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The Elusive Nature of Private Exchanges

By Mike Gaal

The passage and subsequent implementation of the Patient Protection and Affordable Care Act (ACA), with all of its requirements, guidance and excruciating levels of detail, has created a significant amount of additional work for professionals who work in the employee benefits space, much of which was not contemplated prior to 2010. As employers and their advisers have worked diligently over the past five years to implement the key changes brought about by the ACA, other stakeholders have viewed the ACA through a different lens, as an opportunity to potentially redefine the way in which employers deliver care to their employees.

While the ACA gave us *public* exchanges and a new health insurance marketplace geared toward individuals and small businesses, it did not present a similar solution for large employers, at least in the near term. (A provision in the ACA allows for the potential expansion of the Small Business Health Options Program (SHOP) to large employers, beginning in 2017. To date, the adoption of the SHOP by small employers has been limited, and it does not appear to be a practical option to large employers in the near term.) Based on this perceived gap (and opportunity), as well as the historical success of privately-run exchanges for employer-sponsored Medicare retirees, the marketplace reacted swiftly. A number of different players, from technology companies to insurance carriers to benefits consulting firms, began developing solutions to deliver employer-sponsored benefits through this emerging platform: the active employee private exchange.

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The concept of active employee private exchanges has taken the market by storm, and a number of organizations have opined on the potential growth of the market. For example:

- Based on a March 2013 survey, Accenture forecasted that private exchange growth among active employees and pre-Medicare retirees would reach 40 million members by 2018. (Accenture (June 3, 2013). One in four consumers will receive employer health benefits through insurance exchanges in five years, Accenture research shows. News release. Retrieved February 2, 2016, from https://newsroom.accenture.com/subjects/research-surveys/one-in-four-consumers-will-receive-employer-health-benefits-through-insurance-exchanges-in-five-years-accenture-research-shows.htm).

- In October 2013, Oliver Wyman projected that private exchanges will cover nearly 40 million individuals in 2018. (McIntyre, A. et al. (October 2013). A Billion Dollar Decision: Charting a New Course for U.S. Healthcare Benefits. Oliver Wyman. Retrieved February 2, 2016, from http://www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/archive/2013/OW_ENG_HLS_PUBL_2013_Billion_Dollar_Decision.pdf).

- A February 2014 survey by Aon Hewitt indicated that 33 percent of employers said offering group-based health benefits to active employees through a private health exchange will be their preferred approach in the next three to five years, a substantial increase from the 5 percent of employers offering them at the time of the survey. (Aon (February 19, 2014). Aon Hewitt research: Employers will continue sponsoring health benefits for employees and retirees, but deliver those benefits in new ways. News release. Retrieved February 2, 2016, from http://ir.aon.com/about-aon/investor-relations/investor-news/news-release-details/2014/Aon-Hewitt-Research-Employers-Will-Continue-Sponsoring-Health-Benefits-for-Employees-and-Retirees-but-Deliver-Those-Benefits-in-New-Ways/default.aspx).

However, the adoption of private exchanges has not kept pace with early forecasts. Based on publicly available information on private exchange enrollment, covered in greater detail below, it is reasonable to estimate that between 4 million and 6 million *active* enrollees (active employees and dependents in employer-sponsored coverage) and 5 million to 8 million *total* en-

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rollees (active employees, retirees, and dependents) are likely to be covered by private exchanges in 2016, which is well below initial forecasts for 2016 (see below for more detail).

As we try to understand why private exchange enrollment is so far below the initial forecasts, it is important to understand the answer to a key question—what was the driver of the optimistic growth? The premise was that there would be significant movement to this platform because private exchanges offered such a compelling story to large employers. The key considerations touted by private exchange operators included the following:

- Enhanced employee choice;
- Improved technology and decision-support tools for plan participants;
- Reduced administrative burden for employers' human resources staff;
- A best-in-market vendor approach; and
- Plan savings through a defined contribution platform and/or insurer competition.

