Healthcare Systems and Services Practice

Growing employer interest in innovative ways to control healthcare costs

Patrick Finn, Aditya Gupta, Shelby Lin, and Elina Onitskansky

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Employers are showing increasing interest in new payment, delivery, and funding models. To capture the opportunity, payors must be able to target appropriate employers; educate employers, employees, and brokers; and demonstrate savings.

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Over the past 30 years, companies have responded to sustained healthcare cost pressures by adopting a number of significant changes to their employee benefits (Exhibit 1). In the 1970s and 1980s, for example, many employers moved away from indemnity plans toward health maintenance organizations (HMOs) and preferred provider organizations (PPOs). More recently, some employers have adopted high-deductible health plans (HDHPs).[1] Each shift resulted in changes to employee health benefits that were once thought improbable.

Cost pressures on employers continue. After relatively slow growth in medical cost inflation between 2008 and 2013, national health spending began to increase more rapidly again and is projected to continue to rise by more than 5% per year through 2024.[2]

To gauge how employers are thinking about health benefits today, we surveyed 1,265 US senior corporate managers, including 828 C-suite executives, in 2016; we also interviewed more than two dozen brokers and employer benefit decision makers.[3] Nearly one in five of the survey respondents reported that their healthcare costs had increased by more than 10% annually over the past three years; a similar number said they expect to face comparable increases in the next three years.[4] Given that GDP growth is currently about 3% per year,[5] the steep rise in healthcare costs is an intensifying challenge for employers. Not surprisingly, cost was by far the most important factor influencing their decisions about health benefits. Cost remained the most important reported factor, even among the subset of employers who stated that they offer health benefits because they wanted either to provide their employees with the best care possible or to compete for and retain talent.

In this paper, we present both our survey results and other data to show that the strategy employers have used recently to control healthcare costs—cost-shifting—may be reaching its limits.[6] We also describe employers' growing interest in innovative approaches to cost containment, including new delivery, payment, and funding models.

Limitations of existing approaches

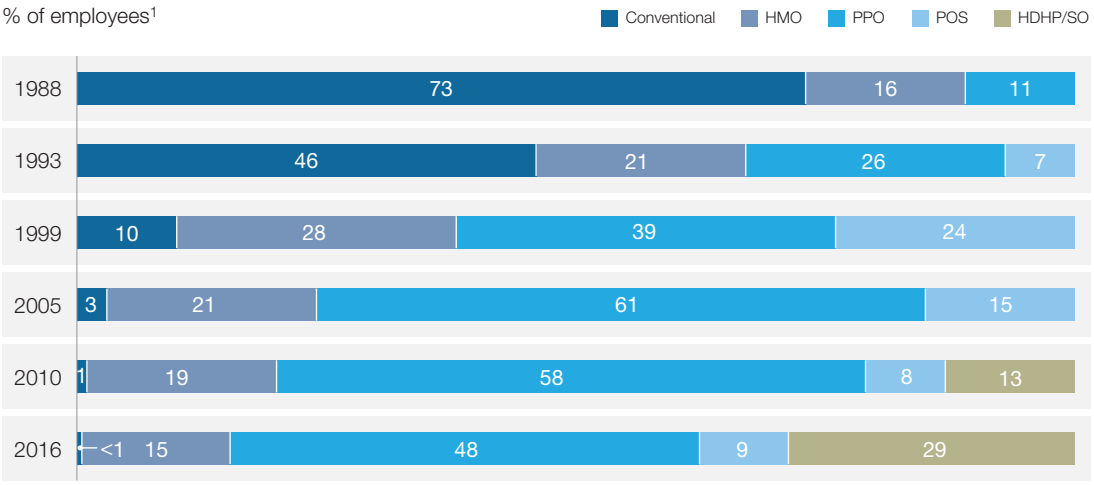
At present, many employers are relying on cost-shifting to reduce the amount they must pay for health benefits. In addition, some employers have adopted self-funded administrative-services-only (ASO) plans. In many cases, however, employers may be reaching the limit of what they can accomplish with these approaches.

