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Examining Private Exchanges in the Employer-Sponsored Insurance Market

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Introduction

The launch of the Affordable Care Act (ACA) has focused attention on the idea of a health insurance exchange (or “marketplace”). Under the ACA, people buying insurance on their own can choose from multiple private insurance options in standardized coverage tiers through a federal or state sponsored exchange and, depending on income, receive a tax credit to subsidize their premiums. The law also created SHOP exchanges for small businesses, though they have not been fully implemented in most of the country.

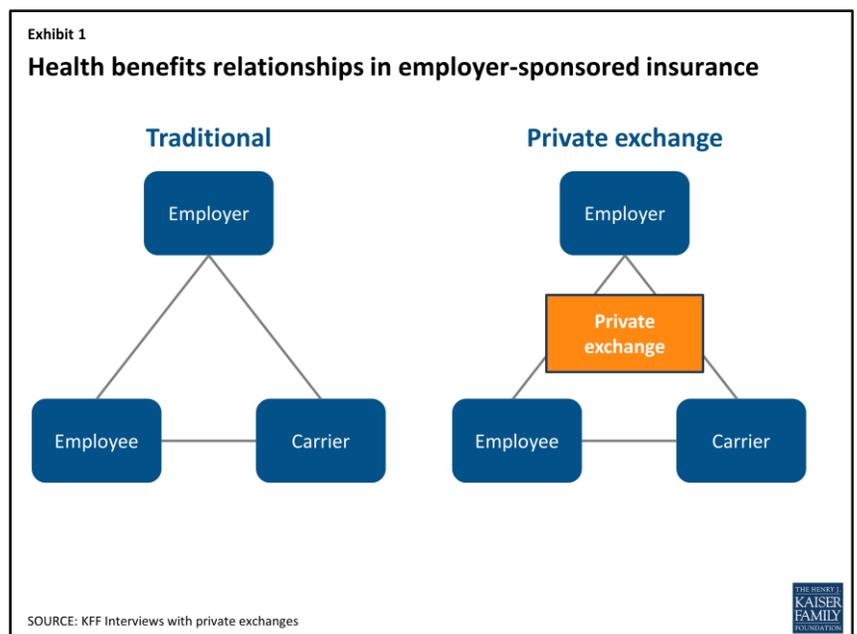
Separate from the ACA, so-called “private exchanges” have also started to emerge as an option for employers providing coverage to their workers. These private exchanges do not provide access to premium subsidies like the public exchanges, nor do they necessarily involve standardized coverage tiers. But, they do have the potential to reshape the employer-sponsored health insurance, which covers 149 million people, or nearly 56% of the U.S. non-elderly population.¹ We conducted interviews with more than fifteen private health insurance enrollment platforms, as well as several employers and health plans moving in this direction, to create a picture of this quickly growing landscape. We identified ten of the platforms we interviewed as full private exchanges (based on the definition described in the next section) and have profiled those in the appendix.

What are private exchanges?

Many approaches are sold as “private exchanges” since the concept is now in vogue. In profiling these efforts, we have sought to define what differentiates the new, more competitive approaches analogous to the ACA’s public exchanges from the traditional technology platforms that simply provide online enrollment. Also, what we describe here as private exchanges are targeted at employers, which eliminates many of the “e-brokers” selling directly to the individual market.

Characteristics that exemplify a private exchange include:

- **A set of health plans:** The exchange contracts with (or creates) its own set of health plans. This is different from a traditional technology platform, where the employer identifies and contracts with one or more insurers. Exchanges have varying levels of involvement in health plan standardization and design.
- **An ACA-compliant environment:** The exchange provides tools for the employer to comply with the requirements for employer-sponsored coverage under the ACA.
- **The ability to switch to defined contribution:** The arrangement provides the employer the ability to shift to a defined contribution for health coverage – an approach where the employee is given a fixed amount of money (e.g., \$300 per month) to spend on health or ancillary benefits within the exchange environment. This is different from a traditional “defined benefit” approach, where the employer generally pays for a set portion of each health plan option.



In addition to these core functions, many exchange platforms include additional elements, which may over time become standard practice within the private exchange landscape. These include:

- **Decision assistance and support:** As exchanges increase the amount of choice available to employees, many platforms offer varying levels of choice support, from general plan guidelines to tailored recommendations and side-by-side plan comparison capabilities.
- **Ancillary offerings:** Additional forms of insurance may be offered as a supplement to major medical coverage, such as dental, vision, critical illness, accident, and other forms of insurance.
- **Health and wellness programs:** Telemedicine, fitness programs, transparency tools, or other health and wellness services may be offered within the exchange's online portal. In some cases exchanges have also integrated wellness programs completely within their plan designs, including monetary incentives in combination with consumer-directed health plans.
- **Benefits administration:** Particularly those exchanges targeted at smaller employers may provide additional benefits administration support, such as payroll and 401(k) integration.

Many employers have separate active employee and retiree populations with a variety of coverage needs. Private exchanges may provide different coverage options for each segment, including *group coverage* for full-time active employees and individual coverage for employees ineligible for full group coverage and early retirees not eligible for Medicare, and individual Medicare plans for Medicare-eligible employees and retirees.

Current size of the private exchange market

We identified more than 20 private exchange platforms (each exchange platform can sponsor multiple exchanges) currently in the market that meet the criteria described above. Of those, we collected data from 10 that we believe to be the market leaders. While some platforms asked that enrollment data not be revealed publicly, we believe the current market in aggregate had at least 2.5 million people enrolled through private exchanges in 2014, including about 1.7 million group plan enrollees, 700,000 individual Medicare enrollees, and 100,000 individual enrollees (this does not include the purely e-broker individual market, which is significantly larger)

Many of the exchange platforms we spoke to were in the process of signing contracts for the 2015 enrollment year, and expected significant (often greater than 100%) growth year over year. Notable large employers who are using private exchanges as of 2014 include:

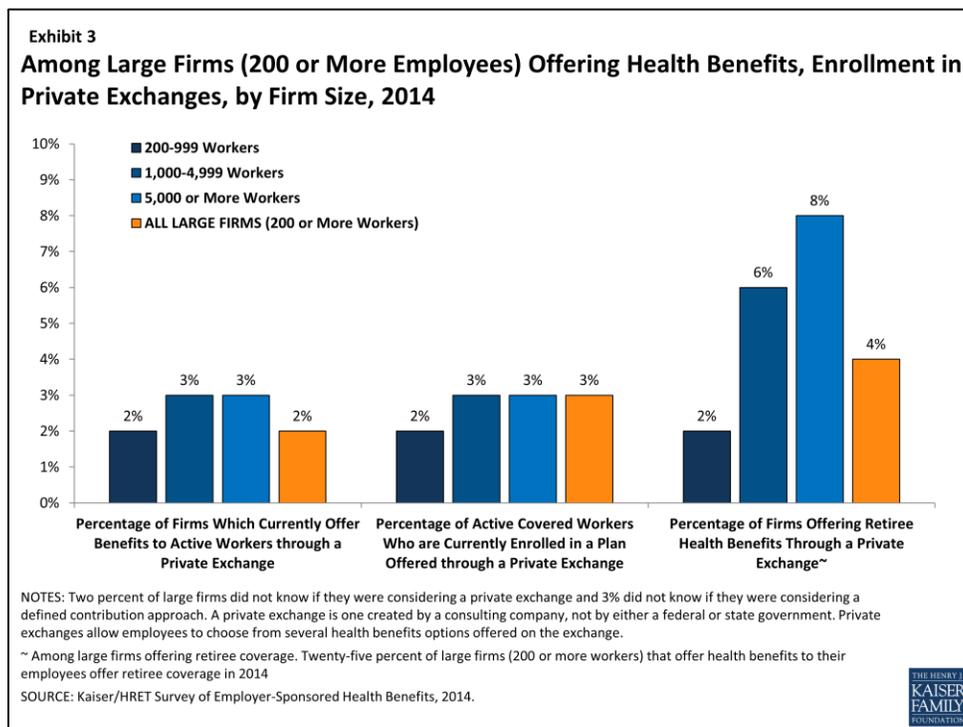
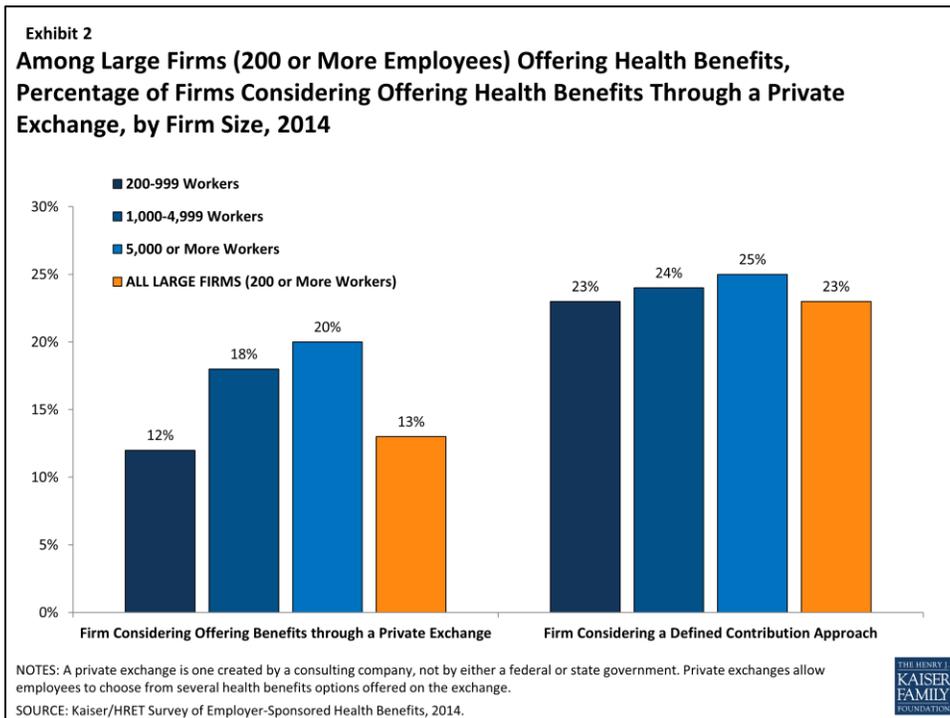
- For active employees: Walgreen's, Sears, Darden Restaurants, Petco, DineEquity (parent company of Applebee's & IHOP)
- For retirees: IBM, Time Warner, General Electric, Whirlpool, Caterpillar, Kinder Morgan
- For part-time and seasonal employees: Target

Thus far, it appears that the employers shifting active employees to private exchange have generally been in lower-wage industries.

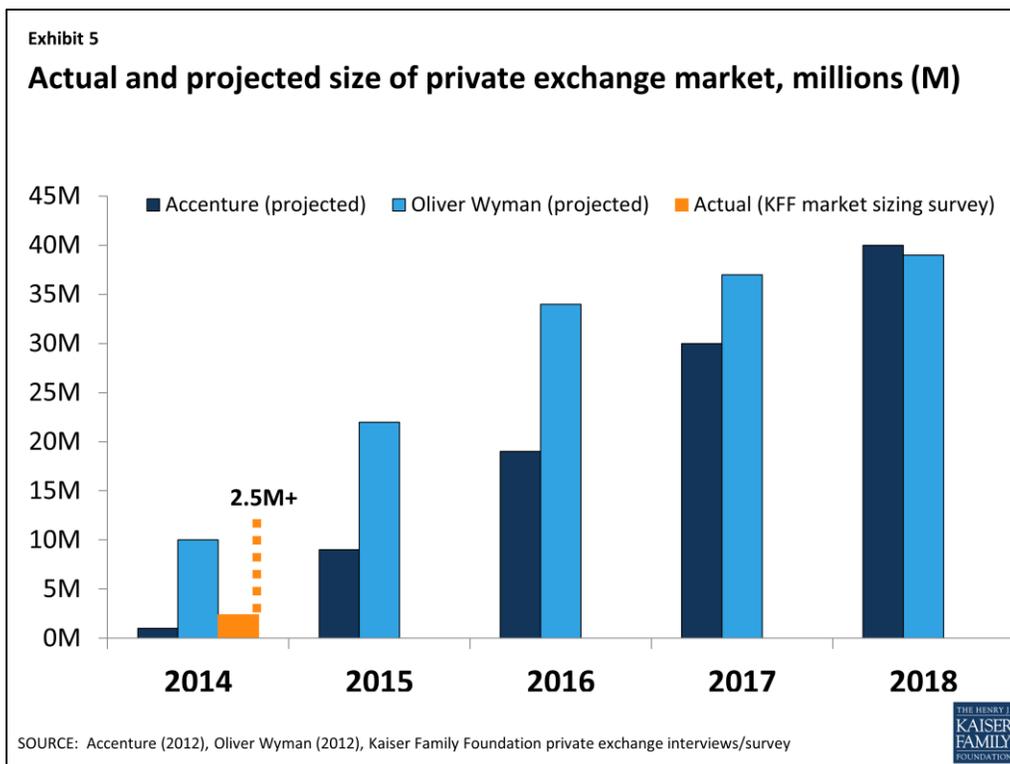
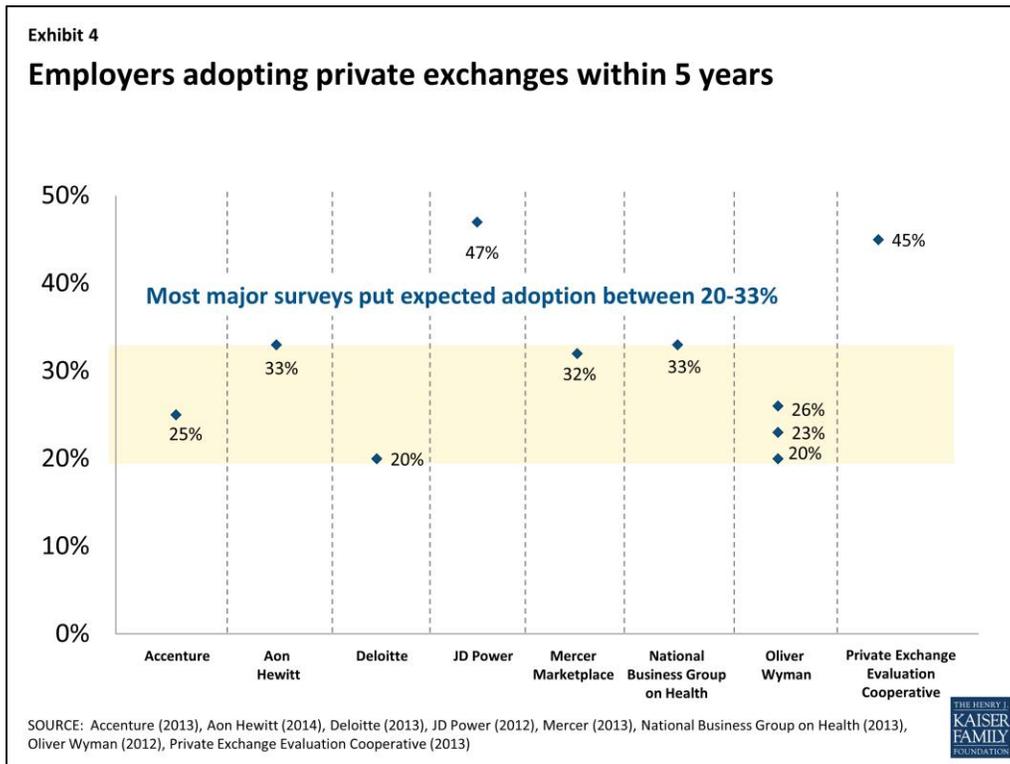
Potential size of the private exchange market

