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# Defined Contribution Health Insurance:

This Time, It's Really Happening. How Should Payers Respond?

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White Paper

## Executive Summary

**A**s employer contributions to employee health benefit costs have continued their steep rise (nearly doubling over the past decade), employers have taken a number of steps to rein in healthcare costs:

- Tweaking plan design and increasing employee cost sharing
- Adopting self funded arrangements
- Launching employee health and wellness programs
- Adopting high deductible health plans (HDHPs)

Now there is another option for employers to address rising costs: defined contribution (DC) health plans. In a defined contribution health plan (similar to a 401(k)), employers make fixed contributions to health accounts that employees tap to purchase health insurance on private exchanges. Although still in the early stages, interest in DC approaches has grown among insurers, intermediaries and employers. We believe there will be a sharp increase in DC plan adoption over the next few years, as:

- DC plans offer lower and more predictable healthcare costs
- They reduce the administrative burden on employers
- Many employees are likely to be enthusiastic about increased plan choice
- Several Affordable Care Act (ACA) provisions will reduce the moral obligation of employers to maintain traditional group insurance

Several large employers have already adopted DC health plans, providing a potential trigger for wider adoption. Carriers need to begin planning now for the emergence of DC health plans, or risk missing a significant opportunity:

- An upfront assessment is critical to pursuing the right strategic path, including market planning, consumer and group needs analyses, and channel conflict analysis
- Solution design and development (even if partnering with vendors), integration with existing systems, testing and roll-out will all take time
- Early adopter groups will consider DC plan alternatives in the 2014 renewal cycle
- Early mover carriers will benefit from the ability to test and evolve solutions over a cycle or two, prior to what we expect will be a meaningful shift during 2015 renewals

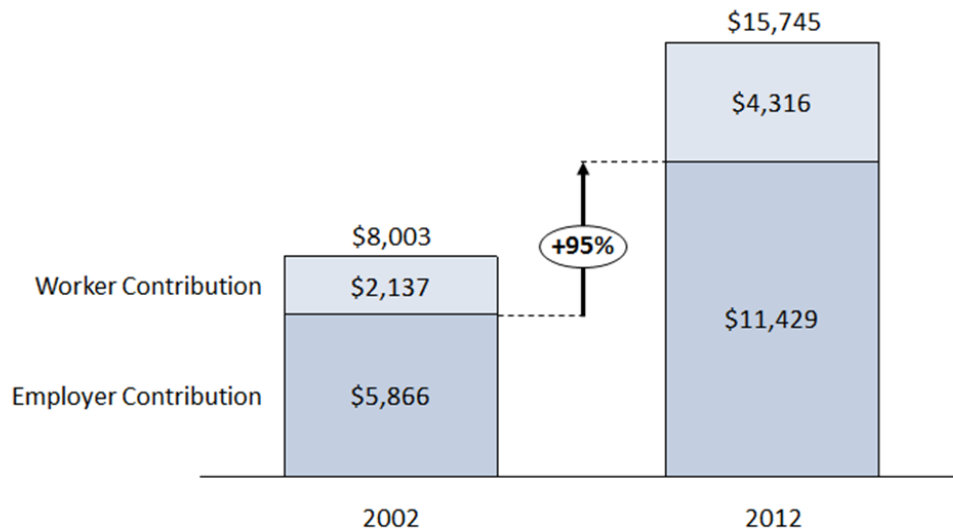
The balance of this perspective provides a review of:

- The largest underlying driver of DC plans – the rising cost of providing health benefits
- A description of DC health insurance mechanics
- A view on the current market landscape – including the emergence of single- and multi-carrier exchanges
- The rationale behind our belief in the growing DC market opportunity
- Strategic considerations for health payers, including exchange participation and development, channel management, planning, and implementation

## Backdrop – The Rising Cost of Providing Employee Health Benefits

Providing health benefits has become increasingly expensive for employers. In the last 10 years, annual employer contributions to employee health insurance premiums (for family coverage) have increased at a rate of 7% annually, nearly doubling from \$5,866 to \$11,429 (see Exhibit 1). These contributions have effectively crowded out worker salary increases, as real median household income (excluding employer contributions to health benefits) declined from \$52,000 to \$50,000 between 2001 and 2011<sup>1</sup>.

**Exhibit 1 – Average Annual Premiums and Contributions for Family Coverage**



Source: Kaiser HRET Employer Health Benefits Survey, September 2012

In addition to rising health costs, it has also become more complex to provide health benefits to employees. Employers are involved in evaluating funding alternatives (including regulatory and reporting implications), benefit design and cost sharing, new plan features (such as narrow networks), and a host of wellness, care management and employee engagement options. Understanding the right approach can be daunting for a group (as well as their advisors and insurers). The complexity and change brought by the cascading implementation of the ACA (Affordable Care Act) has only added to the challenge.

Despite the high cost and complexity, most employers continue to provide health benefits for two fundamental reasons: first, health benefits are an essential component of a competitive total compensation package needed to attract and retain talent. Second, employers are in the unique position to provide health insurance that is tax advantaged and not dependent on an individual's health status. Presented with a health insurance market that is largely inhospitable to individuals with serious health conditions, many employers consider it a moral obligation to provide health benefits for employees.

