# Private Equity Well Poised to Capitalize on Private Health Exchanges

For private equity, early adoption of private health exchanges may prove a highly competitive differentiator among savvy sponsors and portfolio companies, with unprecedented cost predictability and administrative efficiency the driving factors.

As a growing number of employers acknowledge the unsustainability of the traditional employer-to-employee channel of providing health coverage, private health exchanges are gaining momentum as the catalyst that will fundamentally transform the health care landscape and force companies to retool the way they provide benefits — for health care and beyond.

The resounding narrative speaks to an evolution that has now moved well beyond the tipping point, in which a better-educated and accountable consumer occupies the driver's seat, and where the final destination is marked by fixed costs, reduced administrative burden, greater choice and flexibility, and improved transparency — all in the midst of more complex regulatory compliance.

An outgrowth of the cornerstone of the Affordable Care Act (ACA), private exchanges are expected to outpace their public counterparts in very short order — it's projected that private exchange enrollment will approach that of the public exchanges by 2017 and surpass it soon after. Employers of all sizes and across all industry sectors have indicated an interest in moving to private exchanges, with 56 percent today who say they are considering the use of private exchanges to provide benefits to both active and retired employees.

Private exchanges provide a flexible, turnkey solution that offers the long-term ability to turn a variable cost into a fixed cost by transitioning employees from a traditional defined benefit (DB) model to a defined contribution (DC) model. By ultimately moving choice and responsibility to the employee, health care contributions become tied to the overall compensation-growth rate, rather the medical-inflation rate, and future cost increases are uncoupled from any underlying medical trends employees may experience.

Indeed, health care costs historically have fluctuated wildly relative to cost-of-living and wages. And, although health care trend numbers have been lower the last couple of years following some important initial plan design changes, the average gross cost for employee coverage today still comes in at a whopping $12,000 per head.

However, even in exchanges, universal attention to the cost management equation remains more critical than ever. Insurers will face increased pressure to offer more affordable, high-quality products. Employers will have to manage the health costs of their populations while still meeting ACA "minimum" standards —

providing at least 60 percent of the cost of a plan's covered services and ensuring that no more than 9.5 percent of an employee's household income goes toward individual coverage. And employees, who will be exposed to greater transparency and pay a larger share of benefit premiums straight out of their pockets, will naturally gravitate toward the lowest-cost, highest-value denominator, forcing all of the variables to be kept in tight check.

But the appeal of exchanges goes beyond cost containment. With the complex and time-consuming requirements of ACA — particularly for those businesses in the retail and service sectors with sizable numbers of part-time, contract, and seasonable workers — the administrative burden is enormous for already stretched HR departments. The variable "look-backs" required to determine ongoing eligibility of workers at or above the 30-hour-per-week minimum threshold (which now defines full time) are especially daunting for private equity, where "lean and mean" is the mantra of the HR function.

**Right-Sizing Benefits**

Most individuals today, from ages 20 to 70, access health care through an employer, who on average offers two to three plan choices. Unfortunately, none of these typically meets what the vast majority either wants or needs. In fact, as a result, most employees today may actually be over-insured (our numbers show well over half), which can impact healthcare inflation, economic growth, and wage growth.

Private exchanges allow employees to tailor choices to right-size coverage to meet their specific situation and budget. Early data on consumer buying behavior demonstrate a direct link between cost and accountability: The average value of medical plans pre-exchange was 80.4%, dropping to 71.9% post-exchange, with an average cost reduction per employee of $800. Of that $800, 70% went back into the employer's pocket and 30% into the employee's — numbers that will only improve once exchanges fully leverage promising wellness opportunities.

Despite these encouraging numbers, getting employee buy-in remains a challenge. Many are reluctant to give up what they believe is working, regardless of the price tag. Fueling that inertia is a pervasive misconception about the relationship of cost to quality — particularly among the most tenured employees, who often choose the most expensive plan assuming it must be the "best." And higher deductibles remain the source of much fear and anxiety, although these are often overcome by purchasing wrap-around coverage, after which employees likely still come out ahead. Data show that 35% of employees who elected $1,500 or $2,500 deductible medical plans bought some form of supplemental health policy, including accident, critical illness, and hospital indemnity.

