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Not All Exchange Technology Is Created Equal

Top 10 Factors to Consider When Selecting a Private or Public Exchange Solution

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What Will Exchanges Look Like in 2014 and Beyond?

The world of health care and employee benefits is in the midst of a massive transformation. On one hand are the forces being driven by private sector initiatives toward consumerism, wellness, defined contribution and private exchanges. On the other are the numerous changes in the health insurance marketplace legislated by the Affordable Care Act (ACA), including new community rating rules and the establishment of state health Exchanges.

In this complex, rapidly changing and uncertain environment, the question many are asking is: what will Exchanges look like?

All kinds of insurance marketplace mechanisms can be called “Exchanges” – where purchasers buy insurance. And most likely, there will be all kinds of successful Exchanges, with variations driven by employer size and industry, state governments, and carrier and broker responses. With these numerous influences, which types of Exchanges will become prevalent among employers and consumers in a very competitive marketplace?

The table below outlines the different types of Exchanges according to their relative complexity in terms of the administrative and technological challenges.

Despite the fact that the more complex Exchange – an employer-funded, multi-carrier Exchange offering a full suite of benefits with defined contribution and year-round administrative capabilities – is more administratively challenging, it is one of the most compelling options for employers and brokers. The defined contribution model – an old idea in the midst of a significant revival – is particularly appealing to employers who seek new solutions to win in the losing battle against health care costs.

For a more in-depth discussion about the future of health insurance exchanges and their impact on employers, see bswift’s white paper entitled “Emerging Health Insurance Exchange Models: The Intersection of Public and Private Exchanges” at www.bswift.com or contact Don Garlitz at dgarlitz@bswift.com.

Different Exchange Types

Less Complex	More Complex
Consumer-based and Funded	Employer-based and Funded (at least partially)
Single Carrier	Multiple Carriers
Health Insurance Only	Multiple Benefits (i.e., including Dental, Life, Disability)
Defined Benefits (employer choice)	Defined Contribution (employee choice)
One-time Upfront Purchase Only	Year-Round, Ongoing Administration

Health Insurance is Different

On the surface, health care appears to be just another service or commodity that can be quickly and easily purchased online, like music, books and hotel rooms. But the many complex rules and laws associated with health care make the purchasing process far more difficult for both consumers and administrators. Not only must Exchange technology empower consumers with a simple, intuitive yet comprehensive shopping experience and seamlessly deliver the right coverage on the right date, but it must also streamline the back-end administrative process, reduce cost and add value to the overall supply chain of health care and benefits.

Similar to the proliferation of short-lived “dot.coms” at the turn of the 21st century, dozens of new vendors have appeared in the past two years to offer Exchange technology, focusing attention on the consumer user experience for “Shopping,” “Defined Contribution” and “Annual Open Enrollment.” While there is no question that employee benefits ought to move to a more consumer-oriented shopping experience, the reality is that most of the “heavy lifting” for Exchange technology will take place outside of the Annual Open Enrollment consumer shopping experience. Not only are numerous back-end processes required to facilitate a smooth Annual Open Enrollment, *more than 25% of the enrollment transactions are likely to happen outside of the Open Enrollment period, and these are the most complex ones.* Can these new Exchange technology solutions really handle the complexity of these scenarios?

People get married and have kids all the time. And move. And change jobs. Exchanges will need to deal with these tricky scenarios both during and outside of open enrollment periods – elegantly, seamlessly, and in conjunction with the eligibility systems of multiple carriers. “Shopping” during Annual Open Enrollment is one part of the equation. But the administration of the “tough stuff” will separate the Exchange winners from the losers in terms of satisfying – and retaining – consumers and employers as clients.

The tracking of enrollment, billing and collections for these complex transactions is a real challenge – especially since it requires Electronic Data Interchanges (EDI) and synchronization with numerous external partners, including carriers, payroll systems, and third party vendors – not to mention the government, if subsidies are involved.

The Hidden Complexities of Insurance Exchanges

If you are a state government seeking to build an Exchange, or a carrier or brokerage firm managing a large book of business in the small group marketplace, or a large employer with lots of part-timers or retirees, what should you be looking for in a new system or outsourced solution? The good news is that there’s no shortage of options. Players include e-brokers, big system integrators, “shopping” sites, defined contribution players, and new Exchange vendors, as well as many outsourcing firms and technology firms offering Exchange solutions. The bad news is that to the untrained eye, it’s very difficult to determine how these options differ and which solution is right for you.

