Introduction

The Affordable Care Act (ACA) called for the creation of public health insurance exchanges as one path to achieving the coverage goals for millions of Americans. Some states have developed their own exchanges while others have deferred to the federal government to fulfill the requirement (via healthcare.gov).

Meanwhile, health plans, consulting firms, and technology service providers have taken steps to create health care exchanges for active employees as a way to capitalize on the emerging trend and capture new market share. These organizations are doing so with various models, each with their own combination of advantages and concerns. We expect these models to continue to evolve at a rapid pace and are mindful of the possibility that some exchange models may not survive.

Amid the constantly changing landscape for active health care exchanges, employers need to have a well thought-out health care strategy that identifies what role, if any, exchanges will play.

Why health care exchanges continue to generate industry attention.

- Providers of exchange solutions are making significant investments in their product offerings.
- Health insurance carriers are navigating the new landscape.
- Employers are evaluating these new solutions as potential tools for evolving their overall health care strategy.

WE EXPECT THESE MODELS TO CONTINUE TO EVOLVE AT A RAPID PACE AND ARE MINDFUL OF THE POSSIBILITY THAT SOME EXCHANGE MODELS MAY NOT SURVIVE.
Taking a Step Back

Lost amid the marketing brochures and press releases is an important question concerning active health care exchanges—“What is the problem we are trying to solve?” Without a well-defined health care strategy it is difficult for any organization to definitively conclude whether a health care exchange is the right answer. In that context, employers are correct to be wary of falling into the trap of “buying into a solution that is in search of a problem.”

Employers create benefit programs and deliver them to their employees as a way to attract and retain top talent. Health care benefits continue to play a key role in the employment value proposition, representing a significant and tax-efficient portion of an employee’s total compensation, especially for lower-wage workers.

Despite the significant amount of attention given to the employer decision created by ACA whether to “Pay or Play” (with respect to dropping or maintaining health care coverage), employers are staying in the game. In practical terms, large employers have determined that the financial implications to employees are too severe and the impact of dropping coverage too disruptive. Employer-sponsored health benefits remain a tax-effective way to deliver this important element of total compensation.

KEY TAKEAWAYS:

1. Active health care exchanges continue to generate industry attention as exchange providers increase their investments and additional employers implement these emerging solutions.

2. Employers need a comprehensive health care strategy that carefully considers the role that health care exchanges (both public and private) may play in addressing the needs of various populations.

3. Employers should be able to answer the following question about any proposed exchange strategy, “What is the problem we are trying to solve?” and as a follow-up question, “Is an exchange the optimal solution?”

4. Exchanges are complex health care solutions and they require careful evaluation. A comprehensive assessment should look at several different features as a way to compare and contrast the various exchange models available in the market.

5. The profile of a likely candidate for an exchange solution is evolving. But chief among the characteristics are:
   a. **Size of the organization**—small to mid-size employers can see economies of scale;
   b. **Industry**—lower wage and higher turnover employers have been early adopters; and,
   c. **Temperament**—employers seeking to create more of an “arms-length” relationship to health care design and delivery may find exchanges appealing.
In order for an employer to conclude that a health care exchange is a good strategic fit, an employer needs to start with the goals and objectives of their health care program. These objectives might include the following areas.

**HEALTH CARE GOALS & OBJECTIVES**

- **Choice**—of design, carrier, or provider
- **Cost management**—including the ability to migrate to a “defined contribution” approach to the employer funding for health care benefits
- **Health improvement**—with participant engagement in wellness and/or condition management programs
- **Participant advocacy**—to enhance the overall participant experience
- **Group purchasing advantage**—especially relevant for small to mid-size employers that lack scale to get competitive stand-alone pricing from health care vendors (e.g., pharmacy benefit managers, health plans, outsourced administrators)
- **Voluntary benefits**—including the role they play in the overall benefits philosophy

Having established goals and objectives for the health care program, the next assessment should address how best to design and deliver the health care benefit—through an employer-managed system or via an active health care exchange.

**Key Exchange Features**

Health care exchanges are complex arrangements involving the design, delivery, and operations of health care benefits. And there are a variety of different exchange models available in the market.

There is a constant across all models of active health care exchanges. Most exchanges are built around underlying group insurance contracts, where the employer maintains fiduciary responsibility. But there are many key features that vary among exchanges. Employers will need to carefully review and consider the following three sets of inter-related decisions: Model Characteristics, Design & Delivery, and Administration. (See Figure 1.)

**Figure 1: Three Categories for Making Private Health Exchange Decisions**

1. **Model Characteristics**
   - **Employee Populations**—who is included (full-time, part-time, etc.)?
   - **Funding and plan pricing approach**—does the exchange offer both self-insured and fully-insured options? How is adverse selection mitigated? How will the renewal rates be developed in subsequent years (i.e., is the model sustainable)?
   - **Carrier strategy**—is the exchange a single carrier solution (perhaps sponsored by an insurance carrier) or a multi-carrier solution?
   - **Other health & welfare benefit plans plus voluntary benefits programs**—what is the array of products offered? How do they integrate with other employer benefit programs? Does offering them impact other fees? How are they branded? Are employers comfortable allowing access to their employees for broader marketing purposes?
2. Design & Delivery

- **Product philosophy**—what is the array of plan designs and pricing? How does that compare to the value of current plan options? What level of employer customization is available?

