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TOUGH CHOICES ON HEALTHCARE EXCHANGES

Administrators Must Think Beyond Cost Savings

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INTRODUCTION

The healthcare exchange model represents a potential sea change in benefits administration strategy. But while exchanges offer significant cost savings opportunities, they raise some challenging dilemmas around the role of both employers and employees in benefits programs.

Exchanges vary widely in terms of basic philosophies, approaches to provider networks, contracting and employee engagement. As a result, exchange options don't readily lend themselves to apples-to-apples comparisons. Moreover, the use of exchanges requires Human Resources executives to make a fundamental decision: Will the employer narrowly define benefit choices for employees? Or will employees themselves bear the burden of choice and responsibility for selecting their plans?

These questions have far-reaching implications for HR sourcing strategy and can more broadly affect employee perceptions, workforce morale and corporate identity and brand. As such, the myriad options surrounding the implementation of exchanges require careful deliberation.

This ISG white paper examines the basic characteristics of the healthcare exchange model and outlines the strategic and tactical considerations HR executives must address when incorporating exchanges into benefit programs.

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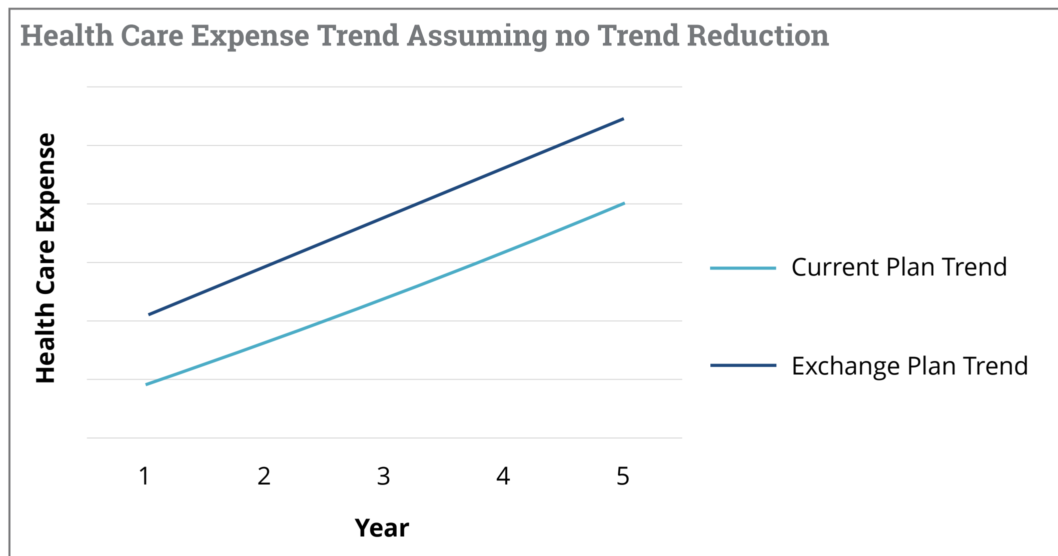
COST SAVINGS

Under the private healthcare exchange model, exchanges negotiate with individual insurance carriers to drive down costs. In return, insurers gain eligibility – either exclusively or as part of a pool – to offer insurance to a firm's employees.

These incentives create the potential for both short- and long-term cost savings and are the major driving force behind private exchange development. The specific means that drive these cost savings can include competition among carriers, improved administrative processes, plan management, wellness programs, visibility into healthcare costs, narrowing of networks and cost shifting to employees.



Projected estimates for short-term savings range from 2 percent to more than 10 percent, depending on the efficiency of the existing plan design. As such, a company spending $100 million might see an immediate cost reduction of $10 million. Over the long term, assuming that healthcare inflation will continue at a similar pace, the impact remains, as outlined in the chart above.

Exchanges are especially appealing since cost savings can increase proportionally over time as a result of ongoing operational improvement. Assuming efficiency initiatives produce just a 1 percent trend differential against traditional delivery models, the long-term impact is significant, as depicted in the chart at right.

EMPLOYER CONTRIBUTION STRATEGY

While cost savings may be top of mind for plan sponsors, additional factors must be considered when formulating an exchange strategy. One central issue is the employer's role in contributing to and managing benefits programs.

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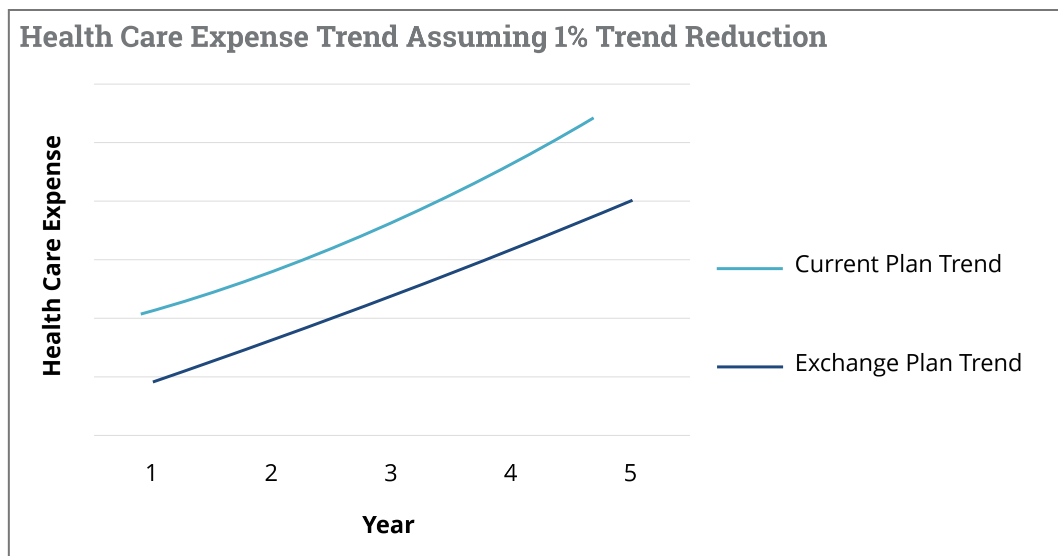
A defined-contribution model is emerging.