Selecting the wrong Exchange technology solution can damage your ability to compete in what clearly will be a competitive Exchange marketplace. Without the right technology, you may face a litany of obstacles ranging from dissatisfied customers, inaccurate billing and payroll deduction errors to excessive custom programming fees or manual processing fees. And, isn’t the purpose of Exchanges to streamline benefits administration and reduce costs?

Before deciding on an Exchange vendor or technology, consider the following 10 scenarios and make sure your vendor can handle them. Avoid implementing a platform that becomes more of a problem than a solution for your organization.

- 1) **Life Events:** in today's individual Health Insurance marketplace, consumers can generally add or drop coverage for themselves or their dependents anytime they want. In other words, it's a relatively "rule-free world." In January 2014, that world changes to look more like the current group health marketplace in which many rules are defined by the federal government's existing tax code (e.g., Section 125) and HIPAA requirements, and consumers must select and "lock in" their coverage once a year for the following 12 months, unless they experience a qualified life event. As a result, each qualified life event – e.g., marriage, divorce, birth of a child, loss of spouse's coverage and many more – must be configurable within the Exchange technology to enforce the appropriate rules. For example, if a person gets married, is that person allowed to drop coverage or change plans and carriers? How about with the birth of a child? Or with a loss of spouse's coverage? For a truly scalable Exchange technology, thousands of scenarios must be configured in advance to enable consumers to make enrollment choices online without administrator involvement.

- 2) **Overlapping Enrollments:** every year, consumers will have the opportunity to make enrollment decisions and changes during the Annual Open Enrollment period, scheduled for October through December in the individual marketplace, and on a rolling employer-specific schedule for small employers. In the individual marketplace, those changes will be effective the first of the following year. But just because people are in the middle of an annual open enrollment period doesn't mean that they are prohibited from getting married during that timeframe, or from having children, or from their job status or income changing – with an effective date in November or December. Therefore, a high volume of overlapping enrollment transactions will need to be handled by the Exchange technology, as depicted in John's scenario (see **Figure 1 on following page**). Not only does the Exchange's user experience need to be seamless for these consumers, but the electronic eligibility files to the carriers need to be intelligently developed and transmitted to enable the carriers to manage their membership accurately and efficiently.

- 3) **Additional Special Enrollments:** numerous scenarios are described in the Affordable Care Act (ACA) legislation and in more detail in the regulations recently published by the Department of Health and Human Services (HHS) in which consumers will have the ability to change coverage throughout the year, including but not limited to:
 - a) a change in location triggering a plan/carrier change
 - b) a change in employment status (including losing a job)
 - c) a change in income which would affect eligibility for Medicaid and/or Premium Assistance.

Again, each of these transactions needs to be handled seamlessly by the Exchange platform, including the transmission of eligibility updates to the carriers.

Figure 1.**How hard can it be? Consider the following scenario:**

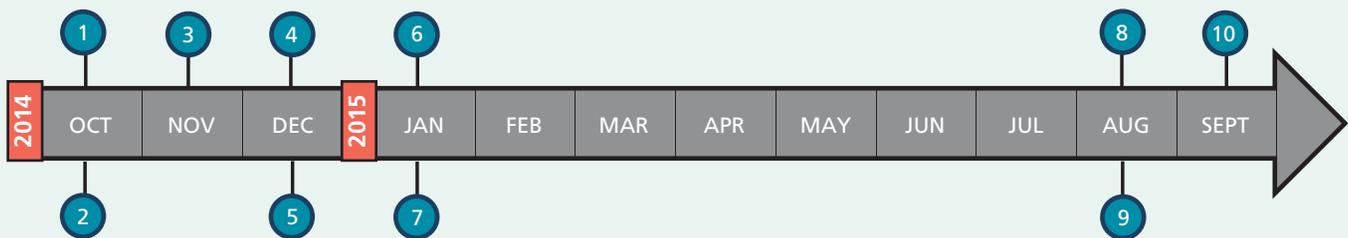
It's October of 2014 and John Smith has just turned 26 years old, meaning that it's the first time he will need to enroll in his own plan (previously, he'd been covered as a dependent on his father's company plan). His career as an engineer is off to a great start, already earning a salary of \$52,000 with access to affordable medical coverage through his employer, so he is not eligible for a subsidy in the state public American Health Benefits Exchange (AHBE). John turns to his employer, ABC Plastics Co., a leading Wisconsin manufacturer with 45 employees and an "early adopter" of a Private Exchange solution. As a result, ABC Plastics offers John \$600 per month to buy one of the dozens of plans available on this Exchange. John selects a limited network HMO plan partially owned by one of the leading hospital systems in his area. This plan selection gives him access to his primary doctor and also happens to be, relatively speaking, a low premium option, at \$450 for single (Employee Only) coverage. That leaves him another \$150 of his employer's dollars to spend on additional benefits, including a dental plan, a vision plan, life and disability plans, and additional contributions to his 401(k) plan.

