

Winning strategies for participating in narrow-network exchange offerings

In the post-reform era, payors will attempt to capture savings by creating limited networks with reduced reimbursement rates. To respond, health systems need a clear understanding—market by market—of their competitive advantages and of when, if, and how to trade price for volume.

Implementation of the Patient Protection and Affordable Care Act (ACA) will usher in dramatic shifts in health insurance coverage over the next decade. For health systems, one of the most important changes will be the significant growth of the individual insurance market. In 2010, only 14 million people—about 5 percent of the US population—belonged to this segment. By 2019, this figure is likely to rise to 24 to 36 million (7 to 11 percent of the population),¹ primarily because of two related trends: first, many currently uninsured patients will gain coverage on the health insurance exchanges, driven by the individual mandate and federal insurance subsidies; second, some workers will likely move from employer-sponsored insurance (ESI) to individual plans on the exchanges.

Our research suggests that there are likely to be important differences between the consumers who purchase individual coverage on the exchanges and today's typical commercial population. For example, purchasers of individual exchange plans are apt to be more price-sensitive and more willing to accept network restrictions in return for more affordable premiums. To be competitive in this new price-sensitive marketplace, payors are looking to lower the cost of their individual plans through the use of limited (narrow or tiered) networks.

Many health systems believe that they will need to offer rate cuts in return for membership in these limited networks. In other words, they will have to accept a discount in order to capture additional individual commercial volume. However, health systems may find it difficult to determine how they can capture value effectively from the growing but price-sensitive individual market and, in particular, how they should respond to narrow- or tiered-network exchange offers from payors.

Why is it critical for health systems to get their exchange pricing strategies right?


First, significant value is at stake. Our reform modeling suggests that growth in the individual exchange population could represent roughly 300+ basis points in additional EBITDA margin for the average health system.² However, every 10-percent discount on exchange pricing (relative to commercial) that an average health system offers will lead to a reduction of approximately 100 basis points in overall EBITDA margin.

Second, rapid growth in the individual exchange segment will occur against a backdrop of substantial threats to health system profitability, including declining growth in government reimbursement rates, shrinking commercial risk pools, and an ongoing shift

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¹This range is based on varying employer opt-out and consumer uptake assumptions.

²A roughly 300+ basis-point margin expansion represents the additional utilization driven by expanded coverage, as well as the impact of coverage shifts (i.e., health systems that are able to capture a substantial share of the growth in the individual segment may be able to drive increased revenue per patient by shifting their patient mix toward commercially insured patients). In the accompanying article, "The impact of coverage shifts on hospital utilization" (p. 73), the estimate of a 100 basis-point margin expansion represents only the additional utilization that may result from the uninsured gaining coverage.



from inpatient to outpatient care. To remain competitive in the new environment, health systems will need to implement large-scale transformation programs to significantly reduce their operating costs. However, capturing a sufficient share of the individual exchange growth could also partially offset these threats.

This article lays out three key steps that can help health systems navigate the challenging path ahead. They should evaluate local market factors influencing the magnitude of the discount required so that they can increase their share of the individual exchange segment. They should calculate a set of “break-even” price and volume points to inform their exchange pricing discussions. And they should bring to bear the full range of contracting levers at their disposal to maximize value.

New pressures on hospital reimbursement

Implementation of the exchanges is likely to unleash new pressures on health system reimbursement rates over the next decade, pressures driven primarily by price-sensitive shopping on the exchanges and subsequent stress on payors’ cost structures. We are already seeing these trends play out in many markets, and they are expected to accelerate when the exchanges come online.

