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Corporate Finance Matters

Cost management. Workforce management. Risk management.

"The public and private health exchanges can potentially offer an efficient and targeted way to deliver health benefits to various segments of the workforce."

Expanding Options for Employers in Next-Generation Private Exchanges

U.S. employers face tough decisions about whether and how they'll offer health care benefits to employees and retirees under the Patient Protection and Affordable Care Act (PPACA). The Obama administration's decision to delay the employer mandate until 2015 doesn't change the need to make those decisions — and sooner rather than later.

The first decision is whether to play or pay — that is, whether to provide employer-sponsored health benefits that meet PPACA requirements or discontinue offering health benefits, pay the penalty and send employees into the government-sponsored health exchanges (and post-age-65 retirees to Medicare). For now, most employers are likely to play. In fact, Towers Watson research indicates that over 88% of employers will continue to offer health benefits to employees beyond 2015.

At the same time, given continuing cost escalation and the looming 2018 excise tax (which will impact over 60% of employers in 2018, according to our surveys and projections), these organizations need to consider more cost-effective ways to deliver those benefits. One avenue is through the public and private health exchanges, which can potentially offer an efficient and targeted way to deliver health benefits to various segments of the workforce, particularly vis-à-vis traditional, self-managed employer programs.

Assessing the Optimal Delivery Channels

Historically, employers offered the same plans to all of their covered groups, whether these groups were full-timers, part-timers, those eligible for retiree medical and so on. In the post-reform world, choosing benefit delivery channels will be more complex, but will also provide the opportunity to customize delivery to different segments of the workforce, depending on which vehicle offers the best cost, benefit and value equation.

The segments employers will need to examine separately include active employees, COBRA participants, pre-Medicare-eligible retirees, Medicare-eligible retirees, and seasonal and part-time workers. By choosing to treat one or more of these segments differently, employers have the ability to improve their plan's performance and provide each segment with a solution that delivers the best value.

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Public and Private Exchanges: What They Are and How They Work

Public exchanges, which are scheduled to launch on January 1, 2014, are state-based and either state- or federally managed marketplaces that offer insurance to eligible individuals through private carriers at various price and coverage levels. Participating insurers cannot refuse coverage, and both annual and lifetime limits on coverage are eliminated. Premium cost differences for applicants based on age and smoking status are permitted, but capped by law. Employers with more than 100 employees will generally not have access to the public exchanges for their active employees before 2017. However, part-time and seasonal employees and pre-Medicare-eligible retirees who don't have access to qualified, affordable employer-sponsored insurance will have access to the public exchanges as individuals beginning in 2014. Low-wage individuals without affordable employer coverage will be eligible for subsidies in the public exchanges, which reduces their premium costs and their out-of-pocket expenses at the point of care.

Private exchanges, sponsored by the dominant benefit consulting firms and major insurers, offer health insurance to Medicare-eligible retirees through private carriers or to active employees through their employers. These exchanges may also provide pre-Medicare retiree coverage if the employer has an early-retiree medical plan. Some private exchanges may also sell directly to individuals who do not have an employer-sponsored plan available to them.

Private exchanges are neither state- nor federally facilitated, nor do they offer the subsidies for low-wage workers that the public exchanges will offer beginning in 2014. Private exchanges currently exist in single- and multicarrier configurations that offer both group-based and individual plans. The largest private exchanges to date operate within the Medicare supplemental insurance market, but after 2014, the number of private exchange offerings for all employer-sponsored populations is expected to grow significantly. While the private exchange concept is newly emerging for active employees, it is well developed and robust in the Medicare marketplace.

Private Medicare exchanges have matured and enjoyed success over the last nine years since the passage of the Medicare Modernization Act. Hundreds of thousands of Medicare-eligible beneficiaries have enrolled in Medigap, Medicare Advantage and Part D prescription drug plans through Medicare exchanges since 2006. In general, due to the conditions that exist in the individual Medicare insurance market, these individuals have been able to find affordable insurance coverage equal to or better than the coverage offered by their former employers.

