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Private Health Exchanges

A Path to Stability

Introduction: Finance Takes the Lead on Health Care Challenges

Overseeing the company health care benefits plan has become more than a human resources chore. Chief financial officers involve themselves in health plan decisions because those plans incur significant costs and have a real financial effect on their companies' bottom lines. For many companies, operating the health care plan is like managing an additional business. This business-within-a-business commands the attention of finance executives because of the volatile and unpredictable swings in plan costs from year to year, and even from quarter to quarter. For the CFO, the keys to the health plan game are eliminating risk, removing volatility and lowering costs. As health care costs continue to rise and the market remains unpredictable, more and more companies are turning to private health exchanges to achieve the financial stability and predictability that CFOs seek.

The Problem: A Shift in the Health Care Landscape

By 2016, overall health care costs in the U.S. are projected to have risen 68 percent since 2006, according to Aon, with employee health care costs rising 124 percent and employer health care costs up 51 percent in that span. But private employer-sponsored health plans in the U.S. have enjoyed historically low annual cost increases with 2015 rate increases coming in at 3.2%, marking it the lowest rate increase since Aon began tracking this data in 1996.

Healthy Skepticism: Selecting Private Health Exchanges

From a finance point of view, here are some factors to consider when selecting a private health exchange solution:

- How will healthcare benefits fit into the longer-term business strategy for the company?
- Will the exchange provide the company with the ability to predict annual costs and manage in-year volatility?
- How comfortable is the company defining its commitment in the form of a fixed subsidy?
- Will the company want to retain responsibility over designing the health care plan, managing vendors or administering the plan, and can the exchange provide those options if needed?
- How much risk will the company manage vs. transfer to the insurance carriers?
- Will an exchange deliver more value than what the company can provide on its own? If so, how much?
- How will an exchange streamline administration costs for the company?
- Do the providers under consideration have acceptable financials?

While some pundits have been eager to point to the recent trend in health plan costs as evidence that a "new normal" has taken hold, a more careful analysis shows that the low annual increases are likely caused by macroeconomic forces rather than factors that can be controlled directly by the employer. The reality is that the recession has forced employees into spending less on health care, not health care legislation or a healthier population. That means that health care costs, which are already high, will inevitably continue on an upward path with larger and more volatile increases.

The health care landscape is shifting. More than 149 million individuals in the U.S. are covered by employer-sponsored health care benefits, according to the Kaiser Commission on Medicaid and the Uninsured. Most large employers want to continue offering health care benefits as a means to attract and retain talent, despite the difficulties and uncertainties in the health care arena. But employers are also rethinking their role in providing coverage, including how they pay for and structure health benefits, along with managing costs. More employers are looking to give more responsibility to their employees for the employees' health decisions as a way to cut costs and encourage employee engagement in their benefits choices.

The top three desired health outcomes for employers in 2016, according to a survey, are:

- Increasing their employees' awareness of and improving employee decision-making on health issues
- Reducing the rate of increase for health insurance premiums
- Increasing employee use of tools and information about provider price and quality

To accomplish these goals, employers are using several strategies. Most employers—53 percent, according to the survey—provide minimal plan options and actively manage their plans through vendor management and paying a portion of the insurance premium. But only 26 percent of employers say they will take that approach over the next three to five years.

The next-most popular current approach by employers is providing a few plan options and incentives to employees, aimed primarily at improving health and services to reduce future health risks. Currently, 40 percent of employers report taking this approach, and 45 percent say they will take this approach in the future.