Cost-shifting

Roughly three-quarters of the survey respondents acknowledged that their companies have already increased, or are planning to increase, the share of healthcare costs borne

EXHIBIT 1 Employer concerns about healthcare costs have driven waves of innovation

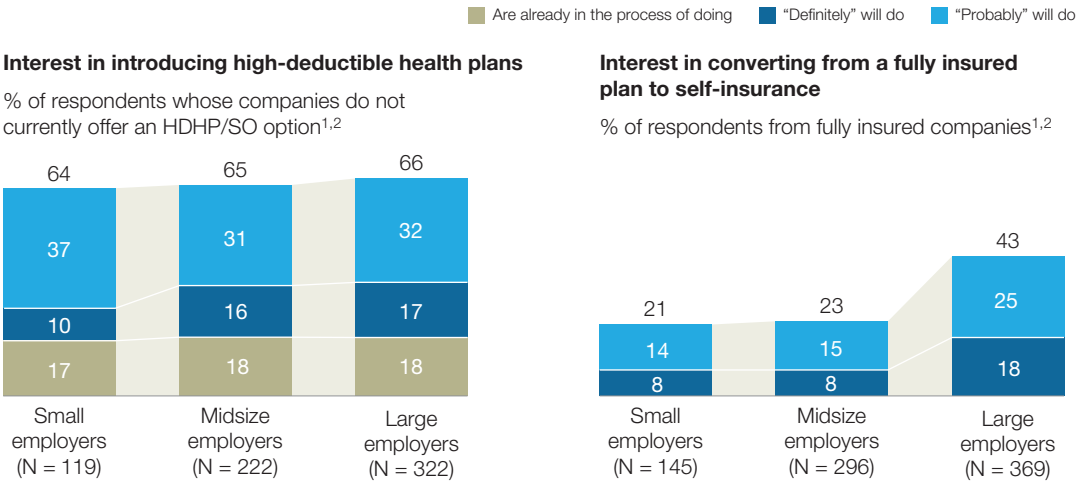
Distribution of health plan enrollment for covered workers, by plan type (selected years)



HDHP/SO, high-deductible health plan with a savings option; HMO, health maintenance organization; POS, point of service; PPO, preferred provider organization.
[1] Percentages do not always sum to 100 because of rounding.

Source: Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey

EXHIBIT 2 Employers continue to be interested in cost-shifting and self-insurance



[1] "Small" employers have fewer than 50 employees, "midsize" employers have 50 to 499 employees, and "large" employers have 500 or more employees. Percentages shown within the bars do not always sum to the totals at the top because of rounding.
[2] See the appendix, which begins on p. 11, for definitions of the specific respondents who were asked to answer these questions.

Source: McKinsey 2016 Employer Health Benefits Survey

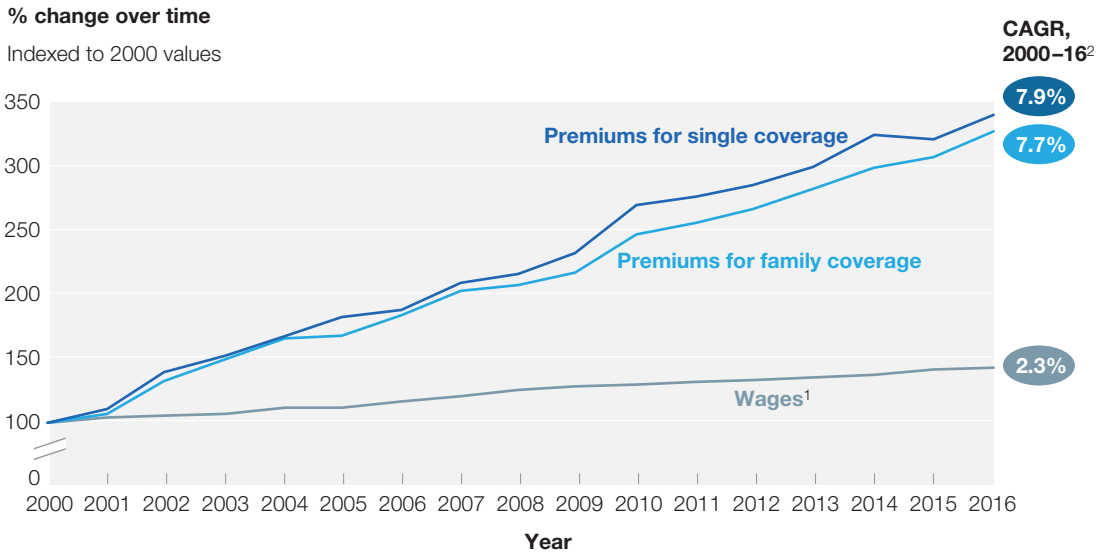
by employees. About one-third reported that their companies currently offer HDHPs, and two-thirds of the others said their companies are in the process of introducing those accounts or plan to do so (Exhibit 2). Interest in HDHP adoption was similar across company sizes.