Some organizations take a traditional *defined benefit* approach to ensure that each employee has adequate coverage through carefully vetted and selected plan choices. At the other end of the spectrum is the emerging consumer-driven or *defined contribution* model. Here, the employer provides the employee with a sum of money and access to a "marketplace" through the exchange to purchase benefits, shifting risk of choice to the employee.

The move from traditional defined benefits to individual contribution from employees is analogous to the evolution from fully funded pension plans to 401K models, where employee contributions are matched by the company. By providing some level of basic coverage, coupled with monetary benefits that employees use at their discretion in the healthcare marketplace, many employers seek to maintain a sponsor relationship with their employee's benefits plans, while enhancing flexibility and cost savings.

The decision on where to land on the defined vs. individual spectrum should reflect broader goals and vision regarding how a company views its "employee contract." Questions to consider include: What role does the benefits program play in attracting and retaining employees? Does the contribution strategy align with goals for health and welfare benefits? Are we a "paternalistic" organization that seeks to oversee employee benefits? Or do we take a more libertarian approach and leave employees to make their choices?

Based on these philosophical considerations, executives can align benefits philosophy and objectives to broad-brush choices regarding exchange options – the critical first step in implementing a successful healthcare exchange strategy.



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DEVILISH DETAILS

Once a benefits strategy is defined at a high level, a more granular investigation of alternatives and options is needed to assess specifics such as provider network development, service offerings and funding models.

Elements include:

Provider Networks. The exchange market is characterized by several approaches to networks. Some plans provide open access to as many as 20 or 30 provider networks throughout the country. In this model, all of the insurers within the exchange can compete for all of the employees within each participating employer's group, regardless of geography. In other cases, each employer works with the exchange to define a set of insurers and providers that are eligible to offer services within a given geographical region. Certain exchange providers, based on their in-depth analysis of networks, offer limited choices of networks to help drive cost and quality.

Service Mix. Plans within a healthcare exchange comprise three types of service: those the exchange requires to be included; those that are included as standard; and those that are optional and available for an additional fee. Each exchange defines this mix differently. The mix can range from simply including medical, dental and vision coverage to an exchange requirement to include life, disability and voluntary insurances. Some exchanges require that benefits eligibility administration be outsourced to them – an important criterion for businesses that prefer to retain certain services such as HSA or COBRA administration.

Employer Funding Requirements. Some exchange providers require a premium (fully-insured) funding method. These are typically aligned with defined contribution exchanges. Others offer both self- and fully-insured models. Some considerations for funding methodology include risk assumption, variability of cost over time and cash flow. Specifically, in a self-funded model the employer assumes risk and absorbs fluctuations in cost due to claims activity. Under a fully funded model, the carrier assumes risk and absorbs those fluctuations – although at a cost to the employer, who pays monthly premiums and bears the associated cash flow implications.

Navigating nuances and their implications presents a challenge.

For executives assessing exchange options, understanding and navigating these nuances and their implications presents a challenge. In many cases, the choices made mean significant differences in the individual employee's role in making decisions and bearing responsibility for plan selection. An additional challenge is the fact that exchanges that are similar in terms of overall strategy and structure often have significant differences in how they package their specific offerings; normalizing these differences to enable an apples-to-apples comparison is essential.

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A final complicating factor is the newness of the model; specifically, the limited experience that exchanges have with managing enrollment, cost savings and employee satisfaction. Put bluntly, while the model might look good on paper, the reality may not match expectations. As such, employers should put post-implementation plans in place to carefully gauge and monitor the quantitative and qualitative impacts of the exchange solution.

An assessment of exchange options should consider both short- and long-term goals. This detailed assessment should be done *prior* to engaging providers in the proposal process to ensure that provider proposals are relevant and meaningful and aligned to specific client organization objectives.

A CHANGING MARKET

The introduction of healthcare exchanges promises to redefine the benefits administration marketplace. Some observers view the defined contribution model as an evolutionary step in the outsourcing of health and welfare administration. While perhaps evolutionary, that step is nonetheless a major one: Potentially, the exchange model outsources much of the program design, provider management, contract negotiation, annual pricing and cross-provider issue resolution activity that for the past 20 years has been done primarily by in-house benefits management teams and their consultants.

The healthcare exchange is a fundamental shift in HR philosophy.

From this perspective, the healthcare exchange represents a fundamental shift in HR philosophy and the beginning of a gradual exit strategy from ongoing employer management of health and welfare programs. Employers can benefit from offloading significant administrative overhead. The potential downside is a loss of competitive advantage and market differentiation for employers that have built a reputation around their benefit programs.

For executives grappling with the strategic and tactical dilemmas posed by healthcare exchanges, insight into the different types of exchange models, as well as a detailed understanding of each exchange under consideration, is imperative to charting a successful course.

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