

Healthcare Systems and Services Practice

# Against the odds:

How payors can succeed  
under persistent uncertainty





## INTRODUCTION

# Leading in an environment of persistent uncertainty

The health insurance industry in the United States continues to be defined by uncertainty. And, increasingly, it looks like uncertainty is here to stay—at least for the next several years. The new administration in Washington has promised regulatory and policy changes with the potential to significantly alter the healthcare landscape. New models of care delivery, from retail sites of care to virtual visits, are challenging the centrality of traditional institutions. As data becomes more accessible, new technologies and analytics capabilities are upsetting old ways of doing business. Consumerism continues its march, with digital technologies providing new fuel for disruption. And the shift of risk across the value chain through value-based care continues. All signs point to continued industry uncertainty, though the pace of transformation remains unclear.

Despite these disruptions, healthcare remains fundamentally important to our society. A few core themes will remain relevant, regardless of what changes lie ahead. Health insurers, like healthcare providers, have an obligation to help keep people healthy and ensure that those who are sick can receive high-quality care. The quest for affordability will remain paramount. The need to improve productivity and promote appropriate utilization will continue to be crucial. Moreover, healthcare will remain a vital cornerstone of the US economy. These truths give rise to the central task facing all healthcare stakeholders: to ensure the sustainability of our healthcare system over the long term. Payors will need to tirelessly pursue this goal if they want to succeed in coming years.

We hope that the insights in the articles that follow will provide guideposts to help you navigate this uncertainty. In this book, we begin by examining broad shifts in the industry. “The next imperatives for US healthcare” describes the two central requirements for ensuring sustainability: achieving rapid, dramatic gains in productivity and improving the functioning of healthcare markets through more effective demand- and supply-side incentives. “Where to compete in today’s healthcare market” provides advice on how health insurers can best identify where to concentrate their resources—both within their core health plan business and in adjacencies. “US health insurers: An endangered species?” challenges the notion that the confluence of disruptive forces presents an existential threat to the industry. Rather, the authors contend that successful health insurers could have their best days ahead. “Why understanding medical risk is key to US health reform” argues that our healthcare system must align risks with the parties best positioned to influence them. This goal will require payors to develop appropriate financing mechanisms and provider reimbursement models for each category of health risk.

Following these pieces on macro trends, we profile five major forces to watch, including the narrowing of networks, the movement to value-based care, the creation of a robust market for retail healthcare, the transformation driven by digitization, and the growth in spending on pharmaceuticals. We then focus on specific lines of business, exploring dynamics within the commercial, individual, Medicare, Medicaid, and provider-led plan markets.

**Shubham Singhal**

Finally, we close with insights about key functional capabilities that payors must master to thrive in coming years: consumer engagement, digital sophistication, and organizational agility. In addition to describing our latest consumer research findings, we debunk common myths about healthcare consumers and explain how health insurers can offer a great customer experience. We then look at digital from two perspectives: how consumer-facing digital technologies could alter the healthcare industry and how health insurers can harness digital to improve operations. Our last article, “Why agility is imperative for healthcare organizations,” explores how healthcare leaders can cultivate

the ability to adapt quickly to respond to a constantly changing environment while maintaining organizational stability.

While the uncertainty that defines this time can produce heartburn, it has also created opportunities for new thinking and new solutions. We look forward to hearing your reactions to this collection of articles. Please feel free to reach out to any of our authors to discuss the implications of these insights for your organization. [O](#)

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# Thank you

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FUTURE OF THE MARKET:  
The big picture







# The next imperatives for US healthcare

*Two steps—increasing healthcare-sector productivity and improving healthcare-market functioning to better balance the supply of and demand for health services—would likely produce sufficient savings to lower medical cost inflation to the rate of GDP growth.*

Since 2010, the US uninsured rate has dropped from 17% to 11% of the population.<sup>1</sup> Some of the new episode- and population-based payment models are achieving savings,<sup>2</sup> and some categories of healthcare utilization have declined.<sup>3</sup> However, medical inflation still rises faster than GDP growth. There is little transparency into pricing, and, in many regions, the price dispersion for similar services exceeds 100%. All too frequently, the correlation between cost and quality is weak. Regulatory constraints often inhibit much-needed innovations. The health status of the population remains below that of most other peer countries.

Moreover, the average healthcare consumer now faces far greater financial exposure to medical costs. Between 2010 and 2015, employees' contributions to health insurance grew almost three times faster than wages.<sup>4</sup> Middle-class Americans are feeling this burden the most—their healthcare spending as a percentage of household income has increased 60% over the past 30 years, and their healthcare costs are now almost half of a typical mortgage payment.<sup>5</sup>

In other words, the US healthcare system is delivering less (through declining utilization) for more (higher spending), a phenomenon that runs counter to basic economic principles.

Within this context, there are three imperatives for improving the US health system's financial sustainability and the value it delivers:

- Achieve rapid—and dramatic—productivity improvements in the delivery of health services
- Improve the functioning of healthcare markets
- Improve population health

The third imperative may arguably be the most important for long-term sustainability, but it requires tackling social determinants of health (e.g., inadequate housing, food insecurity) and changing many people's attitudes about responsibility for their health,<sup>6</sup> factors largely outside the scope of health services companies, including insurers and providers. However, these organizations can and should take the lead on the first two imperatives, and thus our emphasis in this article is on them.

Our conservative estimates suggest that addressing these two imperatives through broad adoption of best practices could lower national healthcare expenditures by a minimum of \$284 billion to \$532 billion per year and reduce the annual growth of those expenditures by about 30%.<sup>7</sup> Achieving a reduction of this magnitude will not be easy, but the impact would be significant—medical cost inflation would likely fall and be roughly equivalent to GDP growth,<sup>8</sup> and the financial stress on individual Americans would be reduced. In addition, innovation beyond current best practices and the application of digital technologies have the potential to deliver substantially greater improvement.

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The footnotes for this article appear on p. 25.

## Achieve productivity improvements

Productivity improvements are the lifeblood of all industries, enabling them to deliver better products and services while reducing or carefully controlling prices. In the past few decades, for example, innovation enabled manufacturers to drop the average prices of laptop computers and cell phones by a substantial amount (Exhibit 1).<sup>9</sup> In both cases, the sharp drops in price occurred despite dramatic technological advances that gave consumers significantly enhanced functionality.

Productivity improvements have also helped a wide range of other industries—from airlines to wealth management services—lower prices. Between 2001 and 2014, for example, the average fee for wealth management advisory services decreased 13%.<sup>10</sup>

If the healthcare industry had been able to achieve comparable productivity improvements, prices for consumers would often be much lower, while payors and providers would be able to maintain wages and margins. For example, if health insurance premiums had followed the same trajectory that wealth management

### EXHIBIT 1 Many non-healthcare industries have been able to deliver “more for less”

Product	Historical year and average price (in current dollars) <sup>1</sup>	Current price <sup>1</sup>
Round-trip, economy class, Chicago–Los Angeles <sup>1</sup>	1975: \$835	\$217
Cell phone <sup>1</sup>	1988: \$5,108	\$649
Laptop computer <sup>1</sup>	1991: \$4,080	\$999
Wealth management advisory fee <sup>2</sup>	2001: 1.88%	1.64%
Average health insurance premium (family of four) <sup>1</sup>	2005: \$13,302	\$18,142
Commercial inpatient admission <sup>3</sup>	2007: \$13,961	\$19,614
Express Scripts Brand Prescription Price Index <sup>4</sup>	2008: \$112	\$297

<sup>1</sup>For these examples, both historical and current pricing are expressed in 2016 dollars. The cell phone comparison is between a Motorola DynaTAC 8500XL in 1988 and an iPhone 7 in 2016. The laptop comparison is between a Macintosh PowerBook 100 in 1991 and a MacBook Air 13-inch in 2016.

<sup>2</sup>The most recent pricing data for financial advisory services are from 2014, and so historical pricing is expressed in 2014 dollars.

<sup>3</sup>For inpatient stays, the most recent data are from 2015, and so historic pricing is expressed in 2015 dollars.

<sup>4</sup>The Prescription Price Index tracks price changes using 2008 dollars and \$100 as a baseline; it gave the 2016 price as \$264. If 2016 dollars are used instead, the baseline price would have been \$112 in 2008, and the current price would be \$297.

Source: Biz Journal. May 8, 2014; Kayak. November 17, 2016; Apple website; PC World; The Cerulli Report: U.S. Retail Investor Advice Relationships 2014; Kaiser Family Foundation; 2005 Employer Health Benefits Survey and 2016 Employer Health Benefits Surveys; American Hospital Association. Trendwatch Chartbook 2016; Express Scripts. Drug Trends Report 2016

advisory fees did between 2001 and 2014, the average annual premium for a family of four would have been \$6,155, instead of \$16,834, in 2014. In reality, very few areas in healthcare have seen costs decrease to any real degree.<sup>11</sup> Innovation in healthcare has created a range of new treatments, services, and technologies, but often at high prices not always commensurate with the benefits delivered.

In short, healthcare innovation has not led to the types of productivity improvements that have enabled other industries to deliver “more for less.” Between 1999 and 2014, labor productivity (defined as real value added per worker) increased by only 6% in healthcare—but by 18% in other service industries and 78% in manufacturing.<sup>12</sup> In most years during this period, productivity in the healthcare industry actually declined at the national level. Only in 2008 did the industry experience a comparatively large (2.9%) year-on-year increase in productivity. (The slowdown in hiring during the Great Recession may have led to a temporary boost as output grew faster than employment in the sector. Our experience suggests that in some regions of the country, 2008 was the only year between 1999 and 2014 that saw an increase in healthcare productivity.)

Calculating productivity changes in healthcare requires agreement on how the intended “output” should be defined and how the underlying costs needed to produce it are measured—two formidable yet surmountable obstacles.<sup>13</sup> Thus, comparisons of productivity gains between healthcare and other industries are inexact. Nevertheless, our experience indicates that healthcare is far behind other industries—and indeed its own potential. Healthcare organizations that develop the ability to define and measure both their target output and associated costs will likely

have a distinct advantage over competitors, because these are the first steps to improving value for consumers while minimizing costs.

If healthcare productivity is to rise—even if only to the level achieved by other service industries—two things need to happen: both payors and providers need to radically alter their business models, and we, as a society, will want to consider adopting “smart” regulations.

### **Business model changes**

Too often today, healthcare delivery is based on outdated approaches that rely heavily on overly expensive labor and care venues. Alternative approaches are possible, though. For example, ambulatory surgery centers (ASCs) have radically redesigned the provider business model for operations by using a smaller capital footprint, better asset utilization, and higher labor productivity. ASCs capitalize on the fact that when surgeons and facilities perform a high volume of specific procedures, care quality improves and productivity increases. ASCs have prices that are, in many cases, close to half those at most health systems,<sup>14</sup> and for consumers, the benefit is clear: more for less.

Diagnostic laboratory chains, retail health clinics, and dialysis companies offer other examples of how the provider business model can be redesigned. We have found, for example, that the lab chains are able to provide most tests at about half of what a typical hospital charges. (We recognize that some of this variation is a result of differences in the complexity of the diagnostics.) They do so by offering consumers convenient, local collection centers and by shipping the samples to much larger centers for analysis. The larger centers gain the benefit of scale and are better able to balance fluctuations in demand, thereby enabling not

*Making the needed changes to improve productivity is not easy, especially for providers, given their fixed assets and labor force restrictions. Change is possible, though—and necessary.*

only better labor capacity utilization but also more efficient use of capital.<sup>15</sup> There is no reason to believe other new entrants will not find ways to offer other traditional hospital services in outpatient settings—at a much more attractive price point and, potentially, with increased convenience for consumers.

The provider business model can also be radically redesigned without abandoning the hospital footprint. In India, the Narayana Health System uses what has been described in news stories as a “Walmart-like” approach, based on heavy use of technology, to continuously improve its cost management and efficiency without jeopardizing patient care.<sup>16</sup> For example, it has standardized its procedures and schedules operations to ensure its surgical suites—and surgical teams—are maximally utilized. The result: excellent outcomes at a price only one-third of that charged by other Indian hospitals. A new entrant introducing a “Walmart-like” approach in the United States could disrupt the provider landscape.

Payors also should consider redesigning their business models. By fully digitizing the consumer decision journey, payors can significantly decrease their administrative costs and, by association, their premiums. Our analyses have shown, for example, that the average cost to

payors for an individual-market member acquisition is \$125 through online sales, but \$500 through traditional sales channels. In addition, digitization can lower back-office costs for account and membership administration by more than 20%. Digitizing claims processing also makes possible the advanced analytics that can significantly reduce fraud and abuse rates.

Payors could also build on the broader market migration toward value-based payment as a way to aggressively shift medical management activities to providers that accept risk-based arrangements. Rather than offering disease management, case management, or wellness programs themselves, payors could use value-based contracting to encourage providers to deliver these programs. This move could potentially cut payors’ medical management-driven administrative spending almost in half.

Payors and providers could take other steps that hold the promise of significantly improving productivity. For example, transaction costs could be lowered by streamlining quality reporting or by redesigning the claims and payment transaction system to a “hub-and-spoke” model, with large-scale clearinghouse utilities similar to those used by credit card companies or in financial securities settlements. Artificial intelligence could improve the speed and accuracy of diagnosis. Other new technologies (e.g., at-home remote monitoring, online physician consultations) could reduce the need for in-person medical care.<sup>17,18</sup> However, empirical evidence is not yet sufficient to establish the savings these technologies might achieve, and thus we did not include them in our calculations of financial impact.

Making the needed changes to improve productivity is not easy, especially for providers, given



their fixed assets and labor force restrictions. Change is possible, though—and necessary. The incumbents first to achieve significant productivity gains will create a material competitive advantage for themselves through growth and margin. They will also be better positioned to defend themselves against attackers.

### Regulatory considerations

Although regulations serve an important role in ensuring patient protection and safety, many current regulations are outdated, unclear, or inconsistent. Stark and anti-kickback laws have slowed the spread of some payment and delivery innovations—for example, the Department of Health and Human Services (DHHS) issued waivers for some new payment models, but excluded commercial models.<sup>19</sup> At times, the payment and delivery innovations encouraged by DHHS and the Centers for Medicare and Medicaid Services have run afoul of Internal Revenue Service regulations.<sup>20</sup> State laws and federal policies governing telehealth services vary on such points as where the services can

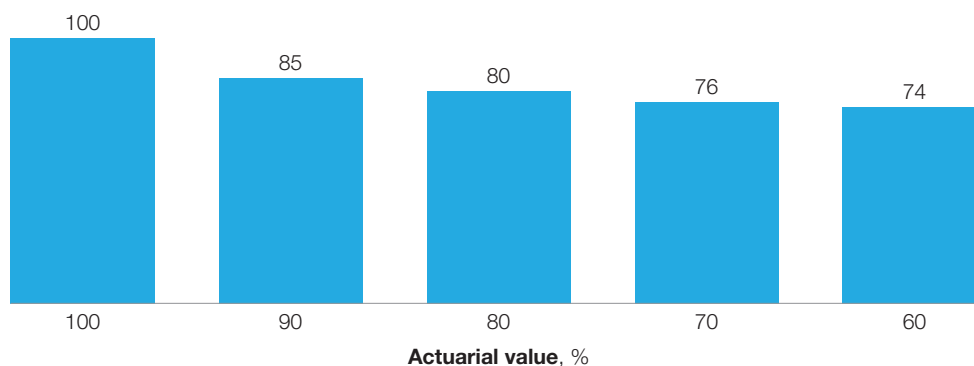
be delivered, what types of clinicians can deliver the services, and where the clinicians must be licensed.<sup>21</sup> The regulations specifying what services nurse practitioners and other ancillary clinicians can offer without direct physician supervision differ widely across states.<sup>22</sup>

Outdated, unclear, or inconsistent regulations such as these can, at times, inhibit innovation, and in many cases it may be possible to streamline them or replace them with “smart” regulations that stimulate productivity improvements while protecting patient safety, fostering competition, and achieving equity aims.<sup>23</sup>

Smart regulations use enforceable standards to promote desired goals, but carefully balance those goals against the cost of compliance and permit a degree of flexibility that enables innovation. Smart regulations can also be used to establish enabling mechanisms that would not be feasible for an individual organization to create (e.g., the creation of data standards and requirements for easy interchange of data across organizations<sup>24</sup>).

## EXHIBIT 2 Healthcare utilization decreases as actuarial value declines

Indexed service utilization,<sup>1</sup> %



<sup>1</sup> Impact of changes in actuarial value on utilization of medical services, holding all else equal (e.g., age, risk).

Source: Brooks RH et al. The effects of co-insurance on the health of adults. Results from the RAND Health Insurance Experiment. Santa Monica, CA: RAND Corporation, 1984. Report R-3055-HHS

## Improve market functioning

In well-functioning markets, demand-side and supply-side incentives are balanced. Think again of consumer electronics: the combination of engaged consumers making informed choices and a competitive market of providers has led to a steady stream of product innovations and frequent price reductions. However, balanced incentives are rare in healthcare. Instead, misaligned incentives—between patients and providers, providers and payors, and among different providers—all too often result in increased costs without any related benefit to consumers.

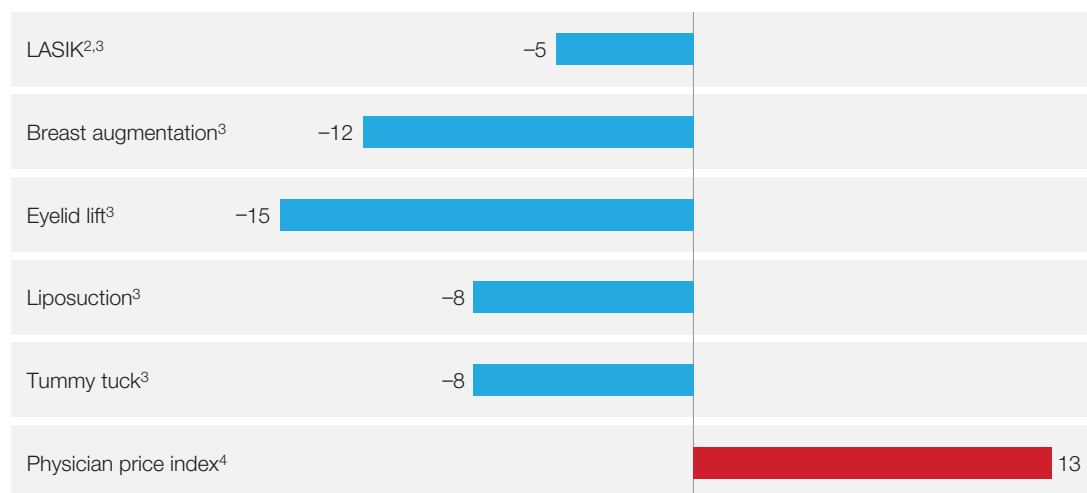
On their own, both demand-side and supply-side incentives can be effective in healthcare.

Considerable evidence shows, for example, that utilization decreases when consumers pay more out of pocket. Even a 10% increase in consumers' share of costs (a 10% reduction in actuarial value) decreases utilization by 15% (Exhibit 2). Similarly, the pressure of engaged consumers paying full costs in a price-transparent market has led to declining prices for elective procedures, in some cases by double digits (Exhibit 3).

Episodes payments and other bundled payment approaches that reward providers for outcomes rather than volume have also been shown to lower prices and reduce the delivery of unnecessary services, including emergency room visits and excessively long hospital stays.<sup>25</sup> The State of Arkansas, for example, launched

### EXHIBIT 3 Price transparency for elective health services also decreases utilization

Change in price for elective, non-reimbursable services, 2006–14,<sup>1</sup> %



<sup>1</sup>Prices adjusted to 2014 dollars, according to US Consumer Price Index.

<sup>2</sup>LASIK costs reflect price for one eye.

<sup>3</sup>Prices are national average surgeon's fee. Not included are fees for hospital services, anesthetist, pathology, or radiological investigations.

<sup>4</sup>National Health Expenditure Accounts price proxy for physician and clinical services (composite index: produce price indexes for offices of physicians, and for medical and diagnostic laboratories).

episode payment for attention deficit/hyperactivity disorder and found that the average episode cost fell by 29% in the first year. It also saw reductions in average episode cost for other conditions, although in a few cases its spending remained flat.<sup>26</sup> Another payor has found that the use of episode payments for hip replacements significantly decreased the average cost of that procedure while substantially reducing the postsurgical readmission rate.<sup>27</sup>

However, both demand-side and supply-side incentives have limitations. When cost-sharing levels are high, some consumers may opt to forego appropriate care. Yet in the absence of consumer cost sharing, attempts to reduce the over-delivery of services may have little impact.

Our experience suggests that the best way to balance the two sets of incentives at scale is to take the level and nature of medical risk into consideration.<sup>28</sup> Simply put, medical problems vary in severity and frequency, the number of times treatment will be needed (acute vs. chronic care), and the extent to which consumers can both control the services received and absorb the cost of those services. (For a fuller explanation of medical risk, see the sidebar on p. 18.)

Each category of medical risk has a potentially optimal financing and reimbursement approach. Compare, for example, preventive services and routine outpatient care for mild conditions, such as influenza in adults (Exhibit 4). In both cases, consumers have considerable discretion

#### EXHIBIT 4 Medical risk categories have implications for payment and reimbursement

Risk category	Consumer		Potential financing approach	Potential reimbursement approach
	discretion	ability to absorb risk/expense		
Routine	High	High	Savings, credit cards, prepaid cards	Fee-for-service
Preventive	High	High	Free	Fee-for-service
Chronic care	High	Medium	Insurance, with incentives for proper management; risk-impaired annuity	Nested episodes within population health models
Catastrophic, chronic	High	Low		
Discretionary	High	Medium	Savings, credit cards	Episodes
Purely elective	High	Medium	Savings, credit cards	Episodes
Catastrophic, not chronic	Low	Low	Insurance	Episodes
End of life	Low	Medium	Savings, viatical, reverse mortgage	Episodes

Source: McKinsey analysis

over which services they receive and can generally afford to absorb the expense. However, many preventive services reduce the long-term cost of care and thus should be offered free or near-free, as is currently done in plans offered through the public exchanges. In contrast, outpatient care for mild conditions

is frequently unnecessary; having consumers bear the full cost of such care would lower utilization rates and/or encourage the growth of lower-cost, more convenient sites of care (e.g., retail clinics). Discretionary procedures (e.g., back surgery when not clinically necessary) are also candidates for full cost sharing.

## Understanding medical risk

The fundamental nature of medical risk in the United States has changed over the past few decades. In most cases, medical risk no longer results from random, infrequent events driven by accidents, genetic predisposition, or contagious disease but from chronic conditions related to behavioral, environmental, or other factors. Treating chronic conditions, and the serious medical events they commonly induce, now costs more than treating the random, catastrophic events that health insurance was originally designed to cover.

Although our country's approach to health insurance—and to paying for healthcare more generally—is changing, it has still not sufficiently adapted to the change in medical risk. As a consequence, consumers still have little incentive to forego unnecessary, inexpensive services yet are ill protected from the cost of very expensive care. The incentives for providers are only starting to change to encourage them to deliver preventive services and discourage them from offering unnecessary or poor-quality care.

Medical risk is not uniform, however. We analyzed US healthcare spending and broke it down into separate risk categories, each of which has unique characteristics. (For more details about how this was done, see “Why

understanding medical risk is key to US health reform,” p. 39.) We then matched the incentives offered to consumers and providers to the characteristics of each category.

### How we did the analysis

Our analysis looked at total annual US health-care spending (excluding government administrative expenses, private insurers' profits, research expenses, and the cost of equipment, software, and public health activities). We evaluated expenditures using four major factors:

**Severity.** The magnitude of the medical expense to treat a specific condition.

**Frequency.** How often the condition occurs.

**Level of consumer discretion.** The degree to which consumers can control costs.

**Temporal dependency.** The amount of time a patient is likely to be afflicted with the condition.

We then considered a number of other issues. For example, we reviewed evidence-based guidelines and evaluated the inherent value of preventive medicine. In addition, we investigated the primary mechanisms used to pay for services delivered:



Catastrophic care falls squarely within the intent of insurance, given that most consumers have little ability to absorb the total costs. However, coverage details should depend on whether the need for care results from a chronic condition that is within a patient's ability to control. Low cost sharing makes

sense when it does not (e.g., accidents, unexpected cardiac events). For catastrophic events resulting from controllable chronic conditions, cost-sharing levels should be higher, but patients should be offered incentives to improve their management of those conditions. In other words, the level of cost sharing should vary

**Out-of-pocket.** Expenses paid by consumers other than insurance premium payments (e.g., copays, coinsurance, and deductibles).