Consumer choice: prioritizing price

Our research³ suggests that many cost-conscious consumers on the exchanges will select individual plans with a comparatively low price within each tier, even if the plans include high deductibles or network restrictions. In repeated simulations of the exchange

purchasing experience, more than half (55 percent) of the participants chose lower-cost Bronze or Silver plans with narrow or tiered provider networks (Exhibit 1), while 24 percent chose a non-broad network, even within the richer Platinum and Gold tiers.⁴

The exchanges will facilitate price-sensitive shopping behavior by making cost data more accessible—typically, by providing standardized information about numerous plans in a centralized display that increases transparency and promotes comparison shopping on many financial features (e.g., premiums and co-pays). Consumers on the exchanges will be free to make trade-offs to suit their unique preferences, and those who prioritize cost will find numerous less-expensive options as long as they are willing to accept network restrictions and/or high deductibles. (By contrast, most commercial group plans tend to provide comprehensive, broad-network coverage because employers must accommodate their diverse employee base.)

Pressure on payors’ cost structures

We expect many challenges to payors’ administrative and medical cost structures from the provisions of the ACA. Although most payors will probably employ a range of tactics to reduce costs—including utilization management, disease management, benefit design, and administrative cost control programs—their use of network configuration to lower both per-unit pricing and utilization is of particular relevance to health systems.

At least initially, payors are likely to use limited networks to exploit existing provider cost differentials and migrate care delivery away from especially high-cost settings. In some

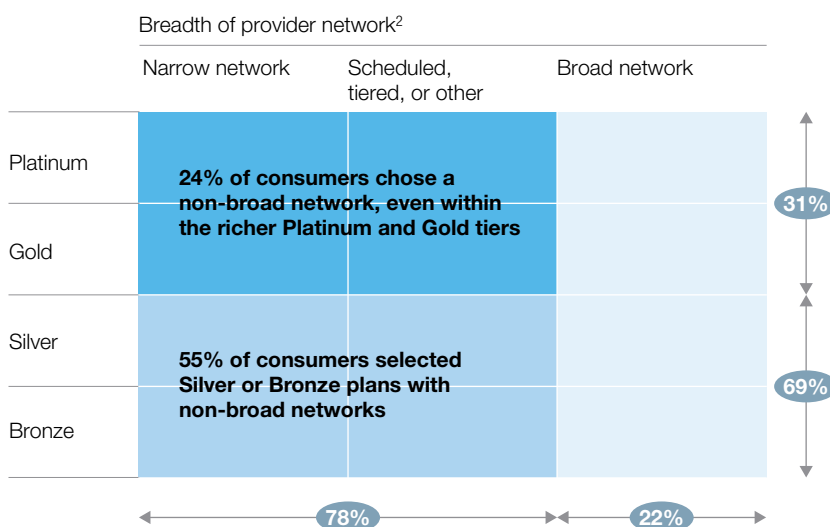
³McKinsey Exchange Simulation. See the appendix for more detail.

⁴The exact proportion of consumers on the Exchange Simulation willing to accept network restrictions varied with the availability of those networks, the degree to which the networks were limited, and the price savings associated with them.

EXHIBIT 1 Among simulation participants who chose to buy, most selected lower-cost options, even with restrictions

22,000 McKinsey simulation participants, representing 46,000 covered lives

● Percentage¹ of consumers selecting this option



¹Percentage represents averages across simulations. Individual simulation percentages varied, depending on portfolio compositions, relative pricing, and other factors.

²Breadth of provider network across primary care physicians, hospitals, and specialists. Does not pertain to pharmacy networks. Note: These figures are not meant as a prediction of the future individual market; rather, they represent consumers' stated decisions under a given set of product options across a range of simulations.

Source: McKinsey Consumer Exchange Simulation 2011-2013

situations, a payor may not be able to exclude a certain health system (to ensure sufficient network capacity, for example, or because the system provides critical service lines that are impossible to exclude from insurance plans in that market). However, in all other cases, health systems may need to consider a rate cut in exchange for inclusion in a limited network.

Over time, we expect payors to pursue more sophisticated, collaborative approaches with providers that move away from fee-for-service reimbursement and offer incentives to providers to maximize the effectiveness and efficiency of care delivered.