As with many young, healthy singles, John didn't put much time or foresight into his benefit decisions during the October open enrollment for plans effective January 1, 2015. But in November, John got married. John and his wife, Katie, were looking forward to starting a family as soon as possible and discovered that Katie's obstetrician was not in John's plan and carrier network. The good news is that the rules of the Exchange allowed for a switch from one carrier to another for certain Qualified Life Events (QLE) such as a marriage. So in November before the wedding, John and Katie went online on his employer's Exchange, and found another plan that would work. John needed to produce a marriage certificate to provide valid evidence of his QLE, so he brought that document back to the office in December after his honeymoon trip to the Bahamas. On December 15, he went online and switched his enrollment from Carrier 1 / Plan 22 to Carrier 2 / Plan 57, effective on his wedding day of November 27, 2014.

On August 1, 2015, the young couple had their first child. The good news is that their preferred pediatrician was in their Carrier 2 / Plan 57 network, so there would be no need to change plans again. But the increase in coverage costs for a family reduced the dollars available for John's other benefit plans, so more employee contributions (via pre-tax payroll deductions) would need to be taken to maintain existing benefits and to add some additional life insurance to give John's family additional security.

Transaction Complexity and Volume

John’s scenario necessitated 10 administration transactions in the Exchange system – just for Health benefits. On top of the Health transactions, for Exchanges that aim to serve the consumer’s full set of benefit needs, numerous benefit elections needed to be processed for Dental, Vision, Life, Disability, Flexible Spending Accounts, and Health Savings Accounts, among others. And sent to the respective carriers, in addition to updating the payroll deductions in the payroll system.



	Functional Area	Transaction
1	Plan Selection & Enrollment	Initial Open Enrollment election for January 1, 2015 in Carrier 1 / Plan 22
2	EDI	Enrollment data sent to Carrier 1 for this election
3	Plan Selection & Enrollment	Life Event Enrollment election for November 27, 2014 in Carrier 2 / Plan 57 (a "Retro Add" because the election wasn't made until December 15)
4	EDI	Retroactive termination of coverage in Plan 22 – cancellation sent to Carrier 1 (a "Retro Term") and enrollment data sent to Carrier 2 for coverage in Plan 57 (a "Retro Add")
5	Invoicing & Payment	Invoice (dated December 3, 2014) sent to ABC Plastics for January 2015 bill
6	Payroll Deductions	Payroll deduction sent to ABC Plastics payroll system for 1/1/2015 election (sent in early January for first 2015 payroll run)
7	Invoicing & Payment	Invoice (dated January 3, 2015) sent to ABC Plastics for February 2015 bill and also retro-adjustments on January bill
8	Plan Selection & Enrollment	Life Event Enrollment election for August 1, 2015 in Carrier 2 / Plan 57 (a "Retro Add" because the election wasn't made until August 12)
9	Payroll Deductions	Payroll deduction sent to ABC Plastics payroll system for 8/1/2015 premium change (a "Retro Change" sent in mid-August)
10	Invoicing & Payment	Invoice (dated September 3, 2015) sent to ABC Plastics for September 2015 bill and also retro-adjustments on August 2015 bill