Cost-shifting is also occurring in other ways. According to a report from the Kaiser Family Foundation, the proportion of workers with single PPO coverage who have in-network deductibles above $1,000 rose from 12% in 2006 to 38% in 2016.[7] Furthermore, over the past 15 years, employees' overall healthcare costs have increased much more rapidly than earnings have.[8] In 2016, average employee contributions to premiums were more than three times what they had been in 2000 (premiums for both groups were indexed to 2000 values); in contrast, wages rose only about 40% during the same period (Exhibit 3). Thus, many employers may be reaching the limit of how much cost they can shift to employees.

Self-insurance

Many large companies use self-funded ASO plans as another way to reduce costs. For employers with a few hundred employees or more, these plans avoid many of the expenses associated with a fully insured plan, and present limited risk and cash flow concerns. They may also offer greater claims transparency and benefits flexibility. According to the Kaiser report, the proportion of workers in companies with more than 200 employees who are in self-

EXHIBIT 3 **Since 2000, employees' premium contributions have increased more than three times faster than wages**



CAGR, compound annual growth rate.
[1] Projected for 2016 based on three-year CAGR trend.
[2] For wages, CAGR is based on latest available data from 2000–15. CAGR for 2016 was projected on CAGR from the three previous years.

Source: Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey; Bureau of Labor Statistics

insured plans increased from 67% in 2000 to 83% in 2010.[9] The same report noted that in 2016, 94% of workers in companies with at least 5,000 employees were covered by plans that were partially or completely self-funded. In our survey, almost half of the respondents from the few large companies that were not already self-insured said that they would "definitely" or "probably" make the switch in the future.

To date, smaller employers have been less likely to adopt self-insured plans. The Kaiser report noted that as of 2016, only 13% of covered workers at companies with fewer than 200 employees were insured through partially or completely self-funded plans, reflecting the higher risks these plans present to small employers.[10] Our survey also found that few small or midsize employers use self-funded plans, but more than 20% of the respondents from fully insured small or midsize companies said their organizations "definitely" or "probably" will adopt self-insured plans in the future (see Exhibit 2).

Employers seek transformative healthcare models

As employers search for the next generation of cost-saving methods, they appear to be interested in a number of options:

- New delivery models, such as high-performance networks that include a limited number of quality-credentialed providers in return for lower premiums, lower out-of-pocket costs, or both.[11]
- New payment models—including accountable care organizations (ACOs) and episode-based payments—that can help reduce the cost of care.
- New funding models, such as self-insured hybrids that combine the cost advantages of self-funding with stop-loss coverage and payment predictability and thus make self-insurance more viable for small and midsize employers.

These approaches are already showing potential benefits. About half of the networks offered through the public exchanges are narrow, and non-narrow plans are typically 18% to 34% more expensive than narrow plans.[12] Since 2000, innovative payment models have transitioned from pilots to large-scale efforts (e.g., the Arkansas, Ohio, and Tennessee multipayor episodes programs and Walmart's bundled payments for cardiac and spine surgery). Savings with these models vary but appear to average between 5% and 10%.[13] (Experience to date with self-insured hybrid products is too limited to allow conclusions to be drawn.)

Interest in these models is high

About three-quarters of all the respondents indicated interest in at least one of the innovative models (Exhibit 4). The highest interest was reported for new payment models, such as ACOs and episode-based payments. Interest in new delivery models was somewhat lower. However, the survey results do not suggest that employers are committed to any specific approach; rather, most respondents indicated that they were interested in exploring several of these options, even though some of the approaches remain relatively untested. For example, the respondents who reported interest in new delivery models were also likely to report interest in new payment models and vice versa.[14]