**Insurance.** Expenses covered by individual insurance, government insurance, and employer-sponsored insurance (including the employee portion of premiums).

**Subsidies.** Expenses covered by federal and state subsidy programs (e.g., Medicaid and the State Children's Health Insurance Program), as well as charity care.

### What we found

The analysis yielded the eight categories of medical risk shown in Exhibits 4 and 5. When we looked at how each of these categories was primarily paid for, we discovered there was often a disconnect between the value the services provided and where the funding came from. For example, insurance often covered a greater proportion of the costs of discretionary care than of preventive care. Similarly, we found a disconnect between the share of costs consumers were expected to pay and their ability to influence the need for that care. (Consumers were often responsible for more of the cost of uncontrollable catastrophic events than of catastrophic events

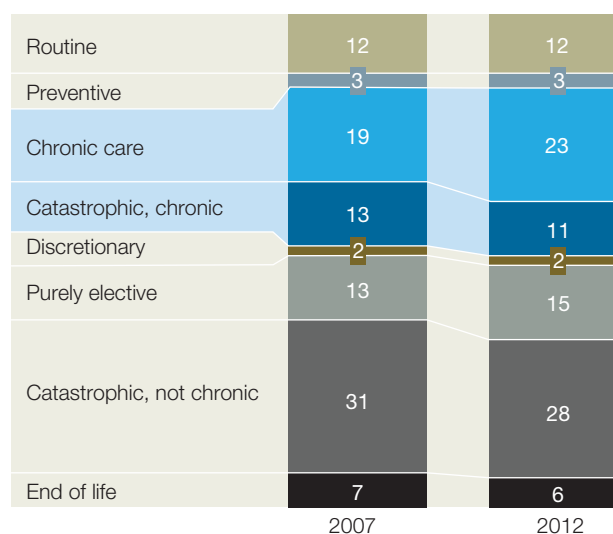
related to chronic disease.) And we saw little or no relationship between the amount consumers were expected to pay in each category and their ability to absorb those costs.

Our findings led us to believe that a one-size-fits-all approach to either consumer cost sharing or payment innovation will not be effective in controlling healthcare costs or improving care quality. Only by matching the extent of cost sharing and the primary reimbursement mechanism to the characteristics of each category of medical risk will it be possible to achieve those goals.

Admittedly, the approach outlined here is somewhat simplified. Patients are not homogenous, and what is an appropriate treatment for one patient may be discretionary or even inappropriate for another. Thus, models designed to encourage high-value care and discourage low-value care through variable cost sharing must be more nuanced to take these differences into account. Payors should rely on clinical evidence when developing smart cost sharing models to move beyond blunt instruments such as high deductibles and uniform copayments or coinsurance rates. And they should re-examine the models periodically to minimize the risk that either patients or providers can game the results.

## EXHIBIT 5 One-third of total healthcare expenditures are related to chronic disease

US healthcare costs, by medical risk category, %



Source: National Health Expenditure Accounts; Medical Expenditure Panel Survey; National Vital Statistics System; Healthcare Cost and Utilization Project; Dartmouth Atlas of Health Care; McKinsey analysis

based on how well patients engage and take responsibility to manage their conditions.<sup>29</sup>

Under this model of “smart cost sharing,” subsidies may be needed to help lower-income individuals afford appropriate routine and elective care. Furthermore, this redefinition of covered benefits does not match most people’s current conception of health insurance, and it is not fully consistent with existing mandatory or essential health benefits. Employers and payors would need to work through mandated benefits requirements, depending on the applicable federal and state regulations. However, the impact of adopting this approach could be profound. Our research has shown that almost 30% of the medical costs covered by commercial plans result from routine, discretionary, or purely elective care

(Exhibit 5). If a payor curtailed coverage for these types of care, the premium reductions it could pass on to consumers could be significant (Exhibit 6).

Furthermore, if the cost of routine, discretionary, and purely elective care were transferred to consumers, utilization of that care would likely decrease substantially or be shifted to lower-cost, more convenient sites of care. This would lower overall healthcare spending. Payors could achieve additional cost savings through innovation around narrowed networks, chronic care management, and bundled payment models. For example, by using bundled payments to cover catastrophic and end-of-life care, payors would protect consumers from the extremely high costs associated with those types of care while discouraging providers from

delivering unnecessary services. In addition, payors could design population health models to ensure that providers are well rewarded for delivering appropriate preventive services and thereby reducing future costs.

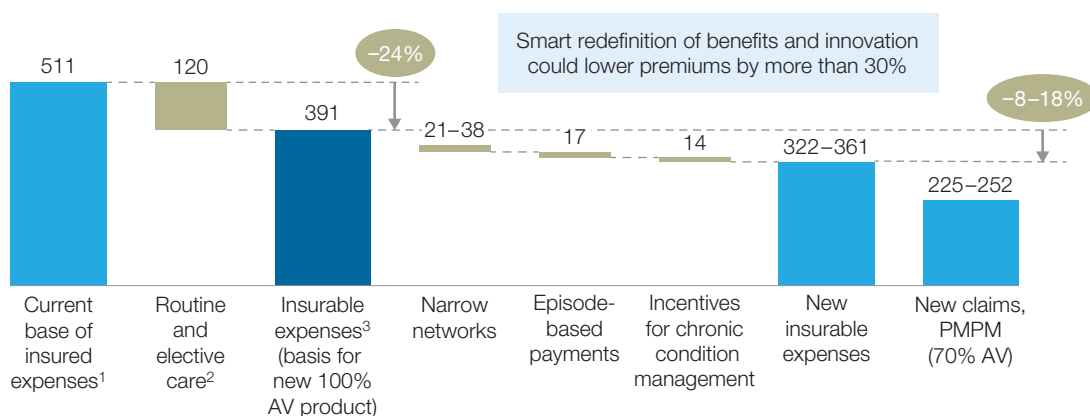
Some providers could also benefit from this redefinition of health insurance coverage. Productive providers, for example, could gain market share by offering consumers more attractive pricing, added convenience, and perhaps higher-end amenities, for routine, discretionary, and elective care. In addition, the providers could partner with payors on outcomes-based payment models for catastrophic and chronic care to earn higher revenues and margins for their more efficient, lower-cost care.

For this redefinition of insurance coverage to succeed, however, certain supportive elements must be in place. Consumers must have effective mechanisms to help them absorb the costs—health savings accounts do not yet meet this standard. Consumers would also need tools to help them understand the benefits and risks of the types of care they are considering, and to enable them to compare quality and prices at different providers. Transparency tools have a long way to go, but evidence is already emerging that when consumers do have access to cost data, they use it. For example, a high proportion of consumers on the public exchanges are comparison shopping for insurance coverage, with many purchasing lower-priced plans.<sup>30</sup>

## EXHIBIT 6 Aligning health insurance with medical risk categories could lower premiums, improve affordability, and help stabilize the individual market

**If essential health benefits were redefined, only 76% of today's covered health services would be insurable**

\$, PMPM



AV, actuarial value; PMPM, per member per month.

<sup>1</sup>Based on 2014 exchange premiums and actuarial value.

<sup>2</sup>Based on breakdown of 2014 Truven commercial claims data.

<sup>3</sup>Includes chronic, catastrophic, and preventive care (excludes routine and discretionary services).

Source: McKinsey analysis of data from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project, Medical Expenditure Panel Survey, National Health Expenditures Accounts, Office of the Assistant Secretary for Planning and Evaluation, Truven, and medical loss ratio reports from the Centers for Medicare and Medicaid Services; McKinsey Payor Financial Database; McKinsey Exchange Offering Database

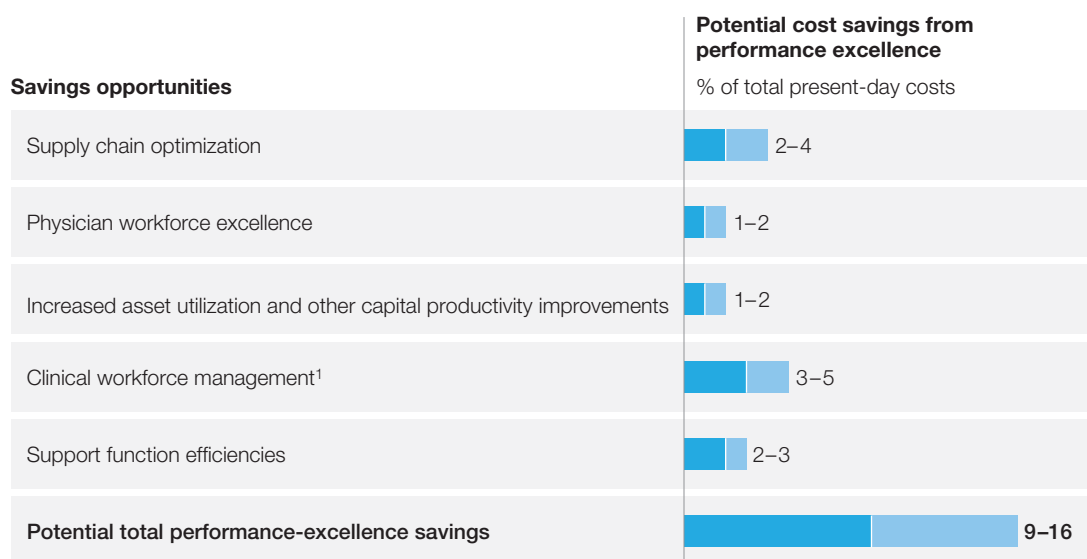
## Economic impact

Our economic analyses are based on the assumption that the current best practices we have observed among certain players could be applied in the industry more broadly—a change that may not be easy to accomplish in an industry as entrenched as healthcare, but is also not impossible. For example, if all providers were to follow best practices, they could achieve savings of 9% to 16%, our analyses indicate (Exhibit 7). These conservative estimates suggest that improving healthcare productivity and market functioning has the potential to substantially reduce near-term spending and slow medical cost inflation. We estimate,

for example, that initiatives targeting productivity and market distortions could achieve a savings of \$284 billion to \$532 billion over the course of the next ten years (Exhibit 8).<sup>31</sup> Achieving these savings equates to a 30% decrease in the average annual increase in national health expenditures. Such a decrease could bring medical cost inflation to about the rate of GDP growth for the next several years—something that has not happened in more than half a century.<sup>32</sup>

The actual impact could be much higher, however. Our analyses did not take into account a range of forward-looking levers, such as regulatory reforms, simplified quality reporting,

### EXHIBIT 7 Providers could achieve more than 3% year-on-year productivity growth



Additional system-wide savings may be possible from reduced inpatient capacity as volume moves to new care settings

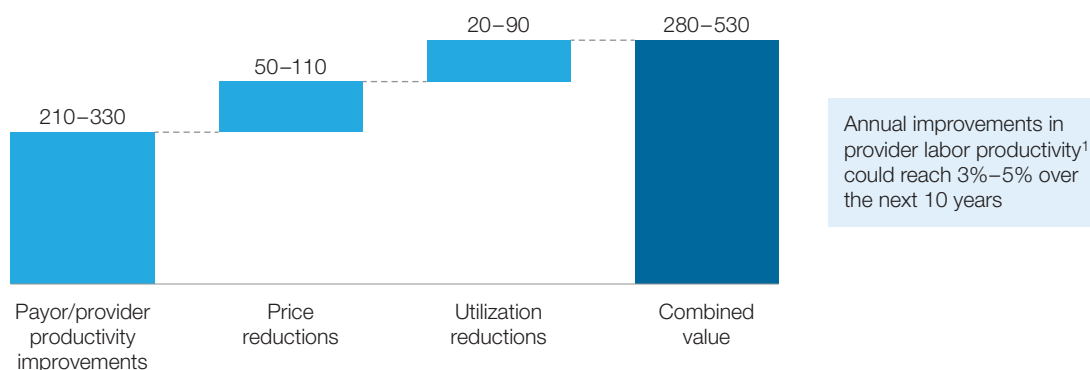
<sup>1</sup>Excludes physicians.

Source: McKinsey analysis of data from the Medicare Payment Advisory Commission and National Health Expenditure Accounts; expert interviews

## EXHIBIT 8 Productivity improvements provide the largest upside

### Additional value to the US healthcare system and society

\$, billions



<sup>1</sup>The calculations make the following assumptions: baseline growth in real value added is 2.3%, plus increase in value added due to cost savings; 50% of savings are due to labor cost savings relative to baseline employment growth; 10%–15% reduction in inpatient beds to decrease excess capacity. These calculations are based on the provider sector only, to maintain consistency with Bureau of Economic Analysis definitions.

Source: McKinsey analysis of data from Blue Health Intelligence, Bureau of Economic Analysis, Bureau of Labor Statistics, Centers for Medicare and Medicaid Services, Congressional Budget Office, Health Affairs, Institute of Medicine, Kaiser Family Foundation, Medicare Payment Advisory Commission, National Bureau of Economic Research, National Healthcare Expenditure Accounts, and US Census Bureau; expert interviews

fraud/abuse reductions, and digital technologies. Yet these levers have the potential to produce considerable savings. Remote monitoring, as one example, could eventually lower the cost of delivering primary care services by \$25 billion to \$40 billion annually.<sup>33</sup>

In sum, the near-term, practical opportunity for reducing healthcare costs presents the possibility that medical cost inflation could be lowered to match GDP growth. Over the longer term, the added potential innovation could make possible would enable the healthcare industry to continually deliver “more for less.”

## Implications for incumbents

The healthcare industry is ripe for disruption, and incumbents must be prepared to respond. New entrants have already demonstrated the

effectiveness of radically rethinking healthcare business models, and there is no reason to think others will not follow. Incumbents that want to avoid being overtaken by these new entrants must pivot quickly to act like attackers themselves (as Charles Schwab did following the advent of online brokerages—it was able to stave off attackers and maintain margins by radically lowering its prices, introducing online trading, and improving customer support).

As payors and providers rethink their business models, improving productivity drastically and quickly must be uppermost in their minds. The first incumbents that can do this will gain a significant competitive advantage. Thus, radical new ideas should be strongly considered—minor tweaks will not be sufficient in a world where an Amazon- or Walmart-like attacker could materialize.

*There is also a real opportunity for collaboration between payors and providers to reduce complexity, and increase transparency and the use of payment for value.*

Some of the changes payors and providers need to make are quite different. Payors, for example, should focus not just on back-office services but also on front-office operations. As we have noted, digital sales are significantly less expensive than traditional sales. Providers could start with supply chain optimization and better clinical workforce management, but they should not forget the other levers available to them. Both groups should be aggressive in their efforts—in our experience, many of them do not pull these levers hard enough.

There is also a real opportunity for collaboration between payors and providers to reduce complexity, and increase transparency and the use of payment for value. In addition, incumbents could collaborate with appropriate public agencies to update the regulatory framework. Smart regulations can ensure that both consumers and medical standards remain protected while enabling the innovations needed to increase productivity and improve market functioning. Collaboration between payors, providers, and public agencies could also help rebalance incentives in the healthcare market, enabling that market to operate more efficiently. For example, redefin-

ing what constitutes essential health benefits has the potential to benefit all three groups—without adverse impact on consumers, who may, over time, see an improvement (i.e., more cost-effective and/or convenient choices).

Finally, payors and providers should remain alert for innovations that advance best practices, as well as for emerging evidence about the value digital technologies can bring. Both of these have the potential to deliver substantially greater improvement than we have estimated in this article.



The time for incumbents to act is now. Simply put, traditional approaches to delivering and paying for healthcare are no longer adequate. ○

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The authors would like to thank Matt Carey and Nina Jacobi for their contributions to this article.



## FOOTNOTES

- <sup>1</sup> Marken S. US uninsured rate at 11.0%, lowest in eight-year trend. Gallup April 7, 2016.
- <sup>2</sup> Evidence for the success of these programs is mixed. For example, of the 333 accountable care organizations (ACOs) that participated in the Medicare Shared Savings Program in year 2, 86 earned payments because their claims costs were below their financial benchmarks. (Introcaso D, Berger G. MSSP year two: Medicare ACOs show muted success. Health Affairs Blog. September 24, 2015.)
- <sup>3</sup> Health Care Cost Institute. 2014 Health Care Cost and Utilization Report. October 2015.
- <sup>4</sup> Kaiser Family Foundation, Health Research & Education Trust. Employer Health Benefits: 2015 Annual Survey. September 2015.
- <sup>5</sup> Schanzenbach DW et al. Where Does All the Money Go? Shifts in Household Spending over the Past 30 Years. Brookings/Hamilton Project Report. June 2, 2016.
- <sup>6</sup> See, for example, Dobbs R et al, "How the world could better fight obesity." McKinsey Global Institute Report. November 2014.
- <sup>7</sup> The actual impact could be much higher, because our calculations did not include anything for which we could not establish a reasonably accurate assessment of economic effect.
- <sup>8</sup> Between 1995 and 2014, medical cost inflation exceeded GDP growth by an average of 1.45%. (CMS. NHE summary including share of GDP, CY 1960–2014.)
- <sup>9</sup> US Department of Labor. Long-term price trends for computers, TVs, and related items. October 13, 2015.
- <sup>10</sup> The Cerulli Report. US Retail Investor Advice Relationships 2014.
- <sup>11</sup> One area in which decreases have been seen is the cost of elective procedures, a reflection of consumerism's power, as we discuss later in this article.
- <sup>12</sup> McKinsey analysis of data from the US Bureau of Labor Statistics and US Bureau of Economic Analysis. Note: Some researchers have argued that provider productivity improvements are understated in these reports because they do not take changes in patients' average severity of illness into consideration. However, even when that factor is taken into account, labor productivity improvements are far lower in healthcare than in most other industries.
- <sup>13</sup> See the article by Dunn et al, "Introducing the New BEA Health Care Satellite Account" (Bureau of Labor Statistics. January 2015), for further discussion on the measurement of output and productivity in healthcare.
- <sup>14</sup> Medicare Payment Advisory Committee. Report to Congress 2016: Medicare Payment Policy. Chapter 5: Ambulatory Surgery Center Services. March 2016.
- <sup>15</sup> The importance of capital utilization as a driver of healthcare value is starting to gain wider recognition. See, for example, Klein DJ et al, "Investing wisely in health care capital." JAMA. Published online September 29, 2016.
- <sup>16</sup> Salter C. Narayana Hrudayalaya Hospitals. FastCompany.com. February 7, 2013.
- <sup>17</sup> Atluri V, Cordina J, Mango P, et al. How tech-enabled consumers are reordering the healthcare landscape. p. 197.
- <sup>18</sup> Aue G, Biesdorf S, Hencke N. How healthcare systems can become digital health leaders. McKinsey white paper. January 2016.
- <sup>19</sup> Department of Health and Human Services. Medicare program; final waivers in connection with the shared savings program; interim final rule. November 2, 2011.
- <sup>20</sup> National Law Review. IRS denial of section 501(c)(3) status for commercial ACO – accountable care organization. May 10, 2016.
- <sup>21</sup> For example, the federal Medicare program limits reimbursement for telehealth services to rural or medically underserved areas. Many state Medicaid programs do not impose this restriction but may include various other limits on reimbursement. Center for Connected Health Policy. August 2016.
- <sup>22</sup> For example, 21 states and the District of Columbia permit nurse practitioners to deliver care independently; 30 states require them to work under the supervision of a physician. American Association of Nurse Practitioners.
- <sup>23</sup> Using smart regulations becomes even more difficult when state laws vary.
- <sup>24</sup> Greene C et al. Costs and benefits of building faster payment systems: The UK experience and its implications for the United States. Federal Reserve Bank of Boston Current Policy Perspectives. February 24, 2015.
- <sup>25</sup> In a sense, these payment approaches also reduce demand, since they can inhibit referrals to other providers for unnecessary healthcare services.
- <sup>26</sup> Arkansas Health Care Payment Improvement Initiative. Building a Healthier Future for All Arkansans. April 28, 2014.
- <sup>27</sup> Brillstein L. Episodes of care: A value-based model for specialty care. Presented at the Second Annual Bundled Payment Implementation Forum. January 25, 2016.
- <sup>28</sup> Singhal S, Jacobi N. Why understanding medical risk is key to US health reform. p. 39.
- <sup>29</sup> Admittedly, this categorization of healthcare spending is a simplification. In reality, insurers will need to identify high- and low-value services at a more refined level, focusing not only on particular procedures or medications but also on specific patient populations. See the sidebar "Understanding medical risk" on p. 18 for more detail.
- <sup>30</sup> Health insurance marketplaces 2015 open enrollment period: March enrollment report. ASPE Issue Brief. March 10, 2015.
- <sup>31</sup> The savings are calculated in 2014 dollars.
- <sup>32</sup> CMS. NHE summary including share of GDP, CY 1960–2014.
- <sup>33</sup> Atluri V, Cordina J, Mango P, et al. How tech-enabled consumers are reordering the healthcare landscape. p. 197.

# Where to compete in today's healthcare market

*To select which markets to focus on—both within health insurance and in adjacent businesses—payors must have strong market insights, the fortitude to make tough decisions, and the agility to alter course rapidly.*

**Shubham Singhal,  
Bryony Winn, Kyle  
Weber, and Susan  
Nolen Foushee**

The power of “where-to-compete” decisions, particularly in an industry in as much flux as US health insurance, is enormous. Our analyses suggest that the bottom-line performance differential between a payor that selects a market-average portfolio across businesses and geographies and an identical payor that instead selects a top-quartile portfolio is likely to be more than twofold (Exhibit 1). In numerous industries, McKinsey research has shown that the majority of the performance differential among corporations results from their alignment with “rising tide” markets rather than from share gain within less attractive markets.<sup>1,2</sup>

Thus, today's payors must carefully choose which markets they want to concentrate their resources on. The choices they make will be critical—not only within the payors' core health plan business but also in adjacent areas within the healthcare value chain.

## Choices within health plan business

Models we have developed suggest that, over the next several years, tremendous variability in growth potential across markets is likely in the US health insurance landscape. Exhibit 2 illustrates our estimates of the extent of this variability across states and business lines. For example, membership in the individual market could decrease by as much as 11% in some states and grow by as much as 27% in others.

Current margins are similarly variable. Our research shows that, in 2015, small-group margins averaged 2% across the country but ranged from –6% to +8% in different states.

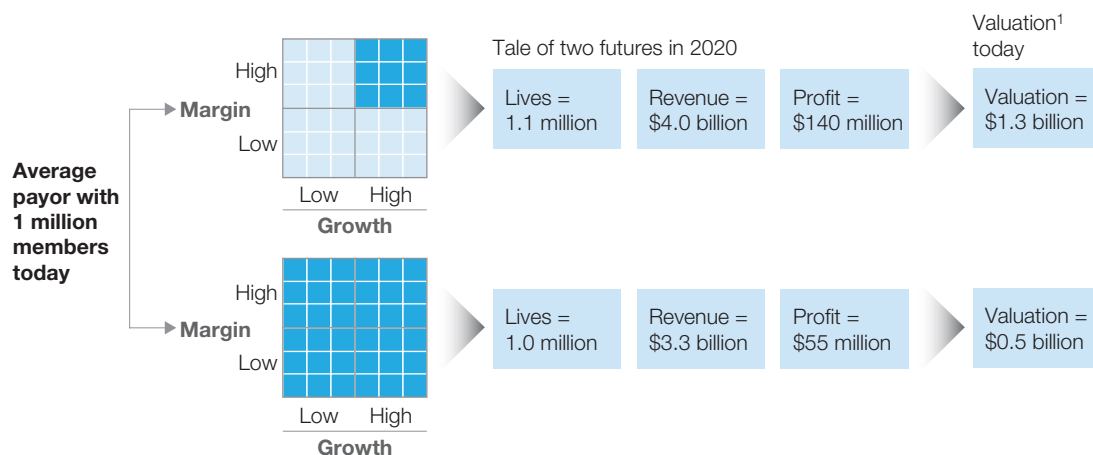
Admittedly, our models cannot predict the future with certainty, and thus actual growth (within specific states or across the country as a whole) may be higher or lower than our estimates suggest. Nevertheless, we believe that growth and margin variability will be a characteristic feature of the US health insurance landscape. Indeed, we have found that the extent of such variability rises when we look at the rating areas or micromarkets within each of the states in which a specific payor operates.

