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Private health exchanges: Where are we headed?

Developing an exchange strategy by employer segment

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Executive summary

A year ago, we wrote about the evolution of private exchanges and the strides made toward consumer-driven purchasing of healthcare. Since then, the development of these exchanges has accelerated rapidly. National benefits consultants have seized the momentum to create multi-carrier private exchanges, actively courting payors and employers to join. Payors have choices to make: Participate in multi-carrier exchanges (if so, which ones and when) and/or offer proprietary, single-carrier exchanges. Payors need to design exchange strategies defined by employer segments that take into account the new players, new ways to play, new risks, and which employer segments will benefit the most from the exchanges. (Worth noting: The large employers that most exchanges are currently targeting may not be the most attractive, and we believe smaller and midsized employers may benefit more from these plans in the long run.) Ultimately, the decision about whether to participate in any particular exchange depends on key strategic and financial considerations unique to each payor, as well as the operational changes required by the payor.

Progress thus far

In mid-2012, just as the Supreme Court handed down its decision on the Affordable Care Act (ACA), we wrote about the future of private exchanges. By that point the development of private exchanges was firmly under way. Even so, the pace of change over the past year has been remarkable, driven mostly by supply-side intermediaries such as brokers and benefits service providers.[1] In particular, national benefits consultants — which historically provide counsel and brokerage services to large employers with thousands of employees across the U.S. — have dominated the news. They are actively promoting their own exchanges by soliciting payor and employer participation, and they have persuaded a few to sign up.

Many payors, fearing disintermediation by these multi-carrier exchanges, have abandoned the wait-and-see approach that we saw a year ago and are now rolling out single-carrier exchanges (or planning to do so soon). Single-carrier exchanges limit an employer's options solely to the payor's health insurance products. So far they have been targeted at employers that are comfortable with the current product choice offered by the payor but want to lower costs through a defined-contribution solution.

On the demand side, adoption within the retiree segment continues to grow, as employers increasingly look for solutions to control their ballooning retiree liabilities. Within the active segment, we see more interest than actual adoption of private exchanges. Among the most interested are employers in lower-wage, higher-churn industries where employers want to use private exchanges to further disentangle themselves from offering health benefits to active employees.

The past year has seen significant developments among private exchanges, but the industry is still in the early stages of evolution and it is unclear how the different exchange models being offered will add value to employers. So far, exchanges have focused on recruiting larger employers to boost their own membership quickly, but we believe that small and midsized employers may benefit more from the emerging exchange models in the long run. The emerging models vary on two key dimensions:

- *Who bears the risk:* Products on the exchange are either self-insured by the employer or fully insured by the payor.

- *Degree of competition:* Exchanges either invite multiple payors to compete or restrict the number of payors to one or two in a given market.

Small and midsized employers may benefit more than larger employers from the emerging exchange.

Where the action is — and isn't

Given their national reach and relationships with many employers, the large health benefits consultants setting up multi-carrier exchanges stand to gain unprecedented market-making power as next-generation insurance brokers. Their goal is to offer value to employers once offered exclusively by payors (*see Exhibit 1*).

To date, most national brokers have focused on creating exchanges that cater to the country's largest institutions. Intuitively, this makes sense. Exchanges want as many members as possible, and where better to start than with the nation's top employers looking to control ballooning healthcare costs for retirees and active employees?

Ironically, however, the promised value proposition of private exchanges for large employers is fairly weak. This is because large companies already enjoy many of the potential scale advantages that exchanges

Exhibit 1
Value migration of intermediaries

Current intermediary value proposition	Emerging intermediary value proposition
- RFP facilitation and review	- Marketplace creation, access, and management
- Benefits design consultation	- Carrier contracting and selection (by market)
- Reporting and analysis	- Benefits design (e.g., metallic tiers)
	- Ancillary product aggregation
	- Employee decision support and service
	- Reporting and analysis
	- Administrative services (e.g., payroll deduction, defined contribution facilitation)

Source: Strategy& analysis

offer. They benefit from a competitive (if not hypercompetitive) insurance market, and they are large enough to self-insure. They also outsource many functions to benefits consultants, and they prefer to control healthcare costs by maintaining independent risk pools. Doubtless, some of these large employers will join these exchanges in hopes of additional cost savings (specifically if employees buy down benefits), but they may be disappointed if exchanges are unable to deliver on their promise to bend the medical cost curve. We expect that the greatest beneficiaries of private exchanges, as currently configured, will be small and midsized employers (*see Exhibit 2*).

Midsized companies are the most challenged by cost pressures and inflationary swings and suffer the greatest administrative burdens. In fact, midsized employers, most of which are "fully" insured by payors, contribute the most to the commercial insurance industry's profits. This is because their negotiating position is weak and their risk profiles more variable. Exchanges give these midsized employers access to greater choice for themselves and their employees, even as they create price competition for health benefits and lower overall healthcare costs. In other words, not only do small and midsized employers stand to gain the most from participating in exchanges, but payors stand to lose the most (*see "Exchange Value Proposition," page 8*).