## Emerging Exchange Models

There is no single private exchange model, however creative intersections among key players in the marketplace have spawned a variety of types: carrier-owned; co-branded between an insurer and third party; offered by a third party with either customized or fixed carrier line-ups; and networks and claims adjudication from multiple insurers that are rented to exchange vendors.

The real bellwether of exchanges is proving to be a highly efficient one-stop shop, offering an online marketplace that not only allows employees to make side-by-side comparisons and take advantage of the best discounts for health insurance products, but also offers the ability to add ancillary and voluntary benefits such as dental, vision, life, auto, homeowners, pet, and legal insurance, while providing 24/7 education and decision support.

In some instances, private exchanges may act as a value-added complement by offering important ancillary and voluntary benefits not available on the public exchanges to employees who work below the 30-hour minimum.

It's worth noting that the commissions from brokering all of these different products from under one "virtual shingle" are significant and can, in effect, subsidize the employer's obligation of dealing with new administrative and reporting responsibilities under the ACA.

In addition, the best models will work with both DC and DB plans, allowing continuation in DB plans for at least the short term to give employees of varying ages the opportunity to properly insure their health, while slowly easing entire populations into DC plans.

Exchanges seeking the widest appeal will offer both self-insured (SI) and fully insured (FI) options in order to respond to potentially greater segmentation in the near future among different employers and industries (those whose interests lean toward strengthening the employee value proposition versus those looking to reduce their own costs and administrative hassles). There's no doubt that FI makes health benefits more expensive overall — premiums can be up to eight times more than for SI. But because in a DC model these costs can be shifted to employees, they will be the ones bearing the brunt in health care's new order. Although the majority of large employers will remain SI for the foreseeable future, with increasingly tighter bottom lines, they may eventually find it difficult to forego the attractive FI health plan windfall of 10 to 20 times the revenue per member compared to SI.

## The Road Ahead

The continued maturing and proliferation of private exchanges will bring with it new and difficult challenges, but also greater opportunities. What has traditionally been a business-to-business or business-to-business-to-consumer play will ultimately become a straight business-to-consumer play, with the potential to marginalize established roles and upend familiar business models.

Certainly the move to private exchanges will disrupt the HR function and the jobs that support it. But exchanges also will alleviate the enormous task of handling employee inquiries, open enrollment management, carrier reporting, and employee communications — allowing HR professionals to focus on other people-related issues and build important strategic capabilities.

Accountable Care Organizations (ACO) will become more commonplace on exchanges as a network option (along with open-network and other PPOs) and will work with providers or insurance companies to offer white labeling or co-branding on products. These changes are part of an ongoing evolution of risk transfer from traditional insurance carriers to a new model, where providers take increasing risk and share in gains according to care that is value-based, rather than volume-based.

Not surprising, the next generation of exchanges is expected to bring together both health care and wealth care, offering a one-stop portal for selecting health, ancillary and voluntary benefits, as well as retirement plans, 401(k)s, and investments. Eventually exchanges will be uncoupled from employment so that regardless of whether individuals move from one company to another, are self-employed, or retired, all of their benefit plan designs and vendors will remain in one location and be portable.

As uncomfortable as these changes may seem, most agree the status quo is no longer a viable option. Put simply: Once people really understand their role in the health care system, costs go down. Fourteen years of industry data show that, based on aggregate numbers of dollars paid in by both employers and employees, companies that have adopted consumer driven health plans (CDHPs) on average pay considerably less per employee than those that have not. This is especially the case for companies that went “full-replacement” — a likely harbinger of the outcome for exchanges.

The emerging health care exchange movement is about first holding employees accountable for understanding the system, then providing open access to real information so they can be educated, make intelligent choices, and take responsibility. Once that happens, everyone else will start lining up, because the consumer will have control. And that power will undeniably transform the industry during the next 10 years.