A second important dimension to consider is the return on capital each business delivers, most commonly assessed as the return on equity (ROE). Since the launch of the Affordable Care Act, we have observed dispersion across different segments as payors have attempted, with varying degrees of success, to adapt to changing regulations and customer risk profiles. For example, current losses in the individual market are resulting in a negative ROE (–11%). At the same time, stable and positive margins in Medicare Advantage contribute to relatively high ROE (+18%). Exhibit 3 shows the ROE growth-return characteristics of various payor business lines at present. However, a number of factors, including competitive conduct and potential changes in regulations,

<sup>1</sup>Viguerie P, Smit S, Baghai M. The Granularity of Growth: How to Identify the Sources of Growth and Drive Enduring Company Performance. John Wiley & Sons. 2008.

<sup>2</sup>For a look at how this general rule affects the Medicaid managed care market, see “The granularity of Medicaid MCO growth” (p. 138).

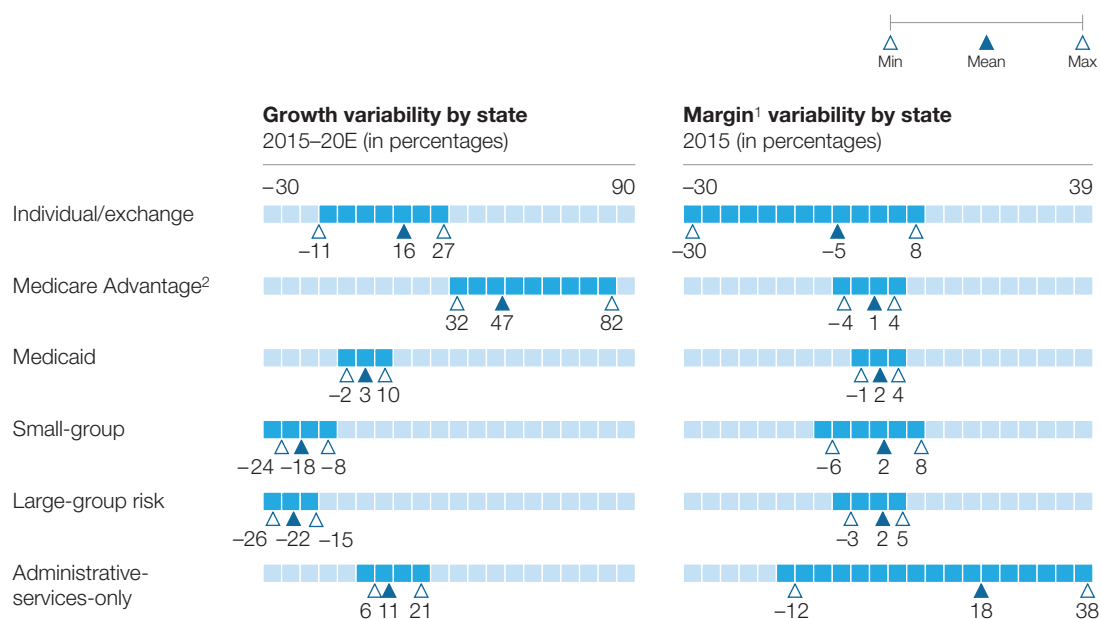
## EXHIBIT 1 Where-to-compete decisions can be powerful



<sup>1</sup> Assuming cost of equity is 10% and revenue/equity is 5.

Source: McKinsey Payor Financial Database; data derived from the National Association of Insurance Commissioners' Accident and Health Exhibits, HHS and Kaiser Family Foundation (for Medicaid growth), and analyst estimates (for administrative-services-only plans)

## EXHIBIT 2 Growth and margins vary across industry segments and states



<sup>1</sup> Margin is defined here as post-tax operating gain.

<sup>2</sup> Medicare Advantage margin range is a national range by company, not by state. As a result, it has a smaller variance than would have occurred had state data been available.

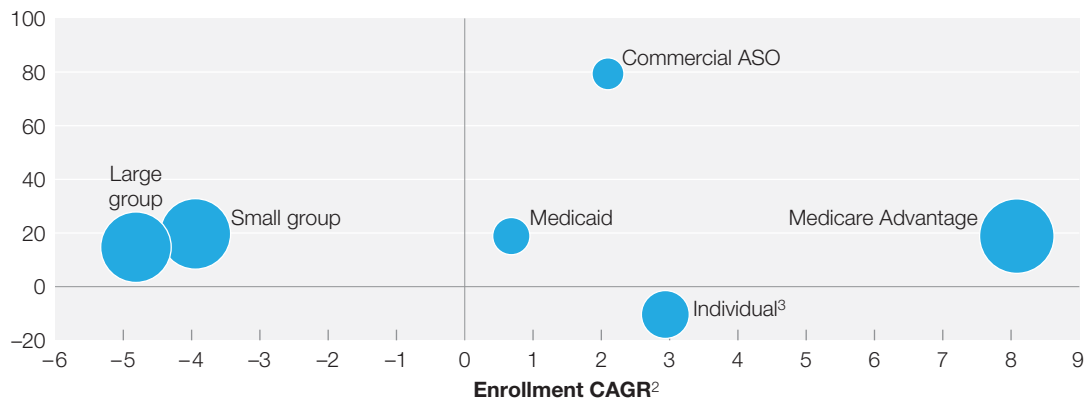
Source: McKinsey Advanced Healthcare Analytics MPACT 7.6.0; McKinsey Payor Financial Database; data derived from the National Association of Insurance Commissioners' Accident and Health Exhibits, HHS and Kaiser Family Foundation (for Medicaid growth), and analyst estimates (for administrative-services-only plans)

### EXHIBIT 3 Growth-return characteristics of business lines<sup>1</sup>

#### Return on book equity

Size of bubble indicates DCF value per member

Average 2015–20, %



ASO, administrative services only; CAGR, compound annual growth rate; DCF, discounted cash flow.

<sup>1</sup>Given uncertainty on potential reform as of the date of this publication, the calculations contained herein assume no material changes to the ACA through 2020 (e.g., exchanges and related subsidies remain in effect, Medicaid expansion status does not change, grandmothering expires December 2017, Cadillac tax goes into effect in 2018).

<sup>2</sup>Enrollment CAGR projected based on 2015–20.

<sup>3</sup>Projected return on equity for the individual market is negative for 2015–17 and shifts to positive starting in 2018.

Source: McKinsey MPACT 7.6.0; company filings; CMS; Kaiser Family Foundation; analyst reports; McKinsey analysis

are likely to alter the trajectories over time. Payors will need to continually assess and adjust their decisions as new information becomes available on market evolution.

### Choices in adjacent businesses

Payors looking for growth today do not have to confine themselves to their core books of business. Opportunities abound in a number of adjacent areas, including supplemental products, data analytics/healthcare IT, distribution to consumers, retail healthcare, and price transparency tools (Exhibit 4). For example, our analysis suggests that the current revenue pool for supplemental coverage is roughly 8% to 10% of the total revenue pool for primary medical insurance products.<sup>3</sup> We expect that revenue pools

in most of these adjacent areas will continue to rise—the growing role of consumer choice in health coverage purchasing (not only through the public exchanges but also through defined-contribution employer coverage and Medicare Advantage) will likely prompt more consumers to buy supplemental coverage and create a greater role for B2C and B2B2C distribution services.

Beyond the sizeable revenue and profit potential, payors have strategic reasons to consider opportunities in adjacent areas. As the capabilities they need to compete in different business lines diversify, payors may find that they are acquiring the capabilities required in adjacent areas. For example, as care management becomes increasingly important for their Medicare and Medicaid business, some payors may

<sup>3</sup>Huber C et al. Supplemental products: No longer just a side dish. McKinsey white paper. July 2011.

find that vertical integration with providers becomes more attractive. (Whether it makes sense to integrate vertically in every instance is another issue that must be analyzed on a granular level.) Similarly, as marketing and selling directly to consumers become more important, expansion into distribution services or retailing could become synergistic.

As payors make the above choices in their core business and adjacent areas, a nuanced understanding of their competitive advantage will be critical. Different payors have different abilities to compete effectively and win in different markets. For example, network cost advantages in different geographic areas will dictate the relative attractiveness of those areas for a specific payor. Existing assets in adjacent areas would make market entry easier for some payors than for others.

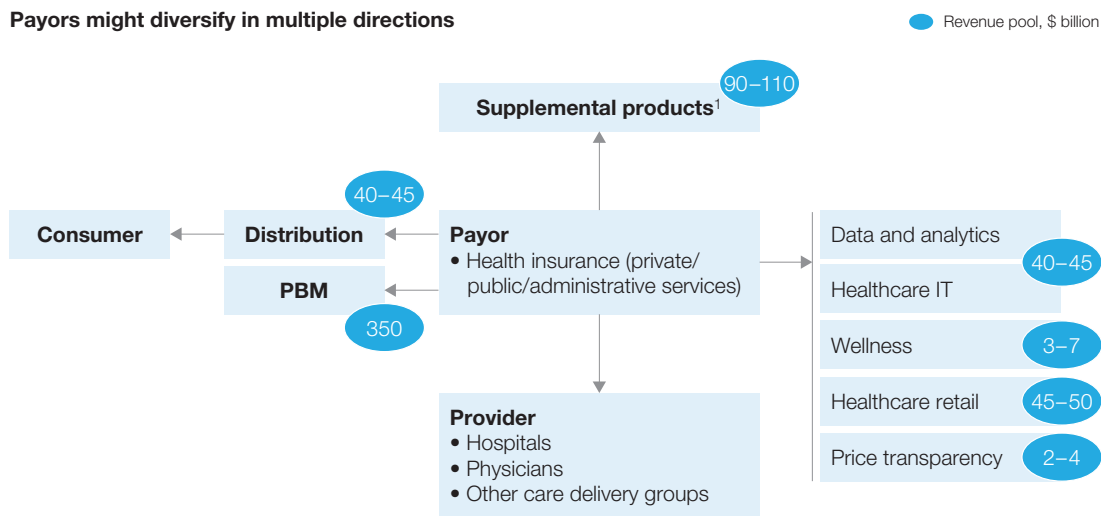
## Acting on where-to-compete decisions

Committing resources—capital, talent, and management attention—is what makes where-to-compete decisions real. However, most organizations fail to make these resource allocation decisions. Indeed, at most companies, the biggest predictor of budget allocations in a given year is last year's budget. We have found that more than 90% of resources are allocated by momentum (that is, to the same areas as the year before).<sup>4</sup> Companies that are more aggressive in reallocating capital to back up their where-to-compete decisions significantly outperform their peers.

Our research into more than 1,500 US companies across a range of industries has shown that those that reallocated a large proportion of their resources in response

### EXHIBIT 4 Where-to-compete choices extend beyond core health services

#### Payors might diversify in multiple directions



PBM, pharmacy benefits manager.

<sup>1</sup>Supplemental products for this purpose include dental, vision, life, and disability.

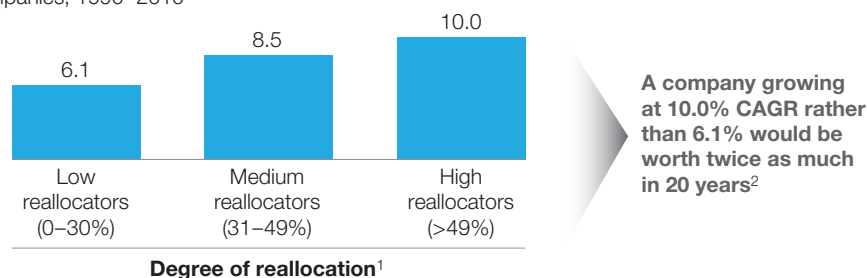
Source: Press reports; KFF industry report; Gartner; DPMC; HIRC industry report; IBISWorld; McKinsey analysis

<sup>4</sup>McKinsey Corporate Strategy Research Program.

## EXHIBIT 5 Companies that can reallocate resources nimbly win

## TRS CAGR, median, %

1,508 companies, 1990–2010



CAGR, compound annual growth rate; TRS, total return to shareholders.

<sup>1</sup> Measures the share of CapEx that shifted between business units over the 20-year period. There were 505 low reallocators, 498 medium reallocators, and 505 high reallocators.<sup>2</sup> Assumes no dividends are paid out. For example, a \$10-billion high reallocator would end up with a market cap of \$67 billion, whereas a low reallocator would end up with \$33 billion.

Source: McKinsey Corporate Strategy Practice research program

to changing market conditions achieved a much higher total return to shareholders over a 20-year period than did companies that reallocated a smaller proportion of their resources (Exhibit 5). This result was surprisingly consistent across all industries. The companies that reallocated a high proportion of their resources were also markedly less likely to be acquired or go bankrupt.<sup>5</sup>

Given the disruptive changes anticipated in the healthcare industry, payors that want to thrive over the next few years will need to develop the discipline to make and act on where-to-compete decisions. They will need insights into where growth and margin will be earned, the foresight to determine when inflection points in the market might happen, a clear view of their own competitive advantages and capabilities (which would give them the ability to win and earn a superior return), the fortitude to make tough resource-allocation decisions, and the agility to alter their course as the market shifts. Acquiring

the needed discipline is challenging but necessary. The upside from getting where-to-compete decisions right is substantial enough to demand top management's attention—and the downside is potentially fatal. ○

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This article leverages proprietary research and analysis that McKinsey has conducted using tools such as our Payor Financial Database. For details on these tools and the other major research sources used in this article, see the appendix, which begins on p. 239.

<sup>5</sup>Hall S, Lovallo D, Musters R. How to put your money where your strategy is. McKinsey Quarterly. March 2012.



# US health insurers: An endangered species?

*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.*

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*)<sup>1</sup>
- "Is this the end of health insurers?" (*Washington Post*)<sup>2</sup>
- "Insurance companies as we know them are about to die" (*New Republic*)<sup>3</sup>
- "Why health insurance companies are doomed" (*Fortune*)<sup>4</sup>

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

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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<sup>5</sup>—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.<sup>6</sup> 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<sup>7</sup>; 142 acquisitions (totaling \$4 billion) were closed in healthcare data and analytics alone (Exhibit 1).<sup>8</sup> 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.<sup>9</sup> Because the

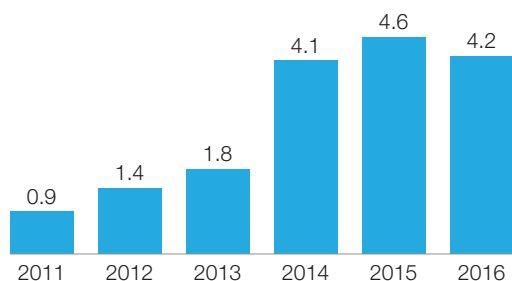
move to value-based reimbursement has had bipartisan support, upcoming changes to federal or state healthcare policies are unlikely to halt it, although the changes may slow it down or shift the focus to other types of payment innovation.

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.<sup>10</sup> 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

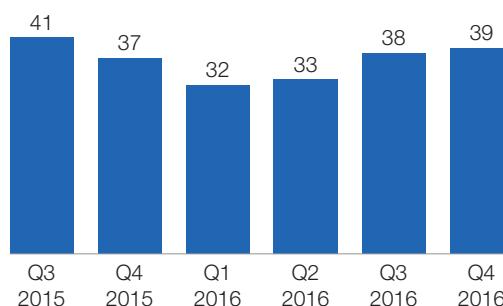
### Venture capital funding in digital health 2011–16

\$, billion



### Acquisitions in healthcare data and analytics 2015–16

Number of acquisitions

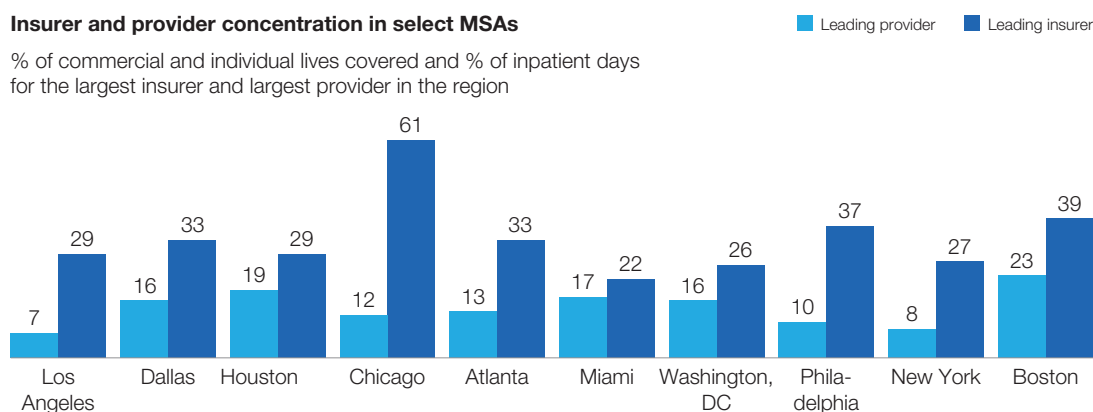


Source: Rock Health; National Venture Capital Association; PriceWaterhouseCoopers; MoneyTree; Thomson Reuters; Dealogic; McKinsey analysis

## 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).<sup>11</sup> 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.<sup>12</sup> More and more consumers have become comfortable communicating with doctors via technology rather than in-person consultations.<sup>13</sup> 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<sup>14</sup> 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

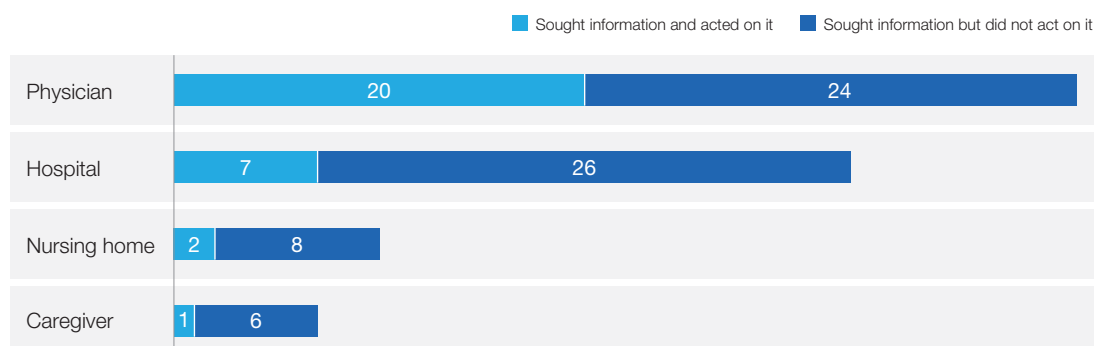
shape industry dynamics, even when their direct control is limited. In many respects, this is what Apple—and, to a lesser extent, Samsung, Google, and Android—have been doing in the mobile ecosystem. From a revenue standpoint, device manufacturers account for only 20% to 30% of the mobile value chain.<sup>15</sup> 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.<sup>16</sup>

## 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),<sup>17</sup> 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.<sup>18</sup> 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.<sup>19,20</sup>

Of course, health insurers have not been immune to scrutiny about pricing, as the coverage about price increases on the public exchanges demonstrates.<sup>21</sup> 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.

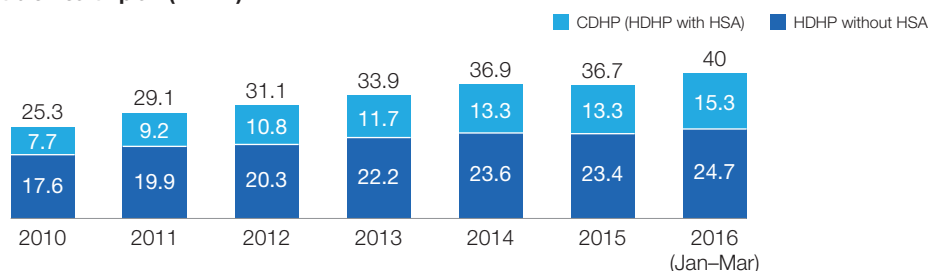
Health insurers are also well positioned to achieve impact from greater transparency in ways that go beyond cost alone. A recent study showed that public reporting of hospital mortality rates was effective in improving compliance on various process measures but had little impact on actual patient outcomes.<sup>22</sup> 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)	<b>Digital offerings</b>	Provide consumers with a fully integrated digital journey
Produce reactive analytics with few real-time insights	<b>Analytics capabilities</b>	Regularly use machine learning across lines of business
Uses pay for performance to create incremental changes in behavior	<b>Provider influence</b>	Proactively partners with high-value providers to shape care patterns
Relies on inefficiencies in the system to drive earnings	<b>Value creation</b>	Produces sources of margin that are robust for great transparency
Impedes investment because of capital constraints and low risk tolerance	<b>Financial capital</b>	Provides freedom to make strategic bets
Sources talent primarily from within	<b>Human capital</b>	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 health-care 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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- <sup>14</sup> 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.)
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# Foreword:

## Why understanding medical risk is key to US health reform

The *McKinsey Quarterly* originally published this article in June 2009. The article explores ways to refine healthcare financing and reimbursement mechanisms in the United States to make them more appropriate for different categories of medical spending—from preventive care to catastrophic and end-of-life care. As the United States embarks on further changes to its health system, our original article has gained new resonance.

Since its original publication, several dynamics of our healthcare ecosystem have changed. First, medical expenditures have risen further, and the proportion of expenditures going to various categories of medical spending has shifted (Exhibit 1).<sup>1</sup> For example, expenses related to chronic conditions have increased, a result of growth in spending on such disorders as diabetes, heart disease, arthritis, some cancers, and asthma.<sup>2</sup> In 2007, care for chronic conditions (both routine care and catastrophic care required because of disease progression) accounted for 32% of US healthcare expenditures (\$594 billion); by 2012, that number had grown to 34% (\$802 billion). The proportion of total expenditures related to elective procedures rose to 15%, from 13%. Although spending for catastrophic care not related to chronic conditions increased in absolute terms, the proportion of total expenditures related to this category fell to 28%, from 31%.

These shifts make it increasingly important that we develop financing and reimburse-

ment mechanisms that incentivize appropriate care for chronic conditions, as well as healthy behaviors and value-conscious use of care among consumers.

Second, since the original article was published, the healthcare system has attempted to better align incentives in provider reimbursement. Both public and private sector actors have made important innovations in this area. For example, in 2009, we recommended that reimbursements should be tied to long-term health management rather than the volume of services provided. In the past several years, there has been meaningful movement toward value-based payment models, such as accountable care organizations (ACOs) and patient-centered medical homes, that aim to restructure provider reimbursements to incentivize care coordination and reward providers for overall management of patients' health. In 2015, nearly 500 patient-centered medical home programs were operating in the United States.<sup>3</sup> At the end of the same year, over 23.2 million people were receiving care through ACOs.<sup>4</sup> Furthermore, most of the ACOs bear at least some financial risk for patient outcomes and cost of care, though provider performance under these programs has been mixed.<sup>5</sup> There has also been significant innovation in the use of episode-based payments. Under these arrangements, providers are evaluated and rewarded based on the quality and cost of care that they provide for an entire episode of care (e.g.,

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an upper respiratory infection or a joint replacement). The Bundled Payments for Care Improvement program, launched in 2013, now includes 1,361 provider participants and 48 distinct clinical episodes.<sup>6</sup> In addition, several state Medicaid programs have implemented episodes of care or bundled payments. For example, by spring of 2017, the State of Tennessee will have launched 34 episodes of care, and additional episodes are under design.<sup>7</sup>

Third, we have seen continued growth in the use of high-deductible health plans and health savings accounts, which seek to align demand-side incentives around healthcare use. Cost sharing has been shown to be effective in curbing healthcare utilization (see “The next imperatives for US healthcare,” p. 11).