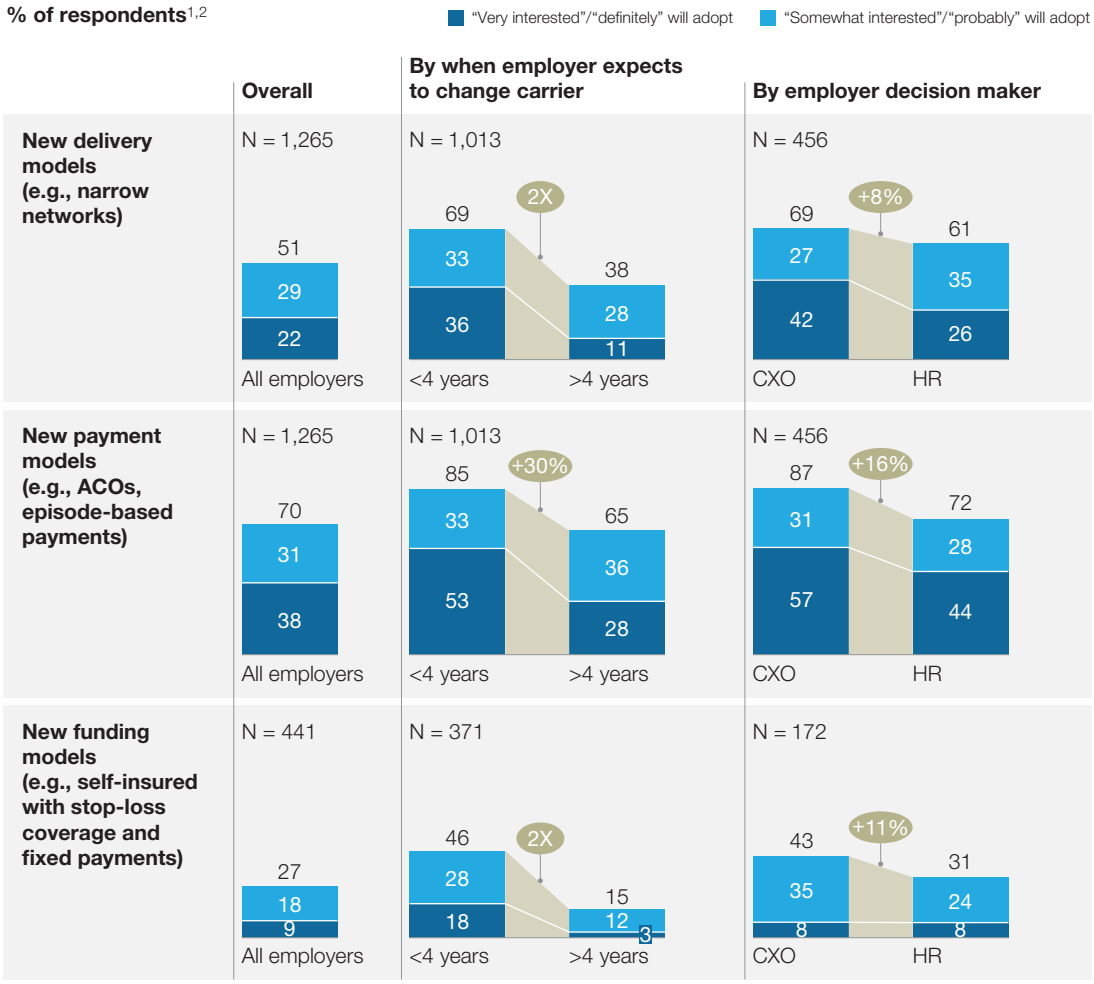
Twenty percent of the respondents from fully insured small companies, and 33% of those from fully insured midsize companies, said they were interested in converting to a new funding

model. In the immediate addressable market—that is, executives from companies that expect to change carriers before 2020—interest in innovative models was especially high: almost 90% expressed interest in at least one model. This finding suggests that employers actively considering alternative carriers may have heightened concerns about cost management.

Interest also varied based on the respondents' corporate roles. C-suite executives were 8 to 16 percentage points more likely to be interested in new delivery, payment, and funding models than HR managers were.

Interest in innovative models has intensified over the past several years. Since 2011,

EXHIBIT 4 **Employer interest in innovative healthcare models is substantial**



ACOs, accountable care organizations; CXO, C-suite executive; HR, human resources.
[1] Percentages shown within the bars do not always sum to the totals at the top because of rounding.
[2] See the appendix, which begins on p. 11, for definitions of the respondents who were asked to answer each of these questions.