There appears to be a great deal of interest from employers in private exchanges, particularly the largest firms which employ a great share of the workforce. The 2014 Kaiser HRET Employer Health Benefits Survey (EHBS) found that 13% of employers with 200 or more workers who currently do not offer benefits through an

exchange were considering such an approach. Firms with 5,000 or more workers are more likely than firms with 200 to 4,999 workers to be considering offering coverage through a private exchange. The EHBS also found that significantly more firms are considering implementing a defined contribution approach (23% of firms with 200 or more workers) than fully adopting a private exchange model. Starting in 2014, the EHBS also measured current market penetration of private exchanges; based on interviews with over 2,000 employers between January and May 2014, the survey estimated that 2% of large employers (200 or more workers) had already adopted a private exchange. Among large firms offering retiree coverage, 4% of firms offered their retiree benefits through a private exchange.



Surveys of employers conducted by exchange providers, consultancies, and 3rd party cooperatives find that 20-33% of employers will adopt a private exchange approach over the next three to five years. Oliver Wyman and Accenture have each published independent reports that estimate the size of the private exchange market in 2018 at 39 million and 40 million lives, respectively.



The emerging private exchange landscape

PRIVATE EXCHANGE SPONSORS

Three major types of companies are building private exchanges:

Carriers: Numerous regional carriers have partnered with technology platforms to build private exchanges, and several of the large national carriers have also invested in their own technology. In 2014, Cigna launched a private exchange for small employers. In 2011, United purchased Connexions, a technology services leader in the healthcare industry.² Also in 2011, WellPoint and two regional Blue Cross Blue Shield plans purchased a majority stake in Bloom Health, a startup private exchange platform.

Benefit consultants: Four of the major benefit consultancies sponsor a private exchange – Aon’s Corporate Health Exchange, Buck Consultant’s RightOpt, Mercer’s Mercer Marketplace, and TowersWatson’s OneExchange. Profiles of these exchanges are in the appendix.

Technology platforms: A range of technology vendors support private exchanges to varying degrees. While certain platforms simply provide the technology to run the data and interface of the exchange, others go as far as contracting with carriers and providing a complete exchange solution directly to employers. Vendors include: Bloom Health, Liazon, bswift, Array Health, Connecture, Connexions, hCentive, Colibrum Partners, BenefitFocus, and ADP.

SINGLE CARRIER VS. MULTI-CARRIER PRIVATE EXCHANGE MODELS

While private exchanges are still in their early growth stages, two major classifications of exchanges have emerged. Each of these types has several variations, and there are several exchange platforms that do business in both arenas or could be classified somewhere in between.

Single carrier exchange: Operated by an insurance carrier, this type of exchange is typically built in partnership with an exchange platform technology player and enables the carrier to bring plan offerings directly to employers with added choice and defined contribution functionality. Numerous regional health plans have partnered with technology platforms to build exchanges, and several large national health plans have invested

Exhibit 6
Two types of private exchanges, with many variations

	Single carrier exchange	Multi-carrier exchange
Overview	Operated by a single carrier, many times in partnership with a technology platform, where the carrier will offer exchange-specific plans to the employer	Operated by a 3 rd party that puts together a line-up of health plans and ancillary offerings from multiple carriers that often (but not always) compete side-by-side on the platform
Selected platforms		
Additional detail	<ul style="list-style-type: none"> Carriers bring benefits to existing group accounts with increased choice and defined contribution, paired with an improved technology platform Target small to mid-size employers, depending on carrier 	<ul style="list-style-type: none"> Range from highly customizable markets, to fully competitive exchanges mirroring the public marketplaces Targets employers of all sizes, with the fully competitive exchanges reserved for jumbo employers

SOURCE: KFF Interviews with private exchanges, KFF analysis



in the technology as well, including Aetna, Cigna and United.

Multi-carrier exchange: This type of exchange is operated by a 3rd party (not the employer or insurance carrier) that contracts with multiple carriers to broker health plans and ancillary offerings. There are several variations on this type of exchange, most prominently including:

- A *customized exchange*, where the plan line-up is customized by the employer or exchange in some way that differentiates it from a more open, competitive market exchange. Examples of this include Mercer Marketplace, whose lineup is fully customizable by employers, and Buck Consultants RightOpt, who contracts with multiple carriers but offers only one network per region to employers.
- A fully *competitive exchange*, modeled after the public marketplaces, where a set of health plans compete side-by-side on the platform. Health plans agree to participate in certain regions on the exchange, and guarantee issue of insurance to any employee of any group in the regions they participate in. When the employer is fully insured, the exchanges may conduct risk adjustment between health plans on the back-end. Examples of this type of exchange include Aon, TowersWatson OneExchange, and Liazon's BrightChoices marketplace.

PRIVATE EXCHANGES BY EMPLOYER SIZE

Exchange options vary for different employers, mostly dependent on their size and associated health benefits administration needs.

Employers with fewer than 50 employees: Groups in the under-50 employee market are primarily served by single carrier and broker-distributed exchanges built in partnership with a technology platform. These groups are not subject to the employer responsibility requirement under the ACA and have an alternative to the private exchanges in the public marketplaces, so many have shown less interest in private exchanges than their larger counterparts.³ Some employers in this segment have chosen to drop group coverage but use a private exchange platform to offer a broker connection to the individual public marketplaces, occasionally even providing a post-tax contribution to encourage their employees to purchase coverage.⁴ Exchanges Array Health and ConnectedHealth, among others, tout this capability as a key part of their offering.

Employers with between 50 and 1,000 employees: Mid-size employer groups have been targeted by both single carrier and broker exchanges, as well as some of the direct-to-employer models (i.e., Mercer Marketplace). Much of this enrollment is driven by brokers and health plans attempting to move their existing books of business to these new approaches. Scott Reid, Vice President of Product Strategy and Development for Medica, notes that the initial focus of My Plan by Medica has been attracting Medica's existing group customers to My Plan. Since 2010, Medica has moved more than 10% of its group lives to My Plan, and those lives make about half of all exchange enrollment.⁵ This focus on existing business is not uncommon, according to Jonathan Rickert, co-founder and CEO of Array Health. He adds that pre-existing business accounts for the "majority" of lives on Array Health's single-carrier exchange platforms.⁶

Employers with more than 1,000 employees: The very large employer market is primarily served by the exchanges created by large consulting firms. Many large employers already use benefit consultants in the design, execution, and evaluation of their benefit plans, so there is a great deal of familiarity between these firms and the organizations sponsoring these exchanges. While the business models and strategies vary across these exchanges, each attempts to provide a comprehensive solution for benefits provision, offering an array of

health plans, decision support and ancillary products in a single system. Additionally, these very large employers are increasingly interested in the individual market approaches that the benefit consultants offer, as they try to find ways to serve their entire employee base. Individual market coverage is appropriate for part-time and seasonal employees and consultants, as well as early retirees. Private exchanges often broker both public exchange QHPs (several private exchanges have attained Web-based Entity certification for the federal marketplace) as well as curated off-exchange individual market plans.

Through the interviews we identified a number of emerging trends with implications for employers and consumers:

Emerging implications for employers

1. **Shift to defined contribution:** By facilitating a shift to a defined contribution through a fixed dollar benefit, private exchanges offer the potential for cost stability to employers, while giving greater choice to employees (albeit with greater financial risk as well). Because the employer defines up front the amount paid to the employee, employers have greater control over how much they spend on health benefits. Meanwhile, although employees may have greater financial risk overall, they also have more control over how to allocate their benefit dollars between medical and ancillary plans. Exchange sponsors report that consumers appear to be re-allocating dollars from medical to ancillary. Interviews with exchange sponsors suggest that of the 1.7 million active group lives on private exchanges, at least half are now using a defined contribution model.⁷

“We’ve had many employers who were already at the brink and ready to drop coverage, and by shifting to DC they were able to maintain a benefits plan.”

– Jonathan Rickert, CEO Array Health

2. **Potential shift back to fully insured among large employers:** Several private exchanges are encouraging or even requiring that large employers move to fully insured if they join the exchange. Aon is a prime example, as all 600,000 of their group lives are fully insured. Over three-quarters of covered employees in larger firms are in self-funded plans today, so the shift to fully insured would represent a significant change in the marketplace.⁸ A self-funded plan is an insurance arrangement in which the employer assumes direct financial responsibility for the costs of enrollees’ medical claims. Large employers with sufficient enrollment to distribute risk typically self-fund because the Employee Retirement Income Security Act of 1974 exempts self-funded plans from most state insurance laws. A shift to fully insured plans would place risk with insurers instead. Tom Sondergeld, Sr. Director of Health & Well-Being at Walgreen’s, noted this on their decision to join Aon and shift back to fully insured: “If we’re really going to drive for competitiveness and pricing in a marketplace, we really need to be fully insured – and the stability is nice.” In an exchange marketplace, the exchanges have an incentive to encourage a fully insured shift by employers, as that is financially beneficial to the carriers who provide their product. A fully insured marketplace also encourages a carrier focus on pricing and cost competitiveness, which could put downward pressure on costs in the long term.

On the other hand, several major exchanges believe that large employers will stay self-insured due to higher costs associated with premium taxes and benefit requirements in fully insured plans. Eric Grossman, Exchange Business Leader Mercer’s Health and Benefits services, explains his perspective on the impact to employers of a shift to fully insured: “If I move from self-funded to fully insured, I should expect a 4% to 6% cost increase. The typical self-funded [employer] will pay their claims and then pay five or six points in

administrative expense above that. But a fully insured employer will pay 10 to 12 points above [claims] costs to the carrier...Moreover, new taxes called for by the reform law will add a couple additional percentage points to the cost of insured coverage.”⁹ The magnitude of such cost increases will vary case-by-case, depending on the fully insured rates the exchange is able to negotiate.