Despite these developments, available funding mechanisms continue to be inadequate

in addressing the true nature of medical risk in many areas. There has not been much progress in ensuring that consumers have appropriate incentives to encourage self-care and appropriate use of resources—for example, through value-based insurance design, wellness incentives, and smart design of essential health benefits. High deductibles and copayments are blunt instruments that have the potential to dampen needed as well as unnecessary utilization, and thus could inadvertently increase long-term expenditures—for example, if these tools discourage patients from using appropriate healthcare services to manage a chronic condition, costly complications could ensue. Finally, a true consumer/retail market for healthcare has been relatively slow to develop, given the pervasive intermediation for routine, purely elective, and discretionary services.

On the following pages, we reprint the 2009 article, with updated analyses.

# Why understanding medical risk is key to US health reform

*In our healthcare system, those in the best position to control risks and costs often have inadequate incentive to do so. Refining healthcare financing and reimbursement requires a deep understanding of the nature of medical risk.*

The fundamental nature of medical risk in the United States has changed over the past 20 to 30 years—shifting away from random, infrequent, and catastrophic events driven by accidents, genetic predisposition, or contagious disease and toward behavior- and lifestyle-induced chronic conditions. Treating them, and the serious medical events they commonly induce, now costs more than treating the more random, catastrophic events that health insurance was originally designed to cover (Exhibit 1). What's more, the number of people afflicted by chronic conditions continues to grow at an alarming rate.<sup>8</sup>

As the nature of medical risk has evolved, neither the funding mechanisms nor the forms of reimbursement for healthcare have adapted adequately, and so the system's supply and demand sides are both hugely distorted. Consumers are over-insured against some risks and under-insured against others; woefully short of the savings required to pay predictable, controllable expenses; and all too likely to be dealing with doctors who have financial incentives to treat isolated problems rather than prevent illness and manage chronic conditions effectively.

These are important—yet frequently overlooked—points in the current debate about the future of healthcare in the United States. With the US government poised to spend billions of dollars to support universal access,

reformers must understand this shift in the nature of risk and move to align financing mechanisms and reimbursement with it. Pouring more money into the system without modernizing it will probably worsen the healthcare challenges facing the country.

Ideally, consumers should be able to buy enough coverage to feel financially secure but also share in the cost of care. In addition, coverage should be structured to give consumers incentives to manage the risks under their personal control in a value-conscious way. Just as important, the United States needs to have the reimbursement and care delivery models that best control each type of risk.

To better inform the debate on the healthcare system, we offer a new way to look at the distribution of costs within it. We break down the country's healthcare spending into separate risk categories, map them to specific medical conditions by their unique characteristics, and identify who pays for what (see the sidebar “Understanding medical risk” in “The next imperatives for US healthcare” on p. 18–19).

## Misalignment with risks

Because insurance is the dominant financing mechanism and fee for service is the primary way of reimbursing providers, the US healthcare system is misaligned in two respects. First, with consumers

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over-insured for some risks and lacking adequate protection for others, the system does not offer incentives for healthy behavior, promote value-conscious consumption, or provide adequate financial security. Second, in a fee-for-service world, providers have a financial incentive to undertake as many procedures as possible—a model especially

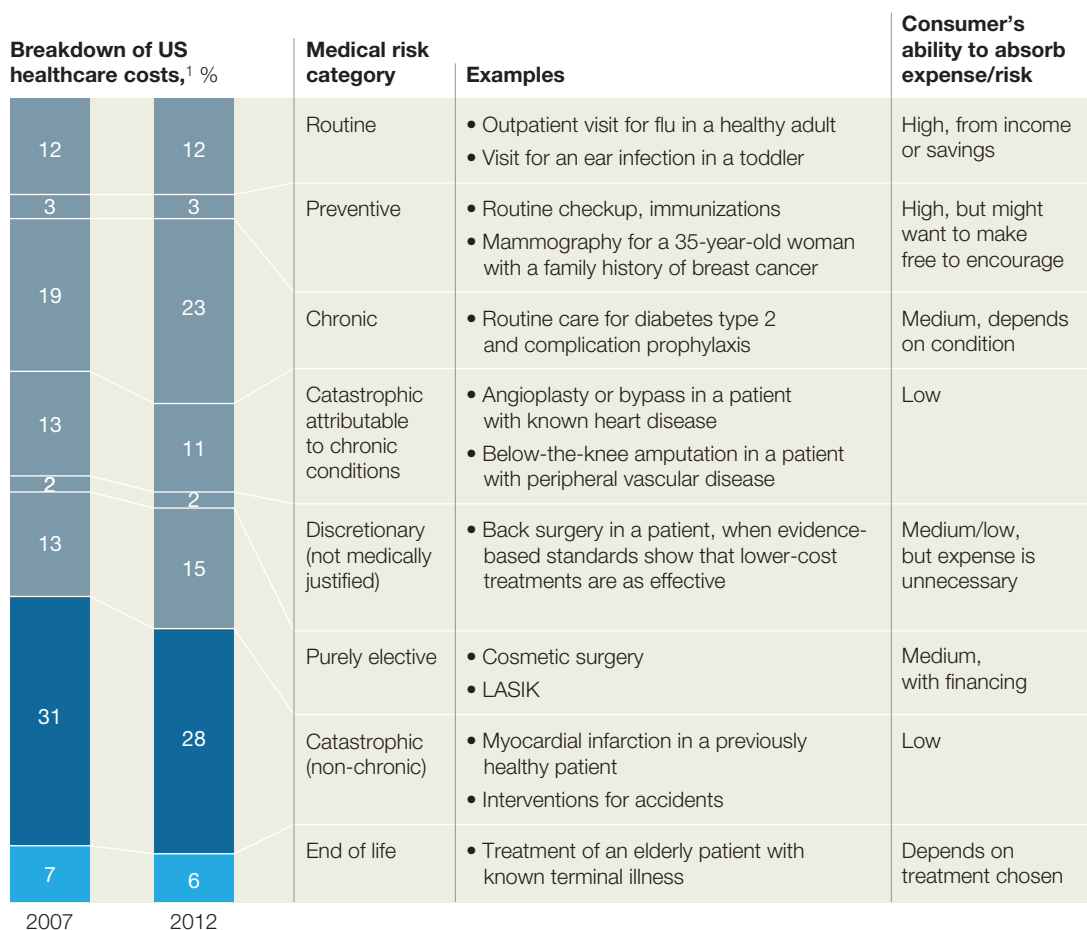
ill-equipped to manage increasingly prevalent chronic conditions.

This misalignment is a relatively recent phenomenon. Insurance is effective if it pools random, infrequent, and unpredictable risks. When health insurance was introduced, in the 1930s, it did precisely this. Over the

## EXHIBIT 1 The nature of healthcare risk

Degree to which consumers have some control over costs

■ High ■ Medium ■ Low



<sup>1</sup> Government administrative expenses, private insurers' profits, research expenses, the cost of equipment and software, and the cost of public health activities are excluded.

Source: National Health Expenditure Accounts; Medical Expenditure Panel Survey; National Vital Statistics System; Healthcare Cost and Utilization Project; Dartmouth Atlas for Health Care; McKinsey analysis

*To better inform the debate on the healthcare system, we offer a new way to look at the distribution of costs within it.*

decades, however, it expanded to cover an increasing array of services, largely because employers wanted to attract workers by providing a tax-advantaged benefit.

In the 1980s and early 1990s, managed care promoted this trend by offering consumers “first-dollar coverage,” reimbursing for routine services and expenses related to conditions that weren’t random, infrequent, and catastrophic in exchange for the patients’ willingness to cede decision rights on treatment choices to primary care physicians. When managed care lost popularity, consumers regained choice but largely retained first-dollar coverage.

The more recent shift requiring consumers to share more of the cost has sought to correct this imbalance through products such as high-deductible health plans combined with health savings accounts. Some of the cost shifting, though, has not been sufficiently nuanced and left many consumers underinsured and financially exposed in certain risk categories. Requiring consumers to bear over 10% of the cost of treating a catastrophic event, for example, exposes many people to financial hardships, given that the expense involved could be tens of thousands of dollars. The current approach also does little to promote value-conscious consumption—after all, people have only a limited ability to avoid accidents and can hardly shop for medical care when they happen (Exhibit 2). Furthermore, the fact that consumers cover almost 30% of the cost of preventive care conflicts with the goal of maximizing its use.

As we have seen, the system also suffers from misaligned supply-side incentives, given the predominance of fee-for-service reimbursements to providers. Prices are set through long-term contracts between providers and government agencies or private insurers, so their primary financial incentive is to increase the volume of profitable services, such as imaging. Current incentives, moreover, fail to encourage the desired outcomes across categories of risk; for example, insurers are mainly responsible for financing delivery risk—the cost and quality outcomes of care. This approach leads to the overuse of healthcare services, since consumers have little incentive to curtail their use of the system, while providers have a strong incentive to increase their volume of services.

These issues are particularly vexing for chronic conditions because the fee-for-service reimbursement model is fundamentally misaligned with the need to manage long-term health outcomes. That kind of management is essential to reduce the incidence of expensive catastrophic events arising from the complications of chronic diseases (amputations, for example, as a result of unmanaged diabetes), but the reimbursement system does little to encourage it. In fact, under the current system, with few exceptions, providers earn more revenue when catastrophic events occur. More troubling still, the fee-for-service model tends to fragment the provision of care into scores of unrelated interventions. Yet the effective

management of chronic disease calls for integrated, coordinated care among many different types of physicians and between them and medical institutions.

## Seeking proper alignment

The underlying goal of reform should be to align risks—both risk exposure (lifestyle choices inducing chronic conditions) and expenses incurred (treatment choices affecting costs

and outcomes)—with the parties best equipped to control them. To achieve this goal, it will be necessary to determine the most appropriate financing mechanisms and provider reimbursement models for each healthcare risk category; one-size-fits-all approaches are counterproductive in an increasingly complex healthcare world. For some risks, it will be appropriate to use sophisticated reimbursement methods: bundled payments for episodes of care, capitation

### EXHIBIT 2 Misaligned funding

Breakdown of US healthcare costs, 2012

■ Insurance<sup>1</sup> ■ Consumer out-of-pocket<sup>2</sup> ■ Subsidy<sup>3</sup>

Medical risk category	Total spending, \$, billion	Funding method, % <sup>4</sup>		
Catastrophic care attributable to chronic conditions	265	83.0	4.6	12.4
Discretionary care (not medically justified)	48	69.7	16.7	13.6
End-of-life care	143	65.5	14.3	20.2
Catastrophic care (non-chronic)	662	65.3	11.7	23.0
Preventive care	70	59.3	29.2	11.5
Chronic care	537	54.4	27.2	18.4
Routine care	285	52.2	38.1	9.7
Purely elective care	361	17.9	66.9	15.2
<b>Total</b>	<b>2,372</b>	<b>55.9</b>	<b>26.8</b>	<b>17.3</b>

<sup>1</sup>Insurance sponsored by public and private employers or purchased by individuals; includes consumer-paid premiums.

<sup>2</sup>Includes copayments, coinsurance, and deductibles; excludes premiums on employer-sponsored and individually purchased insurance.

<sup>3</sup>Includes federal and state subsidy programs, such as Medicaid and State Children's Health Insurance Program.

<sup>4</sup>Funding method analysis based on 2007 data.

Source: Office of the Actuary and National Health Expenditure Data Fact Sheet; US Centers for Medicare and Medicaid Services; Medical Expenditure Panel Survey; McKinsey analysis

(a fixed payment per year per member), or risk-sharing arrangements. In many cases, however, relatively simple fee-for-service payments will remain the model of choice.

### **Routine expenses**

Most US households can afford relatively frequent fee-for-service medical episodes such as a visit to a physician to treat a fever or to a pediatrician to treat a toddler's ear infection. The most efficient way to pay for such services is not insurance but rather savings. (The indigent ought to receive subsidies.) The reimbursement model for these services should resemble that of any other consumer service—providers make value-based sales to consumers who pay them directly. As in the case of other services, each consumer segment will value features such as convenience, speed, and quality differently, so providers have opportunities to differentiate themselves. One such innovation, consumer-oriented retail clinics, provides a clear value proposition by offering convenient locations, limited waiting times, and transparent, fixed, and relatively low prices.

### **Preventive care**

There is also little financial need for insurance to cover preventive-care services, such as vaccinations and screenings (like mammograms) to detect high-risk conditions early, since they too offer substantial benefits at relatively affordable prices. These services, however, are essential to maintain the medical health of society and to control the cost of treating illnesses in the future. As a matter of good public policy, this type of care should therefore be available as widely as possible, at little or no charge, to ensure the greatest possible access. General public health spending by the government could

finance such services, or they could be a required part of the coverage of every health insurance product. Fee-for-service reimbursement is simple and effective here.

### **Chronic care**

The largest, fastest-growing healthcare risks are chronic conditions and catastrophic events attributable to them, such as angioplasty or bypass operations for heart disease and below-the-knee amputations for peripheral vascular disease. Addressing this type of medical risk arguably requires the biggest changes in the current system. New financing mechanisms are needed to manage such conditions cost-effectively over long periods of time by financing investments in wellness and care management today so that costs fall tomorrow. These mechanisms must give consumers incentives based on behavioral-economic principles that promote healthy behavior and value-conscious consumption of care. Finally, it will be important to give the providers incentives compatible with the need to manage health outcomes across the whole population of chronic patients and to provide multidisciplinary, coordinated care throughout the delivery system.

[Devise longer-duration, portable financing mechanisms.](#) Once you have a chronic condition, the cost of managing it is fairly predictable—this isn't an insurable expense, which ought to be random, infrequent, and unpredictable. Further, in effective treatments for chronic conditions, true value accrues over time by precluding their progression and, especially, the catastrophic events related to them.

To encourage investments in wellness, prevention, and disease management, health



insurers or integrated healthcare providers must embrace long-term “ownership” of the patient—something akin to life insurance, which offers coverage that often stretches over many years or even an entire lifetime. Three broad types of financing mechanisms could be effective: multi-year term policies, annuities (pay a lump sum today for a contract covering chronic-care expenses permanently or for a fixed period), or self-insurance (pay out of savings or income).

Private payors in other countries have introduced health insurance products based on actuarial concepts similar to those used in life insurance. Some German payors, for example, offer lifetime coverage products. Under these arrangements, younger customers pay premiums higher than their risk level would typically command; at older ages, the accumulated surplus is used to reduce premiums.<sup>9</sup>

Since the consumer controls much of the risk associated with chronic conditions through behavioral choices, the financing mechanisms should include incentives to address the emotional and behavioral biases that stand in the way of rational lifestyle and healthcare choices. Just shifting costs is ineffective, since it often fails to differentiate between unnecessary and sensible (preventive services) utilization. But rewards and

penalties based on insights from behavioral economics and other behavioral sciences can work well.<sup>10</sup>

**Design reimbursements tied to long-term health management.** Reimbursements to providers should be based on long-term health-management outcomes rather than the fee-for-service model. A sensible system could involve capitation or risk sharing, with outcome-oriented payments reflecting how well a provider manages a condition. The effective management of chronic disease and multiple disorders often requires collaboration among specialists from many medical disciplines, so the reimbursement structure should reinforce coordination of care. Experiments with patient-centered medical homes—a form of integrated care management—may well show how to manage the risks of chronic conditions.

### **Elective procedures**

Today, insurance rarely covers truly elective spending (such as cosmetic surgery, alternative medicine, or LASIK eye surgery), which the consumer pays for out-of-pocket, often using credit. This part of the healthcare marketplace actually works well: elective treatments, as a classic consumer retail item, are available to those willing to assume the full burden of paying for them. In addition, all services not medically justified by evidence-

*The guiding principle should be to redesign financing mechanisms for consumers and reimbursements to align medical risks ... with those who can most effectively control and manage them.*

based standards—for example, certain types of joint surgery if studies show that a lower-cost drug treatment is equally or more effective—should be paid for out-of-pocket by the consumer. Some evidence suggests that a robust consumer market for elective procedures, coupled with transparent pricing, has driven down prices for elective procedures in the United States (see “The next imperatives for US healthcare,” p. 11).

### **Catastrophic care for unforeseen events**

Unpredictable, random, and infrequent risks (heart attacks in previously healthy patients, for example, and interventions for accidents) should be financed through traditional insurance. In such cases, consumers have limited discretion and little ability to exert downward pressure on prices—few victims of auto accidents, for example, can shop for a cost-effective ambulance service and make well-informed cost-benefit calculations about treatments. Deductibles on this type of insurance should therefore be kept low; costs are best managed by redesigning reimbursements for providers.

A provider should be compensated in one bundled payment based on the total episode of treatment, from the moment the health crisis starts until full recovery, rather than on a fee-for-service basis. Such bundled reimbursements would give providers an incentive to improve their efficiency. They would also find it in their interest to restrain costs in a reasonable way—for example, by providing cost-effective services (the correct type of hip joint, say) and high-quality treatment the first time around rather than having to readmit patients for costly corrections after botched initial interventions. Including special-

ists and hospitals in this total-episode-based reimbursement system will be essential.

### **End-of-life care**

Riders on life insurance policies might be the best way to finance end-of-life care—say, for an elderly patient with a known terminal illness—which is generally quite expensive. The insured could decide how much of their benefits to draw down at this stage rather than bequeath them to the beneficiaries. Fee-for-service reimbursement for providers would probably be appropriate, since it is hard to apply outcome measurements or evidence-based standards to many of these treatments (for instance, experimental ones).



As reform efforts move forward, the guiding principle should be to redesign the demand side (financing mechanisms for consumers) and the supply side (reimbursements and the delivery system) to align medical risks—and the attendant financial incentives—with those who can most effectively control and manage them. Continuing reform initiatives provide a great opportunity to restrain costs, deliver more cost-effective care, and ease the financial and psychological burden on hard-pressed US consumers. It can be undertaken fairly, we believe, if the government helps people in difficult financial straits pay for their care. ○

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The authors would like to thank Matt Carey for his contributions to this article.

## FOOTNOTES

- <sup>1</sup> Please refer to Exhibit 5 of “The next imperatives for US healthcare” (p. 11) for further discussion.
- <sup>2</sup> McKinsey analysis of data from the National Health Expenditure Accounts, Medical Expenditure Panel Survey, National Vital Statistics System, Healthcare Cost and Utilization Project, and Dartmouth Atlas of Health Care.
- <sup>3</sup> Neilsen M et al. The Patient-Centered Medical Home’s impact on cost and quality: Annual review of evidence, 2014-2015. Patient-Centered Primary Care Collaborative. February 2016. This report covers both patient-centered medical homes and similar programs designed to enhance primary care.
- <sup>4</sup> Muhlestein D et al. Projected growth of Accountable Care Organizations. Leavitt Partners. December 2015.
- <sup>5</sup> Evaluation of CMMI Accountable Care Organization initiatives. L&M Policy Research. March 2015.
- <sup>6</sup> Center for Medicare and Medicaid Innovation. Bundled Payments for Care Improvement (BPCI) Initiative.
- <sup>7</sup> Tennessee Division of Healthcare Finance and Administration. Episodes by wave.
- <sup>8</sup> For more information, see the National Center for Chronic Disease Prevention and Health Promotion website.
- <sup>9</sup> Singhal S et al. Global private payors: A trillion-euro growth industry. McKinsey white paper. December 2016.
- <sup>10</sup> Cordina J, Pellathy T, Singhal S. The role of emotions in buying health insurance. McKinsey Quarterly. May 2009.



FUTURE OF THE MARKET:  
Forces to watch





# Atomization of the network: How far will it go?

*Narrowed networks are becoming more common as health insurers look for ways to decrease their cost base and lower premiums, but the strategy raises potential risks for both payors and providers.*

Following the strong backlash that arose against managed care in the 1990s, few innovations in hospital network design took place until payors began planning for the 2014 open enrollment period (OEP) in the individual market. At that time, many of them introduced plans with “narrowed” hospital networks<sup>1</sup> as a way to hold down costs. Almost half of the plans offered on the public exchanges during the first OEP had narrowed networks, and the median premium for a narrowed network plan was 11% to 17% lower than the median premium for a broad network plan (depending on the metal tier).<sup>2</sup>

Since then, the trend toward narrowed networks has accelerated. For example, among the plans offered by national payors<sup>3</sup> during the 2017 OEP, 74% had narrowed networks; the comparable number for the national payors that operated in the 2014 OEP was 57%. Furthermore, the cost advantage that narrowed network plans give consumers increased during that time—in the 2017 OEP, the median premium for a narrowed network plan was 18% to 35% below the median premium for broad network plans (Exhibit 1).

Because narrowed networks allow payors to control their spending on hospital care, they hold the potential to help payors reduce their cost base and further lower premiums<sup>4</sup> (see “The next imperatives for US health-care,” p. 11). However, concerns have been

raised about whether narrowed networks restrict patients’ access to appropriate care. (We did not evaluate network adequacy as part of this research.)

Provider-led health plans, which focus their networks on their own facilities, can be considered a type of narrowed network, and they too are becoming more common. Between 2014 and 2017, the number of providers that offered plans on the public exchanges increased from 64 to 76, and 20% of the plans offered in the 2017 OEP were provider-led plans, up from 16% in 2014.<sup>5</sup> This trend has been playing out in the Medicare Advantage and Medicaid markets as well.

Today’s consumers appear to be willing to accept narrowed networks. After the close of the 2016 OEP, we surveyed consumers who were eligible to purchase qualified health plans (QHPs) in the individual market. Among the respondents who said they had purchased a new plan, 45% reported selecting a plan with a narrowed network, up from 34% in our 2015 post-OEP survey (see “Understanding consumer preferences can help capture value in the individual market,” p. 81).<sup>6</sup> Our survey results also suggest that consumers value having their preferred physician in network over having a range of provider options: 21% of the respondents who bought new plans in 2016 cited having their preferred doctor(s) in network as the factor with the strongest

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The footnotes for this article appear on p. 54.



influence on their purchase decisions. By comparison, having a wide selection of doctors or hospitals in the network was ranked first by less than 5% of consumers.

Consumers are not completely satisfied with narrowed networks, however. In our 2016 post-OEP survey, 60% of the respondents who said they had bought a narrowed network plan during the previous OEP reported having had issues (e.g., unexpected out-of-pocket costs, lack of access to a preferred provider) when they tried to access care; the corresponding figure among those who purchased broad network plans in 2015 was 38%. Nevertheless, only 9% of the respondents who had purchased narrowed network plans in 2015 said they had switched to a broad network plan in 2016.

While the penetration of narrowed network plans in the commercial group market is still

relatively low, our employer surveys suggest that many companies are considering adopting them. In our 2016 survey, only 5% of the employers indicated that they offer a narrowed network plan today.<sup>7</sup> However, 51% said they were considering offering such plans as a way to hold down benefits costs. Furthermore, the percentage of employers who said they were very interested in adopting narrowed network plans was nearly twice as high in 2016 as it had been in our 2011 survey (22% vs. 12%). Interviews we conducted suggest that most employers are likely to offer narrowed network plans alongside more traditional broad network products; similarly, 79% of the 2016 survey respondents who said they were interested in narrowed networks indicated that they would offer them as an additional option.

For payors, the economic advantages of offering narrowed network plans are

## EXHIBIT 1 Median premium difference between broad and narrowed networks

Difference between plans in the same rating area, carrier type, and plan type,<sup>1,2</sup> %

	Bronze	Silver	Gold	Platinum
2014	11	16	16	17
2015	14	16	15	23
2016	17	22	23	33
2017	18	18	19	35

<sup>1</sup>In this analysis, the set of narrowed networks included ultra-narrow networks (those with no more than 30% of local hospitals participating in a network) and narrow networks (those with more than 30% but no more than 70% of local hospitals participating). Tiered networks were excluded.

<sup>2</sup>Median prices were based on the premiums for a 40-year-old single non-smoker. When a network was included in multiple plans, the lowest-price plan was used as the price of the network. If there were multiple networks available for selection as "narrowed," the narrowest was selected. If there were multiple networks available for selection as "broad," the broadest was selected.

Source: McKinsey Exchange Offering Database



*Our analysis of 2014 exchange plans showed that ... narrowed network plans had better aggregate margins and lower claims than broad network plans did.*

becoming increasingly clear.<sup>8</sup> Our analysis of 2014 exchange plans showed that once the 3Rs—risk adjustment, reinsurance, and risk corridors (the mechanisms intended to stabilize payor financial performance in the early years of the public exchanges)—are taken into consideration, narrowed network plans had better aggregate margins and lower claims than broad network plans did. This difference likely resulted, in part, from the unit-cost advantages of narrowed network plans. The combination of the improving relative pricing of narrowed network plans and their superior financial performance suggests that the plans may be emerging as a sustainable element of exchange plan design.