- 4) Passive Annual Open Enrollment:** consumers will go into their annual open enrollment period each year with a choice: keep one's current plan and coverage, or make changes. A user-friendly system ought to present that consumer with his or her current coverage and costs and compare this plan with next year's rates to the many other plan options that may be available, with an option to continue the current selection. Given the emergence of tobacco-rated health rates and wellness credits in the Health marketplace, a user-friendly, "active" consumer process also needs to handle the annual tobacco use attestation process to validate the consumer's updated tobacco status and adjust the rates accordingly. Administering a passive annual enrollment becomes even more complex when a carrier discontinues a product at renewal; robust plan mapping mechanisms need to facilitate massive migrations to the replacement plan, enabling carrier marketing strategies in a consumer-friendly manner.
- 5) Age Changes and Coverage Dependent Cancellations (especially mid-year):** in many states, premiums/rates are likely to be age-rated, and therefore, an age change may trigger a change in the premium. In addition, in all states, dependents at some age – usually age 26 but higher in certain states – will need to be dropped from coverage, and the tier and cost of that coverage needs to be adjusted. These age changes and their downstream impact on costs, billing and carrier membership need to be handled automatically by the Exchange system and to enable easy proactive communication (e.g., alerts or messages) to the affected parties, especially the members.
- 6) Rate and Plan Updates:** in the increasingly competitive health plan marketplace, carriers will be regularly modifying and updating plan rates and details (and deciding whether to continue offering various plans). A scalable Exchange technology solution needs to be able to handle current year rates (e.g., October 2014) and next year rates (e.g., January 2015) at the same time within the system, and to present the correct information to the various stakeholders (consumers, administrators, billing/payroll systems) with accurate effective dating for any changes. This process of rate and plan updates requires a collaborative, scalable process with the carriers so that plan information can be imported and updated easily into the Exchange solution without causing substantial additional work on the part of the carriers or other administrators.
- 7) Retroactive Billing:** most transactions which happen outside of the annual open enrollment period (e.g., birth of a child) are likely to be retroactive transactions, meaning that the effective date for coverage (or cancellation of coverage) is before today's date, and the bill for prior months must be retro-adjusted. As a result, accurate retro billing (and payroll deduction calculations) is an absolute must for any Exchange technology. As anyone with group benefits billing experience can attest, this is a complicated process fraught with many challenges.

8) Electronic Data Interchanges (EDI): this area continues to offer unexpected challenges for those players new to the space. Most health carriers in the large and mid-sized employer markets are accustomed to receiving EDI files from benefits technology vendors in the standard HIPAA 834 format, but even today, many small group and individual carriers are new to this process. Dealing with the many nuances of the different carriers – even in an era of “standard” HIPAA 834 formats – is a large challenge in itself.

Handling large volumes of carrier feeds in an efficient and configurable manner is the other large challenge. There are lots of technology vendors who claim to create an EDI feed and send it to a carrier. But the real questions are:

- a) can they do this efficiently and cost-effectively?
- b) can they easily adjust to the differences amongst carriers (and yes, while there may be standard HIPAA 834 formats, there will still be differences amongst carriers in terms of how to map and send data)?
- c) can they maintain a high volume of files in a scalable manner year-over-year, when multiple files need to be handled during annual open enrollment?