Private exchanges became the hottest topic in employee benefits, as employers were trying to rein in the unsustainable increases in healthcare spending, and these selling points resonated with employers. Despite this momentum in the marketplace, employers have been cautious and the exponential growth that was once expected has not materialized. The key question is why.

Cost Savings or Cost Shifting?

The most controversial selling point of the private exchange platform is whether it truly has an ability to control costs better than the status quo traditional self-funded model. After all, large self-funded employers have always had the ability to offer their employees a choice of plans, provide decision support tools, implement a best-in-market approach to vendor management and even employ a defined contribution approach. For a number of large employers, these are core principles that have been part of their program for a decade or more.

Generally speaking, it is reasonable to say that a private exchange platform will allow an employer to reduce its overall administrative burden and outsource tasks, such as plan administration and vendor management, to the private exchange operator.

But what of the promise of plan savings? What, exactly, is inherently included in the private exchange platform that is *not present* in a traditional self-funded model? When answering this question, it is important to ensure that the employer and private exchange operator are speaking the same language as it relates to defining healthcare costs and healthcare trend. Semantics can play a crucial role when trying to define healthcare cost control. The table in Figure 1 illustrates some key terminology related to employer healthcare costs.

While the focus for most employers is on either the *net employer claim costs* or the *net employer costs*, the true measure of year-over-year healthcare trend (as it relates to long-term cost control) is the change in the *gross allowed claim costs*. However, because the concept of employer healthcare trend is often defined as the *employer-only* change in healthcare costs year over year, employers do not always have a full view of how well their programs are managing overall (i.e., gross allowed) healthcare costs.

In this context, many private exchange operators are able to project low annual healthcare trends, particularly in the first year of implementation. But what is not always transparent to the employer is that significant savings might be derived through cost shifting to employees (via lower average actuarial values and/or higher member contributions), not through a reduction in total (gross allowed) healthcare costs. The table in Figure 2 illustrates an example of how an employer can achieve favorable plan trends without any true mitigation of total allowed healthcare trend.

Figure 2 is a simple example to illustrate how employer cost trends under a private exchange can be very favorable, even while total allowed healthcare cost trends are at or above market levels. A fundamental issue is that marketing collateral often centers around the *net employer claim costs* or *net employer costs* per member per month (PMPM) trend (the employer-only portion), which does not always represent more effective management of overall (i.e., allowed) healthcare costs.

The illustrative example in Figure 2 shows that *net employer cost* trends under the private exchange model could produce 6 percent lower trends than under the status quo. This would be an exceptional outcome for the employer-sponsored plan, but it would not tell the whole story. While this example does show a 6 percent lower trend under the illustrative private exchange model, the net employer savings can be traced back to higher point-of-care member cost sharing, which increases by 44 percent in the example (from $150 PMPM to $216 PMPM), as the average actuarial value decreased from 85 percent to 80 percent. These outcomes are sometimes referred to in a positive manner, in that employees are making better choices and ''buying down'' to more appropriate levels of coverage. While this may be true, the reality is that the plan savings, in this example, are derived through shifting costs to employees through higher deductibles, copayments and out-of-pocket limits.

In and of itself, cost shifting is one of the most effective tools for managing employer healthcare costs. Employers have been working for years to ''right-size'' their benefit plans, encourage employees to become better informed consumers of healthcare and select plan designs that are appropriate for their needs. Offering the appropriate benefit designs with a strategically designed contribution strategy is one of the most critical aspects of managing plan cost.

So the question facing employers is: What mechanism does a private exchange platform offer to a large self-funded employer to help control total allowed active employee healthcare costs *more effectively* than a traditional approach? This is the question that employers need to answer before making the leap to a private exchange. Cost shifting as a result of benefit buy-downs does not create an impetus to migrate to the private exchange environment, because most employers understand that they have the ability to offer plan choice and a defined contribution environment outside of a private exchange.

