Healthcare Systems and Services Practice

US health insurers: An endangered species?

Dan Fields, Brian Latko, Tom Latkovic, and Tim Ward

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Converging trends are disrupting the US healthcare industry. Health insurers are not likely to disappear, however, despite predictions to the contrary. Insurers that can take advantage of these trends are likely to find that their best years are ahead.

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In a comparative sense, the US health insurance industry is young (certainly compared with hospitals, which have been around for centuries, or worker's compensation insurance, which predates health insurance in this country by at least 40 years). Yet some observers have wondered whether a confluence of disruptive forces has started to signal the industry's end. If you believe what you read, health insurers have been on the brink of extinction for several years:

- "The end of private health insurance in America" (*Forbes*)[1]
- "Is this the end of health insurers?" (*Washington Post*)[2]
- "Insurance companies as we know them are about to die" (*New Republic*)[3]
- "Why health insurance companies are doomed" (*Fortune*)[4]

These reports about the health insurance industry's extinction are likely exaggerated. Indeed, we believe that successful health insurers still have their best days ahead, regardless of whatever changes in federal or state healthcare policy are made in the next few years. Not all health insurers will survive, of course. But those that can effectively navigate—and take advantage of—several important trends can significantly increase their chances of success.

Facing discontinuity

The US health insurance industry has been challenged by multiple discontinuities in recent years, and this period of disruption may last for another ten years. Five powerful trends have been fueling the disruption:

- **The explosion of data and technology**, which often requires health insurers to make expensive and uncertain investments and also carries with it the potential for new competitors.
- **The shift to provider risk-bearing models**, which has the potential to relegate health insurers to back-office claims processors or cut them out altogether.
- **Greater transparency (through readily available information)** on pricing, networks, costs, and quality, which could impede insurers' ability to capture value from such traditional levers as opaque network discounts.
- **Heightened value consciousness among both consumers and employers**, which often leads to more direct relationships with providers and thus could erode the traditional role of insurers as a necessary intermediary in the healthcare system.
- **Increasing regulatory uncertainty**, which can increase the risks associated with making strategic bets.

How any upcoming changes to federal or state healthcare policy may affect these long-standing trends is currently uncertain. Some trends (e.g., regulatory uncertainty) might intensify, whereas others (the shift to risk-bearing models) might slow. But none are likely to disappear.

In the face of these trends, health insurers (or any organizations that hope to displace them) must address several issues in the near term. They need to lower their cost structure while investing in the capabilities required to better manage rising

medical costs and reach consumers in new ways. In addition, they need to keep pace with new (and sometimes well-financed) competitors and disruptive business models, as well as prove their worth to increasingly skeptical customers. And they need to do all of this with limits on the tried-and-true levers of pricing and underwriting, in a period where uncertainty is pervasive and events could play out differently in different markets.

The five trends have the potential to fundamentally transform the health insurance industry and, already, many insurers have started to evolve (e.g., by offering new services, integrating with providers, or pursuing new distribution channels). However, the trends are not creating an endangered species because most of today's health insurers have a type of "structural influence"—a combination of scale, scope, and local market density[5]—that other actors in the value chain lack. This structural influence combines with other factors, such as health insurers' ability to aggregate and leverage healthcare data from multiple sources, to give them a privileged position in the healthcare value chain. Those insurers that can use that position to navigate the trends are the ones most likely to come out ahead in coming years.

Using structural influence to improve healthcare

The four vignettes below illustrate how health insurers can use their privileged position not only to succeed in the evolving healthcare landscape but also to improve care delivery. In each of these vignettes, the common underlying enablers include scale, scope, and local market density. This is not to say that an insurer's size is the ultimate determinant of success—far from it—but rather that health insurers, as a class, tend to derive greater benefit from these enablers than other actors in the value chain do.

Shaping technology-driven disruption

The healthcare industry is collecting massive amounts of data, not only from traditional clinical and claims information but also from social interactions, health monitoring devices, and the Internet of Things. Estimates suggest that the total amount of health data in the world is growing at a rate of 48% per year, and by 2020 nearly 1 gigabyte of health data, on average, will be created for each person on earth every day.[6] Increasingly sophisticated analytical methods (e.g., machine learning) are being developed to understand and take advantage of this explosion of data.

