Can Private Health Care Exchanges Improve the U.S. Health Care System?

There are already a number of firms entering the active employee exchange marketplace, and the trend will continue as more employers show interest in this model. Private health exchanges will be a permanent and significant avenue for health care benefits delivery because they are dynamic, powerful and necessary for employers aiming to achieve lower, predictable health care costs. The emergence of efficient and effective health exchanges, combined with a responsibility to provide affordable health coverage, presents an opportunity for employers to take advantage of new options available to help manage costs and improve the health of their population in a way that leads to a workforce that is healthy, present and productive.

by **Tina Provancal** | *Aon Hewitt*

Webster's defines *innovation* as "an improvement to something already existing," as opposed to *invention*, which is defined as "a useful new device or process." Private health exchanges fall squarely in the innovation category as a new way of delivering employer-sponsored health care benefits not previously seen in the 60-plus years companies have been providing group insurance benefits to their employees. While these new models of delivery have immediate advantages for employers, employees and participating insurance companies, can they also have long-term impact on the overall health care system? If they enjoy widespread adoption, can this be the private sector's answer to runaway health care costs that can finally create a sustainable employer-based system?

Employer-sponsored health care coverage—the source of health coverage for nearly 170 million individuals[1] in the United States—is at a crossroads. According to Aon Hewitt, the health care bill to large U.S. employers has increased 146% over the last ten years, reaching $10,522 per employee in 2012. Few employers have been able to absorb this entire increase, so over this same period their employees' share of health care costs (payroll contributions plus out-of-pocket spending) increased 222%. Average salaries, regrettably, have increased only 36% over this ten-year period, according to the Bureau of Labor Statistics. The "affordability gap" continues to widen, and there is no evidence that this trend is likely to change.

Faced with these and other business challenges, not least of which are the financial and compliance aspects of the Patient Protection and Affordable Care Act (PPACA), employers are seriously considering alternatives to traditional models of health benefits delivery. One such alternative that has created significant buzz in the benefits industry over the past year is the private health care exchange.

While the market is still premature, early evidence and a growing amount of interest from organizations, employees and regulators show that, when designed properly, private exchanges can be a viable way of delivering health care benefits in the U.S. and could be an inflection point in the future of employer-sponsored health care.

What Are Private Health Exchanges . . . And How Do They Work?

An *exchange* is simply a competitive and efficient marketplace that connects buyers and sellers to purchase products or services. The concept of exchanges is hardly new; think of Amazon, Expedia, Zappos, Orbitz or perhaps the most famous exchange—the New York Stock Exchange—as examples of efficient marketplaces (Figure 1). A health exchange leverages this concept to the purchase of health insurance. It turns an institutional or corporate purchase decision into a consumer purchase decision, where each employee can decide which insurance company or coverage is best for him or her. By moving the purchase decision to the employee, a retail marketplace is created. And in every consumer market where there is real competition, prices go down—every time.

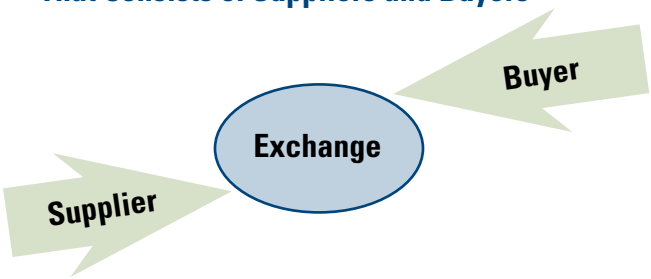
For example, not too long ago, consumers had to drive to a video store and pay $3 to $4 to rent a recently released movie for one day. Today, competition has stores vying desperately for customers by lowering prices and promoting faster service. Anyone can now pull up to a kiosk on the side of a building and rent a movie for $1 in less than a minute, or download that same movie instantaneously without leaving his or her sofa.

Does this work in health care? Of course it does. When a brand-name drug goes off patent, it typically will lose up to 90% of its revenue within the first six months—a direct result of competition from generic manufacturers.

We also see successful health insurance exchanges operating today for Medicare-eligible retirees, where a mature and competitive market already exists. Retirees who purchase health insurance through Aon Hewitt Navigators, Aon Hewitt's retiree health care exchange, can choose from among 80 insurance carriers and 3,300 different plans, saving an average of $1,000 each year over what they were paying for traditional employer-sponsored coverage.

FIGURE 1

An Exchange Is a Competitive Marketplace That Consists of Suppliers and Buyers



Source: Aon Hewitt.

Private health exchanges can reap the same types of benefits in the active-employee market if they are designed in a way that creates competition for health plan enrollment and offers ease of movement across insurers.