- **Financials**—what are the key value drivers? What are the sources of savings for both employers and employees? What are the sources of revenue for the exchange?

- **Network and health plan partner strategy**—how are the networks configured? Are high performance or “narrow network” options available? Are multiple networks offered in any given market? What role do Accountable Care Organizations (ACOs) or Patient Centered Medical Homes (PCMHs) play?

- **Care management, health improvement, and wellness programs**—are these programs included or carved out? What level of integration is there with other employer health improvement programs that may be offered outside the exchange?

3. Plan Administration and Support

- **Implementation and ongoing support**—how much lead time is required to implement the exchange? What role does the employer play? How robust is participant education and communication material? How effective will the exchange be at reducing the employer compliance burden (e.g., ACA, state law, etc.)?

- **Technology and integration**—how intuitive is the enrollment system? How flexible is the technology platform? Is the participant portal easy to use and engaging? Are there robust decision support tools available?

- **Data and reporting capabilities**—what level of integration exists with any existing data warehouse solutions? Does the exchange offer its own data warehouse services?

- **Impact to existing vendor relationships**—for employers that have already outsourced health & welfare administration, when is that contract renewal date? What are the termination provisions? Can the exchange “plug and play” with the existing administration platform?

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Given the prominent role that exchanges play in today’s health care debate, it is important for employers to have conducted a thorough evaluation of the exchange market, whether or not they are prepared to implement an exchange solution in the near term.
Characteristics of an Exchange Buyer

To date, discussions of early adopters of private health care exchanges have focused on size and industry. These attributes are useful, as a starting point. The first employers that elected to implement a private health care exchange tended to be employers with a lower wage/higher turnover workforce (i.e., retail and hospitality industries). Some active exchanges have also seen early success in the smaller, mid-market segment. These “bright lines” will inevitably fade over time, as additional employers conduct their evaluations and make subsequent decisions to implement an exchange.

It may be more helpful to think of likely adopters of an exchange solution as organizations that reflect some combination of the following characteristics:

- Looking for “hands-off” or “arms-length” relationship to the underlying benefit programs, especially health care.
- Deciding to more aggressively shift cost to employees by offering significantly lower value plan designs and/or migrating to a more defined contribution approach to the financial subsidy they provide.
- Interested in expanding benefits outsourcing beyond administration of plans, to include their actual design, sourcing, and management.
- Operating with smaller HR/Benefits departments and, therefore, unable to devote the time required to develop the designs, manage the vendors, and service the participant.
- Questioning if their current health care programs provide enough competitive advantage in relation to the resources required to design and manage them on an ongoing basis.
- Seeking to achieve savings from group purchasing of health care services such as pharmacy benefit management, administrative fees, welfare benefits, or outsourcing expenses (e.g., smaller employers).

In the end, employers will need to decide whether they are best positioned to achieve success by implementing a private health care exchange or continuing to sponsor an employer-managed program.
Putting It All Together

The process an employer uses to evaluate a potential exchange solution needs to begin with an assessment of the organization’s overall health care strategy. (See Figure 2.)

Figure 2: Process Overview for Making Private Health Care Exchange Decisions

This process will create a “health care roadmap” against which exchange solutions, as well as employer-managed approaches, can both be measured.

Conclusion

We will continue to see rapid change in the health care exchange market. Health care exchanges, both public and private, will continue to garner significant industry attention. It will be important for employers to have a well thought-out health care strategy that includes an evaluation of the role that private health care exchanges might play.
MEDICARE EXCHANGES

Beyond the focus on the active health care exchange market, there is even more interest in the Medicare exchange market for retirees. Although there are many similarities between active and Medicare exchanges, differences do exist. And these differences will cause employers to think of exchange solutions for Medicare-eligible retirees as a separate strategic decision that needs to be addressed. Three things to keep in mind:

- Medicare exchanges pre-date active exchanges and have a long track record of acceptance for employers to evaluate.
- The presence of a government-sponsored Medicare program that provides underwriting stability has allowed for the development of a true marketplace complete with guaranteed issue products and individual contracts.
- Changes in the financial accounting for retiree medical coverage in the early 1990s drove employers to begin moving away from their commitment to retiree medical coverage, to include the emergence of “Access Only” coverage and fixed employer subsidy approaches.

Consider the following when evaluating the applicability of Medicare exchange solutions to your retiree health strategy:

1. Employers should first establish a comprehensive retiree medical strategy, along with associated goals and objectives.
2. In this context, exchanges can then be evaluated against employer-sponsored approaches (such as group Medicare Advantage) to determine the best fit.
3. Exchanges are complex solutions and the features of each provider need to be thoroughly evaluated.
4. In the end, employers may decide to implement both employer-sponsored and exchange solutions applying different solutions to different segments of their retiree population.
5. Ideally employers will concurrently evaluate their active employee and retiree strategies. To the extent an exchange is part of the eventual solution for active employees and retirees, partnering with the same exchange provider for both populations may help reduce administrative burden, costs, or risk.

For more information contact Fidelity Benefits Consulting or your Fidelity representative.