Private exchanges have not yet targeted these midsized employers because they've been focused on large companies. Meanwhile, regional brokers and benefits service providers (such as online

Exhibit 2
Value proposition of private exchanges across employer segments

Value proposition driver	Large employers	Midsized employers
Negotiating leverage	→	↗
Competition	→	↗
Product commoditization	→	↗
Administrative streamlining	→	↗
Cost trend control (risk pooling)	→	→
Cost trend control (defined contribution)	↗	→
Rightsizing of benefits	↗	→

Source: Strategy& analysis

enrollment and billing vendors), which traditionally cater to small and midsized employers, have been slow to develop their own exchange offerings. If they don't act soon to provide exchange-based solutions to their customers — likely through partnerships — regional brokers may be outmaneuvered by larger consultants. We expect that the likes of Aon, Mercer, Towers Watson, and Xerox's Buck will eventually move downmarket and target companies with as few as 100 employees. (Some have already taken steps in this direction.) Payors must be prepared to do business with midmarket exchanges or conceivably set up their own exchanges to retain this business.

Exchange value proposition

Exchanges offer a value proposition to employers that rests on several principles: shifting greater cost accountability and medical cost inflation risk to employees; introducing transparency and efficiency into the purchase of insurance; and tailoring product choice for consumers. However, we expect that these employer benefits will be felt differently depending on the employer's size. By our reckoning, five of the seven principal elements of the exchanges' value proposition will benefit only small and midsized employers (*see Exhibit 2, page 7*):

Negotiating leverage: Once a critical mass of members has joined an exchange, employers can extract better prices from payors.

Competition: Multiple payors competing for share on multi-carrier exchanges will put pressure on pricing, particularly in markets dominated by one carrier.

Product commoditization: Transparent, side-by-side comparisons of products will lead to product standardization, which will allow consumers to more easily understand and compare products, further spurring price-based competition.

Administrative streamlining: Administrative functions are outsourced by employers and standardized by the exchange, reducing employer burden, increasing efficiency, and improving the employee experience.

Cost trend control (risk pooling): Risk pooling across homogeneous employer segments will reduce individual employer–driven costs.

Two elements of the value proposition will bestow some benefits on large employers as well as small and midsized employers:

Cost trend control (defined contribution): The defined contribution model allows employers to shift some cost inflation to employees and gain greater visibility into their future premium spend.

Rightsizing of benefits: Giving employees cash to shop for insurance encourages them to make price/benefit trade-offs, leading them to purchase less costly and leaner benefits, on average.

Implications for payors

The idea that large employers will join exchanges sooner but benefit little, while midsized employers will join later but gain significantly, is critical to understanding how the exchange model will evolve. In anticipation of these developments, payors need to design an exchange strategy defined by employer segment that takes into account the new players, new ways to play, and new risks.

New players

Today the competition for large employer accounts involves a handful of "usual suspects" (mainly the large publicly traded plans and Blue plans) that possess the geographic scale to service multisite employers and the sophisticated systems needed to administer the complex, tailored benefits designs typically demanded by this segment of the market. Going forward, private exchanges have the potential to level the playing field if they standardize and simplify products, reduce administrative complexity, share administrative burden, and broaden distribution reach. Consequently, we may see new players enter the market — for example, the dominant health system in the area, or the local Medicaid plan, or even small, nimble upstarts.

New ways to play

Carriers traditionally differentiate themselves on network breadth, customized administration for larger employers, and new tools for cost management. The carrier's long-standing objective was to win the "account" (with the benefits manager as decision maker) rather than winning each "consumer." As a result, there was often a mismatch between individual employees' benefit needs and the benefit needs of their employers.

On private exchanges, however, the employees of companies of various sizes will have a broader range of less expensive options with

streamlined benefits. The old product development mind-set must evolve from winning the account — often by adding more bells and whistles to a plan — to winning the consumer, through cost-efficient options that appeal to an individual's specific circumstances (age, family status, chronic conditions, etc.).

New risks

Multi-carrier exchanges will create greater underwriting and risk management complexity for payors in all employer segments. Today, in the fully insured market, payors set premiums for employees based on a composite rate and offer a few product options. They also require high participation by employees to ensure that the employee group is large and stable, and continues to match up with their original premium calculations. But in a multi-carrier exchange, the calculation becomes much more complex, in that the payor cannot demand a certain participation rate. As a result, the actual risk profile of enrolled employees may differ significantly from the assumptions baked into the original premium calculations, especially in the early days of the exchanges before payors have built up a credible pricing history. Though some exchanges will make risk adjustments to compensate payors with higher-than-average risk, the lag time between pricing and risk adjustment compensation may cause major swings in payor performance (*see Exhibit 3*).