To create a compelling reason for movement, private exchange operators must be able to clearly outline and

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Figure 1: The Anatomy of Employer Healthcare Costs

Terminology	Healthcare Costs	Comments
Gross Allowed Claim Costs*	$1,000	Assumed per employee per month cost
Point-of-Care Member Cost Sharing**	($150)	Assumed actuarial value of 85%
Net Employer Claim Costs	$850	
Administrative Costs	$50	Estimated 5% to 6% administrative load
Total Gross Employer Costs	$900	Total employer claims/administration
Member Paycheck Contributions	($180)	Assumed member contribution of 20%
Net Employer Costs	$720	Final net employer cost

* Total billed charges, less contracted discounts.
** Deductibles, coinsurance, copayments, etc.

Source: Milliman

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Figure 2: Comparison of Net Employer Trend Under Illustrative Private Exchange Model

Terminology	Baseline Year	Status Quo Increase	Illustrative Private Exchange Increase
Gross Allowed Claim Costs*	$1,000	$1,080	$1,080
Point-of-Care Member Cost Sharing**	($150)	($162)	($216)
Net Employer Claim Costs	$850	$918	$864
Administrative Costs†	$50	$52	$52
Total Gross Employer Costs	$900	$970	$916
Member Paycheck Contributions††	($180)	($194)	($183)
Net Employer Costs	$720	$776	$733
Percent Change in Net Employer Costs		7.8%	1.8%

* Assume 8% market-wide increase of allowed charges.
** Assume employees "buy-down" from an 85% plan to an 80% plan, on average.
† Assume 4% increase in administrative expenses.
†† Assume employer target of 80% subsidy of net claim/administrative costs.

Source: Milliman

A BNA Graphic/ben608g2

articulate the fundamental difference that exists in the private exchange environment that is not available to large self-funded employers. Through early 2016, the evidence supports a conclusion that the inability to address the explicit advantage in controlling overall active healthcare costs is likely the key issue that has driven lower-than-anticipated adoption rates of private exchanges, especially among large self-funded employers, while small- to middle-market employers seem to be driving the majority of growth over the past two years.

Where's the Enrollment?

While total healthcare savings can be difficult to quantify, an even more elusive number to quantify is the number of enrollees currently in private exchanges. A September 2014 report published by the Kaiser Family Foundation (KFF) (Alvarado, A. et al. (September 2014). Examining Private Exchanges in the Employer-Sponsored Insurance Market. Kaiser Family Foundation Report. Retrieved February 2, 2016, from http://files.kff.org/attachment/examining-private-exchanges-in-the-employer-sponsored-insurance-market-report) estimated the current size of the market at that time was at least 2.5 million enrollees, broken down as follows:

- 1.7 million group plan enrollees
- 700,000 individual Medicare enrollees
- 100,000 individual enrollees

Of the 2.5 million lives outlined in the KFF report, more than one quarter (700,000) are Medicare-eligible enrollees. The KFF study contained further detailed enrollment information about the four largest private exchange operators—Towers Watson's OneExchange, Aon's Active Health Exchange, Buck's RightOpt Private Health Insurance Exchange and the Mercer Marketplace, which is shown in the table in Figure 3.

Based on the figures reported by KFF and outlined in Figure 3, it appeared as though the ''big four'' private exchange operators controlled more than 80 percent of the entire private exchange market in 2014 (nearly 2.2 million enrollees), with active enrollees and dependents not quite accounting for three-fourths of the total cov-

Figure 3: 2014 Private Exchange Enrollment for "Big Four" Reported by KFF

	Actives	Retirees	Total*
Towers Watson OneExchange	*No detail provided*		800,000
Aon Active Health Exchange**	600,000	*No details*	600,000
RightOpt Private Health Insurance Exchange	400,000	100,000	500,000
Mercer Marketplace	*No detail provided*		290,000
Total			2,190,000

* Includes actives, dependents, pre-Medicare retirees, and Medicare-eligible retirees.