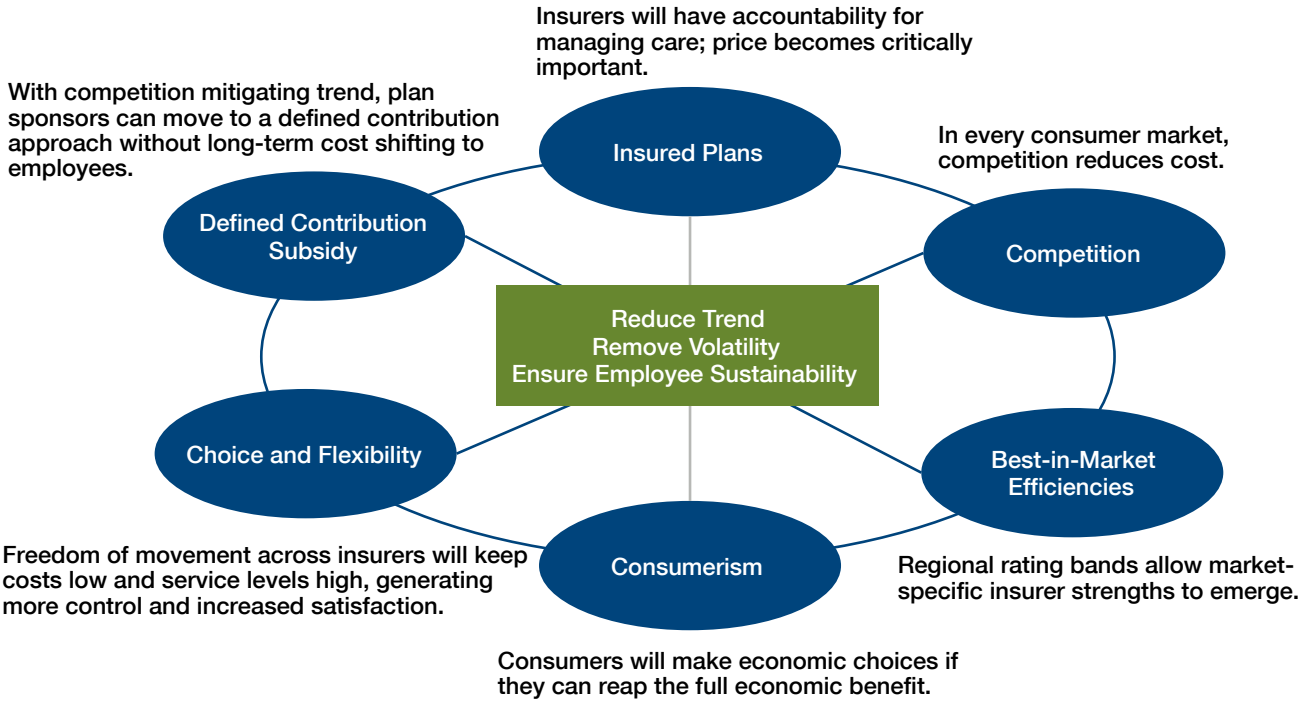
Designing an Effective Private Health Exchange

Several elements are essential to the architecture of private health exchanges that can make them viable as a long-term solution for employers. These include:

- **Risk transfer and insured products.** Many large employers today are self-insured, essentially acting as an open checkbook for health care. By transferring the risk to those most equipped to manage it—insurance companies—employers can achieve a fixed, predictable annual health care cost sensitive only to the number of employees covered. Placing accountability onto the insurance carriers, combined with competition based on standardized products, will result in efficiency and innovation among insurers, extending down through their supply chain.
- **Multicarrier competition and standardized plan designs.** Having multiple insurers offering standardized designs encourages real competition, as there is freedom of movement across suppliers. If an employee is not satisfied with the service he or she receives from one carrier, it is easy to keep the same coverage but switch carriers. This is a significant departure from traditional employer-sponsored models, where mov-

FIGURE 2

Gaining Predictability and Risk Transfer Without Cost Increases



ing an entire group of employees from one carrier to another is disruptive and costly. Insurers cannot cherry-pick risk based on specific coverage provisions; they must compete based on network, service, brand and price.

- **Regional rating.** Health care is local, and no insurance carrier has superior provider contracts or care management systems in every market in the United States. Establishing an exchange with regional rating areas allows best-in-market contracting to rise to the surface and offer optimal value to employers and employees.
- **Consumerism.** A successful health exchange will achieve both health insurance and health care consumerism. Offering a broad range of plan designs (including account-based plans with high deductibles) surrounded by robust decision-support tools creates consumers who are educated about their insurance needs and make the best use of their coverage and premium dollars.
- **Choice and flexibility.** While health plans in a well-designed exchange model are standardized to drive efficiency and competition, there should be a wide range of designs offered to meet the diverse needs of employees. The exchange should let employees decide which plan and which insurance company is best for them, and then enable them to modify that choice on an annual basis.
- **Risk adjustment.** Requiring multiple insurers to compete side by side for a defined population will naturally lead to concerns that adverse risk will land with a specific carrier. While it is mathematically impossible for every carrier to enroll the worst risk, this fear of adverse selection will lead to every carrier loading its rates with a "risk charge," thereby making the overall exchange financials less attractive. The way to mitigate these loads is with a risk-adjustment mechanism, whereby the enrolled population is measured according to a predefined risk-adjustment methodology, and carriers that enroll a

worse-than-average risk are reimbursed by carriers that conversely enroll a better-than-average risk.

