month, then he or she pays the additional $100 through pre-tax payroll deductions.
Transparency, Cost Savings, Choice

As in today’s model, the employer decides how much to increase the credit amount each year. However, rather than being a hidden subsidy where employees see only their own increasing contributions, employees would see the explicit employer contribution increasing—and would make their plan choices accordingly. The control over the coverage/contribution decision transfers from the employer to the employee, and with increased control comes increased satisfaction.

The introduction of consumer choice removes the concern of some employees that their employer is unilaterally making choices that take more money out of their paychecks. For the employer, the movement to a fixed subsidy allows for greater alignment with a total rewards framework. Subsidies may be set to increase at a compensation-like rate of trend (2% to 3%) versus a traditional health care rate of trend (7% to 10%). Over time, jumping off the health care trend curve can create significant cost savings and increased shareholder value.

If the exchange concept performs as designed, future cost increases do not necessarily shift costs to employees. If a true consumer market is created, competition among insurers will create efficiencies that will translate into lower premium increases. The participation of multiple health insurers is the key.

Where do the savings from an exchange go? Some go into the pockets of employees, who are buying more cost-efficient plans and therefore reducing their contributions. Some go to employers, who can use the savings to strengthen the business or invest in other human resources programs that drive employee engagement—such as increased 401(k) match, paid time off, training and development, tuition reimbursement, or wellness programs.

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Individual Market? A Future Possibility

Sometime after 2014, the Corporate Exchange may transition from a group-based model to individual policies if and when the individual marketplace becomes stable and competitive. The employer would no longer have group programs (except those necessary to meet PPACA requirements), filing requirements, or fiduciary responsibilities. The employee would have access to the universe of plans available in the exchange and could choose to keep the health coverage even if he or she left the company and no longer had the employer subsidy. In this future vision, for the first time the employer-based system would be able to provide true portability of coverage. COBRA continuation coverage would no longer need to exist.

Changing Employee Behavior

Another important advantage of the Corporate Exchange is that it helps employees see the value of their coverage and thereby creates incentives for employees to take more responsibility for their health. Currently, employees may choose relatively rich coverage because it is subsidized by the employer and few other options are available that are perceived to offer greater value. Since employees do not see the employer subsidy, they don’t realize how much money is actually being spent to pay for that coverage.

In an exchange, employees clearly see the employer’s share. Their first reaction may be surprise at how large that amount actually is. They also see that if they choose a more expensive health insurance option, they’ll pay more out of their paychecks—and for some options, pay a lot more. This may lead to the “light bulb moment”—the realization that the affordable coverage comes with deductibles and cost sharing. If they want to reduce their exposure, they’ll need to start paying attention to what things cost and the behaviors that generate health care expenses. That may mean using the decision-support tools available to choose the right doctor, get the right treatment, and do things such as exercising, losing weight, and quitting tobacco use.

The range of cost options in the Aon Hewitt Corporate Exchange offers more flexibility to employees and may also offer a better fit with an employee’s lifecycle. Employees who are in their 20s and relatively healthy may choose less expensive plans. In their 30s and 40s, they may want to begin to increase their coverage. In their 50s and beyond, they may want to invest in plans that will protect them even more.

In addition, relief from the administrative burdens of health plan management frees employers to focus their attention on promoting employee health and wellness. The return on this investment includes potentially increased employee productivity and reduced incidence and length of disability.
The Retiree Exchange—A Model that Works Today

The concept of a multi-carrier exchange offering individually based coverage and a broad array of choices is working in retiree health exchanges for Medicare-eligible retirees. Employers are increasingly offering exchange solutions to their retiree communities.

The private exchange concept for individual coverage developed as Medicare-eligible retirees gained guaranteed access to a choice among a broad array of health plans including Medicare Advantage plans, Medicare Part D prescription drug plans (PDPs), and Medicare Supplement (or Medigap) plans. The Medicare Supplement, Medicare Advantage, and Medicare Part D markets do not ask medical questions or deny applicants coverage based on pre-existing conditions.

Aon Hewitt already offers a retiree health exchange called Aon Hewitt Navigators™. For employers sponsoring retiree health benefits for Medicare-eligible retirees, the retiree exchange has become an alternative to traditional employer-sponsored health insurance. Through the retiree exchange, the employer offers a subsidy toward the purchase of individual coverage, and representatives from the exchange assist in their selection of individual coverage from hundreds of competing plans offering significant value. The exchange serves as a centralized place to help seniors pick the plan that is best for them, complete the enrollment process, and receive ongoing customer service and advocacy services if needed.

The success of exchanges in this market, combined with the PPACA changes in the tax treatment of Medicare-paid retiree drug subsidies available to plan sponsors, has started a major shift toward exchange delivery as a preferred employer strategy for retirees. Nearly three-fourths of large employers are considering or already making changes to their retiree health care benefit programs, according to Aon Hewitt research.6 The economics of providing traditional employer-sponsored coverage are changing, and employers are seeking the most cost-effective and tax-efficient delivery models. Retiree exchanges offer these benefits, along with a wider choice of health plans than exists in the traditional employer-provided retiree health plan.

Retiree health exchanges are particularly attractive to companies that have fixed their health coverage subsidies as a result of retiree health plan accounting rules or defined dollar/service-based formulas. Because the employer contribution is fixed, managing the cost of retiree health benefits offers no return to the company; retirees pay the full cost above the fixed subsidy. For retirees, the wide variety of individual products in the open market allows them to use their employer subsidy to buy the coverage that suits their needs. Very often, individual Medicare Advantage or Medicare Part D plans can be purchased at lower rates than the employer can offer with comparable coverage, due to the federal subsidies available to issuers of these plans.