Source: McKinsey 2016 Employer Health Benefits Survey

employer interest in new delivery models has nearly doubled; interest in episode-based payments, a form of payment innovation, has tripled (Exhibit 5).[15]

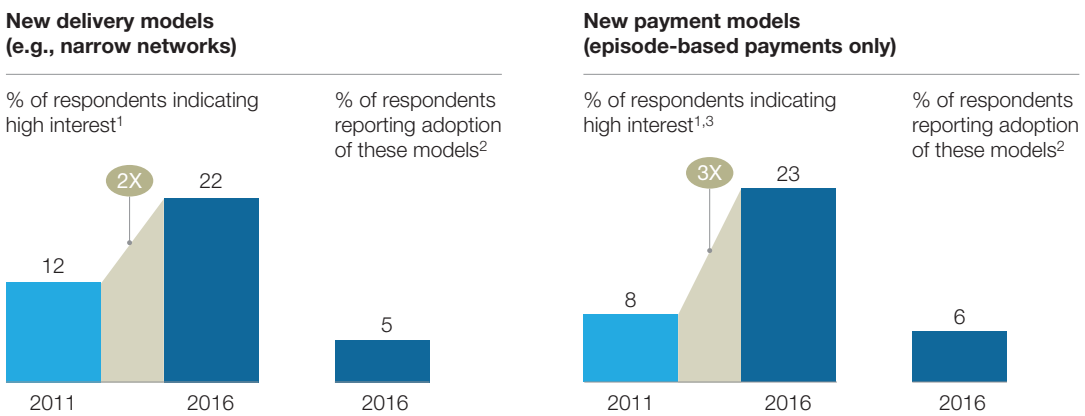
Early adopters were more likely to report cost savings

Less than 6% of the respondents indicated that their companies had already adopted any of the new delivery and payment (specifically, episode-based) models,[16] but these respondents were more than twice as likely as others were to report having achieved significant savings in healthcare costs over the past three years (Exhibit 6). This finding may simply reflect that the early adopters respond more aggressively to rising costs and could have controlled their healthcare spending through other means. However, it may also indicate that the new models offer a savings opportunity to other employers.

Implications for payors

Now that increased employee cost sharing and large-employer self-funding have become the status quo, we anticipate that many employers will turn to innovative options for controlling healthcare costs. Their interest in innovative approaches creates both opportunity and risk, and thus payors are faced with several complicated decisions: For example, how should they proceed? And which models and opportunities should they pursue, particularly given the significant development time? Previous experience with HMOs has shown that when momentum wanes, employer interest can markedly fall. However, innovations can sometimes evolve rapidly following a "trigger" event (e.g., if large or prominent employers adopt a new model, compelling evidence of sustained cost decreases emerges, regulations change, or even greater cost pressures on employers arise).

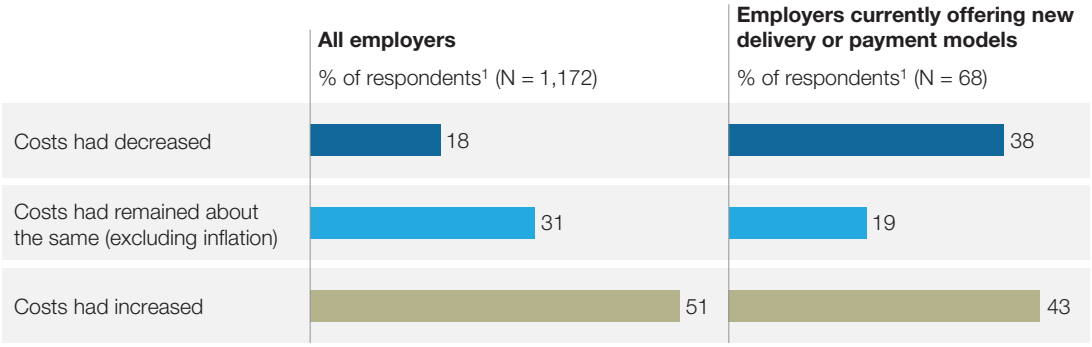
EXHIBIT 5 **Employer interest in new delivery and payment models has grown**



[1] Definitions used in the two surveys differed somewhat, but the numbers shown represent the percentage of respondents who said they were "definitely" interested or were "very confident" they would be interested in offering narrow network/episode-based payments.
[2] This question was asked only in 2016.
[3] Because we asked about only episode-based payments in 2011, the comparison here is with the respondents who expressed high interest in that payment innovation in our more recent survey; the 2016 percentage does not include respondents who said they were interested in other new payment models but not episode-based payments.