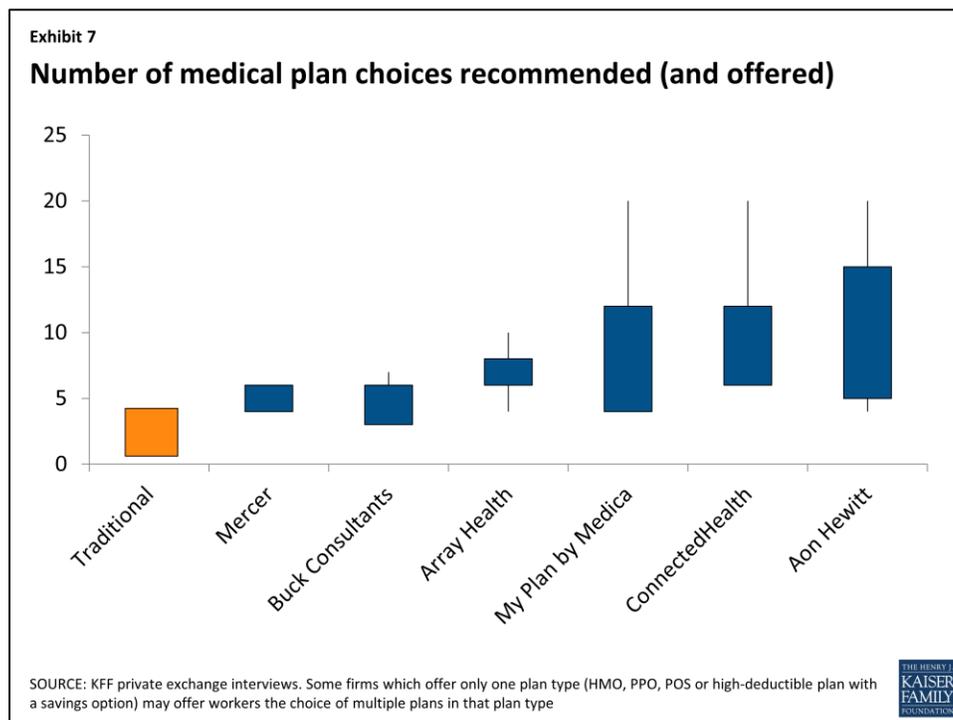
3. **Decreased employer involvement in the administration of health insurance:** Because private exchanges can all aspects of health benefits administration for employers, an employer’s involvement in the provision of health benefits naturally decreases upon joining an exchange. Exchanges provide carrier contracting, enrollment tools, ACA compliance, and oftentimes other pieces, that the employer will no longer be responsible for. They have inserted themselves fully in the middle of the current benefits provision process between the employer, the insurer and the employee. Tom Sondergold from Walgreen’s refers to this as the “health benefits triangle,” noting that: “Aon Hewitt is sitting in the middle of that triangle, [and] we have less control.”¹⁰ If the employer also shifts to a fully insured model on an exchange, additional involvement and control is lost, most notably in claims payments.
4. **Evolving employer approaches to wellness:** Employers and exchanges alike have emphasized that the decreased employer involvement in benefits administration will not necessarily reduce their involvement in health and wellness. In fully insured exchange models, such as Aon’s, employers may focus more narrowly on wellness for employees as a supplement to the carrier’s cost management efforts. Tom Sondergold from Walgreen’s notes that the time his team in the past spent on “managing costs, contracts and relationships” they have been able to re-focus on “wellness strategy and the health goals of the company.”¹¹ On other exchanges, such as Towers Watson’s OneExchange, the wellness programs are built by the exchange and integrated in the plans themselves. In these instances, it may be that employers will slowly become less involved in wellness as well.
5. **Possible new ways for employers to reduce cost trend:** Private exchanges enable several new elements that could help to lower the rate of health cost increases: 1) Purchasing efficiencies at scale - As exchanges gain enrollees, they may be better positioned to negotiate lower premium rates for employers. Dave Osterndorf, Chief Actuary for TowersWatson’s OneExchange, notes that “Joint purchasing efficiencies can help the employer, which benefits from the economies of scale associated with a large purchasing pool.” 2) Carrier competition - On competitive marketplace exchanges, side-by-side competition encourages carriers to price competitively. Even on customized market exchanges, the exchange entity can negotiate with the best-priced carrier in each region, instead of relying on one carrier everywhere. 3) Plan and program design - exchanges with hundreds of thousands of lives may be better equipped to put expertise behind the structure of plan designs and negotiations with carriers.
6. **Private insurance options for all employee segments:** Several private exchanges we spoke to offered options to insure all segments of an employer’s population: group coverage options; broker connections to the public marketplaces (along with off exchange plans) for part-time/seasonal employees, contractors and early retirees; and brokered individual Medicare plans for eligible retirees. For large employers, this flexibility allows all employees to be serviced off the same platform, regardless of their group coverage eligibility.

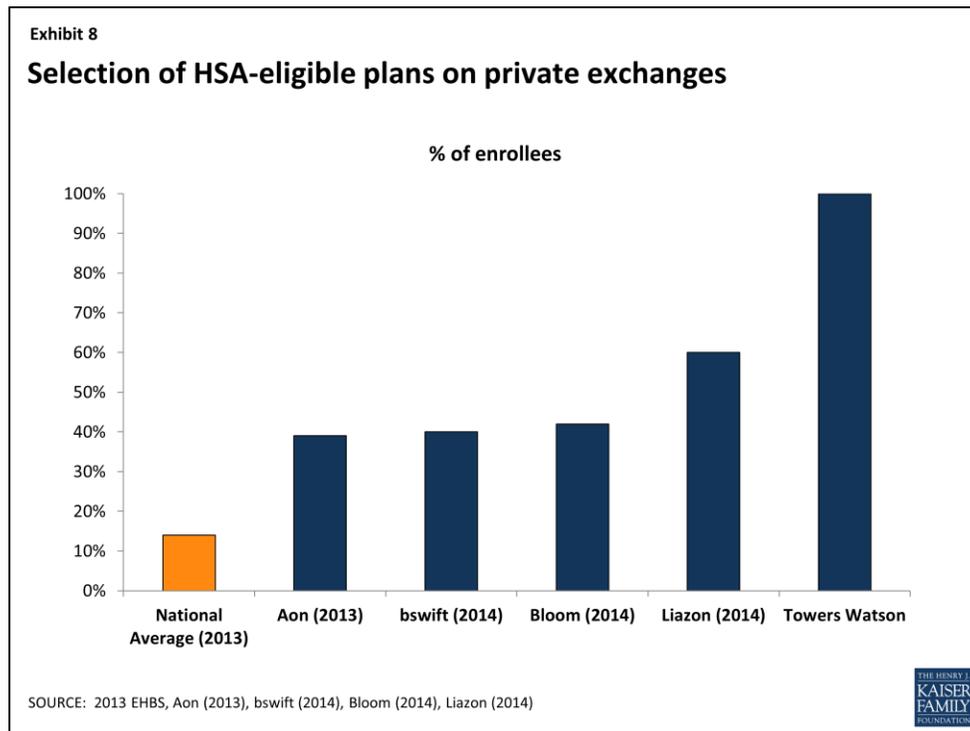
“Joint purchasing efficiencies can help the employer, which benefits from the economies of scale associated with a large purchasing pool.”
– Dave Osterndorf, Chief Actuary
TowersWatson OneExchange

7. Increased access to data: Serving as the connecting point for employers, employees, and carriers, private exchanges have the ability to aggregate data that has historically been unavailable or difficult to access. Cathy Tripp, Director of TowersWatson OneExchange, offered some basic pieces of information that a private exchange can provide: “A well-performing exchange should be able to show the choices employees are making in plans, how the health status of the overall workforce is changing and whether the promised savings are being realized. The employer should ask the exchange: Are the plans delivering savings at the projected levels? Is Rx spending dropping as people make better choices? Is there less spending on people with chronic diseases because they’re getting better support?” The exchange also has the power to aggregate data across employers and carriers, which may lead to new and interesting uses.

Emerging implications for consumers

1. **More choice among health plans:** Switching to a private exchange can increase the number health plans offered to employees. In 2014, 86% of firms with fewer than 200 employees only offered one type of plan to their employees¹². Even at employers with between 200-999 employees, a full 59% of employees were offered only one type of plan¹³. Private exchanges create standard sets of plans with carriers that allow employers to dramatically increase that level of choice. Joe Donlan, President and co-founder of ConnectedHealth, notes that often their mid-size group clients will increase the level of choice offered to their employees from 3-6 plans up to 6-12 plans, up to quadrupling the level of choice available to employees.¹⁴ While many exchanges offer up to 20 total plans, Jonathan Rickert from Array Health notes that 20 plans can be too many for an employee to choose from. Array Health generally recommends a set of 6-8 plans to their employer clients, narrowing down the choices to make the employee’s decision more efficient.¹⁵ Most private exchanges have integrated decision support tools to assist consumers as they choose.

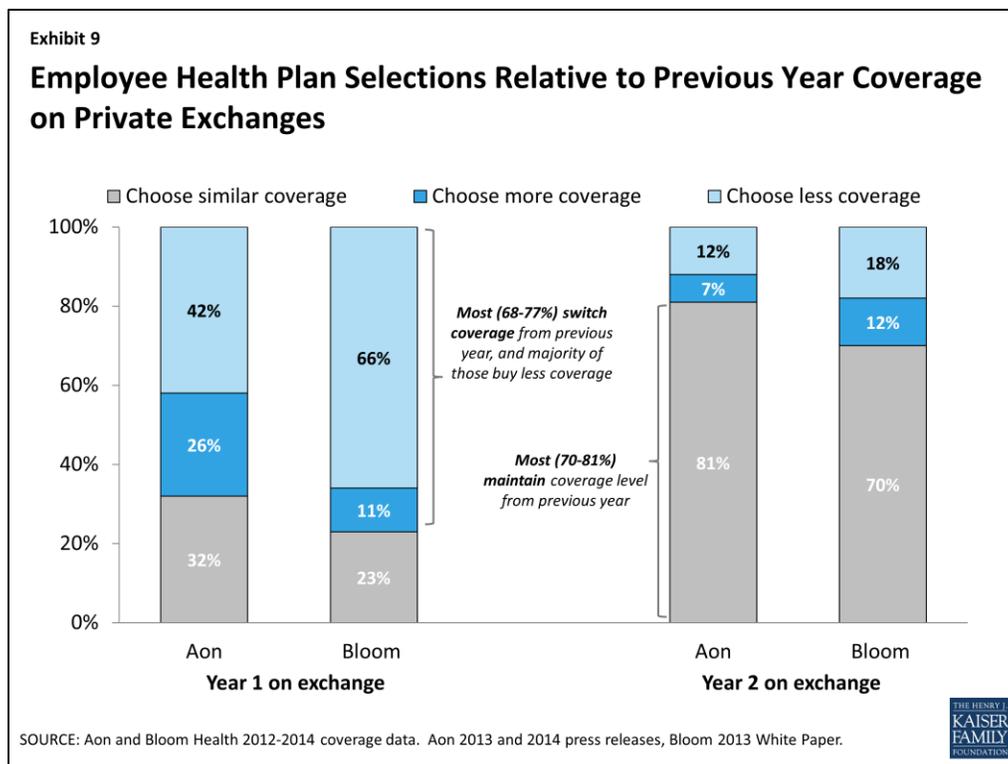




2. **Increased enrollment in consumer-directed health plans:** Early private exchange data shows that consumers enrolled in HSA-eligible plans at a rate of 40-60%, relative to roughly 20% nationally outside of exchanges.¹⁶ Enrollees in Aon’s exchange in 2013 enrolled in HDHPs at more than three times the rate they did prior to joining the exchange (39% vs. 12%). Towers Watson OneExchange offers only HSA/HRA-eligible plans on their group active exchange, so 100% of their participants are enrolled in consumer-directed health plans.¹⁷ Eric Grossman, Active Segment Leader in Mercer’s Exchange business, finds that: “We are starting to see in the early days some significant shift of employees who are “right-sizing” their coverage, which general means on average they’re moving to [higher deductible plans], which offer not only lower cost coverage but also [premium costs] that trends at a lower rate.”¹⁸ Employees may be selecting HDHPs because defined contributions provide them with an economic incentive to enroll in lower premium plans. However, this may also result in higher out-of-pocket exposure for consumers.

3. **Increased selection of ancillary products** – Most private exchanges provide full suites of ancillary products such as dental, vision, critical illness, and accident policies. Some exchanges even bundle ancillary products with medical products in their recommendation engines to encourage purchase. Initial data shows that consumers purchase ancillary products at high rates on exchanges. On Liazon, consumers purchase dental and vision more than 60% and 40% of the time, respectively. On one of Array Health’s single carrier exchanges, the carrier sold twice as much ancillary business as it had prior to joining the exchange. This pattern ties in with the uptake of HSA-eligible plans, according to Liazon Founder and CEO Ashok Subramanian: “We’re trying to array as broad a set of merchandise as possible to help people make good decisions and maximize their dollars; it may make more sense for someone to buy a high deductible or thin network plan and pair that with telemedicine – that small buy-up is probably a lot more cost effective (for them) than buying a richer plan.”

4. **Potential for increased financial burden through defined contribution:** As employers shift to defined contribution on private exchanges, there is a potential for them to cap the increase in contributions at a rate slower than the growth of health care costs (e.g., indexed to inflation or wages). Although there is no evidence for employers behaving like this yet on private exchanges (with only 1-2 years of data), it is a trend to watch for and a natural outgrowth of the shift to defined contributions.
5. **Decreased plan switching over time:** Many consumers switch plan levels in their first year on exchange, but stay in their selections in the second year, which could indicate satisfaction with their choices or simply inertia. Bloom Health, a platform for single carrier and broker-distributed exchanges, reports that in the first year on exchange, 77% of employees choose a plan with a different benefit level than the previous year. In their second year on exchange, only 30% do so.¹⁹ Aon reports similar statistics, with 68% switching in the first year and only 19% switching in the second year. Most of those who switch “buy down” on coverage, choosing less coverage than in the previous year.



6. **Provision of services to consumers beyond enrollment:** At their most basic level, private exchanges facilitate the enrollment process. However, several private exchanges have already begun to extend their reach beyond enrollment into consumer education, navigation, and in some cases, provision of care. Examples of this extension include: integrated in-depth wellness programs where the exchange is the check-in platform, integrated telemedicine, integrated health finance tools, price transparency tools, and health concierges. Joe Donlan of ConnectedHealth says: “We think that enrollment is an opportunity to open the dialog about a consumers healthcare.” As private exchanges continue to grow it will be interesting to monitor their evolution in care navigation and provision.