By replacing the traditional retiree medical plan with an exchange platform, employers are not abandoning their retirees—quite the contrary. For the same dollar subsidy, the employer is providing more choice, greater value, and—in many cases—enhanced customer service.

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The Corporate Exchange Is Not Just for the Private Sector

The Corporate Exchange concept is not just for corporations. Indeed, the same rationale can apply to public employers, including state employee health plans. Like large private-sector employers, state employee health plans are predominantly self-insured, and costs are increasing at three to four times the rate of wage increases. In the future, some state employers might be willing to transfer risk from the self-insured plan to an insurer, to gain greater budget predictability and more accountability along with the risk transfer. The model would further encourage health plan competition within the state, and offer employees a wider choice of options. Some individual self-insured state plans already offer their employees health plan options through different insurance carriers. In Aon Hewitt’s experience of working with state employee health plans, it is not uncommon for the state plan to offer medical options through two or three carriers, with additional carriers used as carve-out plans for prescription drugs, dental, and/or mental health and substance abuse coverage. These are states where the transition to a Corporate Exchange concept might be the easiest from the employees’ perspective. But while this structure offers broad choice, it does not provide competition, because the ultimate accountability for the cost and utilization of health care services still resides with the state as the self-insured plan sponsor.

Other states may be experiencing market dominance by a single carrier today, and would question how a multi-carrier Corporate Exchange could allow sufficient competition under those circumstances. It would perhaps take more time—but such states could be the beneficiaries of those private-sector employers participating in the Corporate Exchange who tend to have operations in most (if not all) of the 49 states (Hawaii is excluded). Served in all their locations through national carriers, these multistate employers might help change the market in states where insufficient competition exists today. In addition, new insurers might be attracted into the market, knowing that individual employees would choose among multiple carriers rather than the employer making a unilateral carrier decision. And even if these insurers don’t start out with a large network, they don’t necessarily need to have market dominance in that state. Providers would still be able to have multiple contracts with different health plans, and networks can be “rented” rather than created from scratch. The Corporate Exchange would thus serve to increase competition in those states by lessening the barriers to entry—a condition that is positive for the overall marketplace.

Finally, as the Corporate Exchange concept evolves toward its intended goal of giving employees access to portable, individual health insurance products, in many states that too may open up the individual and small group markets to more competition than exists today.

A different reason states may be interested in the Corporate Exchange is to explore it as an alternative way of setting up a health insurance exchange under the Affordable Care Act. States interested in setting up an exchange that is more private-sector-driven may welcome the chance to assume those responsibilities required at the state level—while contracting with a Corporate Exchange to provide certain of the additional key functions of exchanges, such as insurance carrier management, certification and evaluation, actuarial pricing, enrollment, and outreach to individual consumers and small employer groups within the state.

In short, the Corporate Exchange also holds the promise of transforming the health insurance marketplace in ways that benefit states, much as they benefit private employers and consumers.
Going Forward

Regardless of a company’s historical approach to health care benefits, the time is right for employers to revisit their long-term direction and take a fresh look at benefit plan options. New models of delivery, new approaches to managing health, and new compliance requirements will challenge employers to think differently about their role in “owning” health insurance responsibilities for employees, dependents, and retirees.

As employers think through their long-term health care goals and strategy, there are several important points to consider.

For employers, health reform is here to stay. As major provisions of health care legislation come into effect, the health care marketplace will grow even more dynamic. In addition, all the forces that have driven health care cost increases—changing demographics, new advances in treatments, and people’s unhealthy lifestyles—are continuing unabated. The stakes for employers are high: Medical insurance is the most highly valued benefit, by a margin of 2 to 1 over the next most highly valued benefit. It is no longer considered a “fringe” benefit by employees, but a necessity. At the same time, the risk to employers is unlikely to ease.

For nine out of ten employers surveyed, the future holds either a movement to a more demanding philosophy of employer-sponsored health care, or a Corporate Exchange. Either case is a significant departure from traditional annual trend mitigation strategies. The choice between the two will depend on how much the company believes its core value proposition to employees is built around delivering a health care benefit plan that is unique to that employer.

For employers that want to move to an environment where liability is fixed and more predictable, where administrative burden is reduced, and where enhanced choices are available to employees, the Corporate Exchange will emerge as a vehicle of choice. The multi-carrier Corporate Exchange model creates a competitive marketplace unlike anything that has come before, while offering employees greater choice, control, and a superior user experience.

This is an unprecedented time in health care. The decisions employers make now—to chart a strategic approach to health and benefits plans and programs, and determine long-term needs and direction—will have a profound impact. For both employers and employees, corporate health care exchanges can provide better health care results.

About Aon Hewitt

Aon Hewitt is the global leader in human resources solutions. The company partners with organizations to solve their most complex benefits, talent, and related financial challenges, and improve business performance. Aon Hewitt designs, implements, communicates, and administers a wide range of human capital, retirement, investment management, health care, compensation, and talent management strategies. With more than 29,000 professionals in 90 countries, Aon Hewitt makes the world a better place to work for clients and their employees.

For more information on Aon Hewitt, please visit www.aonhewitt.com.