Exhibit 3
Economic impact of private exchanges on payor profits

Impact driver	Exchanges with self-insured employers	Exchanges with fully insured employers
Negotiating leverage	→	→
Competition	→	→
Product commoditization	→	→
Rightsizing of benefits	N.A.	↘
Overall	→	→

Source: Strategy& analysis

Designing an exchange game plan

In the new world of exchanges, payors will often find themselves in a difficult situation. By joining an exchange, the payor could encourage current employers to also switch to the exchange, reducing revenue even if many of the employees continue to choose the payor. But by not joining an exchange, the payor could lose all the business of employers that do join the exchange. The hard truth is that the value created by exchanges for consumers and employers comes at payors' expense. The industry's overall profit drops, and the revenue that payors once captured for themselves is spread across employers, employees, and the exchanges. We project that a 10 percent shift to private exchanges in the midsized- to large-group employer segment over the next five years will lower industry profits by 3 to 4 percent.

There is no single correct response. The right path will vary by payor, employer segment, geography, and exchange. The answers will be very different for a local Blue with dominant share and a national player spread thinly across several states. Ultimately, the decision about whether to participate in any particular exchange depends on a handful of strategic and financial considerations, as well as the operational changes necessary for the payor to participate in the exchange.

Strategic considerations

Private exchanges are coming, but they will not dominate overnight: B2B account-based sales will remain the primary model for many years, which means payors must not forget their core business while addressing the exchange challenge. Carriers must devise exchange participation strategies that balance the desire to mitigate disintermediation and margin deterioration with the imperative to participate in the very channels that are disrupting their business. Key strategic questions that payors should ask themselves include the following:

- Under what market scenarios does it make sense for us to participate in an exchange? When should we react to the creation of multi-carrier exchanges by others, and when should we proactively create single-carrier exchanges ourselves?

- What are the attributes of a broker with which we would want to partner? Which should we avoid?

- How can we maintain our differentiation in the increasingly standardized market?

- How should our strategy differ for single-carrier and multi-carrier exchanges?

- Given the uncertainty about the pool of employees we will win on an exchange, how can we design products to ensure that we largely attract the employees we want to attract?

Financial considerations

There are also a handful of financial questions carriers should ask themselves when analyzing the business case for participation in an exchange:

- How much incumbent business will we lose through attrition by not participating in an exchange?

- How much incumbent business will join a private exchange because we decide to participate, thus eroding our margins?

- How much new business through enrollment growth will we gain by participating?

- How much will competition, buy-downs (employees buying less generous plans), and anti-selection (unbalanced risk/product mix) affect our "on-exchange" margins? Also, how much will potential insured conversions (employers moving from self-funding to fully insured) and ancillary cross-sales offset them?

- How much operating and IT investment will be required to connect to the exchange?

The first three questions address demand, which is difficult to estimate because the brokers setting up exchanges often do not readily share information about which carriers and employers are participating. Cultivating strong relationships with brokers and regularly communicating with customers may give payors some insight into potential exchange volume. Even so, carriers should include contingent exit options in their participation agreements, in case promoted pipelines fail to materialize.

The final two questions address margins. Early results from some private exchanges show that margin percentages for individual products may hold steady, but since as many as 70 percent of employees buy less expensive options, the absolute dollar contributions could decline significantly. This revenue reduction flows almost entirely to the payor's bottom line, reducing margins in aggregate. However, market research and an accurate modeling of employee behavior should help carriers design products that attract a balanced employee risk profile and also provide visibility into expected buy-down amounts based on employer industry, wage levels, current benefit richness, and other attributes.

Operational considerations

Many payors understandably focus on the strategic and financial issues associated with participating in exchanges, but it's important not to gloss over operational issues. Whether a carrier's exchange strategy targets large or midsized employers, new operational capabilities will be needed. Joining a private exchange is not business as usual. The payor needs the IT capabilities to interface with exchanges on all aspects of the plan, from front-office marketing and sales (such as modular product catalogs) to back-office member enrollment and split billing (if, for instance, the payor is sharing one company's employees with several other payors) and even to core corporate functions such as financial reporting. What's more, as private exchanges spread from national to local markets, maintaining seamless IT and business connectivity will become increasingly complex and costly. Carriers should assess their ability — and appetite — to meet these operational requirements and conduct due diligence on the readiness of the private exchange vendors themselves.

Conclusion

Ultimately, payors need to determine when, where, and how to participate in exchanges, by weighing the benefits of exposure to new accounts against the risk of undermining incumbent business. Most of the attention to date has been on large employers, but small and midsized employers actually stand to gain the most value by participating in exchanges. Once exchanges begin to target these employers, many are likely to sign up. Given that small and midsized employers account for a hefty chunk of the industry's profits, it's imperative that payors develop a private exchange strategy by employer segment.

The stakes are high. Carriers don't want to join exchanges too soon or unnecessarily, since margins and revenue will suffer. But sitting out completely or waiting too long could cost them dearly in terms of new customers and attrition. Payors need to act deliberately and formulate their game plan while battle lines are being redrawn. This includes choosing where to invest and how to adapt their operational capabilities to compete in a healthcare landscape where private exchanges will gradually become the norm.

Endnote

[1] Akshay Kapur, Ashish Kaura, Minoo Javanmardian, and Paolo Borromeo, "The Emergence of Private Health Insurance Exchanges: Fueling the 'Consumerization' of Employer-Sponsored Health Insurance," Booz & Company, 2012.

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