Appendix

AON



Updated as of May, 2014

Table A1: Aon Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50–199)	Large (200–999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • Medical: HMO, PPO, high-deductible CDHP • Supplemental: Dental, vision 			
2014 Enrollment	600K active (total covered lives), undisclosed retiree			

Exchange Overview

Exchange inception: Aon established its private exchange through its human resources / benefit consultancy division in 2012. With 100,000 enrollees for 2013, it was the first multi-carrier private exchange for large corporations in the United States.²⁰

Exchange approach: Aon’s approach to the private exchange market entails offering only defined contributions and fully insured options on its exchange. It targets large employers, organizations with over 5,000 employees. On the exchange, carriers must meet Aon’s plan requirements to participate in any of Aon’s 21 regions across the United States. While carriers can choose which regions to participate in, they cannot choose between employer groups, and must guarantee issue to all employees in the region. To compensate for this, Aon conducts risk adjustment periodically within each of its 21 regions. For the employee, Aon includes the employer contribution automatically, and allows them to choose from the health plans within their region, sorting by plan level and pricing.

Health Plans

Plan design: Aon is actively involved in defining plan design requirements with health plans. Plans on Aon's exchange must fit one of five standardized designs, including: Bronze, Bronze Plus, Silver, Gold and Platinum. The plans will range from 66% actuarial value (Bronze) to 92% actuarial value (Platinum). Additionally, Aon standardizes all the health insurance products across 200 plan design provisions (i.e., number of therapy provider visits included in a Silver plan). The only levers the health plan can move within a metal level are the deductible, coinsurance, percentage, out-of-pocket maximum, and pharmacy coverage.²¹ Aon offers standardized HMO's, PPO's and high-deductible CDHP's.²² Each consumer can see up to 15-20 different plan choices, up from less than 5 in many instances prior to joining the private exchange.

Carrier participation: To date, Aon has created a national solution using a combination of major national health plans and regional plans. A partial list of health plans participating in Aon's exchange, provided by Aon, can be found below²³:

- Aetna, Inc.
- Anthem Blue Cross and Blue Shield
- Anthem Blue Cross
- Blue Cross and Blue Shield of Georgia
- Empire Blue Cross Blue Shield
- Blue Cross and Blue Shield of Nebraska
- Blue Cross and Blue Shield of North Carolina
- Florida Blue
- Health Care Service Corporation:
 - Blue Cross and Blue Shield of Illinois
 - Blue Cross and Blue Shield of Montana
 - Blue Cross and Blue Shield of New Mexico
 - Blue Cross and Blue Shield of Oklahoma
 - Blue Cross and Blue Shield of Texas
- Health Net, Inc.
- Independence Blue Cross
- Kaiser Permanente
- MetLife
- UnitedHealthcare

Supplemental offerings: In addition to medical health plans, Aon offers dental and vision plans. Aon automatically applies any remaining employer contribution from medical to these benefits.

- Dental through Delta Dental, MetLife, United, Aetna
- Vision through VSP® Vision Care, UnitedHealthcare, MetLife

Additional Services

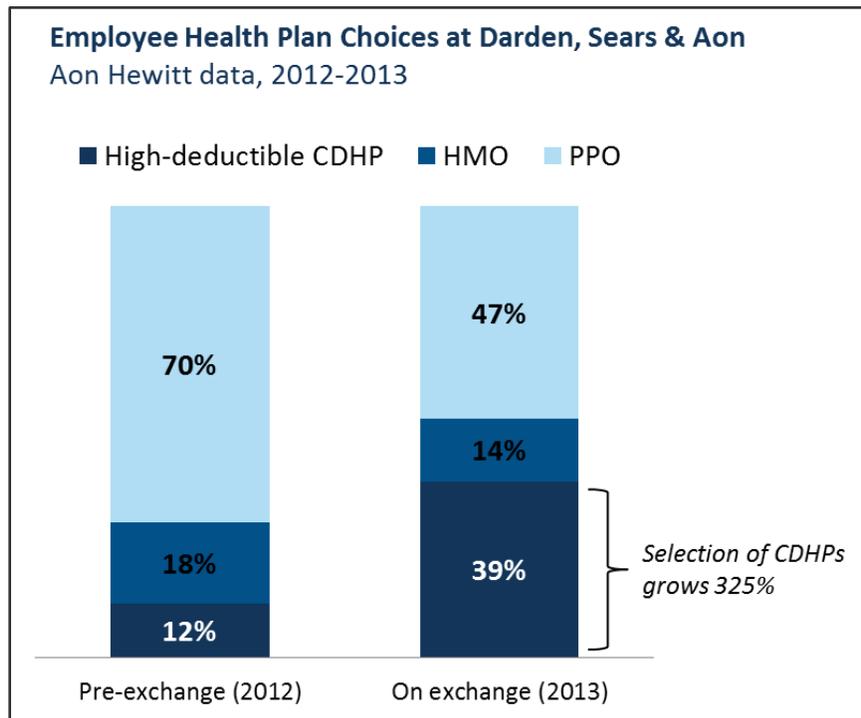
Plan choice support: Aon offers at least three tools to support consumers in their health plan shopping and selection process. Their "Plan Comparison" tool allows consumers to compare high-level design features across plans. The "Network Coverage" tool helps consumers search for a network's doctors and hospitals. Finally, the "Need Help Deciding?" tool, introduced in 2014, walks employees through a step-by-step decision process to

select the plan based on their ability to handle an unexpected medical expense versus the desire to minimize their payroll deductions. For employees who need additional assistance, Aon has a call center with trained staff.

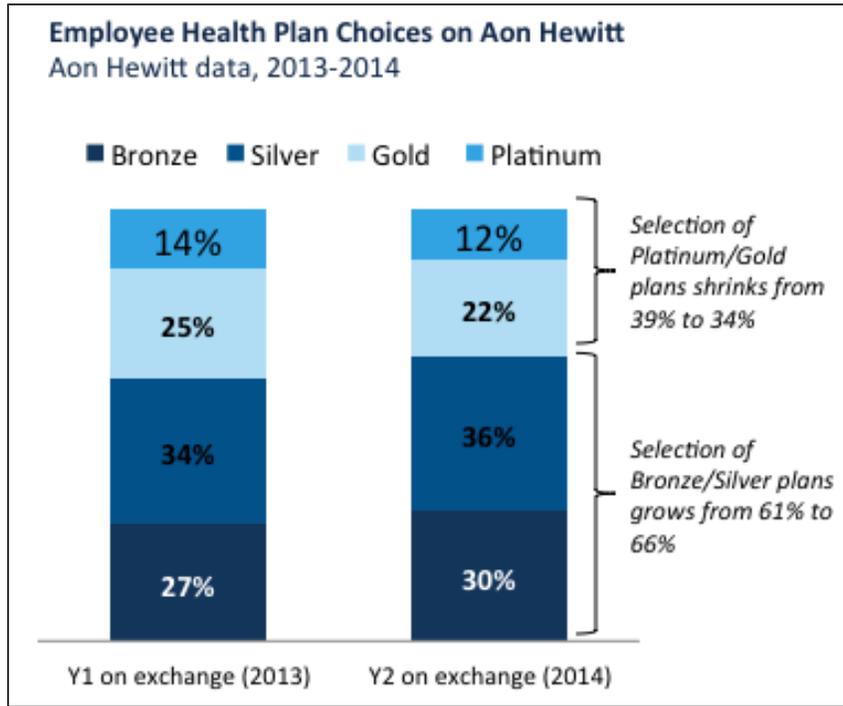
Other Services: Aon allows health plans and employers to integrate their health and wellness offerings, such as Independence Blue Cross with their monetary incentives for employee healthy living choices.²⁴ However, Aon does not offer health and wellness services integrated into their private exchange.

Early Results

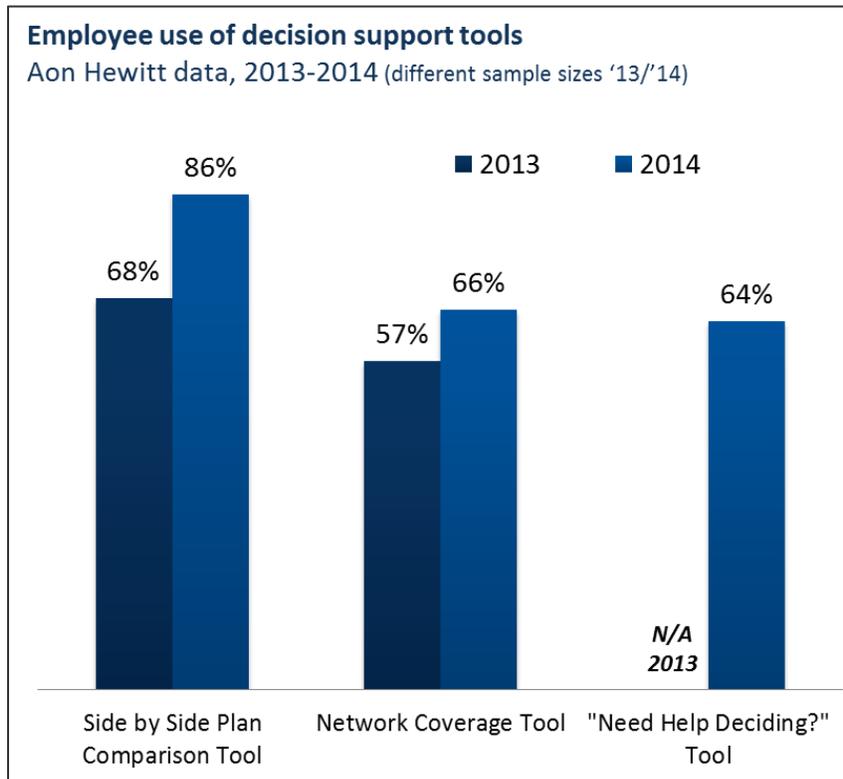
Plan choice: In 2013, Aon released plan choice data on three of its first enrolled employer groups, Aon, Sears and Darden Restaurants, and their employees plan choices before and after joining Aon’s private exchange. Employees shifted their choice significantly towards CDHP high-deductible plans.²⁵



In 2014, Aon released metal level choice data on employers that had participated in Aon’s exchange in both 2013 and 2014. Even in the 2nd year on the exchange, employees continued to shift purchasing patterns towards lower actuarial value plans.²⁶



Customer decision support: Aon also tracks consumer usage of decision support tools at the time of enrollment. A clear majority of employees on Aon’s exchange use decision support tools, and the proportion using them grew from 2013 to 2014, showing signs that employees are behaving like consumers and actively engaging in the plan selection.²⁷



For more information about the Aon Active Health Exchange visit: <http://aonhewittcorporateexchange.com/>



Updated as of May, 2014

Table A2: Array Health Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50–1999)		Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • Depends on the carrier 			
2014 Enrollment	Undisclosed (confidential)			

Exchange Overview

Exchange inception: Array Health was founded in Seattle in 2006, and was originally positioned as a multi-carrier exchange selling to employers via brokers. In 2010, Array pivoted to a purely single carrier technology platform model.²⁸

Exchange approach: Since 2010, Array Health’s technology platform has supported single carrier private exchanges that sell health and ancillary products to large and small groups, individuals and retirees. Array believes it provides a user-friendly marketplace for members, support for diverse funding arrangements, and administrative capabilities that enable insurers, employers and brokers to manage health and ancillary benefits end-to-end. While Array Health’s solution is designed for all market segments, co-founder and CEO Jonathan Rickert notes that “We believe the small groups will be a high area of growth in the private exchange market – (health) plans are realizing they need a capability to support to the small group segment.” Array’s most publicized private exchange partnership began in 2011 with Highmark Health Services, a Pennsylvania-based non-profit health carrier and the fourth largest Blue Cross Blue Shield plan in the country.

Health Plans

Plan design: Array Health works with carrier partners and employers to set up a mix of medical plans for each exchange. On single carrier exchanges, Array often sets up multiple “suites” of plans, each with 5-6 plan

options, for employers to choose from. While some employers prefer different levels of choice than those offered by the suites, Rickert notes that the majority of small group employers on Array give their employers between 4-8 plans to choose from, up from one plan in many cases prior to joining the exchange.²⁹

Carrier participation: Array partners with carriers to create single carrier exchanges. While confidentiality agreements prevent them from sharing a complete list, Highmark Health Services is their major example.

Supplemental / ancillary offerings: In addition to medical health plans, Array Health's platform is designed for carriers to sell ancillary insurance, automatically applying surplus employer contribution to these products³⁰:

- Dental
- Vision
- Critical illness
- Accident
- Hospital indemnity
- Term Life
- Disability income

As Array Health operates proprietary exchanges, the products sold on its platform are determined by its insurer customers.

Additional Services

Plan choice support: Array's patent-pending Smart Fit™ technology is a statement-based plan selection tool. Instead of having consumers take a survey or filter choices based on multiple different criteria, Array feeds consumers simple "jargon-free" statements, to which they can agree or disagree (for example: "I would be able to handle \$1,500 of healthcare expenses this month if I was injured"). Array then guides the consumer into a plan or set of plans.