The use of mobile technologies and wearable devices is likely to accelerate, given the amount of money being invested in them. In 2016, venture capitalists invested $4.2 billion in the digital healthcare sector[7]; 142 acquisitions (totaling $4 billion) were closed in healthcare data and analytics alone (Exhibit 1).[8] New companies at the intersection of healthcare and technology are developing products to better meet customer needs and, in some cases, are creating entirely new value propositions. However, no one yet knows which specific technologies, business models, or companies will win—and which will fail.

In general, health insurers are in a better position than other actors in the value chain (including new entrants) to take advantage of this situation. Compared with providers and most other healthcare stakeholders, insurers have more customers, more revenue, and more capital. They also have greater geographic reach, often have multiple lines of business, and sometimes provide services beyond insurance (e.g., B2B technology platforms and solutions businesses). Scale and access to capital make it easier for them to place strategic bets on new technologies, markets, and offerings—and to weather strategic mistakes or catch up when behind. Scale and scope make it more

economical for them to monetize investments in technology and easier for them to introduce new offerings quickly to a wide range of consumers. (For example, a single decision at a large health insurer could give millions of customers access to a new technology.) Scale and scope also make successful health insurers more attractive strategic partners for technology companies or other institutions outside healthcare.

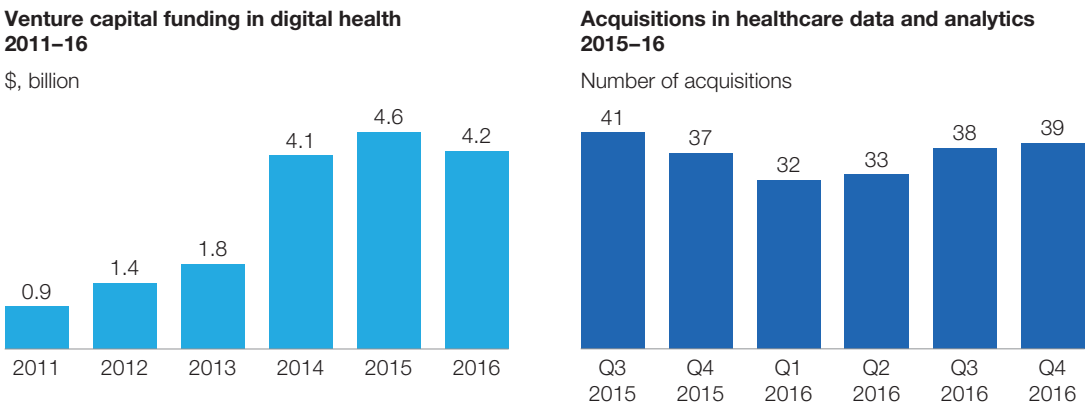
The net result is that health insurers have a greater ability to shape what technology standards are established, what offerings are delivered, and what customers expect.

Leading the shift to value

The healthcare market is increasingly adopting payment approaches focused on aggregate outcomes achieved, not just services delivered. For example, there has been a rapid move away from fee-for-service and toward value-based payment models. Between 2011 and 2015, for example, the number of lives covered in accountable care organizations (ACOs) grew from 3.9 million to around 23.2 million.[9] Because the move to value-based reimbursement has had bipartisan support, upcoming changes to federal or state healthcare policies are unlikely to halt it, although the changes may slow it down or shift the focus to other types of payment innovation.

Despite warnings that the move to ACOs and other new payment models would turn health insurers into back-office claims processors or disintermediate them altogether, there is no compelling evidence that either has occurred. Rather, their capabilities could help support the move. For example, the Centers for Medicare and Medicaid Services (CMS) has reported that 9 million people enrolled in traditional Medicare are currently assigned to one of the 480 ACOs in the Medicare Shared Savings Program.[10] These ACOs have been slow to accept downside financial risk—as of January 2017, only 9% of them did so. Providers have made it clear that they need significant support if they are to participate in risk-sharing arrangements and other payment innovations. Health insurers have the resources required to finance the tools, capabilities, and data necessary to enable providers to succeed