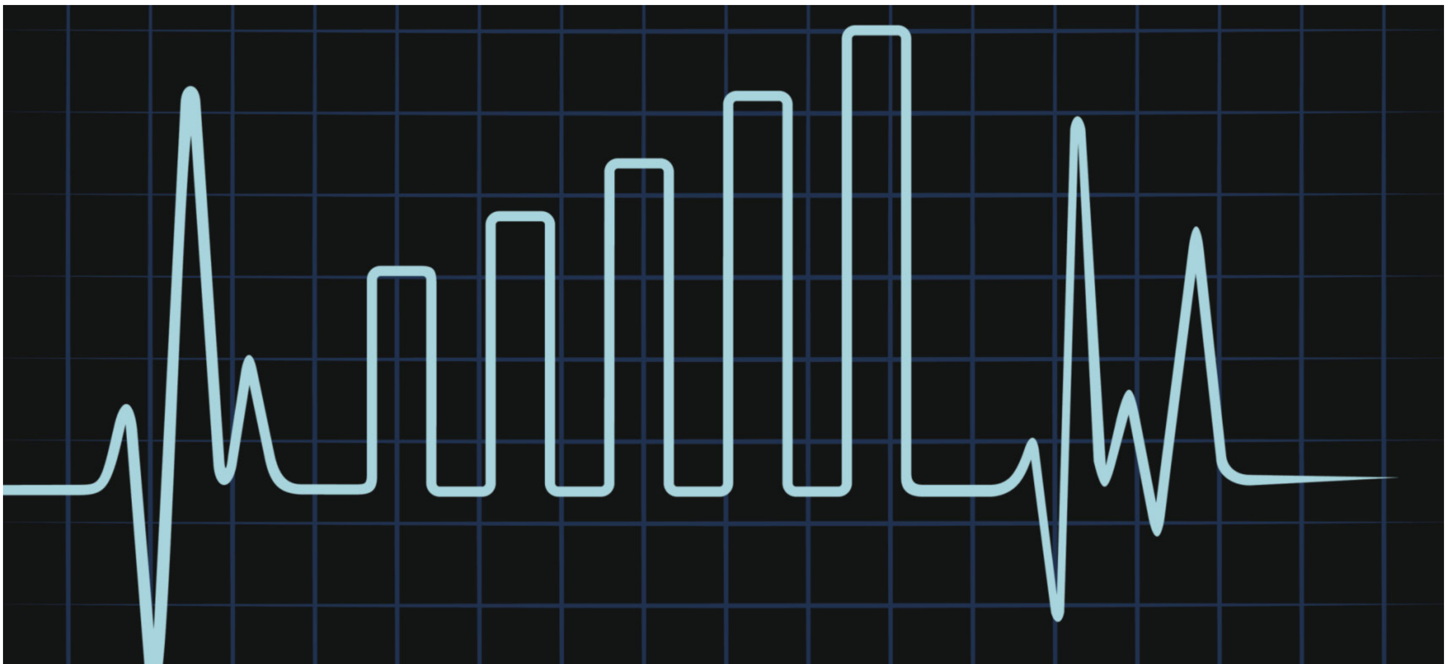
The third-most popular approach, though one that is rapidly gaining momentum for future use, is employers providing access to a private health exchange that provides employees plans to choose from, with the employer sponsoring the plan through a fixed-dollar amount. While only 3 percent of employers currently use this approach, 22 percent report they will use it in three to five years.

Private Health Exchanges: An Incentive for Efficiency and Innovation

Private exchanges are essentially marketplaces where employees can shop for the best health insurance for their individual circumstances, with employers providing subsidies toward the health insurance. Enrollment in private exchanges is expected to increase to 40 million in 2018, up from 1 million in 2014, according to Accenture 2014 – Growing Pains for Private Health Insurance Exchanges.

Besides helping employers implement a defined commitment strategy, private exchanges present an opportunity to implement high-deductible health plans, or HDHPs, to help control costs and give employees more accountability. According to Aon Active Health Exchange enrollment data, employers that moved to a private exchange have had their employees' adoption of HDHPs increase 30 percent.

One consideration for organizations evaluating a private exchange strategy, is whether or not to remain self-insured or fully-insured. While both models offer the benefits of expanded choice and consumerism, the decision around the funding mechanism for the exchange comes down to the organization's preference for managing risk. In a self-insured environment, the risk remains with the employer whereas in a fully-insured model that risk is transferred to the carrier.



Case Study: Christa Davies, CFO of Aon PLC

When Aon moved to a private health exchange in 2012, one of the key financial benefits was moving the volatility of the old plan off our balance sheet, says Christa Davies, Aon's CFO.