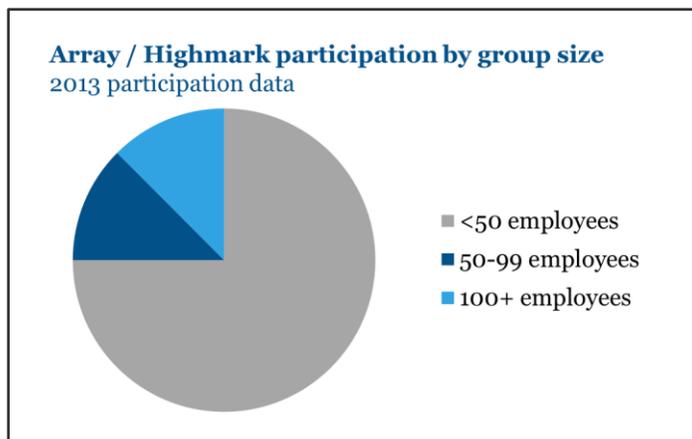
Other Services: Array Health allows carriers to set up and integrate their health and wellness offerings in the private exchange, but does not explicitly provide any additional health-related programs outside of what the carrier does.

For employers, Array Health offers a set of administrative benefits, including: payroll reporting, managing qualified life events, and handling ongoing maintenance. Rickert notes that private exchanges offer an added value proposition to employers in the SMB space, as many do not have the capability or capacity to handle the increased administrative burden of providing health insurance post-ACA.

Early Results

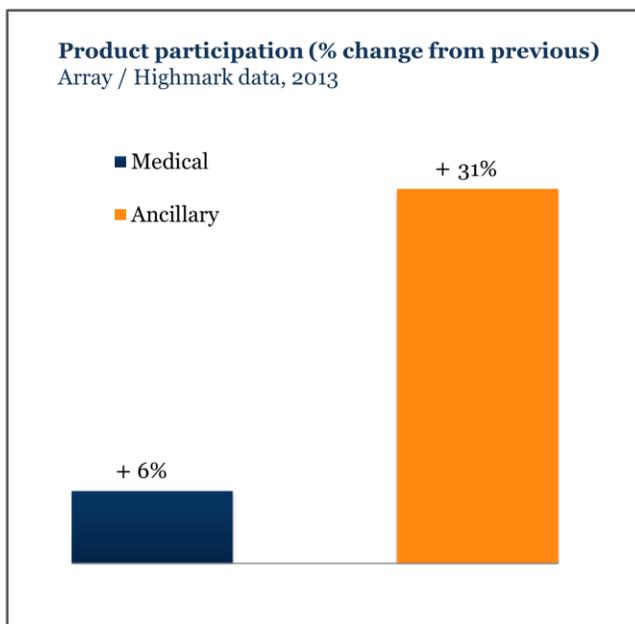
Array has released selected data from its hallmark exchange partnership with Highmark Health Services. Most notably the number of groups live on the exchange has increased more than tenfold from 2012 to 2013. Early data indicates this trend will continue into 2014.

Group data: The Highmark Health Services exchange demonstrates the high interest in single carrier exchanges from small groups, with 75% of groups on the exchange having less than 50 employees.



Array also reported that approximately 14% of the groups on Highmark Health Services' exchange are new to Highmark's health plans, indicating that the exchange has primarily been a tool for transitioning and retaining existing group business, but also has power to attract new groups.

Plan selection data: Moving to a private exchange has increased product participation rates from employees, in both core medical and ancillary products, where the impact is more pronounced. Rickert attributes the significant impact on ancillary uptake to the all-in-one digital environment in which employees can find and enroll in plans, as opposed to the paper-based enrollment many small groups used previously.³¹



Overall, the 31% increase in ancillary product participation has led to 2x the amount of ancillary products being sold on exchange vs. off, giving a boost to carrier margins.³²

For more information about Array Health's insurance exchange visit: <http://arrayhealth.com/>



Updated as of May, 2014

Table A3: Bloom Health Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)		Mid (50–1999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • 5–8 medical plans depending on exchange • Dental and vision through medical carriers – more coming 2014 			
2014 Enrollment	Undisclosed (confidential)			

Exchange Overview

Exchange inception: Bloom Health was founded in 2009 as a private exchange technology platform focused on employers of all industries with more than 50 employees, mainly in the small to mid-size category. In 2011, Bloom was acquired by three insurers associated with Blue Cross Blue Shield (BCBS): Wellpoint, BCBS Michigan, and Health Care Service Corporation (HCSC) took a collective majority share with equal stakes.³³ In each year of operation, Bloom has approximately doubled the number of employees using its platform to make benefits decisions. Bloom currently has nearly 250 employers on its platform, based in 24 different states with employees nationwide.

Exchange approach: Bloom has a relatively flexible exchange model, allowing employers to choose between a defined benefit and a defined contribution model, as well as a fully insured or self-funded model. Most of the employers on the platform have selected defined contribution. Bloom’s primary distribution model is partnering with carriers such as Anthem/WellPoint, HCSC, Horizon BCBS of New Jersey and Medica to offer single-carrier exchanges. The other is distribution by brokers, with options for branding and carrier choices.³⁴ Bloom targets small to midsize employers: as of late 2012, the company had 140 corporate clients with 106,000 employees for an average of less than 1000 per company, and one with more than 20,000 employees.³⁵

Health Plans

Plan design: Bloom offers a variety of medical and ancillary plans, depending on the broker and health plan the exchange is set up for. For health plans, Bloom offers a technology platform to distribute plans, and helps carriers “create ‘plan packages’ that include the appropriate actuarial spread to provide meaningful choice to the consumer, typically 5-8 plans”³⁶. For brokers, Bloom offers a pre-selected set of preferred medical and ancillary plans from partner carriers.

Carrier participation: Bloom has set up proprietary single carrier exchanges for the following health plans:

- Anthem/WellPoint – “Anthem Health Marketplace”
 - Anthem Blue Cross
 - Anthem BlueCross BlueShield
 - BlueCross BlueShield of Georgia
 - Empire Blue Cross
 - Empire BlueCross BlueShield
- HCSC – “Blue Directions”
 - BCBS of Illinois
 - BCBS of New Mexico
 - BCBS of Oklahoma
 - BCBS of Texas
- BCBS of Michigan – “GlidePath”
- Horizon BCBS of New Jersey-“Horizon Select”
- Medica – “My Plan by Medica”

Supplemental / ancillary offerings:

- Dental and vision through existing medical carrier partnerships
- HSA/HRA (paired well with high deductible plans)
- FSA (healthcare and dependent)

Bloom is currently contracting with carriers (outside of medical partnerships) to offer a full suite of dental, vision, life, disability, critical illness, hospital and accident insurance to be available for fall 2014 open enrollment.

Additional Services

Plan choice support: Bloom helps consumers choose between a wide array of medical plans. Its personal Bloom health Advisors are a core part of the Bloom team. Advisors are reachable live via phone or email, and advertise a one-business day response rate to email communication. Employees using Bloom Advisors to select a plan report a 95% satisfaction rate.³⁷ Bloom stresses that Bloom Advisors not only navigate consumers to plans but also have input into the product design and offerings:

“We think about our Advisors as product managers, whether that be for R&D - so they have an input back into what kind of development work should be done, what new tools we should be building - but also in the delivery their mindset and the way they approach their job is that of finding solutions for the consumer.”

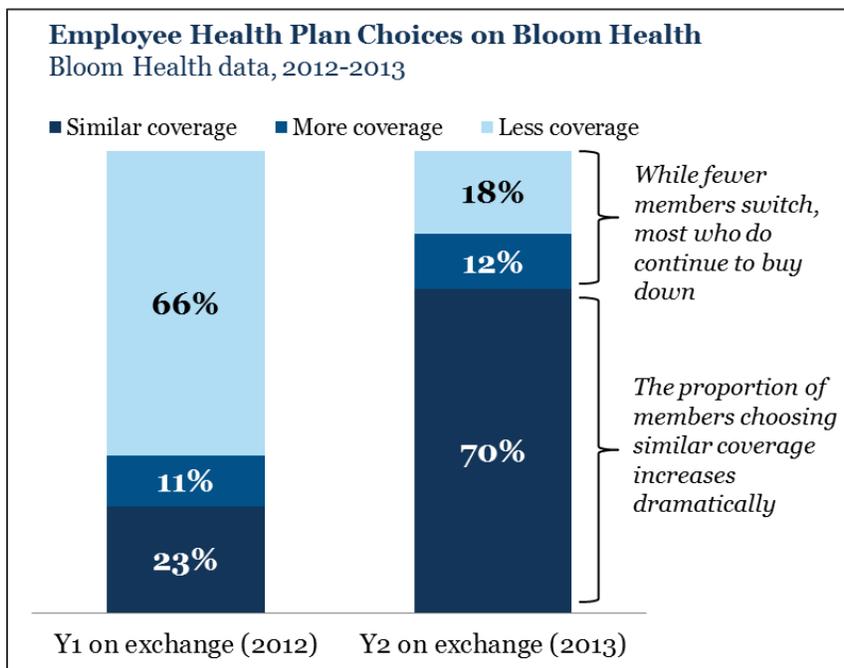
– Abir Sen, Co-Founder Bloom Health³⁸

During the plan selection process the user has an option to take the “Bloom Survey”, which over the course of 5 minutes asks several types of questions about their financial situation, tolerance for risk and health consumption. From there, Bloom creates a personalized user profile called “Our View of You” and the matching algorithm then suggests several plans for the consumer, further sortable by price, coverage levels, HSA eligibility, and other factors.

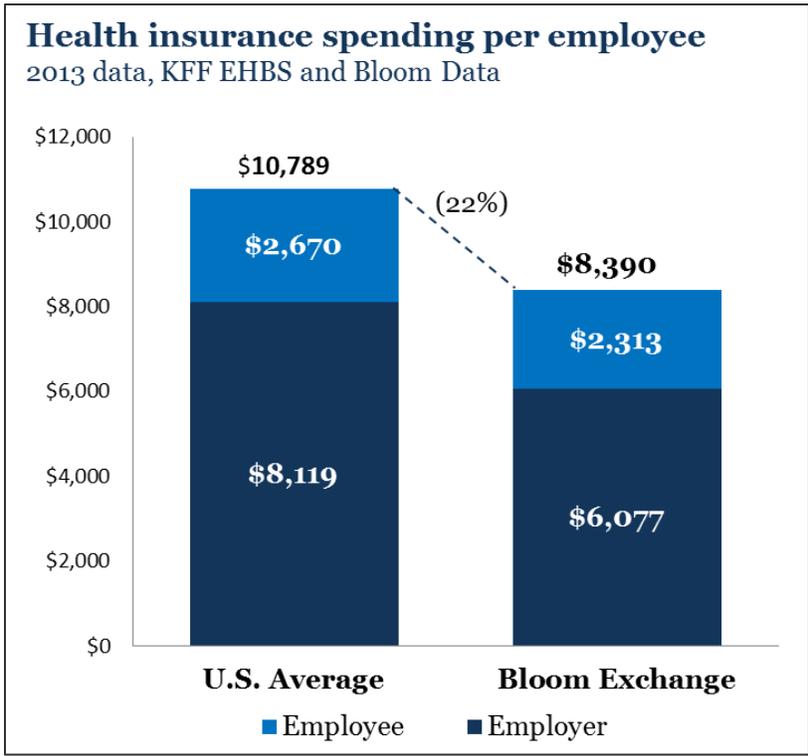
Other Services: Bloom’s wraparound health and wellness offerings ultimately depend on the health plan / broker it is partnered with, as they support these offerings but do not advertise them as part of their core product.

Plan Choice

Plan choice: In 2013, Bloom released data comparing plan choices over its first two years of business. The data shows that in the first year on Bloom’s exchange, 70% of members change their healthcare coverage level. Of those who switch in the first year, the vast majority switch to cheaper plans, indicating that employers were “over-buying” for employees. In the second year on exchange, far fewer members switch, but the majority of those who do continue to switch to cheaper plans.³⁹



Bloom also reported that average health insurance spending per employee in their private exchange was \$8,390. Bloom found that employees choose less expensive plans after switching to defined contribution.⁴⁰ Forty-two percent of Bloom members choose a high-deductible HSA-eligible plan⁴¹.



For more information about Bloom Health’s Private Exchange Platform solution, visit: <http://www.bloomhealth.com/>

Table A4: bswift Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50-199)	Large (200-999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • Medical, dental, vision, life, long-term disability, short-term disability, accident, critical illness, hospital indemnity, legal protection, identity theft protection, pet insurance, along with several wellness programs • Direct purchase of uninsured care (dental, chiropractic, etc.) • Auto and home coverage coming in Fall of 2014 			
2014 Enrollment	Undisclosed (confidential)			

Exchange Overview

Exchange inception: bswift was founded in 2000 as an employee benefits administration technology company, and today operates several lines of business that collectively support several thousand employers and nearly 2 million users nationwide. The company has sustained annual growth rates of 40% for several consecutive years. Great Hill Partners took a minority stake in bswift in early 2014 with a \$51 million private equity investment to help bswift continue its high growth rate.

Exchange approach: bswift offers private exchange technology platforms for insurance carriers, brokers and employers. The Springboard Marketplace allows flexible self-funded or fully insured medical plans structured for a defined contribution strategy coupled with bswift's online enrollment and employee benefits administration platform. Springboard Marketplace also offers several suites of pre-packaged ancillary and voluntary insurance products to accommodate a smooth and quick implementation with minimal disruption of benefits. Springboard Marketplace focuses on employers with 1,000 or more employees, and serves virtually every industry segment and every state in the U.S. bswift also has a partnership with GetInsured to provide brokered individual market policies.