Thus, network narrowing may be here to stay. If true, it raises two questions: How far will network narrowing go? And what risks does further narrowing present to payors and providers? The growing use of health-related digital technologies—including scheduling applications, cost and quality transparency tools, and virtual visits with physicians—could eventually give consumers the ability to create their own hyper-narrow networks. Although this level of atomization of provider networks may seem far-fetched right now, it is not impossible. If consumers are able to create their own hyper-narrow networks, payors may risk being disintermediated.

Payors may also face a less obvious—but more immediate—risk from provider-led plans.

In the 2017 individual market OEP, 48% of QHP-eligible consumers had access to a provider-led plan, and 18% of consumers were in markets where provider-led plans had the lowest-price silver plan (up from 10% in 2014).<sup>9</sup> Thus, provider-led plans may be poised to gain market share.<sup>10</sup>

Another risk payors face is the need to increase their analytic capabilities. To compete in a market with greater penetration of narrowed network products and maximize premium savings for consumers, payors must be able to conduct provider scoring and perform the complex analytics required to estimate the total cost of care as accurately as possible.

Network atomization also presents potential risks to providers. At present, many providers are consolidating, in part because of the belief that vertical integration will give them a stronger position from which to negotiate with payors about network inclusion, and also help them reduce transactional friction and costs. However, the complexity inherent in consolidation produces its own costs, and recent changes in Medicare reimbursement may make further vertical integration less attractive. Atomization could erode some of the advantages of health system integration.

Narrowed networks could evolve in many ways, but the evidence suggests that their

prevalence is likely to increase. Customer-built provider networks may never materialize—but they could also be a logical extension of network narrowing. One thing seems clear, though: the healthcare industry in 2020 is highly likely to be as different from today as today's industry is from the one we

knew a few years ago. It remains to be seen what role the further atomization of networks will play in the future of the industry. [O](#)

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#### FOOTNOTES

<sup>1</sup>Network types vary in their hospital participation. Narrowed networks include narrow networks (more than 30% and no more than 70% of hospitals participate), ultra-narrow networks (no more than 30% of hospitals participate), and tiered networks (any network with multiple levels of in-network cost-sharing for hospital services), unless otherwise noted. Note: Only hospital networks are considered in these analyses. Physician networks are not covered.

<sup>2</sup>Coe E, Bello J, Lamb J. Hospital networks: Perspective from three years of exchanges. McKinsey Center for US Health System Reform Infographic. March 2016.

<sup>3</sup>National: a commercial payor with a presence in more than four states that has filed on exchanges (specifically, Aetna/Coventry, Assurant, Cigna, Humana, UnitedHealthcare).

<sup>4</sup>For more information about the impact of narrow networks on premiums, see "The next imperatives for US healthcare," p. 11.

<sup>5</sup>McKinsey Exchange Offering Database.

<sup>6</sup>Further information is available in "2015 OEP: Insight into consumer behavior." McKinsey Center for US Health System Reform Infographic. March 2015.

<sup>7</sup>McKinsey 2016 Employer Health Benefits Survey.

<sup>8</sup>Coe E, Finn P, Miskufova M, et al. Exchanges three years in: Market variations and factors affecting performance. McKinsey Center for US Health Reform Intelligence Brief. May 2016.

<sup>9</sup>These figures do not include plans offered by insurers that are co-branded with a provider.

<sup>10</sup>For another perspective, please see "US health insurers: An endangered species?," (p. 31).

# Value-based care: Is it sustainable?

*Four fundamental questions can help payors and providers improve productivity and better control utilization—the prerequisites for making value-based care sustainable.*

**Shubham Singhal**

Most people in the healthcare industry agree—in theory, at least—that the time is right for value-based care. Fee-for-service reimbursement is becoming increasingly unaffordable. Data liquidity, rapid advances in data processing and analytics, and the ability to store massive amounts of data have combined to enable us to quantify value. And there is conceptual agreement among healthcare industry stakeholders that such a shift is necessary. Given the bipartisan government support evident in recent years at both the federal and state levels, it is likely that the shift to value-based care will continue.<sup>1</sup>

But is the shift to value-based care sustainable? In other words, can payors and providers find a way to ensure delivery of value-based care without destroying their economic underpinnings? The problem is this: at present, the US healthcare sector is essentially a zero-sum game, and the sector has considerable installed capacity that cannot easily be removed. Thus, financial improvement for one group often comes at the expense of another.

To date, value-based care has driven reductions in healthcare expenditures, but the impact has largely resulted from either decreased utilization or the movement of a small minority of services to lower-cost sites of care. In a zero-sum game, stakeholders put up defense mechanisms to preserve their position when volume is taken out of the system. Furthermore, in thriving economies (or thriving sectors of an economy), value

creation results not from delivering less, but from delivering the same amount, or more, with fewer resources. Thus, volume reductions alone are not a long-term recipe for ensuring the sustainability of value-based care.

The only real way that the healthcare sector can get around this problem—the only way it can thrive while delivering greater value to patients and consumers—is to increase its productivity significantly. In the past 35 years, most US industries have achieved major productivity improvements. The healthcare sector has lagged in this regard.

Our article, “The next imperatives for US healthcare” (p. 11), includes a discussion of actions that healthcare industry players can take to improve productivity. To make value-based care sustainable, incumbent payors and providers must achieve productivity gains along with utilization control. To do so, they can begin by asking themselves four questions:

## [Do they need greater focus?](#)

Most incumbents have been trying to be generalists. Achieving higher productivity is likely to require incumbents to become as efficient as possible through greater specialization and greater scale within those areas of specialization. For example, it is well understood that surgeons who perform a high volume of specific procedures achieve better outcomes.<sup>2,3</sup> Similarly, McKinsey research shows that the minimum effective

The footnotes for this article appear on p. 56.

scale for payors is generally above half a million lives in any one business line. (This threshold is even higher for some lines of business.)

#### Do they need a clean-sheet operating model?

Most healthcare incumbents built their operating models in the 1980s and 1990s for a world that no longer exists. Today, we have different technologies, different information flows, and different ways of delivering care. Few incumbents have truly modernized their operating models—and asset bases—in response. As they rethink their operating models, incumbents should focus on the integration of data, not facilities. If greater specialization results in wider distribution of assets, effective use of new technologies to integrate information from those assets will be necessary for the delivery of value-based care.

#### Are they using labor optimally?

Incumbents, particularly providers, may not be optimizing their labor force to promote productivity. Reimbursement policies of payors can exacerbate this dynamic.


To enhance productivity of the labor force, providers could take steps to access additional capacity within the current workforce, for example by rationalizing appointment types to reduce scheduling gaps. Physicians could also improve productivity of the existing workforce by interacting with patients through a variety of modalities (e.g., video conference, phone, email), which have the potential to enhance efficiency for the clinician as well as convenience and satisfaction for the patient. Current payment systems can discourage this type of productivity enhancement, given

that clinicians are often only reimbursed for in-person patient visits.

Other steps that providers can take to enhance workforce productivity include improving the allocation of tasks based on skill mix and increasing the use of technology to promote clinician efficiency.

#### Do they reward innovation?

Too many actors in the healthcare sector still have what is essentially a cost-plus pricing mentality. As a consequence, innovations rarely achieve the impact they should. All too often, if someone finds a way to reduce costs, the innovators don't see a good return on their efforts. Industry executives need to determine what new pricing and reimbursement models, and what new rules, are needed to ensure that innovation is rewarded.

Without answers to these questions, healthcare will not be able to achieve the types of productivity improvements that are fundamental to sustainable growth of value-based care. 

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#### FOOTNOTES

<sup>1</sup>For more on value-based payment, see “Why understanding medical risk is key to US health reform” (p. 39) and “CMS's final ruling on the Quality Payment Program under MACRA: Strategic implications for stakeholders” (p. 108).

<sup>2</sup>Sahni N et al. Surgeon specialization and operative mortality in United States: retrospective analysis. *BMJ*. 2016;354:i357.

<sup>3</sup>Clark J, Huckman R. Broadening focus: spillovers, complementarities, and specialization in the hospital industry. *Management Science*. 2011;58:708-22.

# Distributed sites of care: At the tipping point?

*Increasingly, consumers are seeking services at sites of care outside of the traditional health system infrastructure. This shift has important implications for how health systems think about their asset base and scale.*

**Shubham Singhal**

Today's consumers, having grown used to on-demand services and online access, are increasingly looking for convenience when it comes to healthcare. Each year, \$330 billion in consumer out-of-pocket spending on healthcare is now up for grabs, and consumers are increasingly seeking services in nontraditional settings.<sup>1</sup>

A significant amount of care delivery now occurs at sites of care outside of the traditional health system infrastructure. For example, while few pharmacies offered immunizations in 2009, approximately 20% of adult vaccinations were delivered in a retail clinic or pharmacy by 2012.<sup>2</sup> Additional volume may be poised to shift away from hospitals and physician offices to more distributed, consumer-oriented settings such as retail clinics, urgent care facilities, and virtual modalities. Many diagnostic tests could be moved into retail care settings, and researchers have estimated that 14% to 27% of emergency department visits could be handled at urgent care centers.<sup>3</sup> Providers are also experimenting with delivering some care for chronic conditions remotely through telehealth platforms.<sup>4,5</sup>

At present, the change may be most notable in the rise of health clinics in retail stores. These clinics have been expanding rapidly and have stronger revenue growth than do somewhat more mature retail sites of care (e.g., urgent care and ambulatory care

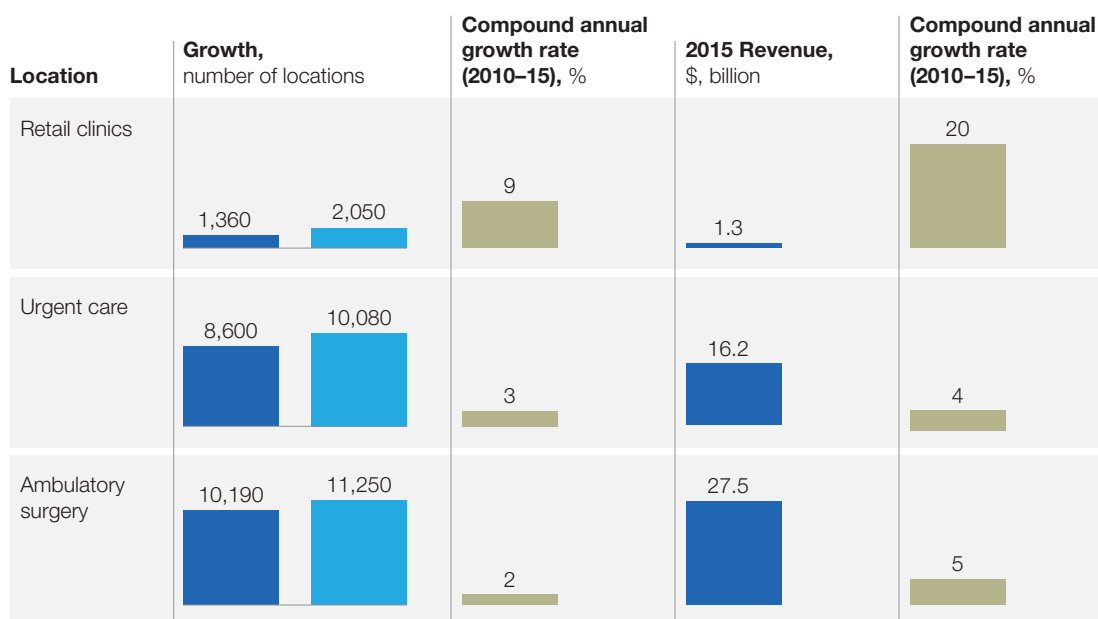
centers) (Exhibit 1). Between 2010 and 2015, retail health clinic revenues increased at a compound annual growth rate of 20%. In contrast, inpatient utilization declined during this period. Though growth in the number of locations has partially contributed to the increase in retail healthcare revenues, same-store sales have also risen as retail clinics attract more volume and expand their service offerings.

The volume that could migrate to retail clinics could increase in the next few years, because large retailers have a significant opportunity to expand the presence of clinics across their locations. In 2015, the footprint of one prominent retail clinic chain was sufficient to serve only about 8% of the US population (Exhibit 2). However, if a retail pharmacy chain such as Walgreens were to open a health clinic in each of its stores, more than half of the US population would have convenient access to its clinics. If Walmart were to take a similar course, more than three-quarters of the population would be covered.<sup>6</sup>

Some evidence suggests that a portion of the care that consumers seek in retail settings represents new utilization, perhaps driven by lower friction costs in accessing care (e.g., lower out-of-pocket costs, more convenient locations and hours). However, one study found that 42% of retail clinic visits are a substitute for a visit to a physician's office or emergency department—

The footnotes for this article appear on p. 60.

### EXHIBIT 1 Healthcare delivery at distributed sites of care has seen strong growth



Source: Kalorama; IBISWorld

representing a shift in volume away from traditional providers.<sup>7</sup>

While retailers are experimenting with different models of ownership and contracting to deliver healthcare in their stores, increasing consumer demand for convenient and affordable options suggests that the number of retail clinics is likely to continue to grow. In a survey of healthcare consumers we conducted in 2016, 12% of the respondents indicated a preference for accessing routine medical care through a retail clinic or pharmacy; another 12% indicated a preference for accessing routine care through an urgent care clinic.<sup>8</sup> The top reasons given by consumers for their preferred site of care included convenient location (cited as the most important reason by 13% of respon-

dents) and great customer service (8%). Another data point: respondents were asked where they would seek care if they moved to a new location. While 43% of consumers indicated that they would go to a primary care provider's office to receive care, 25% said that they would visit an urgent care provider, and 6% said they would seek care from a clinic at a pharmacy or retailer.

Consumer demand for more convenient, distributed sites of care has important consequences for traditional health systems. An environment that rewards broader distribution of assets could make geographic scale more advantageous; many health systems are already beginning to rethink their asset base to expand regionally or nationally. Some health systems are crafting their own

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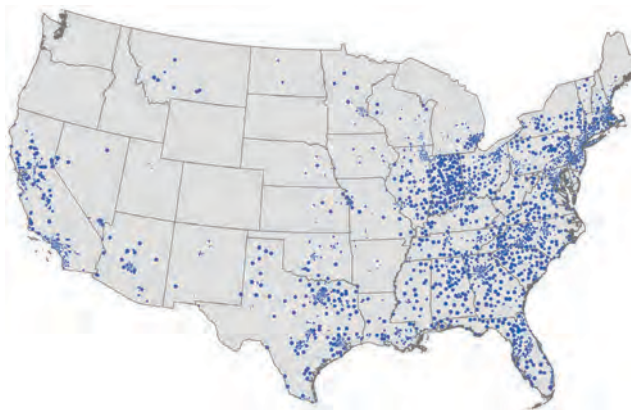
**EXHIBIT 2 The percentage of the US population with potential access to a retail health clinic suggests an opportunity for further growth**

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**In 2015, 8% of the US population had convenient access to a clinic operated by one prominent retailer**



**If a major retail pharmacy<sup>1</sup> were to open a clinic in each one of its stores, over half of the US population would have access**



**If a major retail giant<sup>2</sup> were to open a health clinic in each one of its stores, more than three-fourths of the population would have access**



<sup>1</sup>Analysis based on data on Walgreens locations in 2015.


<sup>2</sup>Analysis based on data on Walmart locations in 2015.

Source: AggData; McKinsey Geospatial Analytics



retail care portfolios—some are investing in or forming partnerships in the retail space, while a few are operating virtual care kiosks and portals. One winning strategy may be broader geographic scale paired with greater specialization of services. A strong brand also becomes more important to attract consumers across a wider geographic footprint.

For health systems, moving into distributed sites of care is not without its challenges,

however. Perhaps the biggest challenge is a mental one: to shift from a worldview in which hospitals are at the center of care delivery to one in which consumers are. For most consumers, hospitals are at the periphery, serving only a narrow subset of their needs. 

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#### FOOTNOTES

<sup>1</sup>World Health Organization. Global Health Expenditures Database.

<sup>2</sup>Bachrach D et al. The value proposition of retail clinics. Robert Wood Johnson Foundation and Manatt. April 2015.

<sup>3</sup>Weinick R et al. Many emergency department visits could be managed at urgent care centers and retail clinics. *Health Affairs*. 2010;29(9):1630-1636.

<sup>4</sup>Vassilev I et al. Assessing the implementability of telehealth interventions for self-management support: a realist view. *Implementation Science*. 2015;0:59.

<sup>5</sup>See “Digital healthcare: How disruptive will it be?” (p. 61) and “How tech-enabled consumers are reordering the healthcare landscape” (p. 197).

<sup>6</sup>AggData, McKinsey Geospatial Analytics.

<sup>7</sup>Ashwood JS et al. Retail clinic visits for low-acuity conditions increase utilization and spending. *Health Affairs*. 2016;35:449-55.

<sup>8</sup>2016 McKinsey Consumer Health Insights Survey. Eight percent of the respondents indicated a preference for accessing routine medical care through a retail clinic, 4% through a pharmacy, and 1% through a retailer (N = 2,809).

# Digital healthcare: How disruptive will it be?

*Digital technologies have the potential to improve both productivity and quality of care by extending care delivery to new modalities, making transactions more efficient, and supporting clinical operations.*

Digital technologies have reshaped almost every industry, and their impact on healthcare has the potential to be similarly transformational—not just to improve patient outcomes, but also to significantly reduce costs and capture new value. We estimate that at least \$175 billion—and possibly much more—could be at stake through the digitization of healthcare in the United States (Exhibit 1).

The digitization of healthcare will not occur in some imaginary future. Given the broad adoption of electronic health record systems, rise in computing power, and emergence of powerful analytics capabilities, the healthcare industry is poised for significant change. Perhaps most notably, it is positioned to realize productivity gains by integrating existing technologies and reducing information asymmetries across the healthcare ecosystem. Three areas hold particular promise.

## The “Internet of People”

Healthcare providers are increasingly able to use technology to enhance and extend care delivery beyond healthcare facilities. For example, remote monitoring technologies exist today that allow providers to regularly check in on patients’ vital signs between office visits. Using machine learning, providers can detect changes in a patient’s health, then engage with the patient through digital platforms (phone, text, email, or an app) to determine if in-person care is required. Remote monitoring and virtual visits

are important elements of the broader trend toward distributed sites of care.<sup>1</sup> Such capabilities have the potential to improve productivity as well as the responsiveness and convenience of healthcare services.

Consumer-facing technologies also have the potential to reshape the healthcare landscape in even more profound ways. Our article, “How tech-enabled consumers are reordering the healthcare landscape” (p. 197), argues that these technologies could disrupt the evolution toward larger, more integrated healthcare systems. Consumers—demanding greater convenience and value, empowered with tools that enhance price and quality transparency, and able to access care through new platforms such as telehealth—may choose to seek care from different service providers at each step along the care continuum. This dynamic could create opportunities for players that can cultivate consumer engagement through digital platforms. Conversely, it represents a real risk for incumbents that are caught flat-footed in consumer-facing digital transformation.

## Digitization of transactions

Transaction costs in healthcare are significantly higher than in other industries. Estimates put the processing cost per transaction in the US healthcare sector at up to 15%, compared with 2% in the retail sector.<sup>2</sup> The digitization of transactions—such as digital sales and service, pre-qualification and insurance

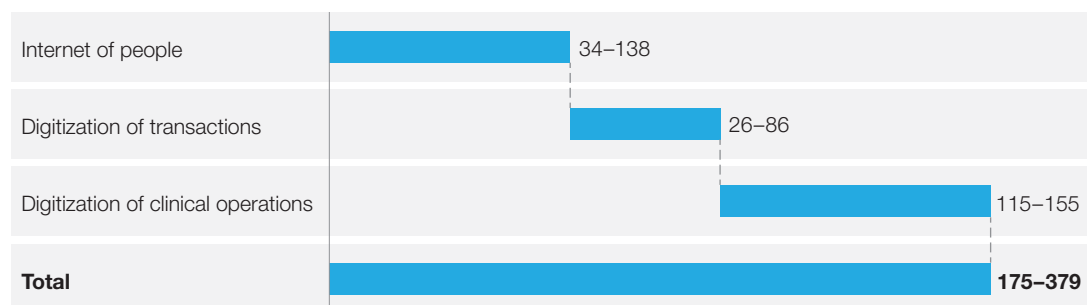
**Shubham Singhal**

<sup>1</sup>See “Distributed sites of care: At a tipping point?” on p. 57.

<sup>2</sup>Singhal S, LeCuyer N. Overhauling the US healthcare payment system. McKinsey Quarterly. June 2007.

## EXHIBIT 1 Potential impact of digital health

\$, billion



Source: McKinsey analysis

validation, billing and payments, and claims processing—holds promise of lowering those costs. For example, claims and payment transactions could be migrated to a model with large-scale clearinghouse utilities that digitally manage transactions, similar to the “clearance and settlement” models used by credit card companies. We may begin to see the emergence of disruptive players that can handle the transactions for multiple companies as an outsourced service, bringing down costs across the industry. In part through lower transaction costs, we estimate that digital initiatives could allow payors to trim 10% to 15% in their SG&A expenses.<sup>3</sup>

## Digitization of clinical operations

The digitization of certain clinical operations to support clinicians is likely the largest category of value at stake, with the potential to create \$115 billion to \$155 billion in value. Applying technology to clinical operations—for example, through application of tools for patient throughput management, dynamic capacity and labor optimization, and clinical

decision support—could not only create a more productive healthcare model but also reduce medical error. Clearly, there is work to be done: a recent study by researchers at Johns Hopkins estimated that medical error is responsible for at least 250,000 deaths each year, which suggests that medical error is the third leading cause of death in the United States, after heart disease and cancer.<sup>4</sup>

The technology already exists to realize these improvements. Payors, providers, and policy makers must now determine how digital tools can be applied on a large-scale basis to create value. Players that figure out how to integrate existing technology with meaningful operational and frontline change in healthcare settings stand to boost productivity and reduce costs. No less significant is the potential improvement in the quality of patient care. Whether the path is one of evolution, transformation, or revolution, the digitization of healthcare is well under way. 

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<sup>3</sup>See “Why digital transformation should be a strategic priority for health insurers” on p. 215.

<sup>4</sup>Makary MA, Daniel M. Medical error—the third leading cause of death in the US. *BMJ*. May 3, 2016.

# Pharma spending growth: Making the most of our dollars

*Pharmaceutical companies want to be rewarded for innovation, but rising drug costs are straining payor economics. This conundrum must be solved, not for one drug at a time but across the breadth of products in the pipeline.*

**Shubham Singhal**

Pharmaceutical spending is at an inflection point. Growth in payors' spending on drugs, which had been relatively tame in the decade before 2013, has accelerated in the past three years.

In the pre-2013 era, patents on a large number of blockbuster drugs expired, which helped offset spending growth from new drugs entering the market. Payors promoted the use of lower-cost generic equivalents, especially through tiered formularies and step therapies. Between 2000 and 2015, the percentage of workers whose health plans included three or more drug tiers rose from 27% to 81%.<sup>1</sup> Today, more than 85% of all prescriptions are filled with generic drugs.<sup>2</sup> By encouraging generics use, payors were able to slow the rise in their prescription drug costs—between 2010 and 2013, per member per year (PMPY) pharmacy spending increased by only 4.1% annually.<sup>3</sup>

More recently, patent expiries have slowed, and innovation in the pharmaceutical industry has led to a host of novel therapies, many of which are potentially transformative—they hold promise of markedly improving the treatment of many common conditions and, in some cases, curing previously incurable diseases. This innovation comes at a price, however. Between 2013 and 2015, payors' PMPY pharmacy spending rose 11.7% annually. Growth has been driven primarily by the introduction of specialty drugs and rising prices (Exhibit 1). In 2015, PMPY spending on specialty drugs jumped 17.8%, compared with –0.1% for other drugs.<sup>4</sup>

Both trends—innovation and rising prices—are expected to continue. As of 2015, there were approximately 7,000 new drugs in development around the world,<sup>5</sup> some of which are likely to come on the market within the next few years. The combination of numerous new products, rising prices, and growing use will likely cause payors' spending on specialty drugs to continue accelerating. Although biosimilar approvals, competition within drug classes, and the increased use of rebates may ameliorate the impact of these innovations, the higher expense resulting from use of these therapies could still be a growing line item in the overall cost of care. By 2018, specialty drugs are projected to account for 50% of overall drug spending. In 2010, only three of the top 10 highest-grossing drugs were specialty drugs; nine of the top 10 are projected to be in the specialty category by 2020.<sup>6</sup>

Payors and pharmacy benefit managers have responded to this trend not only through formulary tiers and step therapy but also through prior authorization and, more recently, by fully closing formularies and excluding certain drugs from them. This year, Express Scripts and Caremark, combined, have excluded more than 240 drugs from their formularies, 39 of which are specialty and oncology drugs.<sup>7</sup> These techniques have been effective in driving substantial increases in pharmaceutical discounts but have also limited access to the drugs.