"Our healthcare costs were rising, much faster than almost any other line item on our P&L, and they were volatile," Davies says. "It was like playing Whac-A-Mole—you never knew quite what was going to come back at the end of the year, in terms of your claims experience."

Under its previous self-insured plan, the amount and types of claims could swing the annual costs by plus or minus 10 percent. Even a few extreme outcomes—a case of diabetes, for example—could have a significant effect on the plan covering about 20,000 U.S. employees.

Aon had a tax benefit of about 10 percent from running the self-insurance plan, but the cost savings achieved with a fully-insured model eclipsed the 10 percent figure by 200 to 300 basis points.

Davies says she and the finance team would run Monte Carlo simulations to forecast the impact of the costs under the self-insured plan projected over five years, just as they did with any big items that are potentially volatile, such as litigation settlements, because they affect earnings. More volatile companies are worth less, and the simulations showed that the health care claims problems were going to get worse.

The fact that health care costs were increasing at a rate exceeding inflation, more than almost every other item on the P&L, also spurred the switch, Davies says. And the potential effect of Affordable Care Act's so-called Cadillac Tax in 2018—a 40 percent excise tax on employer-sponsored health plans with high-cost benefits, was another incentive to change.

In addition to the financial considerations, Davies says, it was important that the employees were happy with the private health exchange because they are the main assets of the company. Preparation and communication was key, spending months on educating managers and employees and addressing their key concerns ahead of the switch. The private exchange plan achieved an 89 percent employee satisfaction rating.

The switch also forced employees to make better decisions about their medical spending, she says.

"I think that level of control around their decisions, whether it's which carrier and which doctors network on their medical side to choose or how they're allocating their dollars across the range of options, has increased the amount of time they spend making their health and other decisions from 2 minutes a year to 22 minutes a year," Davies says.

CFOs who remember the seismic shift in health care to health maintenance organizations, or HMOs, may have reservations about moving to a fully insured arrangement. The reason: When HMOs started entering the market, they frequently were accused of competing for a company's business by offering low premiums, then raising premiums by 25 percent or more in the second year, after the initial members had enrolled.

The key difference with private health exchanges is that the exchanges provide retail competition with a commoditized product. Because the consumer, or employee, has a very low barrier to change, if an individual carrier raises rates exorbitantly, then the employee is free to choose another carrier. It is much easier than the complications that an entire company must navigate when changing insurance providers.

Under the fully-insured, private exchange model, profit—balanced with competition—provides the insurance carriers with an incentive for efficiency and innovation. They compete not only for the initial enrollment, but for every year thereafter. They are motivated and have the control to manage claims during the year in a way that doesn't exist under a self-insured arrangement, where the model is typically a cost-plus-expenses scenario. In that model, the carriers are merely processing transactions.

From a financial perspective, the most important benefit of the fully-insured private exchange model is the stability of costs for the company. Because health care claims in a self-insured plan hit the company's cash flow as soon as they occur, and because all self-insured companies will eventually experience an unexpectedly bad claims quarter, the effect can be devastating for businesses that operate on narrow margins. The risk associated with unbudgeted claims is difficult to assess, predict and mitigate.

Conventional wisdom may argue that it is better for a company not to pay the additive costs for the insurance risk transfer involved in moving to a fully insured arrangement from a self-insured model. But when health care costs to a company can swing wildly and unpredictably—by 10 percent or more per year, in some cases—the effect of that volatility on earnings and investor sentiment can erode company valuations over the long term. Even when health costs are surprisingly low for the fiscal year, the volatility can be damaging. Private exchanges ensure predicable costs and use the competitive forces of the marketplace to keep those costs down.

Conclusion: Finding Balance with Private Exchanges

Private exchanges, especially when combined with a high-deductible health plan approach, can be very effective at using market-based competition and consumerism to rein in the cost increases and volatility experienced under traditional benefit plans. More companies are turning to private health exchanges, and CFOs should weigh the benefits of the exchanges, including lower cost volatility and the effect on valuations, versus the benefits of their current plans.