Source: McKinsey 2016 Employer Health Benefits Survey; McKinsey 2011 Employer Post-Reform Survey

EXHIBIT 6 **Early adopters of innovative models were more likely to report cost savings**



[1] See the appendix, which begins on p. 11, for definitions of the respondents who were asked to answer each of these questions.
Source: McKinsey 2016 Employer Health Benefits Survey

Payors that want to succeed with innovative approaches—regardless of whether they are new delivery, payment, or funding models or other new ideas, such as benefits redesign[17]—should take three actions. First, they should analyze and understand the opportunity based on their customers and competitive dynamics. Second, they should create a product architecture and go-to-market strategy that appeals to employers' desire for innovation and is tailored to the payors' specific markets and competitive position. Third, they should support these new offerings with the education and post-sale capabilities required to empower brokers, employers, and employees.

Analyze the opportunity and risk

To understand the potential impact of an innovative model, payors should know how employers perceive its value and the resulting preference for or likelihood to use the model, and weigh those factors against their own ability to compete and win with that model in each market. Employers' perceived value for a given model depends on two factors: the actual value of the cost savings opportunity (which can be determined by factors such as the employer's cost trend) and each employer's behavioral characteristics, such as level of paternalism and focus on talent. These elements can be used to segment employers and determine their likely perceived value for a given model. For example, a large retailer facing high cost pressure might perceive any opportunity to reduce costs as having very high value; a law firm facing heavy competition for talent might put less stock in controlling healthcare costs with benefit or network changes.

Once the employers' perceived value is understood and segmented, payors should assess their ability to compete in providing the new model and how that ability may differ across employer subsegments. For example, a small payor might be well positioned to offer a regional narrow-network product for small businesses, thanks to its provider relationships. That same payor, however, may lack the ability to build an effective episode-based payments

program around "centers of excellence" across multiple states.

Bringing together employers' perceived value and their own competitive position, payors can evaluate the business impact of potential innovative offerings. Payors should map these factors for their employer base and determine which subsegments may be at risk to competitors (including new entrants) with stronger offerings. Payors should also look at the market more broadly to determine if they could win more accounts by developing a new model (Exhibit 7).