## Employer Responses to Rising Costs

Over the past decade, employers have pursued a number of approaches to rein in the growth of healthcare costs, among them:

- **Adjusting Plan Design & Cost-Sharing:** The typical, incremental approach – including annual tweaks to benefit design, networks and employee cost sharing
- **Self-Funding:** The percentage of workers covered by self funded plans grew from 49% in 2002 to 60% in 2012. Among employees of large (5,000+ employee) organizations, this share grew from 72% to 93%<sup>2</sup>. Self-funded arrangements allow employers to save on premium taxes, avoid some state insurance

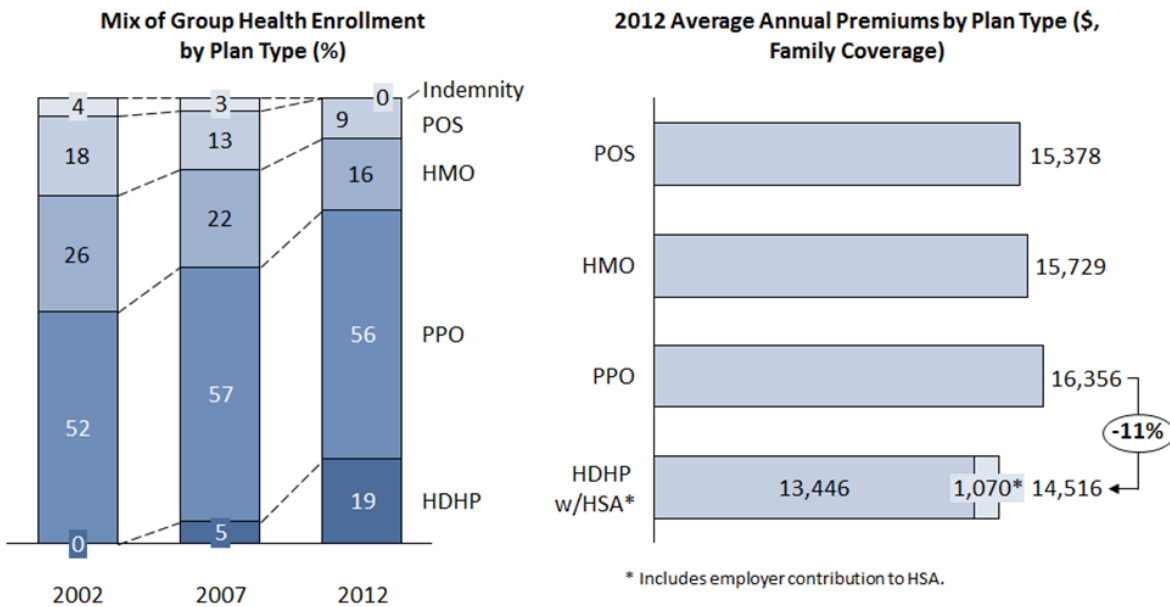
<sup>1</sup>Source: US Census Bureau, 2011

<sup>2</sup>Source: Kaiser HRET Employer Health Benefits Survey, September 2012

and design more tailored health benefit solutions which help them to better manage employee health costs

- Focusing on Health & Wellness:** Employers have become more active in promoting employee health and managing medical costs. Health risk assessments, wellness programs (including smoking cessation, weight loss, stress management and exercise promotion) and worksite clinics are becoming more commonplace. Employers are building incentives into their health benefits to encourage the use of available programs and adoption of healthier lifestyle habits. Employers with self-funded plans are demanding disease and case management that demonstrate claims cost savings
- Adopting High Deductible Health Plans (HDHPs):** Despite being introduced only a decade ago, 19% of group health plan participants are now enrolled in HDHPs. The economic benefit to employers is clear, as annual HDHP premiums are significantly lower than premiums for traditional health benefit arrangements, due both to increased employee cost-sharing and utilization changes as a result of greater employee exposure to the cost of care (see Exhibit 2).

Exhibit 2 – HDHP Prevalence and Premiums



Source: Kaiser HRET Employer Health Benefits Survey, September 2012

Despite these measures, healthcare costs have continued to climb, resulting in some employers dropping out of the health benefits market entirely. Over the past years, the share of small employers (3-199 employees) offering health benefits has dropped from 65% to 61%<sup>3</sup>. Those employers who still offer health benefits (including 98% of those with 200 or more employees) continue to look for new solutions to control their healthcare costs.