** Aon also sponsors a Retiree Health Exchange, which was not reported in the KFF study.

Source: Milliman

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ered population in the report. We note that the KFF report did not specifically provide detailed enrollment figures for Aon's Retiree Health Exchange, but a recent statement from Aon's CEO during Aon's 2015 earnings call (Yahoo! Finance (February 5, 2016). Edited transcript of AON earnings conference call or presentation, 5-Feb-16, 1:30 p.m. GMT. Retrieved February 11, 2016, from http://finance.yahoo.com/news/edited-transcript-aon-earnings-conference-211034841.html.) indicates that Aon's total private exchange enrollment was roughly 1.2 million in 2014, so it is likely that Medicare-eligible enrollees make up an even larger share of total private exchange enrollment.

Accenture's original projection (in 2013) estimated that 9 million enrollees would be covered by private exchanges in 2015. (Accenture. Ibid) In April 2015, Accenture restated the 2015 projection and estimated 6 million members enrolled in benefits through a private exchange, representing double the number enrolled in 2014. (Accenture Consulting. Latest thinking: Private health insurance exchange enrollment doubled from 2014 to 2015. Retrieved February 2, 2016, from https://www.accenture.com/us-en/insight-private-health-insurance-exchange-annual-enrollment.aspx.) Enrollment figures released by the big four private exchange operators support the notion that there was significant growth between 2014 and 2015. Three of the largest four private exchanges made information available publicly about private exchange enrollment, shown in the table in Figure 4.

As illustrated in Figure 4, the Mercer Marketplace experienced tremendous growth in 2015, more than tripling the number of enrollees. Both the Towers Watson OneExchange and Aon's Active Health Exchange also experienced significant growth, ranging from 40 percent to 50 percent higher than 2014 enrollment. No information was available about RightOpt's enrollment, although it can be reasonably estimated that the big four exchanges covered approximately 3.5 million to 4 million enrollees in 2015, based on the 2014 RightOpt figures included in the KFF report, and applying reasonable growth assumptions. In the Aon earnings call noted above, it was noted that Aon's total 2015 private exchange enrollment was roughly 1.4 million, which may indicate that about 550,000 retirees are covered in Aon's Retiree Health Exchange. Given the level of market share of the big four in 2014, and the fact that no significant new players entered the market in 2015, it is likely that the total number of enrollees covered by private exchanges in 2015 was between 4 million and 6 million, with the Accenture projection reflecting the top end of the range.

This estimate includes those individuals covered in group retiree exchanges. As noted above, the KFF figures estimated that more than a quarter (700,000) of the 2014 estimated enrollment reported in the study was for Medicare-eligible individuals, so it is likely that enrollment for actives was between 3 million and 4.5 million in 2015.

As of January 2016, only one of the big four has released enrollment figures for 2016, although most employers concluded open enrollment in November or December 2015. The Mercer Marketplace reported in October 2015 that it expects nearly 1.5 million lives in its private exchange in 2016, growth of about 42 percent over 2015, which represents its second consecutive year of impressive growth. (Mercer (October 15, 2015). Mercer Marketplace private exchange continues growth in individual participants and clients. Newsroom. Retrieved February 2, 2016, from http://www.mercer.com/newsroom/mercer-marketplace-private-exchange-continues-growth-in-individual-participants-and-clients-with-96-participant-satisfaction.html). While enrollment figures have not been made publicly available by other large private exchange operators, if they are able to post growth figures similar to Mercer there could be as many as 8 million enrollees in private exchanges in 2016 (actives and retirees). However, with smaller to moderate growth (or even reductions in covered lives) for the other private exchange operators, it is possible that private exchange enrollment could be as low as 5 million in 2016. It should be noted that, in January 2016, Accenture released an estimate of 8 million covered lives in private exchanges. (Accenture Consulting. Latest thinking: Private health insurance exchange enrollment increases 35 percent to 8 million in 2016. Retrieved February 2, 2016, from https://www.accenture.com/us-en/insight-new-private-enrollment.aspx.)