EXHIBIT 1 **Investment in healthcare data and analytics is strong**

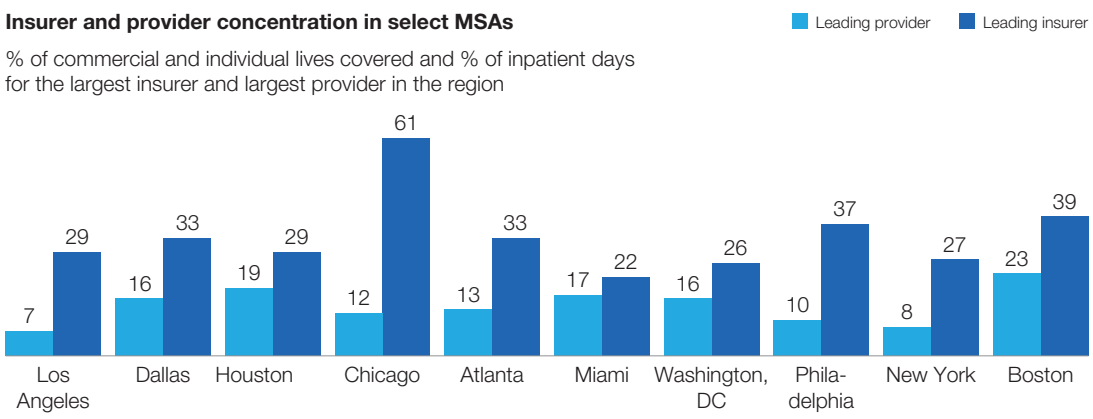


Source: Rock Health; National Venture Capital Association; PriceWaterhouseCoopers; MoneyTree; Thomson Reuters; Dealogic; McKinsey analysis

EXHIBIT 2 **In many areas, health insurers could lead the shift to value-based payment**

Insurer and provider concentration in select MSAs

% of commercial and individual lives covered and % of inpatient days for the largest insurer and largest provider in the region



MSA, metropolitan statistical area.

Source: Interstudy; American Hospital Association

in these efforts. In many parts of the country, they have a large enough presence to be able to influence even the largest providers and lead the shift to value-based reimbursement (Exhibit 2).[11] And this ability to lead is increasing as a growing proportion of government-sponsored health insurance is delivered by private insurers (through Medicare Advantage plans and managed Medicaid programs).

Delivering better consumer solutions

Consumers' needs and expectations about healthcare are evolving, in part because of their experiences with other industries. Consumers increasingly want convenience, such as flexible scheduling, remote or virtual access to care, and multichannel interactions.[12] More and more consumers have become comfortable communicating with doctors via technology rather than in-person consultations.[13] A growing number are looking for tools and services that promote health and wellness. And many consumers now expect to receive greater value for their money from both health insurers and providers.

Very few providers or insurers excel at delivering what consumers want. Health insurers may be better able to address this shortcoming for two primary reasons. First, the number of interactions they have with their members and the data they collect (or could collect) leave health insurers in a good position to build lasting relationships with members. In any given year, health insurers provide coverage for more than 75% of Americans[14] and often interact with consumers at numerous points. Furthermore, the interactions frequently occur at key "moments of truth"—for example, when someone is first selecting a plan or finding a doctor, when a baby is born, when a major illness must be dealt with, when someone moves, or when a family member passes away. These interactions, combined with other data health insurers gather, could enable them to develop a unique understanding of what consumers want and need (at both the aggregate and individual level). The holistic relationships health insurers could develop with consumers as a result are likely to be crucial for organizations that want to take advantage of the other opportunities discussed in this article.

The second reason health insurers may be better able to address consumers' needs and expectations arises from their privileged position in the value chain. More than any other stakeholder, health insurers are in the center of the healthcare ecosystem—they are the industry's de facto "operating system." Health insurers influence or decide what is or is not paid for, and they gather information on healthcare costs and utilization. In addition, they often determine what information is shared with (or withheld from) other stakeholders and are often responsible for developing or providing the information technology systems that enable others to access this information. And they interact with almost all providers, life sciences companies, regulators, and employers, as well as with consumers. Through this central role, they have the ability to influence the perceptions and expectations of many of the other stakeholders. As a result, health insurers have a unique opportunity to create, deliver, and monetize compelling offerings.