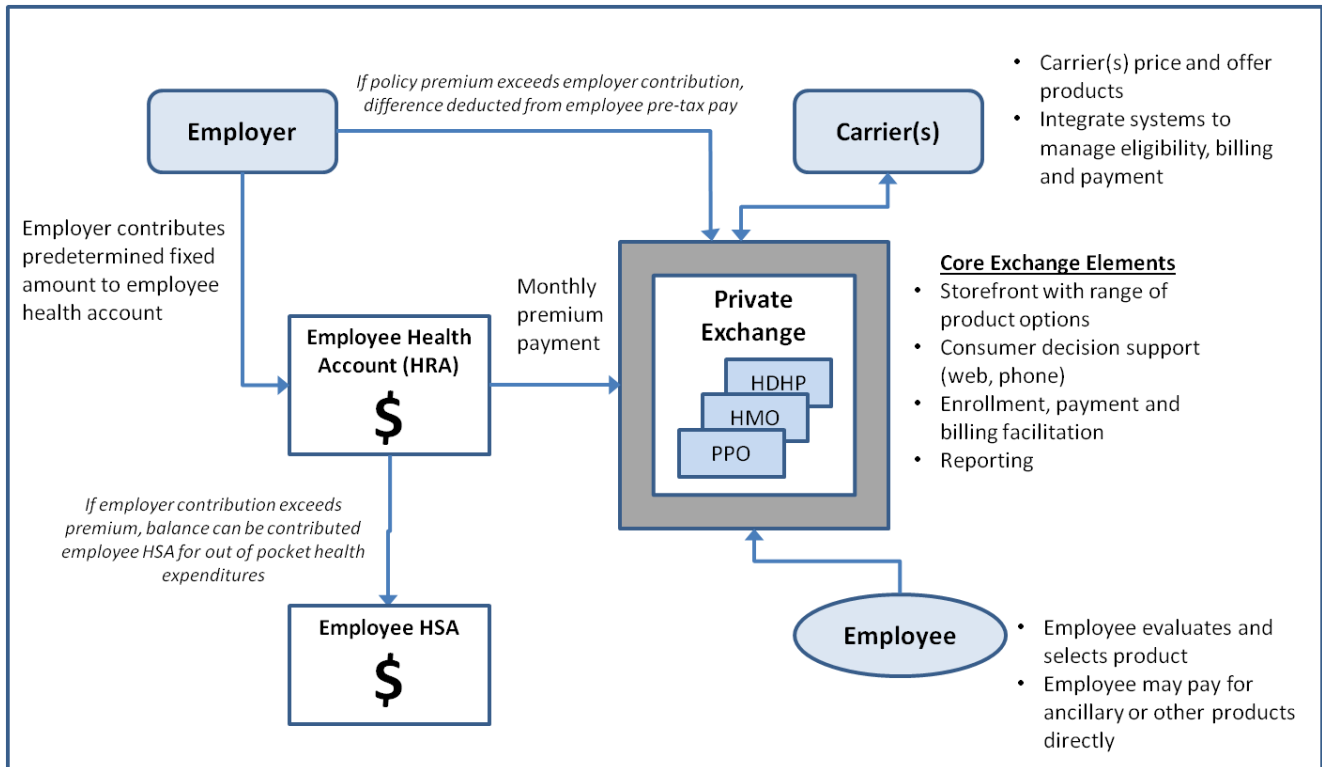
### Defined Contribution Health Plans – a Solution on the Horizon?

Spurred by vendors, carriers and intermediaries, some employers are beginning to explore defined contribution (DC) health plans as a means of addressing healthcare costs. Under a defined contribution arrangement, an employer typically makes predetermined monthly contributions to Health Reimbursement Accounts (HRAs) established for participating employees. Employees access these HRA funds to purchase health insurance on a private exchange consisting of policy options from either a single or multiple health carriers. The private exchanges provide the (typically web-based) platform

<sup>3</sup>Source: Kaiser HRET Employer Health Benefits Survey, September 2012

employees use to purchase coverage, and also provide decision-making tools to help employees better evaluate coverage options. If the premium of the selected policy is greater than the employer contribution, the difference is deducted from the employee's pay on a pre-tax basis. If the premium is lower than the employer contribution, the difference can be used for other qualifying health expenses (or rolled over to the following year). Exhibit 3 presents a simplified depiction of the mechanics of DC health plans.

### Exhibit 3 – Defined Contribution Health Insurance Mechanics



The exchanges where employees purchase coverage are critical to the success of DC health plans. Since these plan arrangements transfer responsibility for selecting coverage from employers to employees, the exchanges need to guide the employee through a largely unfamiliar decision process, meaning they must:

- Provide product options to meet the needs of employees at different life stages, with different health needs, and with different risk tolerances and financial means
- Be user friendly, offering both online and telephonic process support
- Incorporate an enrollment platform to sign up new members and manage changes (e.g. new dependents, change in marital status)
- Use a logic structure (user friendly on the surface, but supported by complex algorithms) to guide employees to the most appropriate product. This logic should ultimately result in a limited set of options (no more than 3 or 4) for the employee, along with the benefits and shortcomings of each based on the employee's circumstances
- Facilitate monthly premium payments from the employee to the carrier, and any additional payroll deductions necessary to meet premium shortfalls. The use of employee-specific HRAs is necessary to maintain the tax-advantaged status of health benefits for both employer and employee
- Link to a carrier's underwriting systems to monitor recommended and selected policies, update policy offerings and pricing, and ultimately guard against adverse selection

Although still in the early stages, interest in defined contribution models and approaches appears to be growing. In response, many single and multi-carrier private exchanges have already sprung up, or are under development (see Exhibit 4).