- **Employer "credit."** In a private exchange model, employers determine how much of the cost of coverage they are willing to subsidize and provide employees with a dollar-denominated subsidy, or credit, to purchase health insurance. The movement to a fixed subsidy, combined with the competitive "juice" that acts to mitigate annual cost increases, allows for greater alignment with an organization's total rewards framework and facilitates an annual health care budget that looks more like compensation (2% to 3% increases) as opposed to historical health care trend (7% to 10% increases) without achieving this on the backs of employees. When used in conjunction with insured products, employers gain predictability and remove the volatility from their annual health care budgets.

Early Results Are Promising

Aon Hewitt launched the first multicarrier, multiple employer private health care exchange for large employers in the fall of 2012 (Figure 2). The postenrollment analysis from Aon Hewitt's Corporate Health Exchange indicates that employees liked having more choice and control over their health benefits. Almost 80% of the 100,000 employees who enrolled in health benefits through the exchange felt confident they chose the health plan that offered the best value for them and their family, and most (93%) liked being able to choose among multiple carriers.

Supported by customer service and enabled by education and guidance, employees also became more active consumers of health insurance. Enrollment results showed that 39% of employees enrolled in a consumer-driven health plan (CDHP), up from 12% in 2012 (see the table). Conversely, the number of employees who enrolled in a preferred provider organization (PPO)-type plan decreased from 70% in 2012 to 47% in 2013. However, while a significant number of employees migrated toward CDHPs, Aon Hewitt's data revealed that when given the choice, a fair number of employees chose to increase their coverage. For 2013, 32% of employees chose a plan similar in type to their current coverage (e.g., PPO to PPO), while 26% of employees chose richer coverage than they had previously. Forty-two percent of employees chose to reduce their regular payroll contributions and select a less rich form of coverage.

TABLE

2013 Exchange Enrollment by Plan Type

	2012	2013
Preferred provider organization	70%	47%
Health maintenance organization	18%	14%
Consumer-directed health plan	12%	39%

Private exchanges also bring transparency, where employees for the first time begin to truly understand—and value—the investment their employer makes toward their health care coverage. Two-thirds of employees who participated in Aon Hewitt's Corporate Health Exchange said they now had a good understanding of how they share the cost of medical insurance with their employer.

Downstream Impact on the Health Care System

Through the fully insured, competitive exchange model, accountability and risk are transferred from the previously self-insured employer to the insurers participating in the exchange. Overall price becomes critically important as consumers shop for coverage using their employer subsidy and their own payroll contributions. This competitive dynamic has the potential to create significant and long-lasting improvements to both the insurance system and the overall health care delivery system. For example:

- Insurers that have high administrative costs will be at a disadvantage over insurers that are more efficient. High-cost insurers will not be able to capture their costs through premiums, so they will either need to subsidize their rates from other coverage lines or become more efficient at the services they provide—just as almost every other U.S. business has been forced to do over the past decade in the face of global competition. Greater efficiency ultimately will result in lower costs across the system.
- Insurers will not be able to sell care management programs that are of questionable value. If these programs do not lower premiums, they will either have to get better or disappear. Programs that do little more than create administrative barriers to care will cease to exist. Conversely, insurers that enroll chronically ill indi-

viduals and effectively manage their care will be rewarded with risk-adjustment payments that will contribute to their bottom line. The incentives to manage health care spending will now be aligned.

- Insurers will have to make choices regarding the provider networks they offer and the associated price points they represent. Some carriers will choose to offer large networks that include high-cost providers and appeal to a broad cross section of employees. Others will choose to offer more narrow networks that exclude high-cost providers to enable a lower price point to consumers. The product/price trade-off will start to resemble other consumer markets, and providers will respond if their volume of patients is affected by these decisions. Prices will go down and quality will improve—again, like every other consumer market in the U.S.
- The exchange structure allows new models of delivery, such as accountable care organizations, to flourish. These models have the potential to provide integrated and clinically superior results to their patients, but they lack the sales and distribution capability of established insurance companies. Exchanges provide this distribution channel.

Private exchanges can also function as aggregation engines that provide value-added services across a very large participant base. One example of this is personal health records, which have gained limited adoption to date because of the difficulty involved in keeping medical records updated and transferring them from insurer to insurer. If medical records are provided at the exchange level and autopopulated with claims data by participating insurers, patients can have current records to share with providers, family members and emergency services personnel. This can reduce redundancy and improve quality and safety.