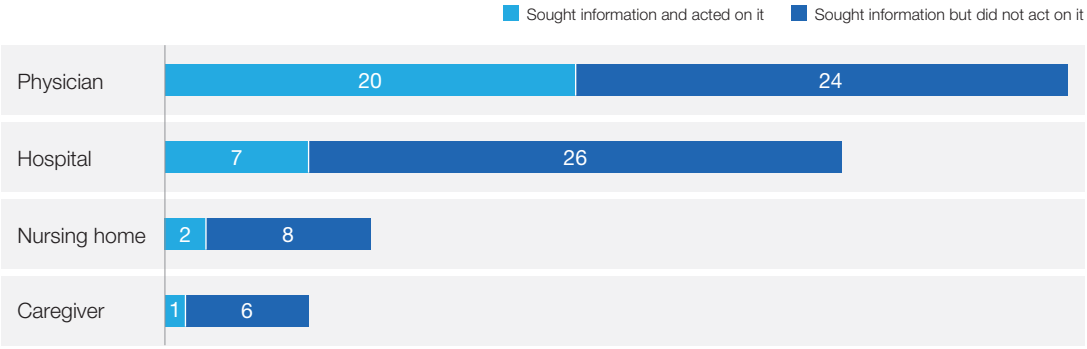
In other industries, similarly situated organizations have been able to use their central position to shape industry dynamics, even when their direct control is limited. In many respects, this is what Apple—and, to a lesser extent, Samsung, Google, and Android—have been doing in the mobile ecosystem. From a revenue standpoint, device manufacturers account for only 20% to 30% of the mobile value chain.[15] But these manufacturers have extended their role to create the platforms (operating systems) through which customers access services, content, applications, and a growing set of connected devices. To be clear, this reality has not led most wireless carriers or content providers to lose, but it *has* given the device manufacturers a disproportionate ability to shape the market and extract rents from the value chain.

Accelerating information transparency

An increasing number of people are actively seeking information to guide their healthcare decisions. For example, nearly half of consumers today report that they consult online sources before selecting providers (Exhibit 3), and many of those consumers say they make decisions based on the information they find.[16]

EXHIBIT 3 **Nearly half of consumers now check online reviews before selecting a physician**

Consumers' use of online reviews, by provider type, %



Source: Rock Health Digital Health Consumer Adoption report; Rock Health consumer survey data (N = 4,017)

Consumers are also assuming greater financial responsibility for their care. High-deductible health plan enrollment has been growing rapidly (Exhibit 4),[17] and this trend is likely to continue if the cost differential between high-deductible plans and traditional plans continues to rise as it has in recent years.[18] The increased financial responsibility is leading many consumers to demand greater transparency about price and value delivered.

Industry watchdogs and regulators are also concerned about healthcare costs. Variation in the cost of common medical procedures has been the subject of repeated scrutiny, and some medical specialists have received press attention for failing to comply with state pricing laws.[19,20]

Of course, health insurers have not been immune to scrutiny about pricing, as the coverage about price increases on the public exchanges demonstrates.[21] However, health insurers have an opportunity not only to rise above the fray but also to play a meaningful role in accelerating and enabling greater transparency into healthcare costs. Their capabilities to analyze, manage, and report on metrics such as utilization and total cost of care can help root out sources of waste in the industry and put pressure on other healthcare organizations to control costs.

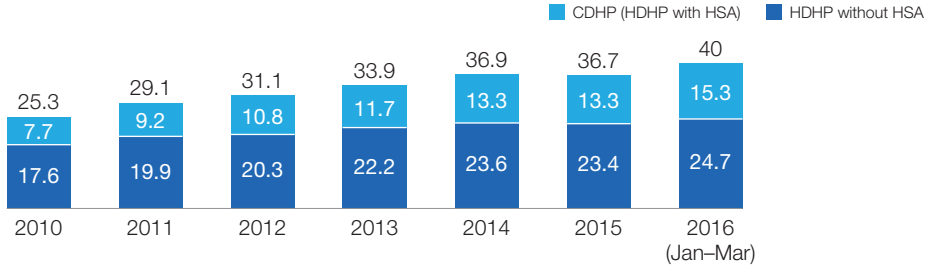
Health insurers are also well positioned to achieve impact from greater transparency in ways that go beyond cost alone. A recent study showed that public reporting of hospital mortality rates was effective in improving compliance on various process measures but had little impact on actual patient outcomes.[22] Achieving greater impact on outcomes is likely to require several additional actions—for example, integrating clinical data with claims data, releasing timely information to providers and the public, and balancing the valid concerns of providers over which information is most meaningful to report. Health insurers have an opportunity to leverage information to meaningfully improve quality and patient outcomes, if they choose to do so.

Rising to the occasion

We believe that over the next decade the disruption resulting from the trends described above will lead to some success stories, some large failures,

EXHIBIT 4 **An increasing number of consumers are enrolled in high-deductible plans**

% of people under age 65 with private health insurance who are enrolled in a high-deductible health plan (HDHP)



CDHP, consumer-directed health plan; HSA, health savings account.