Exhibit 4 – Private Exchange/Defined Contribution Market Landscape

Exchange Type	Company	Partner / Platform	Date Announced	Target Market	Products <sup>1</sup>	Brand	
Single Carrier	Nat'l Commercial	Aetna	None announced <sup>2</sup>	NA	NA	NA	NA
		Cigna	None, however, CEO comments suggest potential future moves	NA	NA	NA	NA
		Humana	Exploring acquisitions and partnerships	NA	NA	NA	TBD
		United Healthcare	None announced <sup>3</sup>	NA	NA	NA	NA
	Blues	WellPoint, HCSC, BCBS Michigan	Bloom Health - Majority owned (acquired 2011)	Sep '11	Not specified	M, De, V, other	WP, HCSC – Unknown MI – GlidePath
		Highmark	Array Health (vendor)	Nov '11	10-99 (initially)	M, De, V	myBenefits
		BCBS Minnesota	eHealth (vendor)	Apr '12	10-50, 50+	M	Blue Choice
	BCBS KC	Online Insurance Corp, BenefitFocus (vendors)	Nov '11, Oct '12	• 2-99 • 100+	M, De, V, L, other	Blue KC Exchange	
Multi Carrier	Aon / Hewitt	Internally developed or private labeled (not publicized)	2010	• Retiree • Commercial 1K+ (initially)	M, De, V	Corporate Exchange	
	Buck Consultants	Xerox/ACS (parent), Connexions (call center)	Oct '10	Retiree (initially)	M	My Medicare Advocate	
	Gallagher Benefit Services (GBS)	Liazon (vendor)	Jul '12	Small to large group	M, De, V, L, Di, other	Bright Choices	
	Hub Int'l	Liazon (vendor)	Sep '12	Unknown	M, De, V, L, Di, other	Bright Choices	
	Mercer	3 platforms (self funded, large fully insured, and retiree plans) Platform unknown	Mar '12	• Self funded • 100+ FI • 300+ retiree	M	• Health Advantage • Benefits Choice Exchange • Retiree Exchange	
	Towers Watson	Extend Health (acquired May 2012 <sup>4</sup> )	May '12	• Retiree (initially)	M	Extend Retiree	

1) M-Medical, De-Dental, V-Vision, Di-Disability, L-Life  
 2) 'Pick-a-Plan' offers multiple standard product choices and a DC funding option to groups, but does not include an 'exchange platform'. Zane Benefits, an industry vendor has promoted their partnership with Aetna in offering a defined contribution / exchange platform to groups, associations and brokers  
 3) Similar to Aetna, UHC's 'Multi-Choice' provides product choices and a DC funding option to small groups, but does not include an exchange platform. Optum, a UHC subsidiary, has acquired Connexions, a provider of exchange solutions, that could potentially serve as a platform for a future DC / exchange offering  
 4) Extend's pre-acquisition channel partners included Gallagher, Lockton, Mercer, Wells Fargo, and Willis. Unclear whether those relationships have/will continue

Source: Bridge Strategy research, October 2012

A few observations on the current state of the market<sup>4</sup>:

- National commercial insurers are not (yet) aggressively pursuing single carrier exchanges. They *are* participating in consultant/brokersponsored exchanges, which provide them an opportunity to obtain more 'slice business'
- A handful of BCBS plans have aggressively brought single-carrier exchange offerings to market. It is too early to tell whether many of these Blues will participate in multi-carrier exchanges, which would expose their books to heightened competition; however one plan – HCSC – has already agreed to join Aon Hewitt's Corporate Exchange
- Many large consultants and brokers are developing multi-carrier exchange offerings, recognizing the need to maintain, and opportunity to enhance, their position in the value chain (and conversely, to avoid significant disintermediation should single carrier exchanges dominate)
- Some but not all exchanges have a multi-product approach (including vision, dental and other ancillary benefits), suggesting that a 'benefits supermarket' approach is not (yet) critical. We expect most to expand their product line in the future

**Many large consultants and brokers are developing multi-carrier exchange offerings, recognizing the need to maintain their position in the value chain**

### Defined Contribution – Why Now?

In the early 2000s, there was significant discussion about the potential for defined contribution in health insurance. The shift from pensions to 401(k)s and the rapid shift to DC for retiree health benefits in response to FAS 106<sup>5</sup> led many to believe that health insurance would be the next market for DC. However, the shift didn't occur for a number of reasons (some explored below).

We believe that DC health plans will see significant adoption over the next several years. From an employer perspective, defined contribution plans offer a number of attractive characteristics:

- **Cost Predictability:** By providing an easy mechanism for companies to make fixed contributions to employee health benefits, DC plans offer predictable annual expenditures and growth rates
- **Lower Cost:** Multicarrier exchange promoters believe premiums will be reduced due to more direct price competition, as carriers are asked to provide broadly similar product offerings for side-by-side comparison. We believe this value is limited, as most groups already benefit from carriers competing for their business. However, we do expect overall cost reduction as employees choose coverage that better matches their own needs – often 'skinnier' products, with reduced benefits and limited networks<sup>6</sup>
- **Employee Enthusiasm & Choice:** Similar to 401(k) plans (see accompanying sidebar), many employees will welcome DC health plans as they will see a tangible or monetized benefit, and gain the ability to choose their own health plan<sup>7</sup>. Choosing lower cost plans that better meet their needs increases the likelihood that employees could see higher wages, as the cost of health benefits no longer crowds out salary increases (as it has for many over the last two decades)