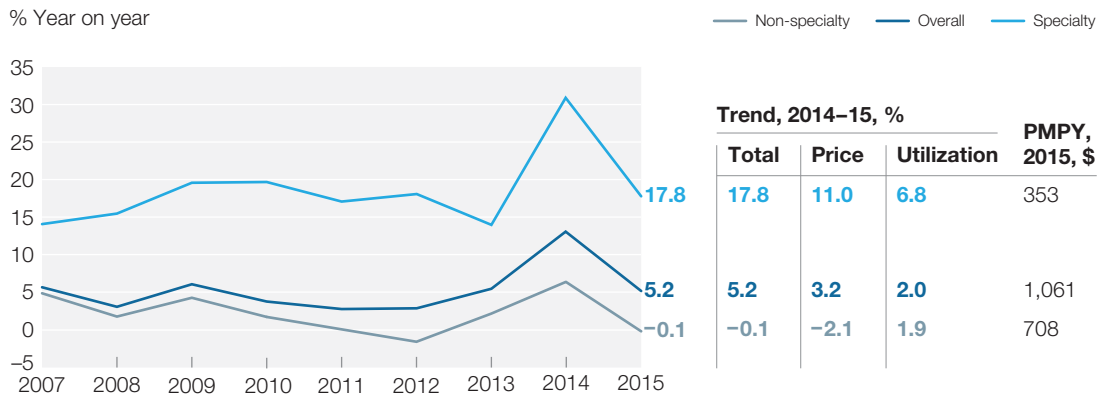
As more of the new specialty products come on the market, payors, pharma companies,

The footnotes for this article appear on p. 65.

## EXHIBIT 1 Increases in pharma spending are driven mostly by specialty drugs

### Growth in drug spending trend (price and utilization)

% Year on year



Trend, 2014–15, %			PMPY, 2015, \$
Total	Price	Utilization	
17.8	11.0	6.8	353
5.2	3.2	2.0	1,061
-0.1	-2.1	1.9	708

PMPY, per member per year.

Source: Express Scripts Drug Trend Report, 2015

healthcare policy makers, and others must address how to balance the value the new therapies bring with affordability. Presently, there are no clear answers. Pharma companies created medical advances and want to be paid for their R&D investments and innovation, while payors need to keep their health plans affordable for consumers. This conundrum must be solved, not for one drug at a time but across the breadth of products in the pipeline. Payors that want to keep up with the rising tide of innovation have three avenues they can pursue:

**First, fully leverage existing formulary and utilization management tools.** Exclusions and utilization management can be highly effective. However, too few payors (be they employers or health plans) implement them at all, and many of those that do limit them to only a subset of products. Furthermore, these tools can offer additional potential if they are used to create more prescriptive lines of therapy for complex conditions (preferred first-line,

second-line, and even third-line drugs) that are implemented by indication. Taken together, these actions could help payors garner larger discounts and help shift a significant proportion of patients to lower-cost therapies.

**Second, bring tighter controls to physician-administered pharmaceuticals.** Historically, physician-administered pharmaceuticals have been far more difficult to manage through post-hoc billing (in comparison with what can be done real-time in a retail pharmacy), and payors have been reticent to disrupt physician practice. Although initial steps have been taken in several drug categories to better control spending on physician-administered pharmaceuticals, progress in this area has been limited. However, as payor and provider systems become more integrated, opportunities will likely arise to make much greater use of control strategies, including formularies, indication-specific pathways (leveraging ready access to diagnostic codes), and differential physician reimbursement.

### Third, explore more creative solutions.

A number of questions have arisen as the United States has started moving away from fee-for-service reimbursement. How, for example, should risk sharing be applied to the pharmaceutical industry? If payors are using value-based reimbursement for hospital care, should they do the same for expensive new drugs? And if so, how should they measure the outcomes achieved and value delivered—particularly given that some of these new drugs can prevent costly complications but only over the long term? Before the US healthcare system can apply value-based reimbursement to pharmaceuticals on a broad scale, multiple challenges must be addressed, including the propensity of patients to change insurance companies; the specific roles that payors and pharmacy benefits managers will play; and the complexity of establishing clinical baselines and collecting data to measure diagnoses, treatments delivered, and outcomes achieved. Nevertheless, the time is now to begin to attempt using creative solutions to these issues. Some ideas we have seen implemented in other countries include:

- **Patient-level cost caps.** Pharma companies assume the cost for patients that remain on a drug for longer than the specified course of treatment.
- **Managed entry.** Payors agree to pay a higher price for certain drugs as more

evidence of the drugs' efficacy becomes available, or pharma companies agree to pay a rebate to payors if the drugs fail to deliver claimed clinical benefits.

- **Guarantees for non-responders.** Pharma companies agree to refund the cost of drugs for patients who do not respond after undergoing a specified treatment protocol.

Finally, having an accurate understanding of the drug development pipeline will be increasingly important when payors negotiate about an expensive new therapy. How many similar agents are in the pipeline, and how many of those are likely to make it to market? The possibility that another drug will be available soon improves a payor's negotiating position; the absence of such a drug works in the pharma company's favor.

The new therapies at pharma's inflection point represent exciting advances in medicine. At the same time, they have meaningful implications for healthcare affordability and health plan economics. While the path forward has yet to be determined, existing models for both pharma companies and payors in the United States will likely shift significantly in the coming years. [O](#)

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### FOOTNOTES

<sup>1</sup>Kaiser Family Foundation/Health Research & Education Trust. Employer Health Benefits Survey, 2008 and 2015.

<sup>2</sup>Generic Pharmaceutical Association. 2016 Generic Drug Savings & Access in the United States Report.

<sup>3</sup>McKinsey Payor Financial Database, based on data from MLR reports, NAIC Supplemental Health Care Exhibits. Analysis based on prescription drugs claims net of pharmaceutical rebates.

<sup>4</sup>The Express Scripts Drug Trend Report, 2015.

<sup>5</sup>PhRMA. 2015 Biopharmaceutical Research Industry Profile. April 2015.

<sup>6</sup>National Business Group on Health. Policy Recommendations to Promote Sustainable, Affordable Pricing for Specialty Pharmaceuticals. January 2017.

<sup>7</sup>CVS Caremark and Express Scripts formulary announcements.





INSIGHTS ON SPECIFIC MARKETS:  
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# Growing employer interest in innovative ways to control healthcare costs

*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.*

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).<sup>1</sup> 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.<sup>2</sup>

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.<sup>3</sup> 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.<sup>4</sup> Given that GDP growth is currently about 3% per year,<sup>5</sup> 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.<sup>6</sup> 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

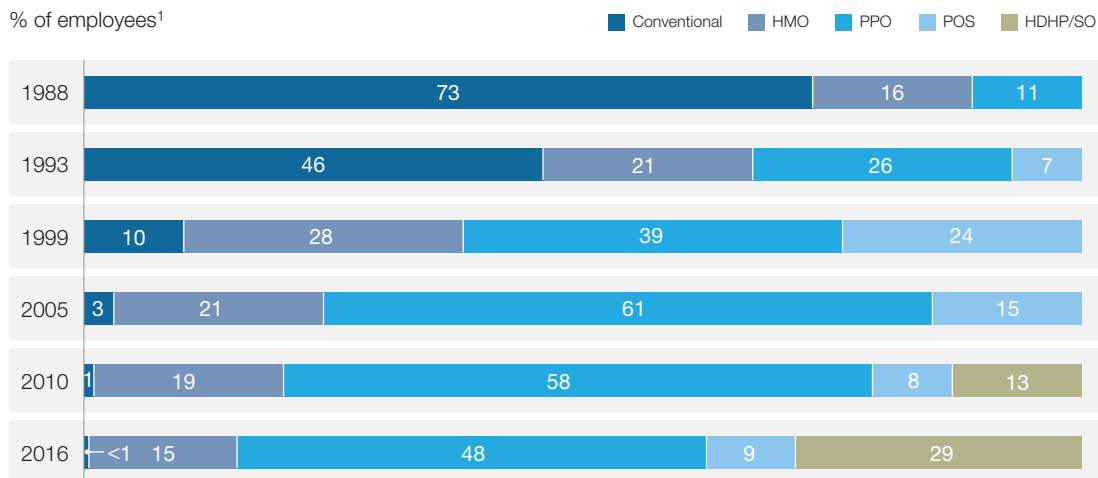
**Patrick Finn,  
Aditya Gupta,  
Shelby Lin, and  
Elina Onitskansky**

The footnotes for this article appear on p. 78.

## 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)

% of employees<sup>1</sup>



HDHP/SO, high-deductible health plan with a savings option; HMO, health maintenance organization; POS, point of service; PPO, preferred provider organization.

<sup>1</sup> Percentages do not always sum to 100 because of rounding.

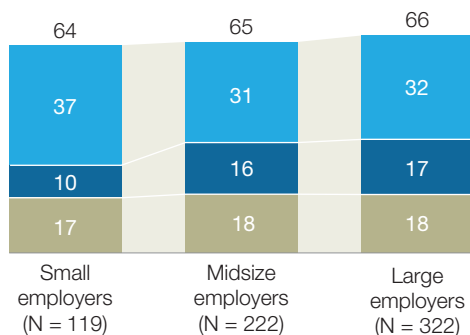
Source: Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey

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

■ Are already in the process of doing ■ "Definitely" will do ■ "Probably" will do

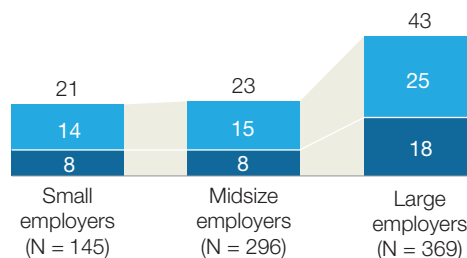
### Interest in introducing high-deductible health plans

% of respondents whose companies do not currently offer an HDHP/SO option<sup>1,2</sup>



### Interest in converting from a fully insured plan to self-insurance

% of respondents from fully insured companies<sup>1,2</sup>



<sup>1</sup> "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.

<sup>2</sup> See the appendix, which begins on p. 239, 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.

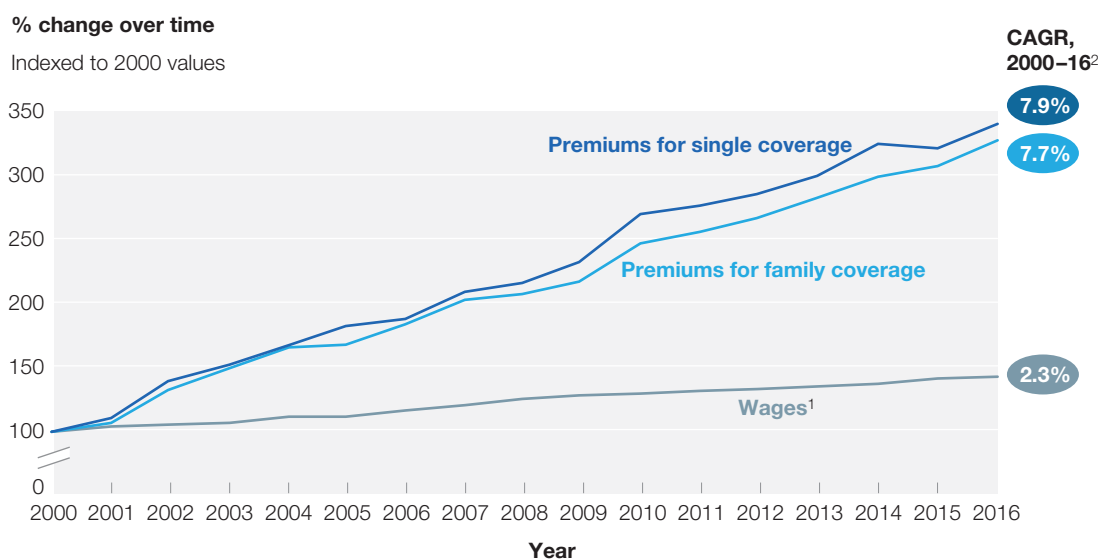
Cost-shifting is also occurring in other ways. According to a report from the Kaiser Family Foundation, the proportion of workers with single PPO coverage who have in-network deductibles above \$1,000 rose from 12% in 2006 to 38% in 2016.<sup>7</sup> Furthermore, over the past 15 years, employees' overall healthcare costs have increased much more rapidly than earnings have.<sup>8</sup> 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.

<sup>1</sup> Projected for 2016 based on three-year CAGR trend.

<sup>2</sup> 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.<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup>
- 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.<sup>12</sup> 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%.<sup>13</sup> (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.<sup>14</sup>

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.

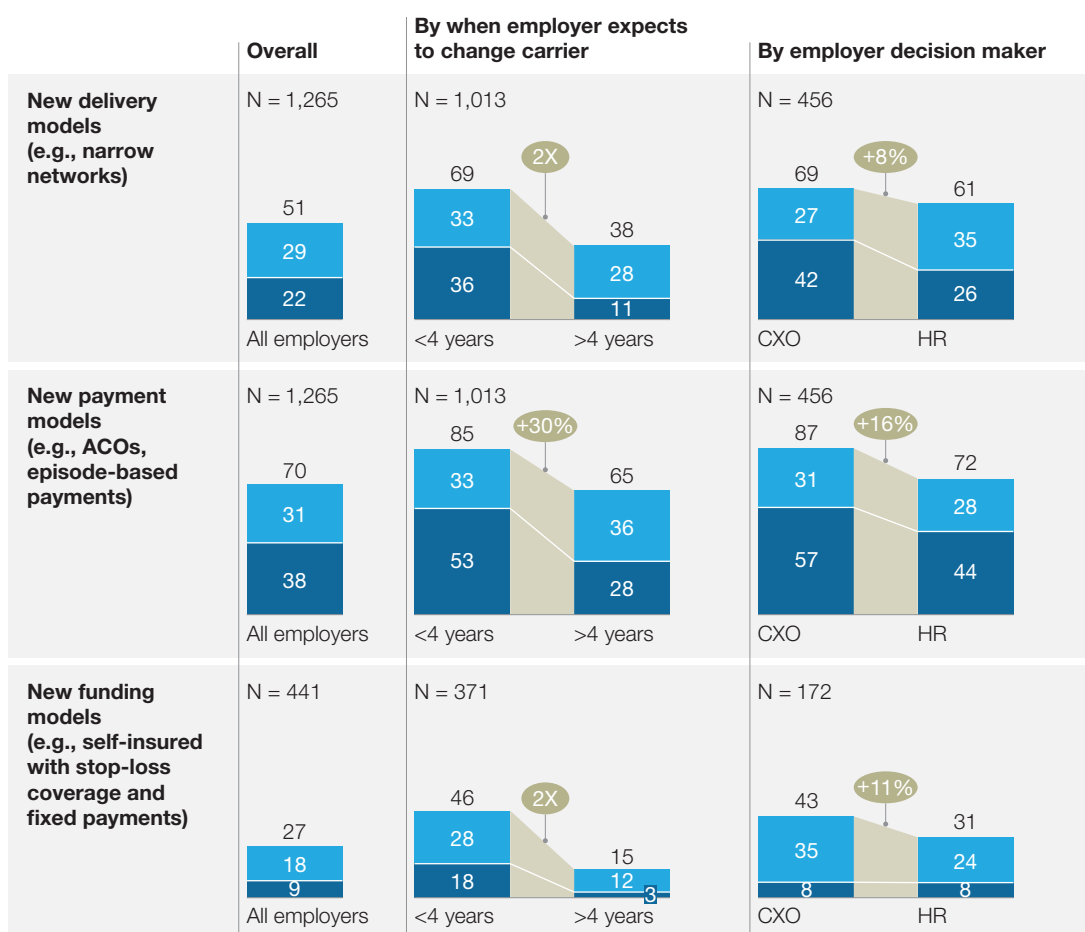
Interest in innovative models has intensified over the past several years. Since 2011,

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

% of respondents<sup>1,2</sup>

■ "Very interested"/"definitely" will adopt

■ "Somewhat interested"/"probably" will adopt



ACOs, accountable care organizations; CXO, C-suite executive; HR, human resources.

<sup>1</sup> Percentages shown within the bars do not always sum to the totals at the top because of rounding.

<sup>2</sup> See the appendix, which begins on p. 239, 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).<sup>15</sup>

### 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,<sup>16</sup> 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.

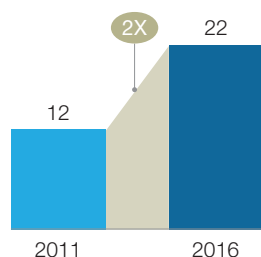
## Implications for payors

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).

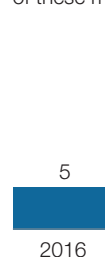
## EXHIBIT 5 Employer interest in new delivery and payment models has grown

### New delivery models (e.g., narrow networks)

% of respondents indicating high interest<sup>1</sup>

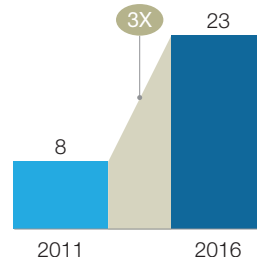


% of respondents reporting adoption of these models<sup>2</sup>



### New payment models (episode-based payments only)

% of respondents indicating high interest<sup>1,3</sup>



% of respondents reporting adoption of these models<sup>2</sup>



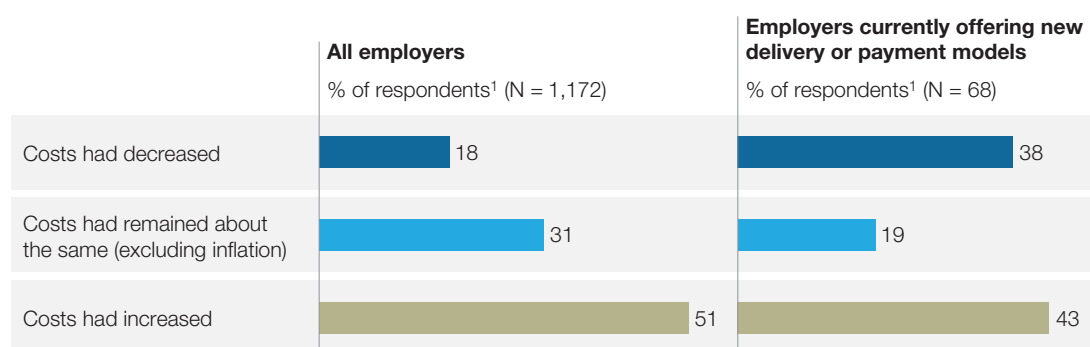
<sup>1</sup> Definitions used in the two surveys differed somewhat, but the numbers shown represent the percentage of respondents who said they were “definitely” interested or were “very confident” they would be interested in offering narrow network/episode-based payments.

<sup>2</sup> This question was asked only in 2016.

<sup>3</sup> 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



<sup>1</sup> See the appendix, which begins on p. 239, 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<sup>17</sup>—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).

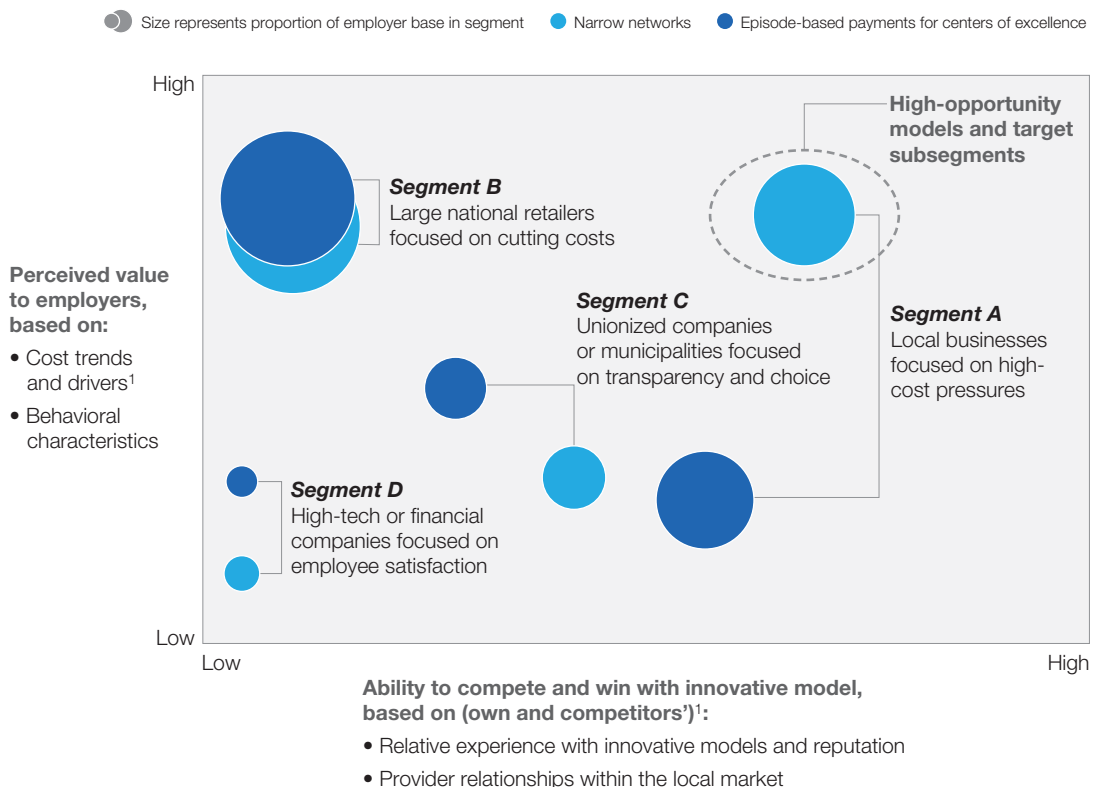
### Build tailored product offerings

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



<sup>1</sup> 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.<sup>18</sup>

### **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.



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” (p. 39).

## FOOTNOTES

- <sup>1</sup> 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.
- <sup>2</sup> 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.
- <sup>3</sup> 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. 239.
- <sup>4</sup> 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).
- <sup>5</sup> The Bureau of Economic Analysis estimated 2.9% annual growth of current-dollar GDP for 2016.
- <sup>6</sup> 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.
- <sup>7</sup> Kaiser Family Foundation/Health Research & Education Trust. 2016 Employer Health Benefits Survey.
- <sup>8</sup> 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.
- <sup>9</sup> Kaiser Family Foundation/Health Research & Education Trust. 2016 Employer Health Benefits Survey.
- <sup>10</sup> Kaiser Family Foundation/Health Research & Education Trust. 2016 Employer Health Benefits Survey.
- <sup>11</sup> Knott D et al. Maximizing value in high-performance networks. McKinsey white paper. July 2013.
- <sup>12</sup> Based on McKinsey Healthcare Reform Center analysis.
- <sup>13</sup> 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%.
- <sup>14</sup> 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.
- <sup>15</sup> Comparison is between the 2011 McKinsey Employer Post-Reform Survey and the 2016 McKinsey Employer Health Benefits Survey.
- <sup>16</sup> Survey data is not available for the early adopters of funding models such as self-insured “hybrids.”
- <sup>17</sup> 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,” on p. 39.)
- <sup>18</sup> Singhal S, Jacobi N. Why understanding medical risk is key to US health reform. p 39.