Source: Health insurance coverage; early release of estimates from the National Health Interview Survey, January–March 2016; National Center for Health Statistics, September 2016

EXHIBIT 5 **What payors need to do to survive and thrive**

Status quo		Winning health insurer
Offer consumers a disjointed experience (result of multiple legacy platforms)	**Digital offerings**	Provide consumers with a fully integrated digital journey
Produce reactive analytics with few real-time insights	**Analytics capabilities**	Regularly use machine learning across lines of business
Uses pay for performance to create incremental changes in behavior	**Provider influence**	Proactively partners with high-value providers to shape care patterns
Relies on inefficiencies in the system to drive earnings	**Value creation**	Produces sources of margin that are robust for great transparency
Impedes investment because of capital constraints and low risk tolerance	**Financial capital**	Provides freedom to make strategic bets
Sources talent primarily from within	**Human capital**	Is a top destination (across industries) for new talent

and a large tail of struggling health insurers. To respond to the increased uncertainty caused by these trends and other recent events, health insurers will need to develop a proactive strategic response (Exhibit 5). Our experience suggests that in the future they will need to:

- Deliver a fully integrated digital experience across all key consumer journeys (e.g., picking a plan, seeking advice, transitioning between coverage types).
- Build massive data lakes and comfortably apply machine-learning techniques to drive deep insights about their customers and the market.
- Go beyond exploiting simple market inefficiencies to fundamentally shaping a healthcare ecosystem that delivers greater value.
- Possess sufficient capital and deploy it to either make substantial bets or address strategic mistakes.
- Become top-talent destinations for the people most likely to be needed in the future environment (e.g., data scientists, designers, technologists, entrepreneurs).
- Create value by designing, launching, and scaling innovative consumer offerings.

• • •

The period of uncertainty and change that lies ahead will create challenges for all organizations in the healthcare value chain. But it does not necessarily spell the extinction of health insurers. Those insurers that can take advantage of the trends leading to the current discontinuity are likely to grow and thrive in the years ahead.

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FOOTNOTES

[1] Pipe S. Forbes Online. March 19, 2012.
[2] Kliff S. Washington Post Online. July 5, 2013.
[3] Ezekiel EJ. New Republic Online. March 4, 2014.
[4] Pfeffer J. Fortune Online. October 20, 2014.
[5] "Local market density" is defined as total market share across segments in a given metropolitan area. Exhibit 2 illustrates this point in select metropolitan areas.
[6] The digital universe: Driving data growth in healthcare. EMC. 2014.
[7] Tecco H. 2016 Year end funding report: A reality check for digital health. Rock Health. 2016.
[8] Dealogic. Acquisition of targets in healthcare analytics as of May 19, 2016.
[9] Projected growth of accountable care organizations. Leavitt Partners. December 23, 2015.
[10] CMS. MSSP Fast Facts, 2014–2017.
[11] McKinsey analysis based on data from the American Hospital Association (providers) and Interstudy (health insurers). Although there are some metropolitan statistical areas in the United States where the balance between health insurers and providers is quite different, there are not many.
[12] Atluri V, Cordina J, Mango P, et al. How tech-enabled consumers are reordering the healthcare landscape. McKinsey white paper. August 2016.
[13] The digitization of the healthcare industry: Using technology to transform care. Cisco. October 22, 2016.
[14] This number excludes Medicare and Medicaid beneficiaries who are not enrolled in Medicare Advantage or managed care plans. (Numbers were obtained from the following Kaiser Family Foundation's reports: Health Insurance Coverage of the Total Population, Total Medicaid Managed Care Enrollment, and Medicare Advantage 2015 Spotlight: Enrollment Market Update.)
[15] McKinsey analysis of data from multiple corporate sources.
[16] Gandhi M, Wang T. Digital health consumer adoption: 2015. Rock Health. October 19, 2015.
[17] High deductible health plans: Increasing in popularity with consumers and what that means for hospitals. Lancaster Pollard. December 15, 2015.
[18] Hayden T. The rise of consumer-driven health plans. Corporate Synergies. September 10, 2013.
[19] Massachusetts healthcare price transparency law still not a reality. Pioneer Institute. August 12, 2015.
[20] O'Donnell J. Huge health care price differences even within same area, by state. USA Today. April 29, 2016.
[21] Abelson R, Sanger-Katz M. A quick guide to rising Obamacare rates. New York Times. October 25, 2016.
[22] Joynt KE et al. Public reporting of mortality rates for hospitalized Medicare patients and trends in mortality for reported conditions. Annals of Internal Medicine. 2016;65(3):153-160.

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