Health Plans

Plan design: Springboard Marketplace offers pre-packaged products on exchange but does not focus on product standardization of plan designs between insurers. bswift is currently focused on procuring medical plans from large national plans or strong regional carriers with substantial market share. However, Springboard Marketplace also considers newer health plans including provider-owned plans and state CO-OP plans.

The employer has full control of medical plan offerings in the Springboard Marketplace. This includes the choice of carrier/administrator/network as well as the suite of plan designs made available to the employees.

Carrier participation: bswift does not release a full list of carriers on contract, but Don Garlitz, Executive Director of Exchange Solutions says they are “currently integrated with most every major carrier in the U.S. From a self-insured perspective, we can provide an exchange experience with any one of them.”⁴² The bswift website also lists several carrier partners, including: MetLife, Guardian, Unum and Assurant.

Supplemental / ancillary offerings: Springboard Marketplace offers a full suite of ancillary products, as well as several wellness programs (i.e., weight loss). The full list of ancillary products is below:

- Dental
- Vision
- Life
- Long-term disability
- Short-term disability
- Accident
- Critical illness
- Hospital indemnity
- Pet insurance
- Legal protection
- Identity theft protection
- Fitness memberships

bswift anticipates having auto and home coverage available for the fall of 2014. bswift also offers several discount plans that allow direct purchase of uninsured care such as dental, chiropractic, massage therapy and other health related services.

Additional Services

Plan choice support: Springboard Marketplace offers bswift’s proprietary ‘Ask Emma’ decision support tools. Ask Emma’s medical module helps the employee identify which plans participate with specific providers, and guides the employee through finding the plan that best fits the employee’s expected utilization pattern. Intelligent modules for other products such as life insurance, account based plans, and worksite programs like critical illness take into consideration the consumer’s demographic profile and other insurance protection to help the consumer make the right choice about what and how much to buy.

Other Services: As mentioned above, available plans include weight loss and other wellness programs, and several discount plans that offer direct purchase of uninsured care such as dental, chiropractic, massage therapy and other health related services. Telemedicine and other consumer oriented plans are contemplated as options in the near future.

Early Results

Plan choice: bswift has observed that approximately 40% of individuals opted to enroll in an HSA-eligible plan when offered a broad array of plan designs, much higher than the national average of 20% enrolled in CDHPs in ESI⁴³.

Don Garlitz, Executive Director of Exchange Solutions for bswift, offers anecdotal evidence around the interests of employers as they sign up for private exchange implementation, noting that: “Employers have expressed interest primarily in expanding consumer choice. Large employers seem fairly realistic about cost savings considering that their group risk will continue to drive rates. The bet appears to be that increasing consumer choice will influence utilization patterns as well as willingness to accept narrower provider networks, both of which have the potential to help cost trends.” Additionally, on the topic of utilization, Don touts the ability of Springboard to integrate with wellness incentive programs, as employers continue to seek to drive down costs.

For more information about bswift’s private exchange offerings visit: <http://www.bswift.com/?/public/springboard>



a private health insurance exchange solution

Updated as of May, 2014

Table A5: Buck Consultants: RightOpt Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50-199)	Large (200-999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded (group)		Fully insured (individual)	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • 7 plan types standardized across geographies • Dental, vision, and a variety of health and wellness products 			
2014 Enrollment	500,000 covered lives (400,000 active, 100,000 retiree)			

Exchange Overview

Exchange inception: RightOpt was created by Buck Consultants in 2013 as an offshoot of their benefits consulting and administration business focused on healthcare solutions. Buck Consultants is itself a Xerox company.⁴⁴

Exchange approach: RightOpt is targeted at employers with 3,000 or more employees, and provides employers a platform capable of delivering health insurance across all population segments. RightOpt provides group insurance options for active employees, individual market options for part-time or seasonal employees, and individual plans for pre- and post-65 retirees. Sherri Bockhorst, principal and leader of Buck’s Health Exchange Solutions, emphasizes that serving all types of employees is central to RightOpt’s exchange model, noting: “RightOpt provides plan sponsors with a smart way to help their retirees and part-time workers evaluate and purchase appropriate individual coverage using available public subsidies.”⁴⁵ Buck partners with GetInsured to provide brokered individual marker policies. Buck Consultant’s distributes RightOpt direct to employers, utilizing existing employer relationships. RightOpt’s model uses its “preferred partner strategy”, in which it creates partnerships with health plans that have the strongest networks in each of the regions it serves employers in.⁴⁶ Additionally, their group purchasing arrangement means that as employers and lives are added, the average total cost of premiums will decrease. This has led it to focus initially on jumbo employers, but Sherri notes that eventually the model will become replicable for smaller employers as well.

Health Plans

Plan design: RightOpt offers seven health plan designs, each standardized by Buck Consultants. They do not require the employer to necessarily follow the metallic levels but do range in actuarial value from 60% to 90%. These plans include four PPO-type plans and three HSA-eligible HDHP plan types. Buck has plans to add narrow network plan types in 9 geographies in 2015 along with several direct contracts, including one with Cleveland Clinic for Complex Cardiac Care.⁴⁷ In the “preferred provider” model, all carriers who participate must standardize their plans to Buck’s requirements, in order to provide plan consistency across regions to jumbo employers with presence in multiple geographies.

Carrier participation: In total, 15 insurers participate in RightOpt, including Aetna, Anthem Blue Cross and Blue Shield, Cigna, and Kaiser Permanente. Sherri Bockhorst points to the requirements to become a RightOpt carrier: “we looked at 300 geographies across the US, and analyzed the quality, the network breadth, and the unit cost pricing of those carriers – we are multi-carrier across the country, but single carrier by geography.”⁴⁸ Sherri also emphasizes RightOpt’s network adaptability, should certain carriers under or over perform, saying Right Opt would have the ability to “plug and un-plug” as necessary. Buck evaluates carriers against these criteria every 6 months.

Supplemental / ancillary offerings: In addition to medical health plans, RightOpt offers ancillary insurance, automatically applying surplus employer contribution to these products⁴⁹:

- Pharmacy
- Dental
- Vision
- Supplemental medical

Additional Services

Plan choice support: RightOpt provides seven types of plans from a single carrier in each geography (the carrier must offer all seven plans in its geography), focusing on giving employees a “meaningful level of choice” so as to not overwhelm them during the decision process. Employers are allowed to choose which of the seven plans to offer. Sherri notes that on average, clients offer 3 plans to employees. RightOpt offers online decision support and licensed call center representatives to help employees through the decision process.⁵⁰

Other Services: RightOpt focuses on providing an integrated member experience for employees beyond just the selection of medical benefits. Sherri Bockhorst says: “Part of the challenge for employees is that they might need to go to their pharmacy manager for one question, and their health plan for another question, and their disease management partner for another question, and we’re really taking that on - to integrate the data, and integrate the member experience.”⁵¹ In addition to integrating different pieces of the system, RightOpt’s personalized portal includes a variety of different tools/programs to help employees engage in their own health, including:

- Lifestyle coaching
- Health assessments
- Biometric screenings

- Health and wellness financial incentives
- Transparency tools
- Access to pharmacy benefits
- “My Healthy Living”: customized health articles and tips

For more information about Buck Consultant’s RightOpt health insurance exchange

visit: <https://www.buckconsultants.com/Services/HealthandProductivity/RightOptprivatehealthinsuranceexchange.aspx>

Updated as of May, 2014

Table A6: ConnectedHealth Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50-199)	Large (200-999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • Depends on the carrier and employer 			
2014 Enrollment	Undisclosed (confidential)			

Exchange Overview

Exchange inception: ConnectedHealth was founded in 2009 in Chicago by former leaders of Subimo, a healthcare decision-support and transparency company for health plans and employers that was acquired by WebMD in 2006.

Exchange approach: ConnectedHealth focuses on the small and mid-size portion of the employer market, but also serves the jumbo market. Their Smart Choices™ Marketplace offers an all-in-one benefits solution for both group active and individual policies, and provides a broker connection to the public marketplaces for employees that do not receive group coverage. Smart Choices is a flexible model, supporting both fully-insured and self-funded employers, and both defined benefit and defined contribution strategies for a wide range of medical, ancillary and voluntary coverage. President Joe Donlan notes that an ideal solution for many mid to large size employers is defined contribution combined with self-insured – and they have seen many of their employer clients go that route. The Smart Choices platform is offered through health plans and brokers, but ConnectedHealth is also a licensed broker and thus often goes directly to employers. In addition, the Smart Choices platform can serve as a full benefits solution for all employee types – full time, as well as part-time or contractors, with employees seeing just the plan options that they are eligible for.

Health Plans

Plan design: ConnectedHealth allows carriers and employers to design plans for each exchange.

Carrier participation: ConnectedHealth works with carrier partners and employers to set up a mix of medical and ancillary plans for each exchange. Donlan estimates that the average employer joining ConnectedHealth will increase the number of plans offered to their employees from 1-3 to 6-12 plans.⁵² They also work with carriers on the individual market to offer selections to non-group eligible employees.

Supplemental / ancillary offerings: In addition to medical health plans, ConnectedHealth offers ancillary insurance, automatically applying surplus employer contribution to these products:

- Dental
- Vision
- Life
- Critical Illness
- Accident
- Pet insurance

Additional Services

Plan choice support: ConnectedHealth recommends medical plans based on its proprietary Recommendation Engine that collects demographic information, the consumer's risk profile and expected behavior or plan utilization. In addition, the recommendations include estimates of the consumer's likely total costs, as well as best- and worst-case out-of-pocket scenarios associated with each plan, so that consumers get an idea of their total financial exposure. Donlan notes that the goal is to provide consumers with holistic recommendations that take into account all their buying options: "We think about someone's health and financial security and, as they go through their lives, being able to calibrate and rebalance their portfolio is an area that we think is increasingly important in this new world."⁵³

ConnectedHealth also prides itself on the simplicity of its enrollment process, estimating that consumers can complete the entire enrollment in "12 minutes or less."⁵⁴

Other Services: ConnectedHealth works with many of its clients to incorporate their health and wellness programs or services past enrollment with its exchange platform, and Donlan says that this is an area of immense opportunity – one where ConnectedHealth hopes to expand on: "We think that enrollment is an opportunity to open the dialog about a consumers healthcare, but that engagement must continue throughout the lifecycle of the entire customer relationship."⁵⁵⁵⁶

For employers, ConnectedHealth offers some payroll services in addition to traditional benefit administration capabilities, which is valuable for smaller companies in particular.

Early Results

ConnectedHealth has released a case study of a private exchange it built for a group of 1000 employees. Among the data released, ConnectedHealth notes that the company achieved a *5% savings on healthcare costs growth* in the first year on exchange as employees switched to higher deductible plans. ConnectedHealth

points to premiums as one reason for that, noting that in the data what they termed as the “\$50 rule”: When employees could save \$50 or more per month on their portion of their health insurance premiums, the majority were willing to switch to a high deductible health plan and take on additional financial risk of \$500 – \$1500.⁵⁷

For more information about ConnectedHealth’s insurance exchange visit: <http://www.connectedhealth.com/>



Updated as of April 1, 2014

Table A7: Connecture Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50–199)	Large (200–999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> Plan types vary by exchange, but Connecture has relationships with more than 70 regional and national plans 			
2014 Enrollment	Undisclosed (confidential)			

Exchange Overview

Exchange inception: Connecture was founded in 1997, and has been rapidly expanding its health insurance exchange solutions. In 2010, Connecture purchased Insurint to add a multi-carrier platform to its capabilities, and followed with an acquisition of Insurix soon after in 2011. Connecture’s acquisition of DRX in 2013 also expanded its reach into the over-65 market, and it now serves the full range of insurable populations.⁵⁸

Exchange approach: Connecture offers technology solutions for both single-payer and multi-payer exchanges. Connecture’s single-payer exchange, “InsureAdvantage”, allows health plans to build a private exchange solution for their target employer and consumer markets, adding decision support tools and supporting ancillary benefits for a one-stop-shopping experience. The multi-payer exchange is available for both active and retiree employer populations, primarily distributed through exchange operators and brokers⁵⁹. Connecture’s “Retiree Transition Solution” serves the Medicare market, and has helped over 12 million consumers enroll in individual Medicare plans.⁶⁰ Connecture has seen a surge in demand for the single and multi-payer exchange active employee exchanges in recent years, particularly in the small group (defined by Connecture as 100 or fewer employees) and mid-market (100-2500 employees) employer segments.⁶¹

Health Plans

Carrier participation: Connecture offers a variety of medical and ancillary plans, depending on the broker and health plan the exchange solution is set up for. For health plans, Connecture offers a technology platform to distribute pre-designed plans, and is less involved in standardization / plan requirements than exchanges set up by the benefits consultants. For brokers, Connecture is able to leverage existing relationships with 70+ medical carriers, many of whom are multi-state or nationals. Connecture works with the broker and employer to choose the set of the carriers and plans on each exchange.⁶²

Supplemental / ancillary offerings: In addition to medical health plans, Connecture can offer several lines of supplemental or ancillary insurance, automatically applying surplus employer contribution to these products:

- Dental
- Vision
- Life
- Disability
- Supplemental HSA/HRA
- Section 125 pre-tax funding

Connecture is currently building an ancillary product “e-store” that they will be able to easily attach to any of the medical exchanges they create.⁶³

Additional Services

Plan choice support: Connecture offers three levels of decision support tools for consumers when choosing between plans on exchange. First, Connecture helps consumers choose among plan types (i.e., deductible levels) based on the consumers description of their risk tolerance and other survey inputs. Second, Connecture has “network mapping” tools for consumers to visualize the network of doctors and hospitals near to them in a given plan, and check for their preferred providers. Connecture also offers a proprietary “Out-of-Pocket Cost Calculator,” a tool that calculates the total annual cost of any given plan based on individual and family needs, as well as predictable life events. Connecture claims the tool helps consumers avoid the natural tendency to select plans that offer low monthly premiums, but which can ultimately cost more over the full term of coverage.