**In the early 2000s, the shift from pensions to 401(k)'s and the rapid shift to DC for retiree health benefits led many to believe that health insurance would be the next market for DC. However, the shift didn't occur**

<sup>4</sup>As of October, 2012

<sup>5</sup>In FAS 106 (<http://www.fasb.org/summary/stsum106.shtml>), the Financial Accounting Standards Board (FASB) significantly changed the practice of accounting for postretirement benefits from a pay-as-you-go (cash) basis to an accrual basis, essentially requiring organizations to recognize a large balance sheet liability for the expected cost of their retirees' health benefits. A rapid shift occurred upon implementation in the early 1990's, with many organizations dropping retiree coverage or adopting a defined contribution model with capped contributions to retirees

<sup>6</sup>Analysis by AHIP, Cigna and others has found that employers tend to over-insure employees, providing benefits that many employees do not value

- **Reduced Administrative Burden:** Converting to a DC arrangement relieves employers of the effort involved in health program design, monitoring/maintenance and buy-up selection (especially for self-funded groups). Groups are left with the relatively simple charge of setting an annual contribution, ensuring employees are aware of how to access their DC benefits, and managing the monthly flows of funds to employee health accounts and carriers. As exchanges expand product offerings, they will also provide groups and their employees with ‘one-stop-shopping’ for a range of benefits, including vision, dental, life and disability. Lastly, should a group adopt an ‘individual’ rather than ‘group’ model for their DC arrangements, Cobra responsibilities (and hassles) are eliminated
- **Avoidance of State Exchange Uncertainty:** DC plans allow employers to continue providing a valuable benefit to employees without subjecting them to the uncertainty of state or federally-run exchanges mandated by the ACA. That doesn’t mean that the ACA won’t have any impact on DC health plans, as according to HHS guidance, employer contributions to employees’ DC health accounts must meet the minimum actuarial value standard<sup>8</sup>. However, some groups will see the DC route as a good middle ground option between traditional health insurance and dropping health benefits entirely
- **Balance Sheet Improvement:** For employers that provide retiree health benefits, conversion to a DC plan allows the company to remove the retiree health benefit liability from their balance sheet, replacing it with a predictable, manageable annual expense (something many have done since the mid-1990s)

In addition, we believe that elements of the ACA will render obsolete the traditional responsibility of employers to directly provide health insurance to their employees. Guaranteed issue, a ban on delays for pre-existing conditions and restrictions on medical (and other) underwriting going into effect in 2014 will eliminate the primary causes of poorly functioning individual insurance markets. Simply providing a stipend to employees to select their own coverage will no longer come with the weight of letting older, sicker employees fend for themselves in a difficult market.

Recent research supports the proposition that DC health insurance could become a significant market. NFIB (National Federation of Independent Business) Foundation research suggests that more than half of small businesses will be interested in a DC health plan arrangement once the ACA is fully implemented in 2014. Research by Aon Hewitt, Towers Watson, and J.D. Powers found similar potential. And a McKinsey study that generated much controversy following the passage of the ACA corroborates this conclusion, finding that over half of employers with high awareness of ACA impacts are likely to consider *alternatives to traditional health benefits* post-2014.

**More than half of  
employers will consider  
defined contribution  
health insurance in the  
next few years**

Their research found that ACA regulations will reduce the “moral obligation” of employers to maintain traditional health insurance and make them *more likely to consider alternative arrangements including defined contribution*. Our conversations with brokers and health plan executives confirm the same. Many of those we spoke with suggested a 2-5 year window for meaningful DC plan adoption.

Finally, there has already been a significant philosophical shift in the market toward defined contribution arrangements. The growth of HDHPs with savings options has been a partial step toward DC for many employers. Taking the next step toward full defined contribution health benefits won’t be that great of a leap. Furthermore, a number of Medicare reform efforts under discussion (including the Ryan-Wyden proposal) rely on premium support which is effectively a defined contribution model. If Medicare moves in this direction, it is even more likely that a large portion of the private insurance market will follow suit.

<sup>7</sup>82% of groups (representing 48% of all currently ensured privately insured employees) currently offer only 1 plan (Source: Kaiser HRET Employer Health Benefits Survey, September 2012)

<sup>8</sup>Since employers must contribute at least 60% of a plan’s actuarial value, they will need to understand the actuarial value of plans offered on the private exchange, and have assurance that plans offered meet PPACA’s minimum essential benefits provision.