Three steps to winning on the exchanges

Given the value at stake, a careful, structured approach to developing exchange pricing strategies is required:

1. Understand your local markets⁵

Health systems must carefully consider a number of difficult questions when planning their long-term exchange strategies. How price sensitive will consumers be in their local markets? How rapidly will those markets shift toward limited networks? How much reimbursement (if any) should a health sys-

⁵The scope of the appropriate "local market" to evaluate will, of course, differ depending on a variety of factors, including demographics, population density, how far patients travel for various services, and the proximity of other potentially competing health systems.



tem sacrifice to capture this volume? How much margin could be at stake in a given market if a health system does not participate in the limited networks—and others in that market do? To what extent are a health system's service offerings non-excludable from any network?

There is no single, correct answer to any of these questions because the healthcare landscape—including reimbursement pressures—varies. At the local market level, a number of factors, including the rate of growth in the individual market, consumer behavior and perceptions, market structures, capacity utilization, and local exchange design and regulations, could affect the growth of limited networks.

Health systems therefore need to have a strong understanding of these local market dynamics before entering into negotiations with payors and determining acceptable and/or necessary discount levels. Factors that they should consider include:

Growth in the individual exchange segment

The growth rate for the individual segment is apt to differ greatly by locality; some will have much higher uptake than others (Exhibit 2). Variability is likely driven by regional differences in demographic and other factors, such as the number of uninsured patients, income distribution levels, state regulations affecting individual insurance premiums, and current industry and employment mix. When estimating growth in the individual exchange population in local markets, we often use the McKinsey Predictive Agent-based Coverage Tool (MPACT) to develop a range of scenarios, based on

varying employer opt-out and consumer uptake assumptions. (See the appendix for more information about MPACT).

Consumer behavior

Narrow and/or tiered networks will succeed only if consumers are willing to accept them. As discussed earlier, nearly two-thirds of participants in a simulated exchange experience were willing to accept restrictions in their plan design in return for lower premiums. However, consumer willingness to accept network restrictions varies widely across providers. In repeated simulations of the exchange purchasing experience, the proportion of likely exchange participants who stated that they would either change insurance plans or pay extra to go out of network if their insurer removed their hospital from their network varied widely (Exhibit 3). Hospitals that are well known for their quality or clinical excellence, or that have a highly respected brand within their community, inspire more consumer loyalty than other facilities. The extent to which pricing will outweigh consumer loyalty is therefore likely to vary from health system to health system and from locality to locality, as well as by product tier within a given locality.

Market structure

Market structure is an important factor determining the degree to which payors will be able to drive discounts on exchange products. For example, a rural health system with more than a 75-percent market share would be difficult to exclude from a limited network, especially if smaller, competing hospitals have capacity restrictions. Similarly, a health system with unique offerings (such as the only facility in a region that can provide advanced oncology services) will be difficult to exclude from a limited network.

³McKinsey Exchange Simulation. See the appendix for more detail.

⁴The exact proportion of consumers on the Exchange Simulation willing to accept network restrictions varied with the availability of those networks, the degree to which the networks were limited, and the price savings associated with them.

However, it is important to remember that each market is different—there are no hard rules around the way each market will respond in the presence of the exchanges.

Capacity utilization

Hospitals that are using only a small amount of their available capacity are generally eager to capture additional volume (or defend against erosion of existing volume) so that they can spread their fixed costs over more patients. These facilities may be willing to

offer deep discounts to payors in exchange for more volume. By contrast, facilities with more balanced capacity utilization may see less value in trading price for volume.