In addition to online decision supports tools, Connecture also offers “Click-to-Chat” and “Click-to-Call” for live interaction and advice from health insurance solution experts.

Other Services: As primarily a technology player, Connecture does not offer any integrated wrap around health and wellness services, but allows brokers and carriers to customize their own programs.

For more information about Connecture’s exchange solutions visit: <http://www.connecture.com/>

LIAZON: BRIGHT CHOICES® EXCHANGE



Updated as of May, 2014

Table A8: Liazon: Bright Choices® Exchange Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50–199)	Large (200–999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • Health: Medical plans, prescription carve-out, supplemental health insurance, dental, vision, health coaching, telemedicine • Money: HSA, FSA (medical, dependent care, transit, parking) • Protection: Life, disability, legal plans, pet insurance, identity theft protection • Custom: Liazon’s technology allows groups to add at will 			
2014 Enrollment	94,000+ covered lives (43,000 employees)			

Exchange Overview

Exchange inception: Liazon was founded in 2007 with Bright Choices® Exchange, a private exchange for employers. In 2013, Liazon was acquired by Towers Watson. Early in 2014, Liazon launched its fully competitive and risk-adjusted Bright Choices national multi-carrier exchange for employers with 3,000 or more employees.⁶⁴

Exchange approach: Liazon is distributed primarily through brokers and consultants, and currently is working with over 450 brokers to deliver health insurance and other benefits. Liazon also provides exchange approaches for health plans building proprietary exchange presences, such as Blue Cross Blue Shield of Massachusetts.⁶⁵ Bright Choices facilitates a shift for employers to the defined contribution model, and allows both fully-insured and self-insured plan funding. Early on, Liazon targeted small employers, and the majority of its first 2,000 employer groups had less than 50 employees.⁶⁶ Recently however, Liazon has expanded its

reach upmarket, and currently services over 700 mid-sized and large businesses. Now, most new businesses Liazon targets are between 100 and 10,000 employees. Founder Ashok Subramanian attributes this shift upmarket to Liazon’s broker distribution model, noting with respect to target employer size that “Our model is to support our channel (brokers) and their clients, and their priorities become our priorities.”⁶⁷ In addition to facilitating a shift to defined contribution and increased employer choice, Liazon has focused on the health and wellness aspect of care, offering such services as Tele-medicine and health coaching on its exchange.

Health Plans

Plan design: The exchange offers a broad range of medical plan designs as well as ancillary products and services. Liazon works with national and regional carriers across the country to offer pre-stocked “stores” (Complete Stores) full of benefit options. Liazon offers over 50 different variations of Complete Stores today, providing employers with numerous carrier options for many lines of coverage. The available carriers and products are typically based on a client’s geography.

Liazon also has a multi-carrier store available with a national footprint, available to employers with at least 3,000 full-time employees. In this offering, Liazon allows employees to have a choice of both carrier and plan design for medical, dental and vision coverage, as well as the full suite of ancillary products.

Carrier participation: Liazon partners with over 85 medical and ancillary product providers. Liazon’s Bright Choices multi-carrier exchange includes medical plans from Aetna and UnitedHealthcare as well as many regional health plans. Liazon has also built single carrier proprietary exchanges for several health plans.⁶⁸

Supplemental / ancillary offerings: In addition to medical plans, Liazon offers several lines of supplemental or ancillary insurance, allowing employees to allocate a portion of their employer contribution to these products:

Table A9: Medical and Ancillary Insurance Offered by Liazon

Health	Money	Protection
Medical Plans Prescription Carve-Out Supplemental Health Insurance Dental Vision Health Coaching Telemedicine	HSA FSA <ul style="list-style-type: none"> • Medical • Dependent Care • Transit • Parking 	Life Disability Legal Plans Pet Insurance Identity Theft Protection

Ancillary plan providers include: Aetna, Allstate, CVS Caremark, Express Scripts, Guardian, MetLife, Sun Life Financial, and UnitedHealthcare, amongst others.⁶⁹

Additional Services

Plan choice support: Liazon offers comprehensive plan decision support for consumers. Consumers fill out their profile which includes questions about the consumer’s health profile, financial status, risk tolerance and preferences. Liazon’s proprietary algorithm predicts all possible health expenditure scenarios for the individual/family, and recommends a personalized benefits portfolio for the coming year, including medical

and ancillary products. The algorithm also matches for: types of plans, desired balance of premiums with total OOP expenses, and a match to the physician network.

In addition to decision support, Liazon also offers a plan comparison tool, and a “Tell Me More” resource center where consumers can get answers to questions related to insurance and health care.

Other Services: Liazon provides additional services to help consumers navigate care post plan selection. Their partnership with Simplee® allows consumers to track bills and claim status automatically on the platform. They also offer several health and wellness options on the exchange, including access to registered nurses, personal health coaches, and 24/7 telemedicine. Ashok Subramanian explains the vision as a desire to de-aggregate consumers’ health consumption choices into more personalized packages:

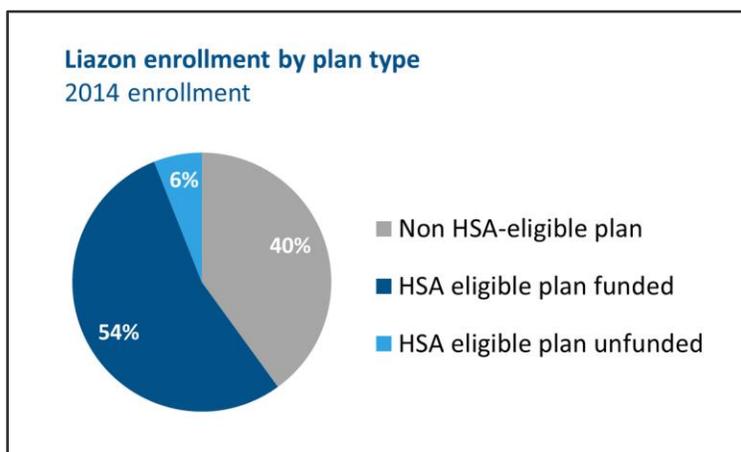
“We’re trying to array as broad a set of merchandise as possible to help people make good decisions and maximize their dollars; it may make more sense for someone to buy a high deductible or thin network plan and pair that with telemedicine – that small buy-up is probably a lot more cost effective (for them) than buying a richer plan.”⁷⁰

By allowing consumers to choose between a broad array of plans and supplements, Liazon hopes to tailor consumption to their individual needs.

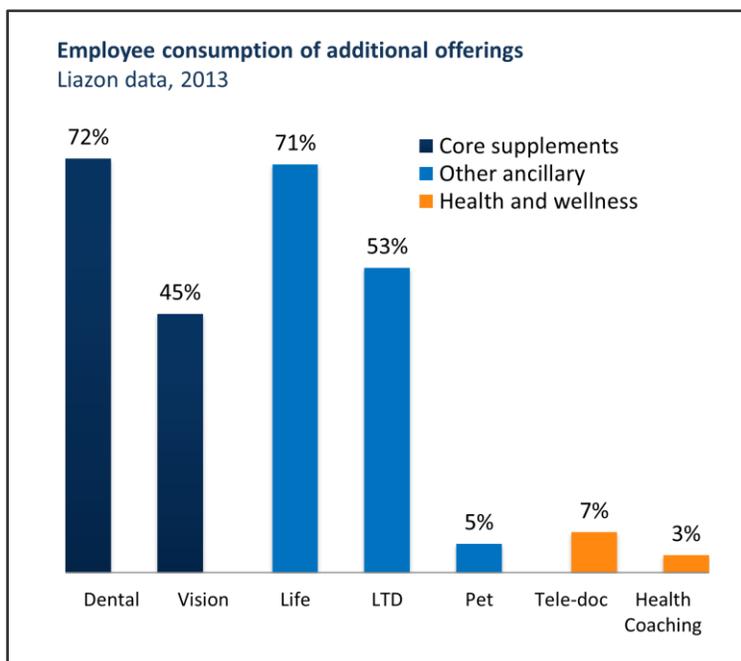
Services are also available to assist employers with health benefits administration, such as the Employer Administration Portal, which creates seamless management and administration of employees’ benefits. Administrators can view employees’ benefit elections, initiate new hire and terminations, process life events, and access numerous reports with ad hoc reporting capabilities.

Early Results

Plan choice: In 2014 approximately 60% of individuals on Liazon opted to enroll in an HSA-eligible plan⁷¹. Liazon has protected against this with several safeguards however, educating consumers on the tax benefits of HSA’s and sending them to fund HSA’s with their employer contribution, even prior to selecting supplemental benefits. This has resulted in 90% of Liazon enrollees with HSA-eligible plans opening *and* funding their accounts.⁷²



Supplemental offerings: In a July 2013 white paper, Liazon released data on the uptake of supplemental benefits in addition to core medical offerings on its private exchange. Liazon’s recommendation engine packages medical with other suggested supplements, and the data indicates that there is high demand for the core supplements (dental and vision) as well as other ancillary products – in all, 91% of employees purchased ancillary products to complement their health plan. Interestingly, up to 10% of the population also purchased the Tele-medicine and Health Coaching offerings, demonstrating consumers’ willingness to mix and match while packaging their optimal coverage portfolio.⁷³



Citing the high uptake of ancillary products, Alan Cohen, chief strategy officer and co-founder of Liazon, noted: “From the data it was clear that employees were able to navigate a myriad of health insurance choices along with ancillary products and make educated decisions. Employees welcome the opportunity to personalize the benefits package that works best for them and their families without being forced to buy benefits or services they don’t need.” According to survey data released in this report, employees using Bright Choices have a better understanding of their benefits: 58% of users surveyed said they better understand what their health insurance covers, 53% said that they understand their ancillary benefits more clearly, 63% of users reported being more aware of the costs of medical care, and 60% said they are now more engaged in their health care decisions.

For more information about Liazon’s private exchange visit: <http://www.liazon.com/bright-choices/exchange/>

Updated as of May, 2014

Table A10: Mercer Marketplace Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)		Mid (50–1999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • 5 standardized medical plans depends on client / partner • 20+ types of ancillary coverage available 			
2014 Enrollment	290,000 lives ⁷⁴ – 67 employers in 2014 (covering active workers or retirees) ⁷⁵			

Exchange Overview

Exchange inception: The Mercer Marketplace was launched in 2013, under the direction of Sharon Cunningham and Eric Grossman. The exchange is marketed to both retirees and active workers at firms with more than 100 employees. Mercer's capacity for retiree coverage was expanded in March of 2014 through the purchase of Transition Assist, an exchange focusing on Medicare eligible retirees. In April of 2014, Mercer reached an agreement with GetInsured to provide a brokered connection to the public exchanges and individual off-public exchange market for employer clients with part-time and seasonal employees, contractors, COBRA beneficiaries, and pre-65 retirees. Mercer will have an integrated approach across all employee and retiree types.⁷⁶

Exchange approach: Mercer has maintained flexibility in their exchange design, allowing employers to choose defined benefit or defined contribution and self-funded or fully insured health coverage. Mercer works with employers to model the costs and benefits of each when joining the exchange. To date, most clients have also maintained their previous funding status when moving onto the exchange platform, with only one of the 33 active employers in 2014 having switched funding status upon joining Mercer's Marketplace.⁷⁷ Employers are allowed to choose between carriers, and likewise carriers can choose to decline participating in certain employer groups.

Health Plans

Plan design: Mercer is heavily involved in plan design and standardization with its carriers. Medical carriers typically provide 5 standardized plan designs, including a PPO, HDHPs (HRA and HSA-based) with \$1500 and \$2500 deductibles, and EPO-like plans.⁷⁸ These plans range in actuarial value from 61%-92%, although Mercer did not attempt to match their plans to their metal tier levels offered on the public exchanges.⁷⁹ Starting in 2015, Mercer will add three more HMO plan designs in the California Market. Mercer selects carriers on the basis of their ability to provide administrative services, as well as their capabilities in certain cost management areas such as patient-centered medical homes, ACOs, and centers of excellence.

Carrier participation: Mercer offers 30+ carriers for medical products alone, including several major national carriers such as:

- Aetna
- Cigna
- Humana
- Kaiser
- UnitedHealthcare
- Health Net
- Anthem
- HCSC

Employers may elect which of these carriers can offer plans to eligible employee, and also choose between the 5+ core plan designs.⁸⁰ In addition to core medical benefits the Mercer exchange has focused on incorporating a wide variety of ancillary benefits that the employee can choose from, and apply defined contribution dollars to, if available and legally allowable (certain products are not eligible for defined contribution dollars). Mercer offers 20+ ancillary and supplemental product types. The exchange currently has products from carriers such as MetLife, ING US, Allstate, Prudential, The Hartford, VSP, Eyemed, Delta Dental and VPI Pet Insurance.