### Sidebar: The 401(k) Analogy

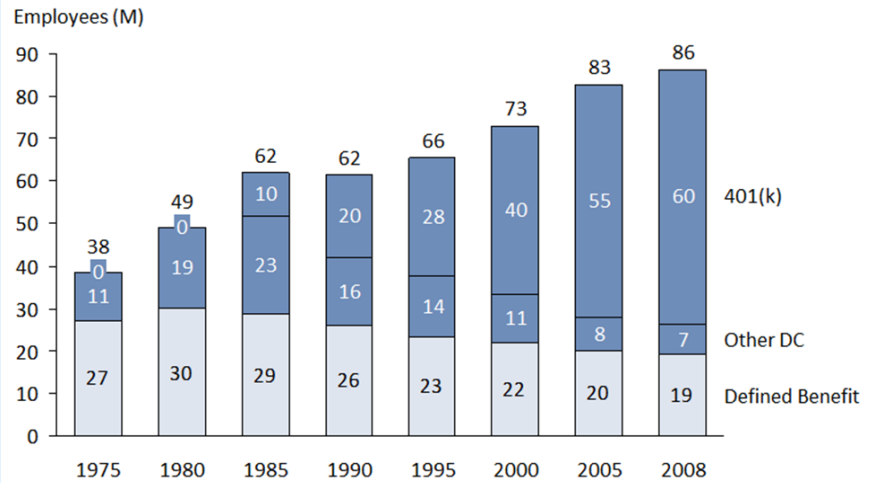
A case example as to how DC health plan adoption may proceed can be found in the growth of defined contribution retirement plans (predominantly 401(k) plans) at the expense of defined benefit retirement plans from the 1980s through today. Since the first 401(k)s were adopted in the early 1980s, defined contribution participation has grown by over 250%, while defined benefit participation has declined by about 40% (see Exhibit 5).

Defined contribution retirement plans are preferred by employers due to their lower cost, reduced fiduciary liability for investment management and funding, and the tangible nature of the benefit. Also, as 401(k) plans are an annual expense (as opposed to defined benefit plans which create a long-term liability), they align well with the contract between employers and employees in the U S , which has become year-to-year in nature.

Although the differences between health insurance and retirement plans make for an imperfect comparison, there are some lessons and implications from the 401(k) experience that can be applied to DC health insurance evolution:

- Companies with a substantial retiree health benefit liability may be more interested in a DC plan which can remove the liability from their balance sheet. Those with positive retiree exchange experiences will likely be among the first movers to DC for active employees
- Follow-on legislation in the name of employee protection (e.g. testing participation, mandating the number and types of plan options offered, limiting employers' ability to differentiate contributions by employee) is a real possibility
- Although changing health coverage is easier than transitioning retirement benefits, the transition to DC health plans is likely to occur over many years
- Smaller employers are likely to lead the adoption of DC health plans, but large, well known employer shifts to DC will trigger broader adoption (see Exhibit 6)

Exhibit 5 – Active Participants in Retirement Plans



Source: US Department of Labor – Employee Benefits Security Administration, December 2010

Exhibit 6 – Defined Contribution Trigger Event?

September 26<sup>th</sup>, 2012 announcement:

2 large groups choose DC private exchange – is this a ‘trigger’ event for big employers?



Platform	Aon Hewitt Corporate Exchange
Eligible Employees	Sears – 90k Darden – 45K
Effective	1/1/13
Participating Carriers	United, Cigna, HCSC, 6 other national and regional carriers
Other Notes	<ul style="list-style-type: none"> <li>• Shifting from self-funded to fully insured</li> <li>• Group experience rated</li> </ul>

## In Summary: The Case for Change

Employers offer health insurance to their employees for a few simple reasons:

1. To attract and retain workers to remain competitive with peers who provide health benefits
2. To meet their moral obligation to look out for the health and financial well-being of their employees in an environment without a viable individual market (particularly for those with poor health status or pre-existing conditions)
3. As a mechanism to provide tax-efficient compensation
4. To promote worker health and productivity

Going forward, the first reason will remain relevant. However, a shift to DC is not an elimination of benefits, merely a change in the financing and offering mechanisms. We believe that adoption by large, well known employers (noted above) will trigger widespread discussions among CFOs and HR leaders about the potential risks and rewards of shifting to DC. The passage of the ACA essentially neutralizes the second reason by implementing guaranteed issue and community rating nationwide. Tax efficient compensation (reason #3) is still accomplished by a DC arrangement. And efforts to promote worker health and productivity (reason #4) can and will likely continue regardless of whether a group provides traditional or DC health insurance. Finally, the concept of defined contribution and exchanges in health insurance will come

**We believe that a meaningful percentage of groups will shift to defined contribution health insurance over the next 2-5 years.**

to the forefront as state and federal exchanges are implemented and premium support becomes a more likely path for Medicare. With widespread consumer exposure to this transition, and years of experience with online exchange-type shopping and 401(k) plans, the shift to DC healthcare faces few end user hurdles. In sum, given the potential benefits to employers (lower and more predictable costs, reduced administrative burden, etc.), we believe that a meaningful percentage of groups will shift to DC health insurance over the next 2-5 years.

## Strategic Considerations for Health Payers

In determining how to respond to the emergence of defined contribution in health insurance, payers should consider several questions, which we discuss in some detail below.

1. Which employers are most likely to consider defined contribution arrangements?
2. Should we develop a captive, single-carrier exchange? Should we participate on multi-carrier exchanges?
3. If we decide to develop a DC offering, what new capabilities will we need? Should we develop or partner/acquire those capabilities?
4. How will defined contribution plans impact our traditional sources of competitive advantage?
5. How should brokers and consultants be engaged in the transition to defined contribution? How may our relationships with these intermediaries change?
6. When should we begin planning for a potential shift to defined contribution?