Local exchange design and regulation

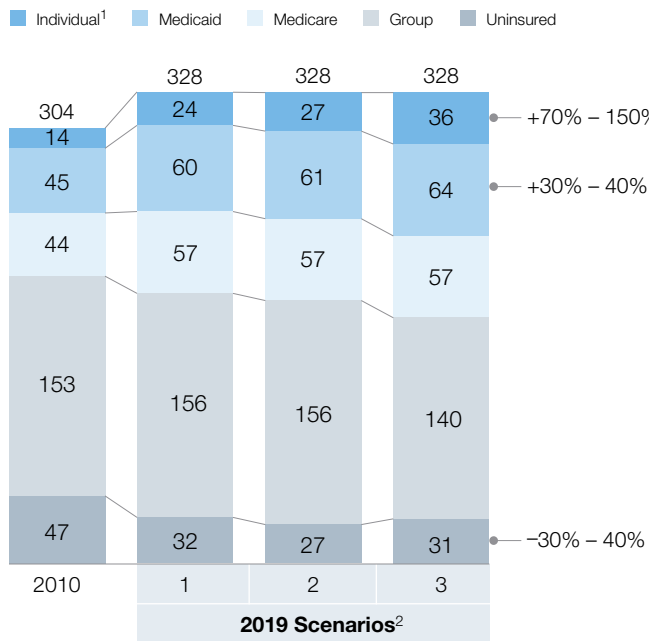
The exact designs of the federal and state exchanges will not be known until the fall of 2013. Given this uncertainty, health systems should actively track exchange development in their markets. In particular, it is important for health systems to evaluate how plan offer-



EXHIBIT 2 Reform will dramatically increase individual consumer health coverage

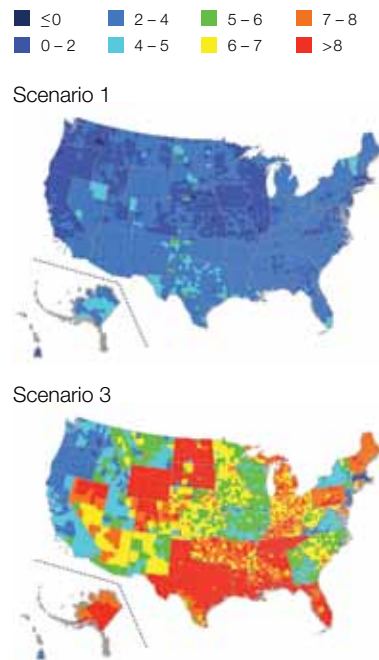
US population by coverage type

Millions of members, 2010 and 2019



Increase in share of individual coverage

Percentage points, 2010-2019



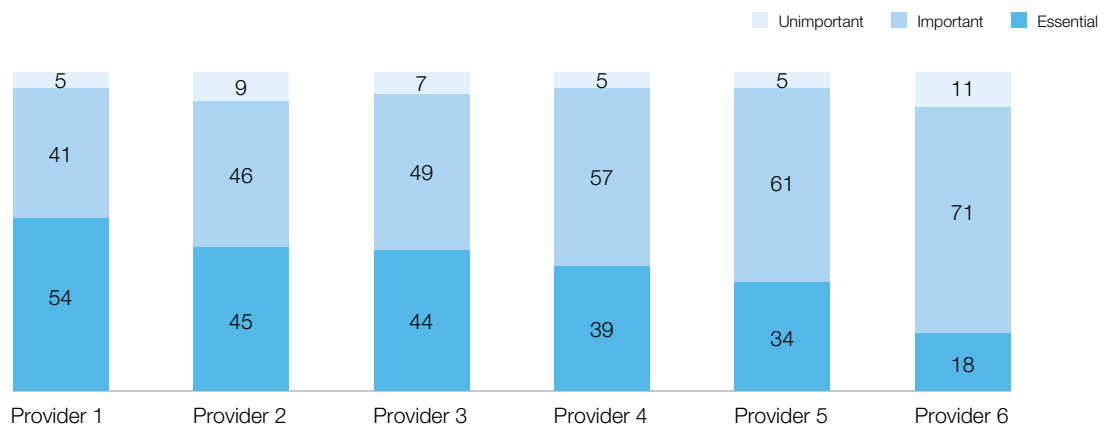
¹Approximately 75% of future enrollment in the individual market nationally is likely to be through the exchanges (25% off the exchanges).