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The Private Exchange Premise for Active Employees

All of the dominant active private exchange models require employers to continue to sponsor and fund the health benefit plan in compliance with ERISA, the PPACA and other regulations. However, the exchange operator has general control of the plan design, administration and vendor contracting. A private exchange model doesn't allow an employer to abrogate its obligations under ERISA, applicable insurance law, COBRA, HIPAA, the PPACA and the like.

Where the different private exchange models diverge dramatically is in their financing arrangements, and their ability to provide access to both public and private arrangements for all segments of an employer's population, and customize that access by population segment. All multicarrier models offer a choice of carriers and benefit plans, thus increasing employee choice.

In the first generation of active private exchanges, the dominant model was a fully insured arrangement with coverage available through the private exchange for actives only (and, potentially, pre-Medicare retirees). For self-insured employers, this type of private exchange required a transition to a fully insured model, which often carried higher costs — sometimes as much as 5% to 8% above current plan costs to make the transition. And while some proponents of this approach say that managed competition will drive down costs over time, there is some skepticism about that claim. Often, any "savings" demonstrated come from a reduction in employer coverage subsidies rather than from the private exchange model itself. In addition, this first-generation model is not structured to support access to the public exchanges, and this ability can be important for certain segments of a population. But

perhaps most important, the first-generation models don't focus on the elements that directly impact a plan's performance, including improved care delivery, better management of population health, best-in-class pharmacy benefit management strategies and optimal network contracting.

A second type of private exchange has emerged this year. It gives employers access to both public and private exchanges, as well as selected individual and group products, and uses multiple financing arrangements, including government subsidies in some cases. Arguably a good option for self-funded organizations to consider, this new model allows employers to continue to offer a high-performing health care program (defined as one that consistently delivers financial results in the top quartile of plans and is on a trajectory to remain below the 2018 excise tax thresholds).

Like the older-style private exchange, the new model includes more choices for participants and reduces an employer's involvement in direct plan management. But it differs from the older approach by introducing a variety of programs that the best-performing self-funded employers have come to expect: a focus on member accountability and engagement, best practice care coordination, condition management and wellness initiatives, top-notch pharmacy benefit management, and optimal use of current and emerging network contracting arrangements.

By using this mix of best-in-class strategies to promote health, manage health conditions and improve the delivery of care, this type of exchange can improve a health plan's financial performance, helping to ensure its sustainability and reducing or mitigating the risk that the employer will hit the 2018 excise tax thresholds. (Unless an employer manages its plan to stay below the tax threshold, the organization will face a 40% tax, putting the plan's survival at significant risk.)

Which Options Are Best for Your Employees and Your Organization?

As the range of benefit delivery models and features expands, choosing the right option for each segment of your population can be complex. The first issue to weigh is the role of employer-sponsored health care benefits for your organization in light of your overall corporate objectives, competitive environment, total rewards philosophy and employee needs. If that role is important for the foreseeable future, some questions arise:

- What is your cost trajectory? Have you modeled the costs of your organization's various health care plan options for your population segments: active employees, COBRA participants, Medicare-eligible and pre-65 retirees, and seasonal and part-time workers? Will an exchange-based solution or hybrid approach make sense for one or more of these groups?
- Do you understand the benefits and risks — both financial and in terms of your employee value proposition — of private exchanges compared to your current plans? What private exchange model most closely aligns with your financial and workforce objectives?

While employers' decisions about providing coverage will differ across population segments, some trends are already taking shape. Public exchanges are likely to prove a valuable option for non-Medicare-eligible retiree populations, COBRA participants, and seasonal and part-time workers. Because private exchanges for Medicare-eligible retirees already offer a proven way for employers to control spending on health care for this group while giving their post-65 retirees access to affordable coverage in a competitive market, that option is likely to continue to prove its value.

As for active employees, current evidence suggests that many U.S. organizations will want to continue sponsoring health care delivery for their active populations in one form or another, at least for the next five years. The emergence of public and second-generation private exchanges creates new opportunities and new decisions that every employer needs to consider to determine the best way to meet their health benefit commitment.

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