## 1. Which employers are most likely to consider defined contribution arrangements?

Two types of employers are most likely to be early adopters of defined contribution health arrangements: small-to-medium sized employers, and employers currently providing health benefits to large retiree populations. Smaller employers are less able to manage healthcare costs today, are more sensitive to healthcare cost uncertainty, and would benefit most from reducing the administrative burden of providing health benefits. Employers with a large population of retirees receiving health coverage carry a substantial liability on their balance sheet for retiree health benefits. Converting to a defined contribution arrangement allows these companies to remove the liability, and replace it with an annual expense. Those with positive experiences in the retiree DC market are likely to be more willing to move forward with DC plans for active employees, having confidence that the plans can work well.

## 2. Should we develop a captive, single-carrier exchange? Should we participate on multi-carrier exchanges?

A key decision for health plans is whether to participate in single carrier exchanges, multi-carrier exchanges, or both. Single-carrier exchanges allow plans to capture the entire population of employers adopting DC plans, and also enable group (as opposed to individual) underwriting<sup>10</sup>. However, implementing a single-carrier exchange can be complex, as the payer needs to develop (or partner to acquire) exchange capabilities, including the user experience, decision support tools, underwriting and payment mechanisms. Multi-carrier exchanges, established by broker or other third parties may be easier to participate in, however, they also:

- Place the payer in an environment where they must compete for individual employee business
- Increase the risk of adverse selection

Exhibit 7 (next page) depicts how payers may view single and multi-carrier exchanges depending on their current competitive position (nation scale versus local share dominant).

While some large local share Blue plans have already chosen to participate in multi-carrier exchanges (e.g., HCSC in Aon Hewitt's Corporate Exchange), others may decide not to participate in order to protect their existing blocks of business. For national commercial carriers, the choice is more straightforward. To quote one national carrier promoting their involvement in Aon Hewitt's exchange: *"Private health care exchanges enable employers to offer a wide range of health insurance options so their employees can choose a health care plan that is best suited for them and their families. We welcome the opportunity to participate in Aon Hewitt's groundbreaking new corporate exchange," Elizabeth Winsor, Chief Executive Officer of United Healthcare National Accounts.* Most national commercial carriers will jump at the opportunity to compete directly for more 'slice' business.

**Multi-carrier exchanges established by third parties may seem attractive, however they will lead to more direct price competition and increase the risk of adverse selection**

**Most national commercial carriers will jump at the opportunity to compete for more slice business on multi-carrier exchanges**

<sup>10</sup>To avoid the possibility of some employees facing high premiums or denied coverage, employers may prefer group underwriting, at least until guaranteed issue and rating restrictions take effect in 2014.

Exhibit 7 – Strategic Considerations for Plans

Exchange Type	Local Share Dominant Payers (e.g., Blues)	National Commercial Carriers (United, Aetna, Cigna, Humana)
Single Carrier	<p><u>Pros</u></p> <ul style="list-style-type: none"> <li>Compelling offering for:                             <ul style="list-style-type: none"> <li>Groups seeking to reduce internal administrative burdens or achieve better cost predictability</li> <li>Cost conscious groups considering dropping coverage entirely or (small groups) shopping in public exchange</li> </ul> </li> <li>Defend existing block vs. intermediaries looking to shift their groups to multi-carrier platform</li> </ul> <p><u>Cons</u></p> <ul style="list-style-type: none"> <li>Potentially high investment to develop exchange offering, with no guarantee of large market</li> <li>Increased channel conflict</li> <li>Execution risk</li> </ul>	<p><u>Pros</u></p> <ul style="list-style-type: none"> <li>Potential to penetrate segment of market demanding DC options where higher local share Blues plans are slow to respond</li> </ul> <p><u>Cons</u></p> <ul style="list-style-type: none"> <li>Potentially high investment to develop exchange offering, with no guarantee of large market</li> <li>Increased channel conflict</li> <li>Execution risk</li> </ul>
Multi Carrier	<p><u>Pros</u></p> <ul style="list-style-type: none"> <li>May gain access to select large accounts currently with commercial carriers</li> <li>Low relative investment to participate</li> </ul> <p><u>Cons</u></p> <ul style="list-style-type: none"> <li>On balance, more of own groups and members opened up to competition from national carriers</li> <li>Adverse selection risk</li> <li>Costs of integration with proliferating intermediary exchanges</li> </ul>	<p><u>Pros</u></p> <ul style="list-style-type: none"> <li>Access to more groups and members currently with higher local share Blues plans</li> <li>Low relative investment to participate</li> </ul> <p><u>Cons</u></p> <ul style="list-style-type: none"> <li>Converts group business (the strength of most national carriers) to individual business</li> <li>Adverse selection risk</li> </ul>

It is possible that establishing single-carrier exchanges before multi-carrier exchanges are able to gain a significant foothold could stunt the growth of multi-carrier exchanges and make it more likely that single-carrier exchanges will ultimately prevail. This could prove especially important to high share Blue plans looking to:

- Protect their market against national carriers’ use of multi-carrier exchanges to pry away group business
- Maintain/enhance their relationships with groups and prevent increased control by large consultants and brokers

3. If we decide to develop a DC offering, what new capabilities will we need? Should we develop or partner/acquire those capabilities?