INSIGHTS ON SPECIFIC MARKETS:  
**Individual**







# Understanding consumer preferences can help capture value in the individual market

*As consumers gain experience purchasing health insurance in the individual market, their attitudes are evolving—and so is the market. McKinsey's 2016 Individual Market Open Enrollment Period Consumer Survey reveals the changes.*

Implementation of the Affordable Care Act (ACA) has given millions of US consumers access to a new health insurance marketplace. As consumers who purchased health plans through the public exchanges have experienced the benefits and consequences of their selections, their attitudes about coverage have been changing. By understanding these changes, payors can develop better strategies for competing on the 2017 exchanges.

To investigate this issue, we conducted a survey of consumers eligible to purchase ACA-compliant coverage just after the close of the 2016 open enrollment period (OEP).<sup>1</sup> The survey was taken by 2,763 consumers, of whom 1,187 said they had bought ACA plans, also called qualified health plans (QHPs). Another 500 respondents had purchased non-ACA plans, and 1,076 remained without health insurance. (For more details about the survey, see the methodology section, which begins on p. 91.)

Results show that consumer preferences for coverage types are contributing to a gradual evolution of the individual market, rather than an abrupt rebalancing. Movement between coverage types has been relatively limited: nearly three-quarters of the respondents who said they bought ACA plans in 2016 reported having had similar coverage in 2015, and 87% of those who said they were uninsured in 2016 had also lacked coverage in 2015.<sup>2</sup> Comparatively few respondents said they purchased health insurance for the first

time in 2016 or switched from a non-ACA plan to an ACA plan, even though insurers discontinued transitional plans in several states.

However, a closer look at the purchasing decisions made during the 2016 OEP reveals changes in consumer behavior that could have important implications for the next OEP. In this paper, we focus on the attitudes and behaviors of insured and uninsured consumers.<sup>3</sup> In addition, we briefly discuss “payment stoppers”—individuals who signed up for 2015 coverage but halted premium payments before the year was up. We also describe steps payors and providers can take to help increase enrollment and minimize the risk that consumers drop coverage.

## Insured consumers

Consumers shopping for ACA plans on the public exchanges or elsewhere typically consider a variety of factors before making a purchase. However, a comparison of this year's results with findings from similar surveys conducted in 2014 and 2015<sup>4</sup> shows that many consumers made more nuanced decisions in the 2016 OEP. For example, when respondents who reported buying new ACA plans were asked about the factor that most strongly influenced their plan choice, premium price was the answer given most often in all three years. However, the percentage of people who cited price as their top influence fell from 60% in 2014 to roughly 40% in 2015 and 24% this year.

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The footnotes for this article appear on p. 90.

The change in sentiment is reflected in consumer enrollment patterns. A report from the Department of Health and Human Services (DHHS) found that 43% of the consumers who purchased coverage during the 2014 OEP bought the lowest-price plan in their metal tier, but only 31% did so in 2015.<sup>5</sup> In our survey, just 16% of the respondents who purchased a new plan in 2016 reported selecting the lowest-price plan.

### Importance of preferred provider in network

The respondents who bought new plans in 2016 were almost as likely to cite having their preferred doctor(s) in network as the factor with the strongest influence on purchasing decisions as they were to choose premium price (Exhibit 1). In fact, having a preferred provider in network overtook price as the top factor among some subsets of consumers—

especially those with medium or high health risk, those over the age of 50, and those whose annual income is more than 250% of the federal poverty level (FPL). This factor was also a high priority for the respondents who had group coverage in 2015. By comparison, other factors related to care delivery, such as having a preferred hospital or pharmacy in network, or having a wide selection of doctors or hospitals in the area, were ranked first by just 2% to 4% of each consumer segment.

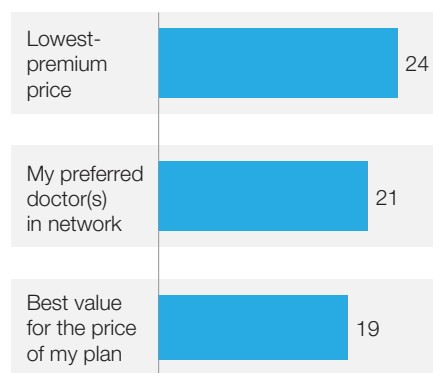
### Acceptance of narrowed networks

Despite their desire to have a preferred doctor in network, many consumers are willing to accept a narrowed network (one with narrow or tiered network breadth). Among the respondents purchasing new plans for 2016, the share who reported selecting a plan with a narrowed network was 45%, up from 34% last year

## EXHIBIT 1 For consumers, price is not the only important factor

### Most important factor in plan selection

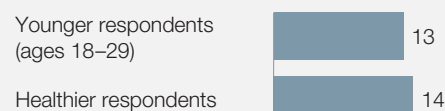
% of respondents who purchased a new plan in 2016



### The groups that ranked 'having my doctor in network' highest, %



### The groups that ranked it lowest, %



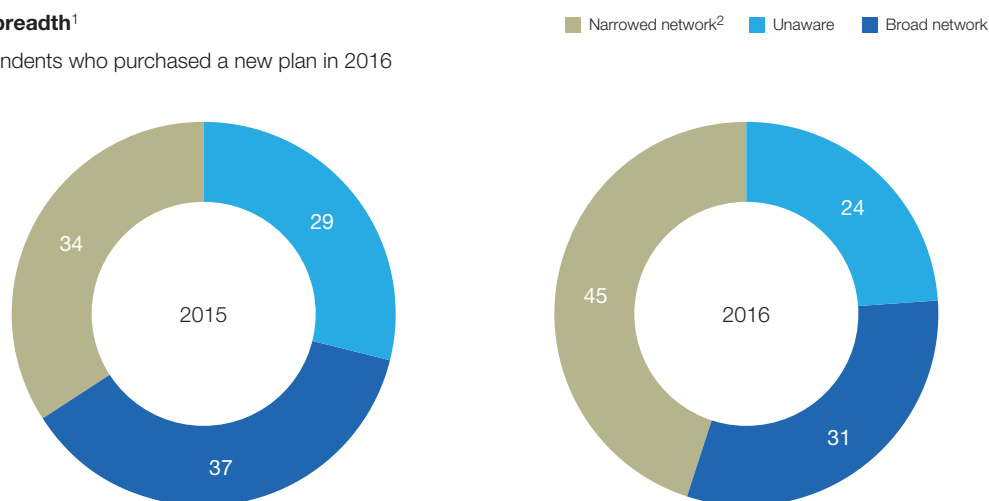
<sup>1</sup> Defined as those who had "medium" or "high" health risk based on the number of chronic conditions, expected number of doctor visits, and likelihood of requiring an inpatient stay.

Source: McKinsey Individual Market Open Enrollment Period Consumer Survey, March 2016

## EXHIBIT 2 A growing number of consumers are purchasing narrowed network plans

### Network breadth<sup>1</sup>

% of respondents who purchased a new plan in 2016



<sup>1</sup>For both years, network breadth was determined based on respondents' answers to our 2016 survey. Thus, the 2015 sample is not completely random because it does not include those who left the individual market in 2016 (e.g., because they gained another form of insurance coverage or remained uninsured).

<sup>2</sup>Includes respondents who selected "narrow" or "tiered" for reported network breadth.

Source: McKinsey Individual Market Open Enrollment Period Consumer Survey, March 2016

(Exhibit 2). At least three factors help explain the higher purchase rate. First is availability: among competitively priced silver plans, the proportion based on narrowed networks increased by about 11 percentage points between 2015 and 2016.<sup>6</sup> Second, narrowed network plans tend to have lower premiums (by an average of about 18% in the silver tier) than do broad network plans. Third, because of improvements to healthcare.gov and the state exchange websites, consumers now can more easily determine whether their preferred doctors are part of a given network.

However, consumers are trying to obtain the cost advantage of narrowed networks without losing their preferred doctor. Of the respondents who purchased new plans in 2016, 73% attempted to research whether their preferred

primary care provider (PCP) was included in at least some of the plans they considered. Furthermore, among the new-plan purchasers, those citing "preferred doctor(s) in network" as the most important factor in plan selection were 60% more likely than others to purchase a narrowed network plan rather than a broad network plan. This finding suggests that these consumers value continuing to see their preferred physician over having a range of other provider options.

### Key factors affecting retention and switching

Our survey results help shed light on DHHS marketplace reports that the number of consumers renewing their ACA plans is increasing. Among the respondents to this year's survey, 42% of those who bought ACA plans said they

renewed their previous year's coverage; in last year's survey, only 27% said the same.<sup>6</sup> Auto-renewals helped fuel this trend: last year, 18% of the respondents who bought ACA plans did so through auto-renewals; the comparable number this year was 28%. However, the increased overall renewal rate may also reflect the increase in enrollment that occurred last

year—that is, more people had the chance to renew plans. Among the respondents who purchased ACA plans in both 2015 and 2016, 57% remained with the same plan, and 80% stayed with their carrier, suggesting that customer loyalty (or switching costs) may be high in the absence of dramatic changes to products or pricing.

## A closer look at payment stoppers

In this year's survey, 21% of the respondents who said they bought ACA plans in 2015 reported they had stopped paying premiums before the end of the year.<sup>1</sup> Over half of this group said they had halted payments by September 2015.<sup>2</sup> The survey results suggest this behavior is often repeated: 67% of the respondents who stopped paying their 2015 premiums said they had also purchased individual coverage in 2014, and two-thirds of this group reported halting premium payments early that year. However, 87% of those who suspended their 2015 payments repurchased an ACA plan in 2016, and 49% of those who repurchased coverage re-enrolled in the same ACA plan.

The "payment stoppers," according to our survey results, were more likely than the other respondents to have at least one chronic condition. They were also almost twice as likely to say they had used certain healthcare services within the past year.<sup>3</sup> The two primary reasons cited for stopping premium payments were gaining other coverage (36%)—although many appear to have lost the other coverage during 2015, because they repurchased an

ACA plan in 2016—and no longer being able to afford it (26%).

Payors and providers could take steps to help these consumers avoid losing coverage. For example, payors could identify those who stopped payments early in the past and direct them to auto-pay options whenever possible or issue regular reminders about making payments. They could also reach out to any members they believe are likely to stop making future payments and make sure they understand both the penalties they may face and subsidies they may be eligible for. Consistent payment of premiums in one year increases the likelihood that consumers renew with their carrier the next year.

Providers also have a role to play. For example, when patients appear to have financial difficulties, their provider could connect them with third-party organizations that may be able to offer assistance with premiums. Providers also could connect patients to in-house financial counselors or certified application counselors to ensure that the patients understand subsidies and penalties.

<sup>1</sup>The group we define as "payment stoppers" is not a completely random sample, because it includes only those who purchased individual coverage or were uninsured in 2016 (and thus does not include those who may have gained employer-sponsored insurance, Medicaid, or another form of coverage).

<sup>2</sup>Of this group, 29% reported stopping their premium payments after September, while 17% said they didn't remember when they had stopped paying. Rounding causes the total to sum to 101%.

<sup>3</sup>Respondents were asked about their utilization of emergency room services; inpatient hospital stays; same-day surgeries; MRI, CT, or PET scans; and procedures involving injectable drugs.

Several factors increased the odds a consumer would decide to switch carriers:

**Plan discontinuation.** One of the top reasons individuals gave for shopping in the marketplace and switching carriers was plan discontinuation. Among the respondents who bought ACA plans in both 2015 and 2016, about 17% reported their 2015 plan was discontinued; these consumers were three and a half times as likely to switch carriers as those whose plan was still offered in 2016. However, among those whose plan was discontinued, only 14% discovered that their carrier had left the marketplace in 2016, indicating that carrier withdrawals were not the primary cause of carrier switching.

**Carrier dissatisfaction.** Respondents' dissatisfaction with their carrier also increased the likelihood of switching. Those who were dissatisfied—about 14% of our sample—were two and a half times as likely to change carriers as those who were satisfied. Among those who did switch, commonly cited areas of dissatisfaction were a plan's deductible amount, the perceived value received for the money, and the process for signing up or renewing a plan.

**Purchase channel.** The channels consumers used to purchase plans had a significant impact on the rate of switching. Consumers who bought directly from an insurer, through either a website or a help line, were about 30% less likely to switch carriers than those purchasing on the exchanges. This pattern held even after the analysis was controlled for demographics and health status. In contrast, those who used brokers in 2016 were almost 50% more likely to switch from their previous carrier as those who purchased plans on the exchanges. The extra support of a broker may help consumers

choose an insurer that fits their needs; those who had consulted brokers in 2015 tended to stick with the same carrier in 2016.

**Price increases.** As expected, rising premium prices also played a role in carrier switching. Among the respondents whose plans were not discontinued, those whose premiums jumped 10% or more were nearly three times as likely to switch carriers as those whose premiums decreased.<sup>7</sup>

**Behaviors and demographics.** Respondents who had changed plans in 2015 were twice as likely to switch carriers this year as those who had renewed in 2015. Two demographic factors were also linked with higher switching rates. First, respondents age 50 or older were more than twice as likely to change carriers as those under 50. And those with incomes below 400% FPL were more than 1.5 times as likely to switch carriers as those whose incomes were over 400% FPL.

## The uninsured

According to the DHHS, 11.5% of US adults below the age of 65 still lacked health insurance as of early 2016.<sup>8</sup> To better understand this segment, our 2016 survey explored the demographics, attitudes, and behavior of those who opted not to buy insurance. We also looked at “payment stoppers”—individuals who signed up for 2015 coverage but halted premium payments before the year was up (see the sidebar “A closer look at payment stoppers”).

Of the respondents in our sample who were uninsured at the time of the survey, 59% had been without coverage for three or more years (Exhibit 3). These respondents were much less likely to shop for, and subsequently purchase,

health insurance than those who had been uninsured for only one year. Part of the explanation for this behavior may be financial: 43% of the uninsured said they had calculated that remaining without coverage was less expensive than purchasing insurance.

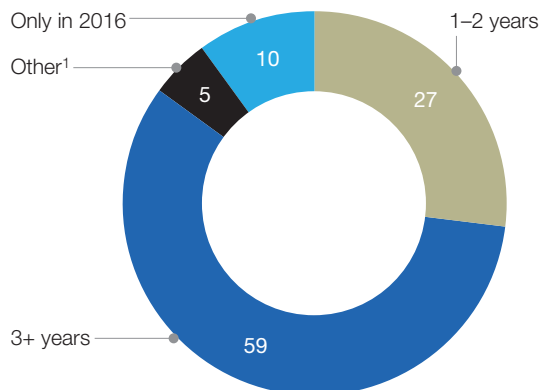
Although many consumers are making these decisions with limited knowledge, more are becoming informed about subsidies and penalties. Among those without coverage, awareness of the potential subsidies for purchasing health insurance rose from 41% in 2015 to 62% in 2016. However, just 30% of the 2016 respondents were aware of the size of the premium subsidy for which they were eligible. Awareness of the penalty for not having coverage increased from 59% in 2015 to 70% in 2016. However, considerable uncertainty about the penalty remains. We asked respondents whether they had paid a penalty for not being covered

in 2014, the only year for which respondents would have been assessed a penalty at the time the survey was conducted. Only 55% of the respondents who said they had been uninsured in 2014 reported paying a penalty; another 14% said they did not know whether they had paid one. (The mechanics of the automatic tax deduction may have contributed to the lack of knowledge.) In any case, those who reported paying the 2014 penalty were no more likely to purchase insurance in 2016 than those who did not pay.

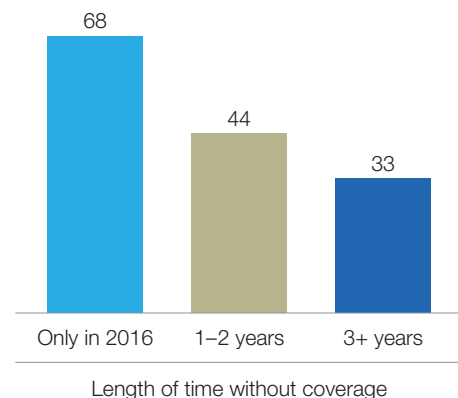
If not subsidies and penalties, then what might persuade the uninsured to gain coverage? We investigated possible factors with the use of predictive regression analysis (Exhibit 4, pie chart on left). About 14% of the uninsured might respond to targeted, comprehensive education about health insurance, penalties, and subsidies, particularly the size of the premium subsidy they are eligible for. Another

### EXHIBIT 3 Likelihood of shopping for coverage decreases as time without coverage lengthens

**Length of time 2016 uninsured respondents had gone without coverage, %**



**2016 uninsured respondents who shopped for a 2016 health plan, %**



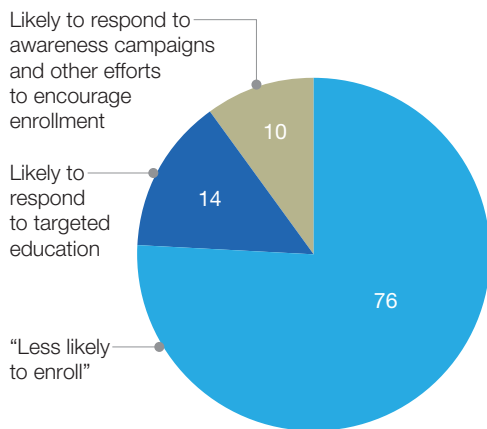
<sup>1</sup>“Other” includes those who, during the past 3 years, transitioned more than once between having coverage and being uninsured.

Source: McKinsey Individual Market Open Enrollment Period Consumer Survey, March 2016

## EXHIBIT 4 Segmentation can identify opportunities to increase enrollment

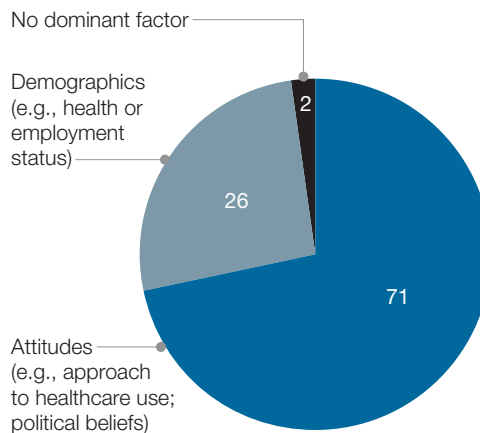
### Predictive analysis identified three subgroups among the uninsured ...

% of uninsured respondents



### ... and the primary reasons for not purchasing coverage

% of the "less likely to enroll" respondents



Source: McKinsey Individual Market Open Enrollment Period Consumer Survey, March 2016

10% might be convinced to purchase insurance if they were targeted with awareness efforts, given encouragement to shop, and given at least one recommendation about which insurer to select.<sup>9</sup>

The remaining 76% of the uninsured are likely to be much harder to reach. Our results suggest that efforts to raise awareness among this group, educate them, and encourage shopping may not be sufficient to persuade them to purchase coverage. Certain characteristics are more common in this group than in the other 24% of the uninsured (Exhibit 4, pie chart on right). More than two-thirds of them are distinguished by attitudes that discourage purchase, including political opinions and beliefs about use of healthcare (e.g., tendencies not to have a relationship with a primary care physician and not to see a doctor unless a major problem arises). A much smaller share (26%) of these consum-

ers are primarily distinguished by a set of demographic characteristics: they have low to medium health risk, live in an urban area, and are unemployed or working part-time. Three-quarters of the harder-to-reach individuals have been without insurance for three or more years. However, one-third of them shopped for health insurance in 2016, suggesting that some may be more reachable than others. Women accounted for a disproportionate share of those who shopped; men accounted for a disproportionate share of those who did not.

These facts suggest that targeting certain demographic groups with comprehensive education about the ACA and encouragement to shop for insurance (with personalized recommendations of which insurer to select) might help persuade a significant proportion of the uninsured population—even those considered less likely to enroll—to obtain coverage.



## Takeaways for the industry

Taken together, our survey results highlight several issues payors and providers should keep in mind as they develop their strategies for the 2017 OEP and beyond (see below).

### Physicians matter to consumers

Many consumers appear to have learned the significance of network design—they want to retain access to their preferred physician. Industry stakeholders could consider a number of actions to address this desire. For example, both payors and providers could make it easier for consumers to determine whether a physician is in a given network. Payors could also ensure that their websites are easily navigable. Providers could put information about network inclusion on their websites and in office pamphlets.

Both groups could work to identify members/patients on ACA plans who may be likely to

switch because of plan discontinuation, dissatisfaction, or price increases. They could then reach out to help these individuals retain access to their preferred physician. When payors are revising their networks, they could contact affected members and help them enroll in another plan that includes their preferred physician.

In addition, providers could think about their physician alignment strategy to ensure they are affiliated with the most preferred physicians in their area. They could also take steps, especially near and during an OEP, to make local consumers aware of the physicians they are affiliated with and the ACA plans that include these physicians in their networks.

### Basic consumer retention levers might minimize attrition

Payors have an opportunity to minimize attrition by making auto-renewals as easy as possible and by addressing the primary

## Key insights from the 2016 OEP Consumer Survey

- Consumers, when purchasing plans, are increasingly considering factors other than premium price—particularly whether their preferred doctor is in network.
- Consumers may be becoming more willing to choose a narrow-network plan, especially if their preferred physician is part of that network.
- Most consumers are renewing coverage with the same carrier. Those who switch carriers tend to be older, to have lower incomes, and to have previously changed carriers.
- Carrier switching is largely driven by plan discontinuation, carrier dissatisfaction, broker influence, and large premium increases.
- Roughly one-fifth of 2015 ACA plan enrollees stopped payment on their premiums in 2015, yet most repurchased an exchange plan in 2016, and many repurchased the same plan.
- Over half of the uninsured respondents have been uninsured for longer than three years; many of them understand the trade-offs involved in remaining uninsured.
- While awareness of penalties and subsidies continues to rise, awareness of personal eligibility remains low, and fewer consumers are shopping for health insurance.

causes of carrier switching. Plan discontinuation and rate hikes may sometimes be unavoidable, but payors could actively lower the risk of churn. Payors could also reduce consumer dissatisfaction by investing in customer service upgrades to websites and call centers, keeping deductibles as low as possible (and making the deductibles more transparent to purchasers, to prevent surprises later on), and communicating the value of health insurance more effectively. To further improve consumers' perceptions of value received, payors could offer members free, personalized health information and other comparatively low-cost benefits. Lastly, payors could consider strengthening their relationships with brokers to increase the likelihood the brokers recommend their—and not another company's—products.

Providers also have a role to play in increasing consumer retention. For example, they could work with payors to ensure that patients appreciate the value of health coverage and understand which networks the providers participate in.

### **Targeted, personalized outreach might help lower the uninsured rate**

Although awareness of subsidies and penalties among those eligible for QHPs has grown, it remains low. Payors and providers alike have an opportunity to educate uninsured consumers about their potential eligibility for subsidies and help them learn how to calculate the amount they might receive.


Payors, for example, could segment consumers carefully and hone messaging to each group. Some efforts tailored to the

uninsured could be geared to the consumers most likely to enroll—for instance, repeat care users, those who are married or recently uninsured, and persons with greater health risk. In addition, payors should not ignore the less-likely-to-enroll group. Particularly useful would be efforts targeted toward those who have already shown a propensity to shop (e.g., messages directed to nonmembers who visit the provider's website). Also, payors could identify and contact members who recently left group coverage to see if they have obtained another form of coverage.

Providers could focus on engaging uninsured patients at the point of care, when they may be most amenable to behavior change. Providers could, for example, sponsor certified application counselors, partner with brokers, or provide enrollment and network inclusion information in high-use patient areas. In addition, in-house financial counselors could give self-pay patients enrollment information (especially about which plans include the provider in their network), ensure that patients are aware of the next OEP, and explain the subsidies and penalties associated with ACA plans. Providers could also continue to investigate opportunities to partner with third-party foundations or organizations that help pay premiums or support cost sharing to make it easier for uninsured consumers to purchase plans. However, providers must be careful to follow the Center for Medicare and Medicaid Services' guidance and any applicable state regulations in this area.



Our survey results shed light on how consumers are adapting to the public exchanges and suggest steps that payors and providers

could take to increase enrollment. The next OEP is rapidly approaching, bringing with it heightened consumer expectations as well as the opportunity to reach a greater share of the market. By developing plans that reflect evolving consumer preferences and working together to coordinate outreach, payors and providers will be well positioned to reduce the number of uninsured in the year ahead. 