²Scenario 1: lower employer opt-out, weaker consumer uptake; scenario 2: lower opt-out, stronger uptake; scenario 3: higher opt-out, stronger uptake.

Source: MPACT version 5.0; McKinsey analysis

EXHIBIT 3 Consumers place varying levels of importance on whether certain hospitals are included in their network (disguised state example)

Importance that a specific hospital or health system¹ is within a plan's network (%)



¹May or may not be the "preferred hospital" to which a participant was affiliated.

Source: McKinsey Consumer Exchange Simulation 2012-2013 (state-level data)

ings will be regulated on the exchanges. For example, some states may require standardized benefit design, and the resulting competition on price would be based almost entirely on network cost and restrictions.

Pricing regulation

State regulations on health system pricing will also shape pricing strategy. Does the state currently have balance billing limitations? What are the usual and customary restrictions on billable charges? And based on the above, what level of reimbursement will a health system receive for patients who seek care out of their networks?

2. Calculate "break-even" points to inform negotiations

The next step is to calculate a series of "break-even" price and volume points that will inform exchange pricing discussions,

taking into account local market factors, current commercial and government reimbursement rates, overall health system financial and operational goals, and other effects of reform. In particular, health systems that are contemplating offering deep discounts to participate in limited networks will need to carefully quantify whether they can compensate for the discounts' impact through volume growth, pricing on the commercial book of business, and/or ongoing cost reductions.

To begin this exercise, health systems should understand the price and volume levels for the individual exchange population that would enable them to achieve their EBITDA targets for a given market, as well as the price and volume levels that would enable them to simply maintain their current EBITDA (across all lives, and across those shifting to the exchanges). In other words, health

systems should understand what the individual exchange price and volume levels will need to be (relative to commercial) to offset expected reductions in government reimbursement growth rates, potential cannibalization of patients with group commercial coverage, and any expected increases in balance after insurance, while taking into account increased revenue from the currently uninsured who will move onto the exchanges and any reduction in costs that the health system can reasonably expect to capture through operational improvements.

Next, the health systems should understand the price and volume levels at which they may be better off remaining outside the network. If a payor establishes a limited network for an individual exchange product in a market, what could happen to health systems that declined to participate in that network? The systems might lose volume in the individual segment if some of their patients bought such products and switched to in-network facilities for elective care. However, these systems would probably maintain some out-of-network (OON) individual volume through emergency department (ED) admissions. The reimbursement level for OON care (emergent or non-emergent) might be higher than current commercial rates—in some cases, even at or near charges. However, it is important to bear in mind that, in many states, payors bear no obligation to pay providers for non-emergent care if they are not in the network. Some payors may refuse to honor a patient's assignment of benefits to an OON provider, compelling the provider to chase the patient for payment instead of being paid directly by the payor.⁶ The extent to which these billings benefit a health system will therefore depend, in part, on how

easily the health system can collect payments from the patients involved.

A health system contemplating the price–volume trade-off associated with an exchange offer will therefore need to determine what proportion of the individual exchange segment it can expect to capture, whether that volume justifies the discounts given for exchange-predominant product types, whether the discount is sustainable (relative to competitors' ability to discount), and how the exchange offer compares with staying OON.

Thus, the key price and volume variables that health systems should consider when calculating these break-even price and volume levels include:

- The potential volume to be gained by joining the limited network, including the potential size of the exchange population, the percentage of exchange patients who will buy lower-cost, limited-network plans, the expected market share capture of the payor in question, and the proportion of elective (non-ED) volume covered by the limited network that will shift to in-network health systems.
- The OON opportunity cost, including the proportion of ED volume that will continue to be captured (and remain OON) if a limited network is formed in the market and the percentage of billed charges that will be reimbursed for OON ED services.
- The potential spread of discount pressure to the small group segment.
- Expected changes in bad debt levels in comparison with current commercial bad debt projections.