Establishing exchanges (specifically single-carrier exchanges) will require payers to develop:

- Product Inventory:** Sufficient product options to serve a breadth of individual DC participants with different needs, preferences, and circumstances
- Decision Support Tools:** Robust, yet easy-to-use web-based decision support tools to guide participants through the process of selecting appropriate coverage
- Customer Service:** Online and telephonic delivery of customer support to DC participants (particularly during enrollment), many of whom will be actively involved in the purchase of health coverage for the first time
- Enrollment Integration:** Linkages to enrollment platforms to sign up new members to DC arrangements, and manage changes to employment, dependents, and marital status
- Funding and Billing:** Processes and mechanisms for managing the flow of funds from the employer to the employee’s HRA, from the HRA to the carrier for premium payment, from employer to the carrier for premium payments beyond the employer contribution, and potentially from the HRA to an employee HSA for HDHP plans

Limited, lower cost network and benefit designs will be important in DC plan offerings

- **Product and Underwriting Capabilities & Integration:** Product development, actuarial and underwriting work to address the challenges of offering group and individually underwritten product in a DC exchange environment. Linkages to product/underwriting systems to manage product options, pricing and risk, and monitor potential adverse selection
- **Reporting and Analytics:** Reporting and analytics for internal (sales, underwriting, benefits administration) and external (group leads, intermediaries) constituencies, especially during enrollment, where information needs will likely be real-time

Given the limited time available to establish a competitive offering, it will likely be necessary to find partners to support some of these capabilities. That is the path followed by WellPoint, HCSC and BCBS Michigan in their acquisition of Bloom Health, Highmark in their partnership with Array, and a handful of other Blues and commercial carriers.

#### 4. How will defined contribution plans impact our traditional sources of competitive advantage?

Health plans compete largely on their ability to manage healthcare costs in the group market, including:

- Deep negotiated discounts with provider networks (and more recently, narrower, lower cost/higher performance networks)
- Care management and wellness offerings
- Reporting and analytics, which allow groups to understand and manage their healthcare expenditures

Under defined contribution arrangements, competitive advantage will be derived from tools, products, and capabilities designed to manage costs:

- Tools which help individuals select the plan most appropriate to their circumstances
- Slimmed down benefit plan and network designs that are more appealing to individual consumers looking for ways to reduce the cost of their health coverage
- Access to services which identify alternative therapies or providers who offer better value without compromising quality (especially for individuals who select HDHPs)

**Carriers and intermediaries will face an unavoidable increase in conflict. Brokers and consultants recognize their diminished role in a single-carrier exchange – hence the rush to develop multi-carrier exchanges**

While some of the existing sources of advantage will still be important to the health plans (e.g. disease and care management), they will not be a key part of the value proposition to individual DC plan participants. Limited, lower cost network and benefit designs will become increasingly important, as early experience with DC plans suggests a majority of employees choose less expensive plan options<sup>11</sup>.

#### 5. How should brokers and consultants be engaged in the transition to defined contribution? How may our relationships with these intermediaries change?

While the shift of health insurance purchase decisions from groups to individuals may be unsettling for brokers and consultants, they have an important role to play both during and after the transition. In the near term, brokers need to understand the circumstances of their group clients, and advise them on the appropriate health benefit strategy going forward: continue to offer group coverage (either fully insured or self funded), adopt a defined contribution arrangement, or allow employees to purchase coverage on state exchanges. The role of the broker will evolve to helping groups evaluate the effectiveness of their DC platform in covering their employee population. By recognizing this changing role, educating brokers on defined contribution plans, and developing compensation models appropriate for a defined contribution environment, payers can continue to partner effectively with their intermediaries.

<sup>11</sup>In Blue KC's early experience, 60% of employees chose a less-rich benefit plan than they had under their previous defined benefit arrangement

In addition, carriers and intermediaries will face an unavoidable increase in conflict. Brokers and consultants recognize their diminished role in a single-carrier exchange hence the rush to develop multi-carrier exchanges to solidify and even increase their role in the value chain. These multi-carrier exchanges could significantly reduce carriers' relationship ownership with groups and individuals. Decisions to participate (or not) in intermediary-sponsored exchanges will have major strategic implications on the nature and strength of relationships with all of a carrier's customers groups, individuals and intermediaries.

#### 6. When should we begin planning for a potential shift to defined contribution?

Carriers should begin planning *now* for the emergence of defined contribution health insurance:

- Strategic decisions on participation in multi-carrier exchanges (and potential alternatives for groups seeking a DC option) will become pressing for early adopters in the 2014 renewal cycle
- An upfront assessment is critical to pursuing the right strategic path for DC healthcare. This effort will require market planning/forecasting (enabled by group consumer segmentation), as well as risk management work, consumer group needs analyses, and channel conflict assessments
- Solution design and development (even if partnering with vendors), integration with existing systems, testing and roll-out will all take time. Despite some vendor claims, plug-and-play solutions are more promise than reality
- Early moving carriers will benefit from the ability to test and evolve solutions over a cycle or two, prior to what we expect will be a meaningful shift during 2015 renewals. These carriers will gain critical experience with risk management, consumer guidance, sales and support strategies, and channel management

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