Mercer is currently building in additional wellness services into the platform for the coming enrollment year.⁸¹

Consumer Support

Mercer works with employers on personalized communications, online decisions tools and provides a call center for support as employees choose plans. Mercer's primary online decision support tool is a questionnaire that consists of simple questions (i.e. "If an unexpected medical expense occurred, do you think you can afford it?") that Mercer expects people to be able to answer in 20 or 30 seconds. If consumers want to drill a level deeper into detailed utilization, Mercer allows this, but does not force it. Mercer has indicated they are focused on "right-sizing" medical coverage, believing that much the current employer sponsored insurance population is currently over-insured.⁸²

Early Results

In 2014, 33 employers will offer coverage to active employees and 19 will offer coverage to Medicare retirees through Mercer's Marketplace. Petco, DineEquity and Kinder Morgan are among the firms participating.

Mercer has observed evolving employee selections in line with its "right-sizing" coverage focus. In the first year of active employee medical selections, Mercer saw average medical plan actuarial value move from 80.4% (prior to joining exchange) to 71.9% (on exchange), driven by an increased selection of their high deductible

plan offerings. In tandem, among those employees who selected one of Mercer's HDHP offerings, 35% chose to purchase a supplemental health product, vs. 24% of all enrollees.⁸³

Mercer announced in 2014 that changes in employees plan selection had saved firms on average \$800 per employee; nearly one-third of those savings went directly to the employees themselves.⁸⁴

For more information about Mercer's health insurance exchange visit: <http://www.mercer.com/content/mercero/north-america/us/en/insights/focus/mercero-marketplace.html>



Updated as of May, 2014

Table A11: My Plan by Medica Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50–199)	Large (200–999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment	
Plan types	<ul style="list-style-type: none"> • 6 plan packages with up to 20 plan options per package 			
2014 Enrollment	30,000 members			

Exchange Overview

Exchange inception: My Plan by Medica was conceived as a partnership with Bloom Health in 2010, and launched for its first enrollment cycle in Fall of 2011. Through My Plan, Medica aimed to create a private exchange platform to help bring predictability in costs to employers and greater satisfaction to employees. Medica provides product, network and service, while Bloom provides the technology and enrollment decision support tools. My Plan has about 30,000 members enrolled for 2014, from employers with between 50 and 3,000 lives.

Exchange approach: My Plan’s approach is to offer four different ACO networks, a product that is unique to its private exchange environment. The ACO networks are a part of Medica’s commitment to bending the cost curve for its groups. Medica also prides itself on increasing employee choice between medical plans, and employee satisfaction through best-in-class enrollment support tools provided by Bloom. Medica targets employers with at least 50 lives, but has begun to focus on larger employers, and is currently in talks with several employers with 3000+ lives for the 2015 enrollment year. About half of business on My Plan comes from Medica conversions, and half is new to Medica business.

Health Plans

Plan design: Medica offers up to 20 pre-designed private exchange plans from its proprietary portfolio, adapted from its off exchange group offerings. Exclusive to the My Plan private exchange, Medica also offers four ACO networks as an additional option to the plan designs, including: Fairview and North Memorial Vantage with Medica, Inspiration Health by HealthEast with Medica, Park Nicollet First with Medica, and Ridgeview Connect with Medica. According to Scott Reid, Vice President Product Strategy & Development at Medica, the ACO's are only offered on exchange because of the importance of education: "We've created microsites for every one of our ACO partners to talk about features of their care system, features of their service experience – to help consumers understand at the point of enrollment why they (each ACO) would be a better fit."⁸⁵ The ACO networks range from 500 to more than 2,500 providers, and may include such benefits as 24/7 access to nurses, guaranteed same-day appointments, and wellness discounted fitness programs.⁸⁶

Medica offers a total of six different "plan packages" to employers that they can choose from, ranging from a subset to the full 20 plans offered. Reid claims that most employers to date have elected to offer all 20 plan options.

Supplemental / ancillary offerings: My Plan by Medica has plans to introduce a line of ancillary offerings onto the exchange in 2014 or 2015.

Additional Services

Plan choice support: Medica emphasizes the importance of the decision support tools that Bloom provides on its technology platform. Reid notes that such support tools are particularly important because Medica offers so many plan choices on its exchange: "There's a strong correlation between choice and employee satisfaction in their benefits," he says. "When you introduce that much choice to members you need to make sure you've got good decision support tools surrounding those choices." He continues, noting that tools can help a consumer optimize their plan selections: "It (shift to private exchange) moves that responsibility of decision over to the consumer (and) consumers make different decisions than their employers would make on their behalf. And that shows in the plan design selections they make."

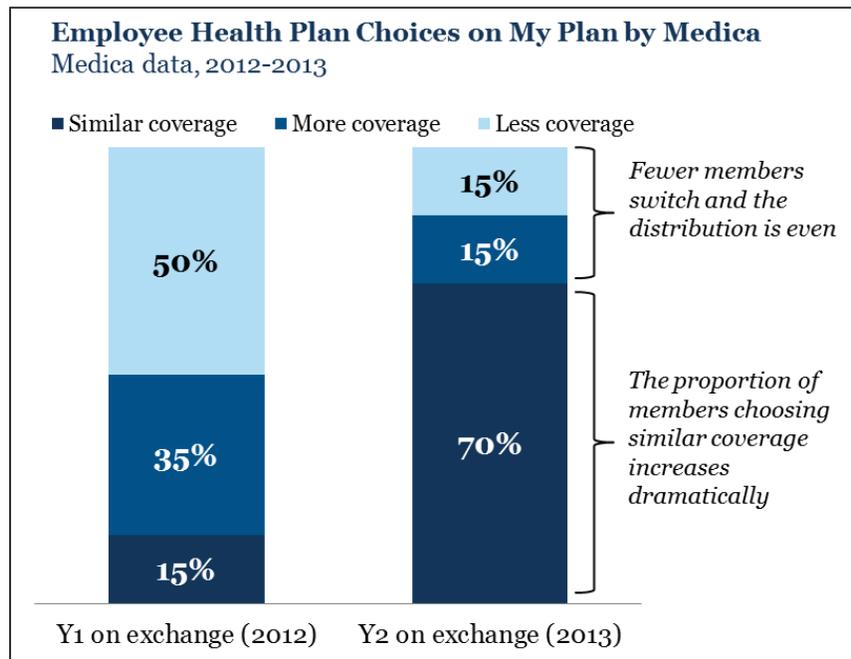
A description of the full range of Bloom's decision support tools is available in their exchange profile, but Reid notes that for Medica they have centered around two pieces: a health, wealth and risk profile to recommend a plan type, followed by a network education process to select between the network options, including the four ACO's.

Other Services: The ACO's offered on My Plan by Medica offer several Other Services, such as online portals, fitness discounts, and text messaging access to doctors.

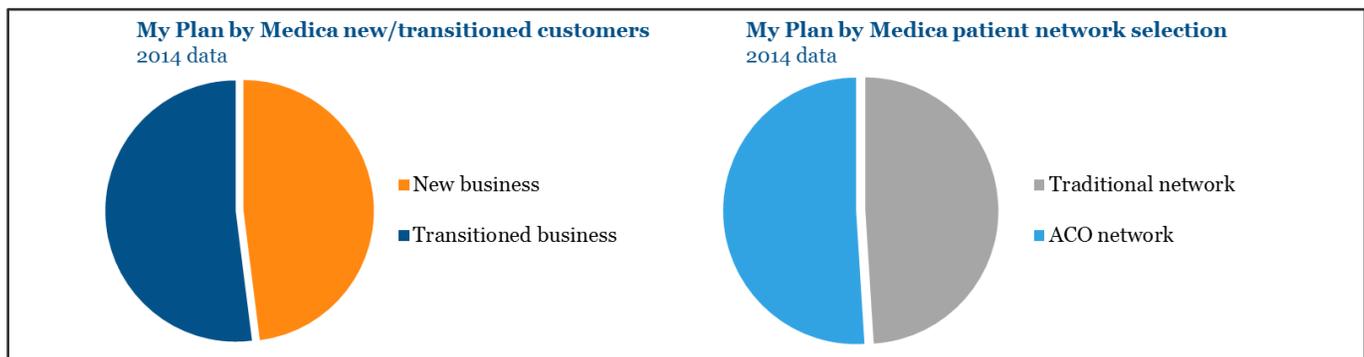
Early Results

Plan choice: My Plan by Medica also released data comparing plan choices over its first two years of business. In members' first year on My Plan by Medica, 85% change their healthcare coverage level; 50% purchase less coverage, while 35% purchase more. This demonstrates the challenge many employers face as they attempt to meet the diverse benefit needs of their populations with one or two plans. In fact, 60% of My Plan members choose an HSA-eligible plan, in sharp contrast with HDHP's 20% market share in the US overall.⁸⁷ In the

second year on exchange, far fewer members switch their coverage levels (just 30%), and those who do switch are equally as likely to purchase more coverage as less coverage.⁸⁸



Forty-eight percent of My Plan members are new to Medica, indicating that the exchange is a tool for new client acquisition in addition to retention. Finally, after choosing a plan design nearly 51% of My Plan members pair their selected plan with an ACO network rather than a traditional network.⁸⁹ Notes Reid: “This is important because our ACO partnerships represent our best opportunity to collaborate with care systems to improve the patient experience, engage members in their health, and have a positive impact on costs.”



For more information about Medica My Plan, visit: <https://www.medica.com/myplanbymedica/>

Updated as September, 2014

Table A12: Towers Watson: OneExchange Exchange Overview

Exchange type	Single carrier exchange		Multi-carrier exchange	
Sponsor type	Health plan	Benefit consultant	Technology platform	Niche member group
Target employer size	Small (<50)	Mid (50-199)	Large (200-999)	Jumbo (1000+)
Insurance market	Individual <65	Individual Medicare	Group Active	<65 Retiree
Employer contribution	Defined benefit		Defined contribution	
Insurance funding types	Self-funded		Fully insured	
Risk adjustment capability	None required		Risk adjustment (fully-insured/multi-carrier)	
Plan types	<ul style="list-style-type: none"> • Active employees: Eight group medical plan types and a variety of supplemental benefit offerings • Part-time employees and early retirees – Public exchange qualified individual health plans and off-exchange plans • Medicare-eligible retirees – Private individual Medicare plans 			
2014 Enrollment	800K lives total between group active, individual market, and individual Medicare plans.			

Exchange Overview

Exchange inception: Towers Watson acquired Extend Health to expand its retiree benefits services and add a private exchange approach to its offerings in 2012. In 2013, it launched OneExchange, a private exchange for active employees, part-time employees and early retirees, and Medicare-eligible retirees. Also in 2013, Towers Watson acquired Liazon, a New York-based private exchange focusing on the small-to-medium sized company group market through the broker channel.⁹⁰

Exchange approach: Towers Watson targets medium- to jumbo-sized employers with OneExchange, which is distributed directly to employers. OneExchange offers health coverage for the entire range of employee populations: full-time active employees (group market); part-time employees and early retirees (individual market); and Medicare-eligible retirees (individual Medicare market). Towers Watson reports that it works with 80% of the Fortune 1000, more than 100 of which have adopted the OneExchange private Medicare exchange.⁹¹ The OneExchange active employee offering is a multi-carrier exchange that allows employers to choose either self-funded or fully insured plans.

Health Plans

Plan design: For its active employee exchange, Towers Watson created its own plan designs, modeling them after the PPO and consumer-directed plans they help design as benefit consultants. There are eight standard plan designs, and OneExchange provides a number of plans that are HRA or HSA-eligible.

For part-time employees and early retirees, OneExchange provides decision support and enrollment assistance in all state-run exchanges and the federally facilitated marketplace, for which Towers Watson is a Web Broker Entity.

For Medicare-eligible retirees, OneExchange provides decision support and enrollment assistance for its plans from more than 90 carriers; and in addition to medical plans, it offers dental and vision plans.

Health and wellness: Towers Watson has developed a proprietary health and wellness program. Coupled with the HRA/HSA accounts, consumers can earn money through wellness incentives. The program – which is optional for employers -- includes biometric screenings, case management, chronic condition management, and drug use management.

Carrier participation: Towers Watson partners with five carriers to offer its group active medical plans: Aetna, Cigna, Kaiser Permanente, and United HealthCare and a Blue Cross Blue Shield Association member plan (e.g., Anthem, Blue Cross Blue Shield of Massachusetts, Health Care Service Corporation) depending on a company's corporate location.⁹²

Supplemental / ancillary offerings: In addition to medical plans, Towers Watson's OneExchange offers dental and vision plans, as well as additional ancillary benefit offerings.

Additional Services

Plan choice support: Towers Watson offers online decision support, as well as call center support that includes upwards of 2,000 licensed benefit advisors and trained staff to guide consumers through the process of selecting plans.

Other services: Towers Watson is not only heavily involved in plan design for the full-time active health plans offered on OneExchange, but also in care management programs, serving as a proactive manager of high-cost cases. OneExchange also offers ongoing patient advocacy through the year after enrollment.

Early Results

100% of its customers are enrolled in CDHPs, much higher than the national average of 20% in employer-sponsored coverage.

In 2014, OneExchange had over 800K customers across all three OneExchange populations: 1) full-time active employees, 2) part-time employees and early retirees, and 3) Medicare-eligible retirees.⁹³

For more information about OneExchange please visit: <http://www.towerswatson.com/en-US/Services/our-solutions/OneExchange>

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