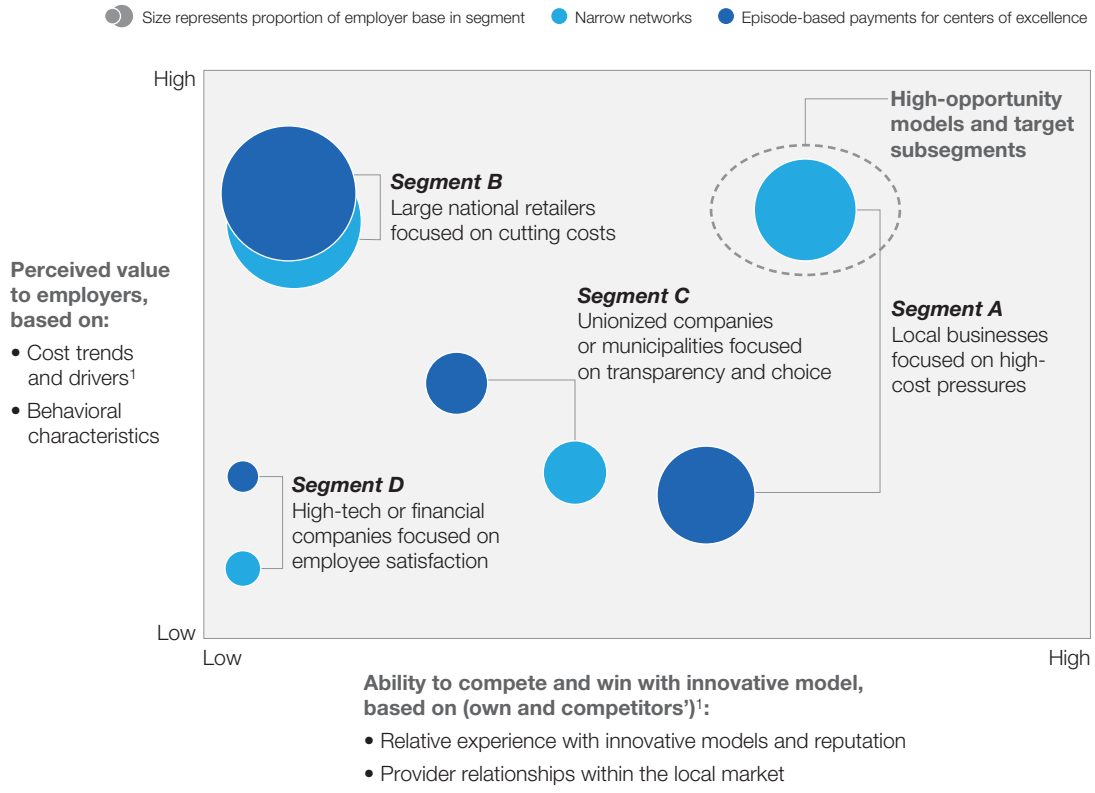
Build tailored product offerings

Based on this analysis, payors can determine which of the innovative models best suit their position and market aspirations. Among the factors payors should consider when creating new offerings are these:

Delivery. Payors should understand the tradeoffs between network adequacy, quality of care, and cost at the provider level. This understanding will determine which providers to target for narrow networks and will influence how employers and employees are likely to react.

EXHIBIT 7 **Payors can use segmentation to identify high-opportunity approaches**

Illustrative innovative model: Market-opportunity mapping for a small regional payor



[1] Drivers of perceived value and ability to compete/win will differ by innovative model.

Payment. To assess potential payment innovations, payors should identify the ones most likely to be attractive to its corporate customer base and evaluate whether the models should be targeted to a specific region (such as a local ACO offering) or more broadly as part of a national network (e.g., carve-outs of episode-based payments for specific conditions).

Funding. Payors should develop products for small and midsize employers that combine cost savings with payment regularity and that minimize risk to the companies, such as self-funding "hybrids" with stop-loss and fixed monthly claims payments.

Benefits redesign. Payors should investigate which types of employers are most likely to be interested in benefits redesign and what types of changes they are willing to contemplate. For example, a small local business may be more willing to contemplate significant changes to its benefits package than a company with a largely unionized workforce.[18]

Support new offerings with education and capability building

The ability of payors to smoothly manage transitions to innovative models will be a major determinant of their ultimate success. Thus, clear communication to both brokers and employers about how the new products work will be an important part of a payor's go-to-market strategy. Clear, accountable reporting about the savings achieved is also crucial. Furthermore, payors may want to increasingly engage the C-suite, which may have more interest in innovative models than some HR decision makers.

Equally important to enticing employers to adopt these innovations is education. Both employers and employees must be taught how to understand and navigate their benefits easily. If the new models are difficult to use or have a negative impact on quality of care, they may fail despite their cost advantages. Thus, innovative models that affect employees directly, such as narrow networks or benefits redesign, should be supported by convenient, intuitive navigation tools. In addition, the introduction of self-funding "hybrid" models to smaller employers will require that the companies be given easy-to-use reporting capabilities to help them understand their claims experience.

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Although the adoption of innovative models has been limited to date, employers are expressing growing interest in a wide variety of new offerings. And while some early adopters have achieved promising results, there is no consensus yet about which models are the most effective, leaving payors without a clear direction for developing new offerings. However, cost pressures will continue to be top-of-mind for many employers. Whether the next wave of healthcare innovation is ultimately fueled by the models discussed here or by alternatives that will emerge in the future, payors that prepare for potential disruption in the benefits landscape and determine how they can best address employer needs will be optimally positioned to succeed.

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For more information about benefits redesign, see "Why understanding medical risk is key to US health reform." McKinsey white paper. April 2017 (updated).

FOOTNOTES

[1] HDHPs require consumers to pay considerably more out of pocket for healthcare before any expenses are covered by insurance (on average, about $4,300 to $4,400 for a family of four). However, they typically have lower premiums than other types of health insurance. Some employers help employees establish health savings accounts to make it easier for them to pay the higher out-of-pocket costs.

[2] Keehan S et al. National health expenditure projections, 2014–24: Spending growth faster than recent trends. Health Affairs. 2015;34:1407–1417. Hartman M et al. National health spending in 2013: Growth slows, remains in step with the overall economy. Health Affairs. 2015;34:150–160.

[3] The total number of survey participants was 1,546, but some of the respondents indicated that their companies did not offer employee health benefits. In this paper, the numbers we cite pertain to the respondents whose companies did offer such benefits. Additional details about the survey's scope and methodology can be found in the appendix, which begins on p. 11.