All indications are that group retiree exchanges for Medicare-eligible individuals will continue to flourish, given the mature nature of the marketplace and the clear benefits to employers from migrating retirees to these exchanges. However, active enrollment for 2016 is estimated to be only 4 million to 6 million lives, and these estimated figures are well below the early prognostications, which speculated that active-only enrollment in private exchanges would reach about 20 million

Figure 4: Estimated 2015 Growth in Private Exchange Enrollment for Major Exchange Operators

	2014	2015	Increase
Towers Watson OneExchange*	800,000	1,200,000	50%
Aon Active Health Exchange**	600,000	850,000	42%
Mercer Marketplace†	290,000	1,035,000	257%
Total	1,690,000	3,085,000	83%

* 2015 source: Towers Watson (March 19, 2015). Enrollment in health benefits through Towers Watson's Exchange Solutions expected to reach about 1.2 Million in 2015. Retrieved February 11, 2016, from https://www.towerswatson.com/en-US/Press/2015/03/health-enrollment-via-towers-watsons-exchange-solutions-to-reach-about-1-pt-2-million-in-2015.

** 2015 source: Three HR execs detail transition to private exchanges and results (March 2015). Inside Health Insurance Exchanges. Retrieved February 11, 2016, from http://www.aon.com/attachments/human-capital-consulting/US-2015-AIS-March-Inside-Health-Insurance-Exchanges.pdf.

† Source: Mercer (October 13, 2014). Mercer Marketplace—the flexible private exchange—posts individual participant and client gains. Newsroom. Retrieved February 11, 2016, from http://www.mercer.com/newsroom/mercer-marketplace-posts-gains-in-individual-participants-and-clients.html.

Source: Milliman

A BNA Graphic/ben608g4

by 2016 and 40 million by 2018. It appears as though active-only enrollment is tracking at only 20 percent to 30 percent of those initial projections, although, as noted earlier, these figures are very elusive.

What's Next for Employers?

There is a compelling case to be made for employers to migrate active employees to private exchange environments as a way to reduce the administrative burden of their human resources staffs. In addition, there is also a strong case for the value of group retiree exchanges. However, the case for overall active employee healthcare cost control is one that private exchange operators have yet to make, and this appears to be the key reason that enrollment in private exchanges has not lived up to early expectations.

In addition, there was also an expectation that the implementation of the ''Cadillac tax'' in 2018 would be a key driver of change for employer benefit programs, and that this could be a significant factor for potentially boosting private exchange growth. However, the recent two-year delay in the implementation of the Cadillac tax (until 2020), could further suppress interest in private exchanges for active employees. With the possibility of additional delays or even a complete repeal of the Cadillac tax in the future, employers are unlikely to use the tax as a catalyst for making a move to a private exchange.

For employers that are considering making the leap to a private exchange for *active employees*, here are key questions to consider:

- What explicit mechanisms exist in the private exchange model that are not available to large self-funded employers that will reduce overall healthcare costs for my active employees (i.e., allowed healthcare costs)?
- While competition among carriers for market share could create short-term savings in a fully insured structure, is it reasonable to believe that a fully insured private exchange model can be less costly than a self-funded model over a long-term horizon? With additional costs such as premium taxes, ACA fees, risk and profit charges and commissions, how can a fully insured model produce *long-term* sustainable savings?
- What are the most compelling aspects of the private exchange platform that pique my interest and can I efficiently and effectively implement these items (e.g., decision-support tools, defined contribution approach) under a traditional self-funded model?
- How many *active* enrollees are in private exchanges, and what is the *allowed charge cost trend* experienced by plan members over the past three years?
- What is the administrative cost to move to a private exchange? Are there additional fees or commissions being received by the private exchange operator and, if so, is this additional revenue offsetting my administrative costs?
- What is my exit strategy if the private exchange does not deliver on its promised outcomes?
- Am I receiving objective, unbiased advice and analysis as it relates to evaluating this decision?

Private exchanges have been the shiniest new toy in the benefits world over the past few years, and every employer is in search of the silver bullet to control healthcare costs. While the marketplace is still evolving rapidly, employers that are able to obtain clear answers to the above questions will be well on the way to making informed decisions about the feasibility of private exchanges for their organizations.