⁶Lucas CK, Williams MA. The rights of nonparticipating providers in a managed care world: Navigating the minefields of balance billing, reasonable and customary payments and the right to control care. Presentation to the American Health Lawyers Association. January 31, 2009.

⁷We use the Provider Reform Impact and Stress-test Model (PRISM) to project the impact of reform on hospital economics. See the appendix for more detail.

- The impact of underlying trends on health system economics (market-by-market), including reimbursement growth rate declines, expected coverage shifts, and utilization trends.⁷

These variables will always be subject to some uncertainty. However, health systems can make a range of assumptions about them (from worst case to best case) and

About the research and analysis

This article leverages proprietary research and analysis that McKinsey has conducted over the past 18 months. This appendix describes the major tools and data sources we used.

McKinsey's Consumer Exchange Simulation

With this tool, users (typically, payors) design a suite of insurance products that can then be sold on a simulated online exchange. Consumers browse the exchange, which highlights information on premiums, deductibles, coverage tiers, and other key product attributes, before making a selection. As of the end of 2012, nearly 150,000 consumers across the United States had participated in simulations. On average, it takes each consumer about 25 minutes to complete the process.

The first round of simulation requires about five weeks and typically involves about 4,000 local consumers between the ages of 18 and 64, who have incomes above 133 percent of the federal poverty level. An additional round can be conducted for users who want to test detailed product configurations and trade-offs.

The Exchange Simulation collects a wide range of demographic data about the participating consumers, as well as information on their current coverage, health status, and prior purchase behavior. Thus, the tool allows users to:

- Assess the impact of different product attributes (including brand name, price points, network designs, and availability of dental care or other

additional services) on consumer buying preferences and choices.

- See what types of consumers purchased their products, as well as the types that preferred competitors' products.
- Estimate how their product offerings would fare in terms of revenue, margin, medical loss ratio, and market share in a real market.
- Understand local market dynamics, competitive issues, and the effect of subsidies on insurance choices.

The "real" consumer feedback gives users unique insights into consumer preferences and what their behavior on the exchanges is likely to be, information that is not available through any other source.

Several payors have already used the McKinsey Consumer Exchange Simulation to support product design, off-exchange strategies, and strategies for handling the transition of existing members from employer-sponsored insurance to individual plans.

McKinsey's annual Consumer Health Insights (CHI) survey

This unique survey provides information on the opinions, preferences, and behaviors of more than 14,500 consumers, as well as the environmental factors that influence their healthcare choices. The survey also enables insights into the current market environment and can be used to make predictions

calculate the break-even price and volume levels for a range of scenarios. Among other advantages, this type of scenario planning enables health systems to identify the

discount level at which their participation in such a network does not confer financial benefits and forms a solid foundation for exchange pricing discussions with payors.

about the choices and trade-offs consumers are likely to make in the post-reform environment.

The CHI collects descriptive information on all individuals who participate in the survey and their households. It also assesses shopping behaviors; attitudes regarding health, healthcare, and the purchase and use of healthcare services; awareness of health reform; opinions about shopping for individual health insurance and using an insurance exchange; preferences for specific plan designs (including trade-offs among coverage features, such as benefits, network, ancillaries, service options, cost sharing, brand, and price); employee perceptions of the employer's role in healthcare coverage; attitudes about a broad range of related supplemental insurance products; opinions, use, and loyalty levels regarding healthcare providers; and attitudes and behaviors regarding pharmaceuticals and pharmacies.

We supplement the information from the CHI with data from other sources, such as information on a consumer's estimated lifetime value to a payor, consumer behavior, and marketplace conditions. This combination provides a holistic view of healthcare consumers that is not available through other means.

We have used CHI data in a range of customized analyses that address both current and post-reform healthcare issues. We expect that payors and others will primarily use the information in applications that assist with product design, marketing strategies, consumer segmentation, consumer targeting, network configuration design, and assessment of new channel opportunities.