[4] In our survey, 23% of small employers, 16% of midsize employers, and 14% of large employers reported annual increases above 10% per employee; 24%, 15%, and 13%, respectively, expect this trend to continue. Part of this increase above healthcare cost trends is likely driven by "deductible leveraging" (as underlying health expenses increase, employers with higher-deductible plans see higher proportional increases in their share of expenses, resulting in premium growth above the rate of growth in total expenses).

[5] The Bureau of Economic Analysis estimated 2.9% annual growth of current-dollar GDP for 2016.

[6] Although some survey respondents reported interest in reducing benefits coverage in response to rising costs, the share of firms reducing coverage has slowed. The percentage of firms offering health benefits decreased from 68% in 2000 to 57% in 2013 and 56% in 2016.

[7] Kaiser Family Foundation/Health Research & Education Trust. 2016 Employer Health Benefits Survey.

[8] Annual employee contributions to single and family coverage premiums were derived from the Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey. Median earnings of full-time employees were obtained from the Bureau of Labor Statistics. Employee contributions to premiums have grown at an average annual rate of 7% to 8% a year since 2000, while earnings have grown approximately 2% per year during that time.

[9] Kaiser Family Foundation/Health Research & Education Trust. 2016 Employer Health Benefits Survey.

[10] Kaiser Family Foundation/Health Research & Education Trust. 2016 Employer Health Benefits Survey.

[11] Knott D et al. Maximizing value in high-performance networks. McKinsey white paper. July 2013.

[12] Based on McKinsey Healthcare Reform Center analysis.

[13] Published reports of savings achieved with episodes-based payment vary from about 3% to more than 20%. (See, for example, the CMS report, "CMS bundled payments for care improvement initiative models 2-4: Year 2 evaluation & monitoring annual report" (August 2016) and the article by Navathe AS et al, "Cost of joint replacement using bundled payment models," (JAMA Internal Medicine. January 3, 2017).) McKinsey research and analysis of the reports suggest that, on average, savings are typically between 5% and 10%.

[14] In our survey, more than 90% of employers interested in narrow networks were also interested in new payment models (e.g., ACOs or episode-based payments); similarly, more than 65% of employers interested in new payment models were also interested in narrow networks.

[15] Comparison is between the 2011 McKinsey Employer Post-Reform Survey and the 2016 McKinsey Employer Health Benefits Survey.

[16] Survey data is not available for the early adopters of funding models such as self-insured "hybrids."

[17] Benefits redesign is another type of innovation that, to date, has not received much attention from employers. It customizes the level of cost sharing based on how much control consumers have over the underlying health problem and how able they are to absorb the cost of care. For example, using this type of approach might require consumers to pay the full cost of discretionary procedures, but they would be reimbursed for almost the full cost of catastrophic care not related to an underlying, controllable chronic condition. We did not include benefits redesign in our survey because it is currently less well known and there is less certainty about exactly what form it might take. However, it will likely be included as an option as employers contemplate their next wave of innovation. (For more information about benefits redesign, see the article, "Why understanding medical risk is key to US health reform." McKinsey white paper. April 2017 (updated).)

[18] Singhal S, Jacobi N. Why understanding medical risk is key to US health reform. McKinsey white paper. April 2017 (updated).

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Appendix: Employer Health Benefits Survey

The McKinsey Employer Health Benefits Survey polls employers to generate insights on benefits strategies; benefits purchasing preferences, including opinions on health insurer mergers; outlook on reform; perspectives on defined contribution private exchanges; interest in alternative funding arrangements; and small-group trends (e.g., professional employer organizations, the Small Business Health Options Program (SHOP), and level-funding arrangements).

The survey, most recently conducted in 2016, reached about 1,550 employer benefits decision makers, including roughly 700 C-level executives and 450 benefits leaders. The sample was weighted to match the profile of employers at the national level using two methodologies:

(1) the number of employers in each employer size and industry cell, and

(2) the number of employees in each employer size and industry cell.

Respondents were distributed across employer sizes: 400 in small-group (2–49 employees), 450 in mid-group (50–499), and about 700 in large-group (500+). The survey included respondents from all four census regions and 2-digit NAIC industries. Additionally, respondents included employers with varying benefits structures, for example, employers with differential part-time, unionized, and/or low- or high-income employees.