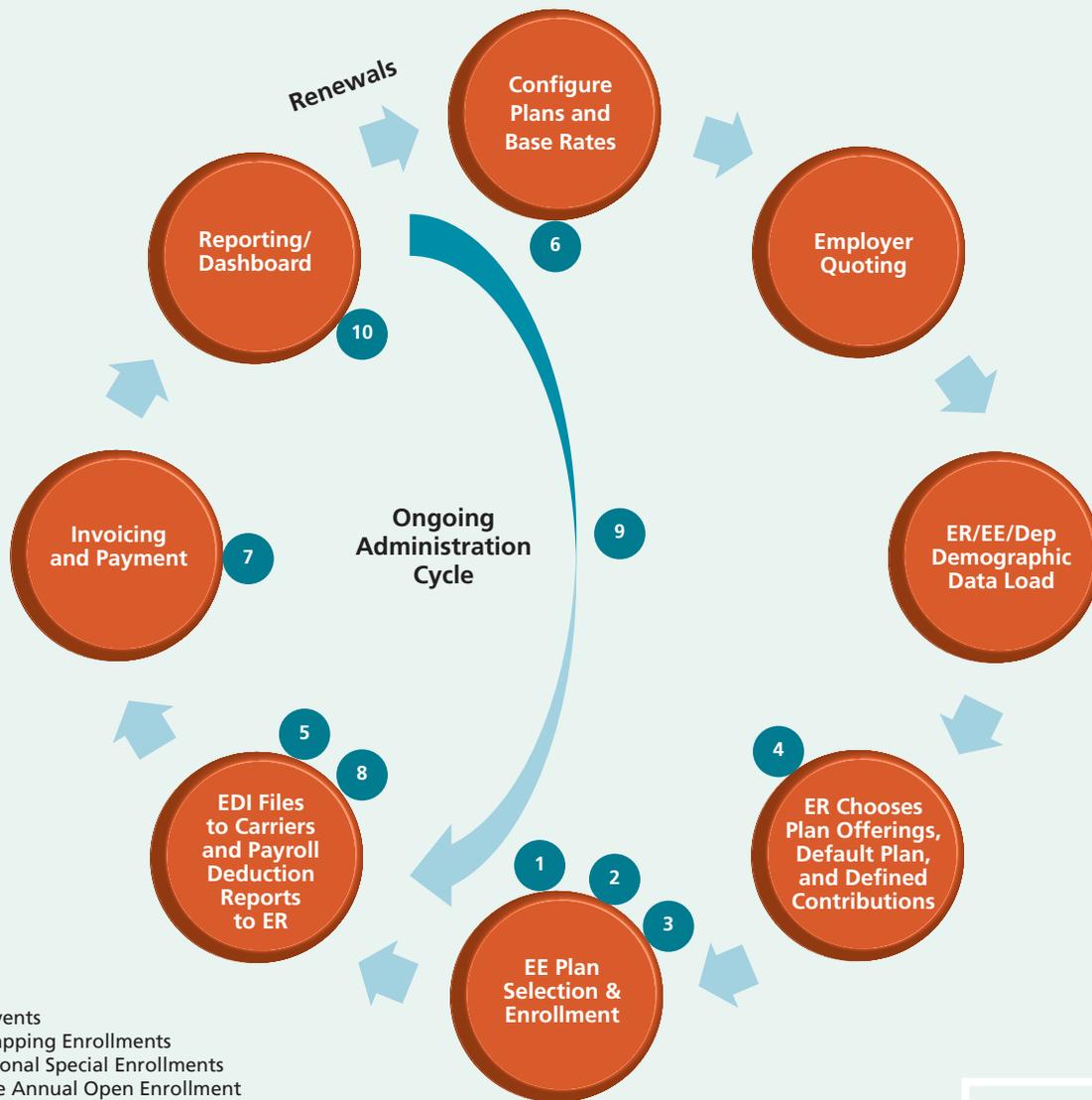
9) Security and Permissions: different stakeholders need to be able to access different information within the Exchange platform, and access to certain kinds of confidential information needs to be restricted. For example, carriers ought to be able to see their own membership on the Exchange platform, but not that of their competitors. Likewise, brokers and agents need to be able to access only their book of business.

10) Reports, Alerts and Dashboards: given all this valuable Exchange enrollment and premium data, different stakeholders will demand to see different types of information presented in all kinds of different ways – from regularly scheduled reports (e.g., monthly billing reports) and strategic snapshots (e.g., dashboards showing market share by carrier) to ad hoc custom reports and alerts that can be transmitted out to members and/or administrators (e.g., dependent cancelled due to becoming age 26). Exchange technology ought to be able to deliver this information easily and efficiently to users.

It's not enough to just put together an RFP to evaluate Exchange technology solutions. Everyone says “yes, we can do that,” with a wink and a “we-can-build-that-later” attitude. In addition, put together a demo script and watch the demo closely to see exactly how the technology vendor can administer the above transactions and scenarios. Talk to references that can establish a vendor's track record in delivering these solutions. And keep in mind that the above “Top 10” list of scenarios is just that – the top of a long list. There are hundreds more scenarios to consider in Exchange technology that could make or break the success of your Exchange.

Figure 2.

End-to-End Exchange Functionality



- 1 - Life Events
- 2 - Overlapping Enrollments
- 3 - Additional Special Enrollments
- 4 - Passive Annual Open Enrollment
- 5 - Age Changes and Overage Dependent Cancellations
- 6 - Rate and Plan Updates
- 7 - Retroactive Billing
- 8 - Electronic Data Interchanges (EDI)
- 9 - Security and Permissions
- 10 - Reports, Alerts and Dashboards

EE = Employee
ER = Employer
Dep = Dependent



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