McKinsey Predictive Agent-based Coverage Tool (MPACT)

MPACT is a micro-simulation model that uses a comprehensive set of inputs and a distinctive approach to modeling consumer and employer behavior to project how health insurance coverage may change post-reform. MPACT contains 300 million "agents" representing all residents of the United States. Each agent is characterized by his or her county of residence, type of insurance coverage, and eight demographic variables. Over the course of the micro-simulation, agents in each geo-demographic segment make health insurance purchasing decisions depending on their eligibility, prior purchasing behavior, demographics (including health risk status), subsidy eligibility, and penalty impact, among other factors.

Provider Reform Impact and Stress-test Model (PRISM)

McKinsey's PRISM model combines hospital financial data, MPACT county-level covered lives projections, McKinsey's national hospital operational benchmarking database, and information about the likely impact of legislated changes to project hospital performance market by market. Add-on modules enable projections of financial impact and service utilization at the level of clinical service lines (e.g., cardiology, orthopedics), bad-debt modeling, and a rapid, outside-in analysis of the projected impact of reform on hospital economics. PRISM has in-built flexibility to model a range of scenarios, based on reform and non-reform factors.

3. Maximize value beyond price and volume

Once health systems have established the break-even price and volume levels to inform exchange pricing discussions, they will need to bring to bear the full range of contracting levers available to maximize the value of the discount offers that come their way. Here are a few examples:

Contracting terms

Among the contracting terms health systems can use to mitigate the risks associated with limited-network discount offers are these:

- Volume thresholds for exchange products, associated with specific actions or payments that should occur if these thresholds are not met (e.g., an automatic price increase).
- Terms that limit the extension of exchange rates to other patient segments and/or forbid an automatic extension to new products.
- Terms that ensure the health system's inclusion in all limited-network products offered by the payor, to prevent the payor from forming exclusive relationships with other providers that might negatively affect the success of plans that include the health system.
- Bad debt protection, including a clear process for monitoring bad debt levels and provisions for any significant increases in bad debt.
- Covenants to re-open negotiations, especially if there is a high degree of cannibalization.
- Terms that ensure that the provider receives access to network performance data, including physician and hospital performance information.

Innovative reimbursement models

Many exchange offers will primarily be traditional fee-for-service rate agreements. However, health systems may want to consider using innovative reimbursement models (such as a performance bonus contingent on meeting agreed efficiency and quality targets) as a way to respond to payors' demands for lower fee-for-service rates. These models may be attractive to payors, since they incentivize lower-cost, higher-quality care.

Access

Health systems may want to consider offering payors preferential access or services for their members (e.g., dedicated private rooms or same-day appointments) in exchange for higher reimbursement rates.

Co-branding

Our research has shown that brand familiarity is likely to play a key role in consumer choice on the exchanges. Consumers on the exchanges will not pick their hospital, physician, and specialist to create a customized product (and price)—they will pick an insurance product. Health systems that already have strong brand recognition could develop highly competitive co-branded products with insurance partners or even their own proprietary branded products (using a white-box insurer backbone for the plan component). By offering a distinctive product on an exchange, a health system could potentially strengthen its ability to negotiate higher reimbursement rates.



Health systems that are able to capture a substantial share of the rapidly expanding individual exchange population may be able

to create distinctive value. The risk, however, is that in their eagerness to capture this opportunity, they will agree to unnecessarily steep discounts. As health systems develop their exchange pricing strategies, they must therefore have a clear perspective on how and when they will trade price for volume. Among other things, they must understand how distinctive their value proposition is in the local market, when it makes sense for them to compete for exchange patients (and at what discount), and when they may be better off charging higher reimbursement rates for OON volume. Furthermore, robust exchange pricing strategies should always be combined with other levers to drive systemwide value creation, including large scale clinical operations programs to reduce costs and improve quality of care.⁸ ○

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⁸For more information about such programs, see “Clinical operations excellence: Unlocking a hospital’s true potential” on p. 17.