Is a Private Exchange Right for a Company?

Private health exchanges enable employers to stay in the benefits game but change the way they deliver those benefits. Aon Hewitt's data shows that more than 28% of large employers plan to move to a private health exchange model in the next three to five years.

These models are piquing the interest of employers of all sizes across all industries and geographies. They are most attractive to organizations with an impetus for change—when the status quo will no longer suffice—and those looking for new alternatives to lowering future cost trends.

They also appeal to employers that want to continue to provide employer-sponsored benefits, but remove themselves from the annual vendor, plan design and administrative decisions.

While this move will not be for all employers, those more likely to adopt private exchanges:

- Are philosophically aligned with "monetizing" their commitment in the form of a defined contribution or subsidy
- Are most attracted to the risk transfer element of shifting from self-insured to insured arrangements
- Want to avoid managing annual plan design changes and negotiating vendor relationships, but still want to invest in wellness and population health
- Believe that their health benefit plan design is not the differentiating element of the organization's total rewards program
- Are comfortable with employees accessing information and support from a third party, being the exchange itself.

What's to Come . . .?

So what's to come? A number of firms already are entering the active employee exchange marketplace, and the trend will continue as more employers show interest in this model. Competitive forces will drive the marketplace to evolve. Private health exchanges will enhance their offers and continue to innovate, the health care system itself will respond, and the individual insurance marketplace will evolve and become viable.

Private exchanges will not only need to continue to improve the "shopping" experience during enrollment, but provide education, information and guidance to help employees make informed choices and use their plan benefits wisely all year. Many employees have little to no experience with health insurance, so engaging employees as consumers will be critically important. Private health exchanges that will be judged successful are those with high consumer satisfaction as employees use their benefits, those with strong enrollment and plan selection guidance, those with user-friendly tools and education and, most importantly, those that mitigate health care cost trends.

The shift to private exchanges for delivery of employer-sponsored benefit programs likely will have far-reaching im-

plications in reforming the health care system itself. Competition, consumerism and efficiency at the insurer level will affect contracting, payment models and consumer behaviors. As exchanges grow in popularity and success, more employers will make the leap. As this happens, carriers will become more innovative and creative in how they compete for a slice of an ever-growing membership and earnings opportunity. In a private exchange, decisions around health care spending move away from employers to those able to apply pressure to the health care system—providers that deliver health care services, consumers who use services and insurers that price and pay for services.

As we enter 2014, and insurers are no longer able to medically underwrite and apply preexisting condition limitations, an individual health insurance marketplace will evolve. It may take a few years for insurance carriers to get comfortable with the new risk pool and for the market to become stable and competitive, but a time will come where private exchanges will have the ability to truly alter the way employers provide health coverage to employees. Exchanges will begin to transition from group-based models to individual models, providing individual insurance policies to employees. At that point, two significant things will occur:

- Employers will truly be in a defined contribution environment. They will no longer be plan sponsors, fiduciaries and benefit providers. "Comp and benefits" will transition to "comp and comp."
- Health insurance will become portable and, like it is in almost every other country, health insurance will be decoupled from the employment relationship. An employee who leaves a company's employ might lose the company's subsidy, but coverage can be continued. COBRA requirements would no longer be needed. From a policy perspective, this cannot come soon enough.

In Closing

Private health exchanges will be a permanent and significant avenue for health care benefits delivery because they are dynamic, powerful and necessary for employers aiming to achieve lower, predictable health care costs. Despite how employers have traditionally subsidized and delivered health care benefits to their employees, the time is now to revisit and set a new vision for the future. As the marketplace undergoes significant transformation, health care reform provides the "air cover" for employers to reevaluate the ways in which they want to continue to provide health benefits to employees, dependents and retirees. The emergence of efficient and effective health exchanges, combined with a responsibility to provide affordable health coverage, presents an opportunity for employers to take advantage of new options available to help manage costs and improve the health of their population in a way that leads to a workforce that is healthy, present and productive.

Is this a tipping point? Only time will tell. BQ

Endnote

1. U.S. Census Bureau: *Income, Poverty, and Health Insurance Coverage in the United States, 2010.*

AUTHOR

Tina Provancal is vice president of product development for exchanges at Aon Hewitt.

International Society of Certified Employee Benefit Specialists

Reprinted from the Fourth Quarter 2013 issue of *BENEFITS QUARTERLY*, published by the International Society of Certified Employee Benefit Specialists. With the exception of official Society announcements, the opinions given in articles are those of the authors. The International Society of Certified Employee Benefit Specialists disclaims responsibility for views expressed and statements made in articles published. No further transmission or electronic distribution of this material is permitted without permission. Subscription information can be found at iscebs.org.