#### FOOTNOTES

<sup>1</sup>An ACA-compliant plan, also called a qualified health plan, is one that complies with the Affordable Care Act's regulations, including requirements that it cover ten essential health benefits and have no annual or lifetime coverage maximums. Our definition includes all ACA-compliant plans, whether purchased on the public exchanges or elsewhere. A non-ACA plan is one that does not fit the regulations of the ACA and may be short-term coverage, a hospital indemnity plan, a transitional or grandfathered plan renewed from before 2014, or other.

<sup>2</sup>Behaviors and experiences measured by our 2016 Individual Market OEP Consumer Survey, like the surveys we conducted after the 2014 and 2015 OEPs, are self-reported. Thus, the results may be subject to recall bias.

<sup>3</sup>Our consumer research has enabled us to segment the population of people eligible for an ACA-compliant plan in different ways. For example, we can identify differences in behavior between consumers who renew ACA plans with the same carrier and those who switch carriers, or between those who are new to an ACA plan from those who are new to health insurance altogether.

<sup>4</sup>For more details about the earlier surveys, see the appendix (p. 239).

<sup>5</sup>Office of The Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and

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The authors wish to thank Avnav Anand, Max Hu, Elizabeth P. Jones, and Ellen Rosen for their contributions to this article.

Human Services. Health plan choice and premiums in the 2016 health insurance marketplace. October 30, 2015. ASPE has not yet released comparable figures for the 2016 OEP. Note also that the ASPE report reflects consumer actions that occurred on the marketplace, while our survey is based on self-reported actions. Furthermore, ASPE's percentages are derived from those who "selected a plan on the marketplace," whereas ours are derived from consumers who purchased a new ACA plan in 2016.

<sup>6</sup>Among those who were in the ACA market in 2016 and 2015, respectively. Note that the 2015 sample is not a comprehensive random sample, but instead contains only those who were also individually insured or uninsured in 2016.

<sup>7</sup>This finding was based only on respondents who reported a change in premium price between 2015 and 2016; it excludes those whose premium prices may have stayed the same.

<sup>8</sup>Department of Health and Human Services. 20 million people have gained health insurance coverage because of the Affordable Care Act, new estimates show, news release. March 3, 2016.

<sup>9</sup>Roughly 40% of the insured respondents followed recommendations from brokers, insurance agents, or friends and family, suggesting a possibility that these channels could be effective for drawing in uninsured individuals as well.

## Methodology

### McKinsey's annual Individual Market Open Enrollment Period (OEP) Consumer Survey

Through a collaboration between McKinsey's Center for US Health System Reform and its Marketing Practice, we survey a national sample of uninsured and individually insured consumers each year, shortly after the close of the individual-market open enrollment period (OEP). This year's survey, conducted between February 2 and 18, 2016, had a sample size of 2,763. Of these respondents, 1,187 had ACA plans, 500 had non-ACA plans, and 1,076 were uninsured. The survey sample was defined by the following characteristics:

- Ages 18 to 64
- Income above 100% of the federal poverty level (FPL) in states with no Medicaid expansion and above 138% FPL in states with expansion
- Primary 2016 coverage (by self-report) was either individual insurance or no insurance

Each response was weighted demographically, using 2015 population data from McKinsey's Predictive Agent-based Coverage Tool,<sup>1</sup> to be representative of the national QHP-eligible population (insured and uninsured), using the following factors: age, gender, geography, household size, and income. In addition, responses were weighted based on respondents' reported primary 2013, 2014, and 2015 health insurance coverage to reflect the known national distribution of prior-year uninsured and individually insured QHP-eligible consumers. (Individuals with prior-year Medicaid or group insurance were not weighted by these cross-coverage weights, only by demographic weights.)

The survey aimed to understand respondents' demographics and descriptive characteristics, as well as to assess their shopping behaviors; attitudes regarding health and healthcare; purchase and use of healthcare services; awareness of health reform; opinions about, and experience shopping for, individual health insurance; and preferences for specific plan designs.

Sample sizes for the seven market segments we identified were: non-ACA insured, 500; carrier renewers, 568; carrier switchers, 130; new to individual coverage, 263; new to insurance, 56; payment stoppers, 169; and uninsured, 1,076.

### Predictive uninsured-market modeling

To estimate the relative importance of a set of factors, or independent variables, on the outcome of interest, or dependent variable—in this case, whether a respondent was insured or uninsured—the analysis used logistic regression modeling. The more than 30 factors put into the model included demographic, awareness, past experience, attitudinal, and utilization factors (derived from our full survey sample).

The following factors showed a significant correlation (confidence interval  $\leq 0.05$ ) with the dependent variable:

- **Attitudes.** Attitudinal segment,<sup>2</sup> political beliefs
- **Experience.** Whether the respondent had accessed healthcare or shopped for health insurance in 2015, currently had medical debt, or knew if his or her hospital or healthcare provider offers discounts for the uninsured

<sup>1</sup>McKinsey's Predictive Agent-based Coverage Tool (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.

<sup>2</sup>A McKinsey proprietary consumer segmentation methodology based on consumers' degree of agreement with 26 attitudinal statements about healthcare.

- **Demographics.** Health risk level,<sup>3</sup> urban or rural, employment status, income (as percentage of FPL), marital status
- **Awareness.** Awareness of one or more of the following factors<sup>4</sup>: penalty amount, existence of premium subsidy, eligibility for premium or subsidy, ability to check subsidy eligibility online, and amount of premium subsidy respondent is eligible for; whether respondent shopped for health insurance in 2016; whether respondent received a recommendation about which insurer to purchase from

These factors were then used to build a predictive model to estimate an individual's probability of purchasing health insurance. This predictive model has a Gini coefficient of 0.852, which indicates a very strong model. The characteristics of the uninsured respondents were then evaluated based only on the awareness factors to understand how each individual's probability of purchasing coverage would change if he or she were educated about penalties and subsidies, encouraged to shop, and given a recommendation for which insurer to purchase from. If an individual's probability of purchasing insurance exceeded a certain threshold after the awareness factors were manipulated, he or she was considered part of the "movable" group. This threshold was set at the average predicted probability associated with the individually insured respondents in our survey.

#### Drivers of switching carriers: Regression modeling

Next, the analysis sought to understand the factors that were correlated with carrier switch-

ing (and the relative magnitude of those factors). For this, logistic regression modeling was again used. The outcome of interest, or dependent variable, was whether an individual switched carriers between 2015 and 2016. This model included only those respondents who were insured through an ACA plan in both years (sample size: 868).

More than 50 self-reported demographic, awareness, past experience, attitudinal, and utilization factors (derived from our full survey sample) were put into the model. The following factors showed a significant correlation (confidence interval  $\leq 0.05$ ) with the dependent variable:

- **Actions and demographics.** Actions related to healthcare insurance in 2015 (e.g., auto-renewed, renewed, purchased new), whether respondent had an inpatient stay in 2015, age
- **Providers.** Whether the respondents had a preferred primary care physician, hospital, and/or pharmacy in their 2015 network
- **Purchase channel.** Purchase channel in 2015, purchase channel in 2016
- **Satisfaction.** Level of satisfaction with the copayment and coinsurance amounts in the respondent's 2015 plan, that plan's coverage of preferred specialists, and the 2015 carrier overall
- **2015 plan elements.** Premium price increase associated with the 2015 plan, whether respondents knew the name of their 2015 plan, deductible in their 2015 plan

<sup>3</sup>A McKinsey proprietary categorization of respondents into three types of health risk (low, medium, high) based on respondents' self-reported chronic medical conditions and details about their use of the healthcare system.

<sup>4</sup>The model controlled for the differential effect of awareness within FPL bands by using interaction variables between FPL segment and awareness variable.



INSIGHTS ON SPECIFIC MARKETS:  
**Medicare**







# Improving acquisition and retention in Medicare

*According to our annual enrollment period survey of 2,208 senior consumers, the Medicare population is a loyal bunch, and loyalty increases with age. Payors can use a variety of strategies to attract newly Medicare-eligible consumers and retain them once these seniors are on board.*

When people get to the age of 75, chances are they'll stay put—with their health plans at least. According to our annual enrollment period (AEP) survey of 2,208 senior consumers, the Medicare population is a loyal bunch, and loyalty increases with age. Eighty-one percent of Medicare customers 75 and older said they renewed their plans without shopping for a new plan in the past year. Seventy-six percent of 71- to 74-year-olds and 70% of 65- to 69-year-olds reported doing the same.

What, then, do insurers need to do to attract consumers to their plans when they become eligible for Medicare? And once in, how do insurers keep these consumers satisfied? The answer lies in three buckets: value, provider options, and consumer experience. Insurers need to pay attention to all three—and adjust their strategies accordingly.

## Value

Contrary to popular perception, most people, including seniors, do not make healthcare product purchasing decisions based on price—or total cost—alone. In fact, in our recent AEP survey, seniors were given the opportunity to design their own plans, and 30% designed a plan that was more expensive than the one they were currently enrolled in. While the physician network is also critical, only 24% of respondents decided to make a cost trade-off for a narrow network plan to save between \$25 and \$50 a month. Moreover, when asked

about the premium of their current plan, only 14% of respondents believed they were in the lowest-cost plan, and 50% weren't sure how their premium compares.

## Provider options

Besides economics, access is also important to seniors. Having both their current physician and preferred hospital in network, and a wide array of doctors and hospitals to choose from, were key considerations. In the McKinsey AEP survey, 34% of consumers said having their doctor in network is one of the top three factors in selecting a plan. Twenty-three percent said the same of their hospital. When it comes to having choices among doctors and hospitals, 30% and 20%, respectively, said these are priority considerations. Potential customers also considered the health insurer's brand and its reputation.

Developing the right product and network design is a great start to attracting members to a plan, but a significant investment in raising consumer awareness and optimizing the distribution strategy is also required. When considering average revenue, margin, and the length of time members stay in a plan, the lifetime value of a Medicare Advantage (MA) member is more than three times that of a large-group member, and almost ten times that of an individual member. Insurers should consider this disparity in lifetime value as they develop budgets and invest in building acquisition capabilities in Medicare.

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## Consumer experience

Once members have enrolled, a health insurer's brand and reputation take a backseat to the experience its customers have with it. That experience is of paramount importance in determining how satisfied members will be—and whether they'll shop around come enrollment season. Medicare customers who renew their plans tell us that the top drivers of overall satisfaction are the coverage provided and three specific types of interactions: paying bills, making claims, and getting answers to questions or concerns. These factors are directly related to either customer experience or access and well within a payor's control.

## What health insurers should do

Here are some best-in-class techniques payors can use in their acquisition and retention efforts.

**Make sure you are creating the right customer experiences** for different member segments—one size does not fit all. When your customers engage with you, have a full view of all the ways they are interacting with their plan. Developing this view requires extensive cross-communication among different business functions.

**Use consumer insights** based on demographic, behavioral, and attitudinal data to drive decisions and tactics, including how you communicate with your members. In the acquisition process, for example, know what type of coverage your potential members are coming from. Are they aging in, coming from fee for service, or switching from another plan? Understanding their previous experiences and expectations will help you target them more effectively. Once they're enrolled in your plan, use data to keep tabs on what might make them shop around. Know whose premiums are increasing, whose networks have changed,

whose doctors are leaving, and who's calling the customer service line—why, and how many times.

**Understand the lifetime value of each member.** This will help you identify your high-value members and determine how much you would be willing to spend to keep them.

**Know how much you have invested in each member,** using transactional and investment data, online profiles, and life-stage indicators, and by keeping track of the promotions they've taken advantage of and contacts they've made. The data will help you provide your members with a personalized—and ultimately, better—experience.

**Test your approaches to engaging members**—and potential members—to learn what approaches work best: create pilots, test sample data, and conduct member surveys to understand the impact of everything you do.

**Invest in the product design process** and focus your efforts on the benefits that members use frequently (e.g., copays for primary care providers, formularies). This exercise will have the dual benefit of attracting new MA members, and improve member experience when they are in the plans.



Seniors are a sticky group. By following some of these techniques, insurers are more likely to acquire and retain this loyal cohort. ○

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# Assessing the 2017 Medicare Advantage Star ratings

*Enrollment-weighted Star ratings for MA plan performance rose slightly between 2016 and 2017. Analysis of the data reveals that both enrollment growth and plan maturity correlated with Star ratings and that, on average, plans built on health maintenance organizations or integrated delivery systems outperformed their competitors.*

On October 12, 2016, the Centers for Medicare and Medicaid Services (CMS) released the Medicare Advantage (MA) Star ratings for 2017 plans. Given the multiple sources of volatility in the MA market, including the recent election results, we wanted to understand how payors are performing on these metrics, because delivering high-quality programs that receive a Star bonus is an important lever payors can use to improve their MA performance.

We therefore analyzed CMS's data covering 530 MA health plans—from the 50 states, District of Columbia, and Puerto Rico—to develop a perspective on the payor industry's Stars performance. We also compared this year's results with the Star ratings CMS released in previous years. We found that the overall enrollment-weighted average Star score in 2017 was largely unchanged from 2016, although, on average, contracts<sup>1</sup> did improve their underlying performance on the Star measures. We also uncovered trends indicating it will be critical for payors to continue to invest in their capabilities. For example, contracts with a 4-Star rating or higher (4+ rating) appear to be more likely to survive in the market and to experience much stronger enrollment growth than lower-performing competitors.

More specifically:

- The industry-wide enrollment-weighted average Star rating was 4.03 in 2016 and 4.00 in 2017.<sup>2</sup> This year, like last year, the enrollment-weighted average score for
- contract performance improved by 0.10 Stars. However, changes in cut points and the addition of the Categorical Adjustment Index (CAI)<sup>3</sup> offset the increase.
- Health maintenance organizations (HMOs) outperformed the market, with an enrollment-weighted average Star rating of 4.08 in 2017. The score for preferred provider organizations (PPOs) decreased to 3.80.
- Contracts built around integrated delivery networks (IDNs)<sup>4</sup> received a higher rating (4.45) than did contracts offered by commercial carriers<sup>5</sup> (3.89) or Blues carriers (3.93).
- Star ratings correlate with enrollment growth rates. Among the 2014 contracts that remained in the market in 2016, those that retained a 4+ Star rating experienced 40.9% growth. However, contracts that lost a 4+ Star rating had much slower growth (7.8%), and contracts with consistent performance below 4 Stars had only 0.9% growth.
- On a member-weighted basis, 90% of contracts that left the market between 2013 and 2016 were below 4 Stars.
- Plan maturity is associated with higher Star ratings: scores were 3.42 for contracts that have been in the program for fewer than five years, 3.72 for those with five to ten years' participation, and 4.09 for those in the program for more than ten years.
- A plan's ability to handle member complaints, manage chronic conditions, and deliver preventive care had the strongest correlation with overall performance changes.

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<sup>1</sup> Star ratings are awarded at the contract level. Contracts can contain multiple plans and multiple plan designs.

<sup>2</sup> Methodology used to calculate enrollment-weighted average is described in the methodology section, which begins on p. 106.

<sup>3</sup> The CAI is a factor that is added to (or subtracted from) a contract's Star rating to adjust for the within-contract disparities in performance associated with a contract's percentages of beneficiaries with low-income subsidy/dual-eligible and disability status.

<sup>4</sup> Includes both provider-led IDNs and payor-led IDNs.

<sup>5</sup> Commercial carriers are defined as those operated by for-profit entities that are not part of the Blue Cross Blue Shield Association and not considered part of an IDN.

## Star ratings have remained flat since last year

Between last year and this year, the enrollment-weighted average MA Star rating remained essentially flat—changing from 4.03 to 4.00 (Exhibit 1). This is the first time in six years the score did not increase. Similarly, the proportion of contracts that received 4+ Stars did not change from 2016 to 2017 (Exhibit 2).

To better understand the 2017 Star ratings, we isolated specific independent variables that influence those ratings, including changes in performance, enrollment, and cut points (CMS's cutoff scores for each rating), as well as the CAI it introduced this year. The enrollment-weighted average score for performance rose 0.10 this year (the same level of improvement that was seen last year). Enrollment changes also created a slight uplift. However, these gains were offset by changes in cut points, the addition of the CAI, and other factors (Exhibit 3).

## HMOs outperformed the market

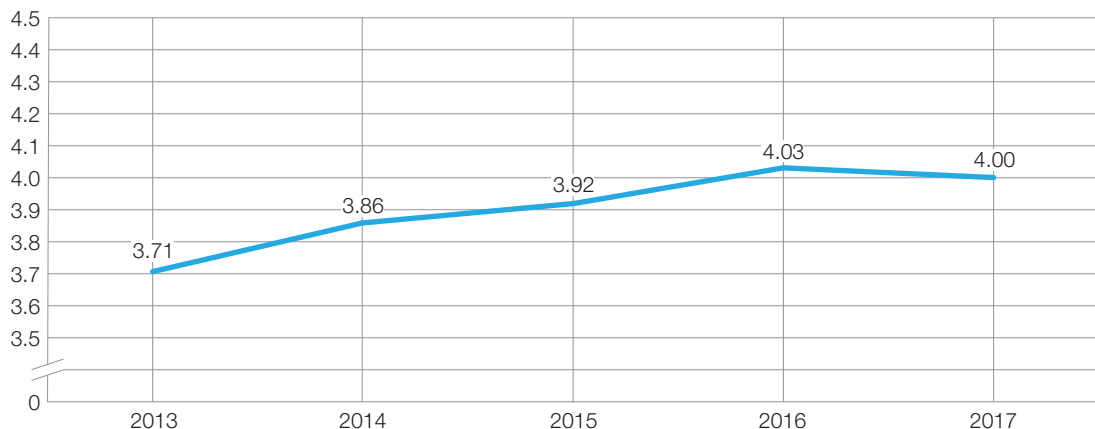
Among all MA contracts, HMOs received the highest enrollment-weighted average 2017 Star rating (4.08), on par with last year's 4.07 and higher than the overall average. PPO scores declined from last year. Local PPO contracts dropped from 4.16 to 3.94, and regional PPO contracts decreased from 3.33 to 3.18 (Exhibit 4).

## IDNs continue to outperform Blues and commercial contracts

Between the 2016 and 2017 ratings, the enrollment-weighted average score for Blues plans rose slightly (from 3.86 to 3.93), whereas commercial plans experienced a small decline (from 3.95 to 3.89); 2017 was the first time since 2013 that Blues plans had a higher score than commercial plans. The 2017 rating for IDNs was much higher

### EXHIBIT 1 Average enrollment-weighted MA Star ratings remained flat between 2016 and 2017

#### Enrollment-weighted average Star rating for Medicare Advantage (MA) plans



Source: CMS Star ratings fact sheet (2016–17)

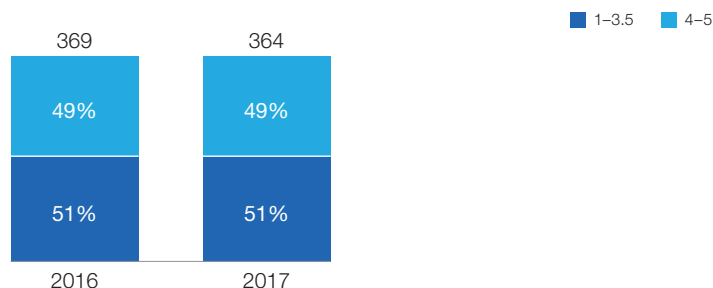
(4.45) but was largely unchanged from the previous year (4.47). IDNs have held the lead position for the past five years (Exhibit 5). However, if Kaiser Permanente is excluded,

the enrollment-weighted average 2017 score for IDNs drops to 4.02, significantly closer to the national average for all plans without Kaiser (3.92).

## EXHIBIT 2 The number of contracts above and below 4 Stars remained constant between 2016 and 2017

### Medicare Advantage contracts by Star summary score<sup>1</sup>

Total number of contracts, %



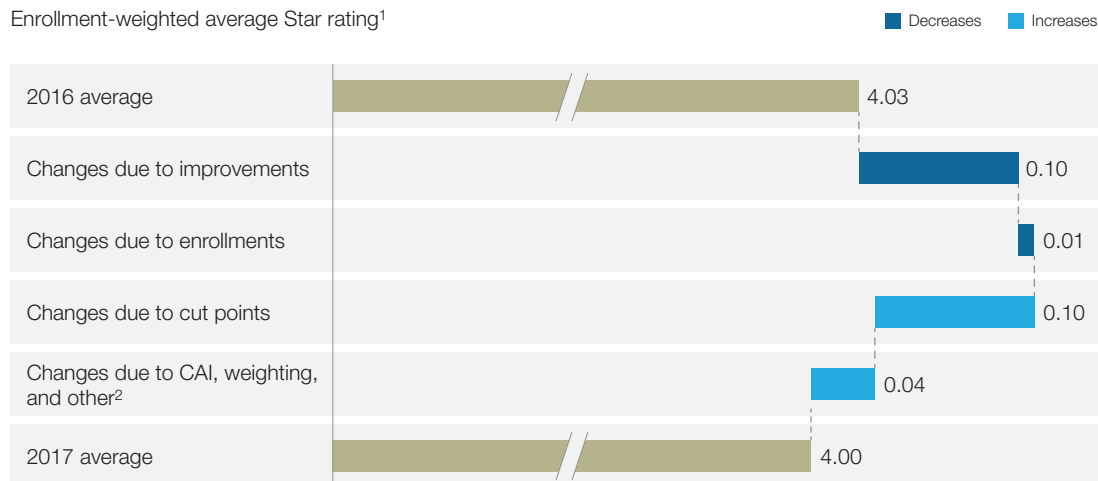
<sup>1</sup>Excludes Medicare Advantage (MA) prescription drug (PD) contracts that were not rated, PD-only contracts, and MA-only contracts.

Source: McKinsey analysis of CMS Medicare Star ratings data (2016–17)

## EXHIBIT 3 CMS measurement changes negated plan improvements

### Change in Stars performance from 2016 to 2017

Enrollment-weighted average Star rating<sup>1</sup>



CAI, category adjustment index; CMS, Centers for Medicare and Medicaid Services.

<sup>1</sup>Based on CMS published averages for 2016 and 2017 rating years.

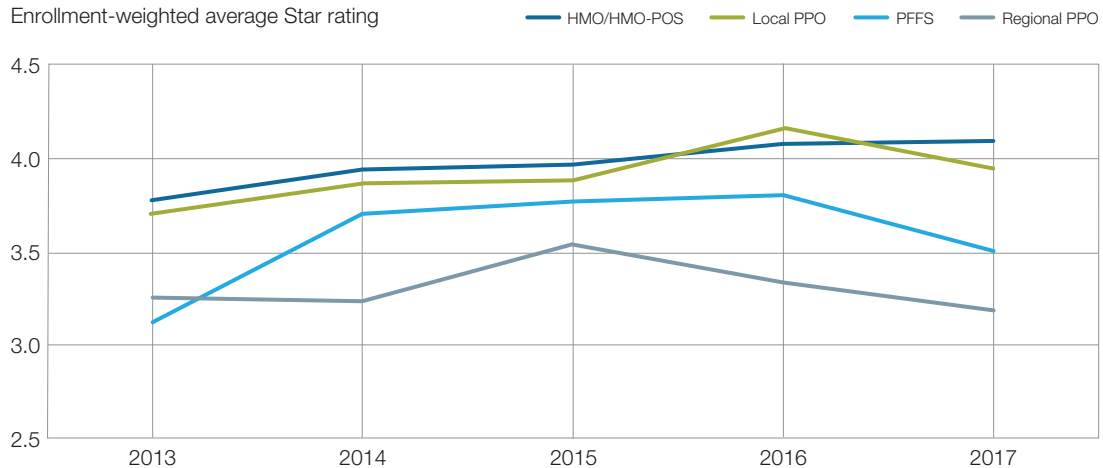
<sup>2</sup>Changes due to the addition of the CAI (socio-demographic and disability adjustment), weighting changes for some measures, addition/deletion of contracts (–0.004 impact for new contracts), improvement measures, and r-factor bonuses.

Source: McKinsey analysis of CMS Medicare Star ratings data (2016–17); CMS April enrollment files (2015–16)

#### EXHIBIT 4 PPO performance declined, whereas HMOs outperformed the market

##### Medicare Advantage Star rating by plan type

Enrollment-weighted average Star rating



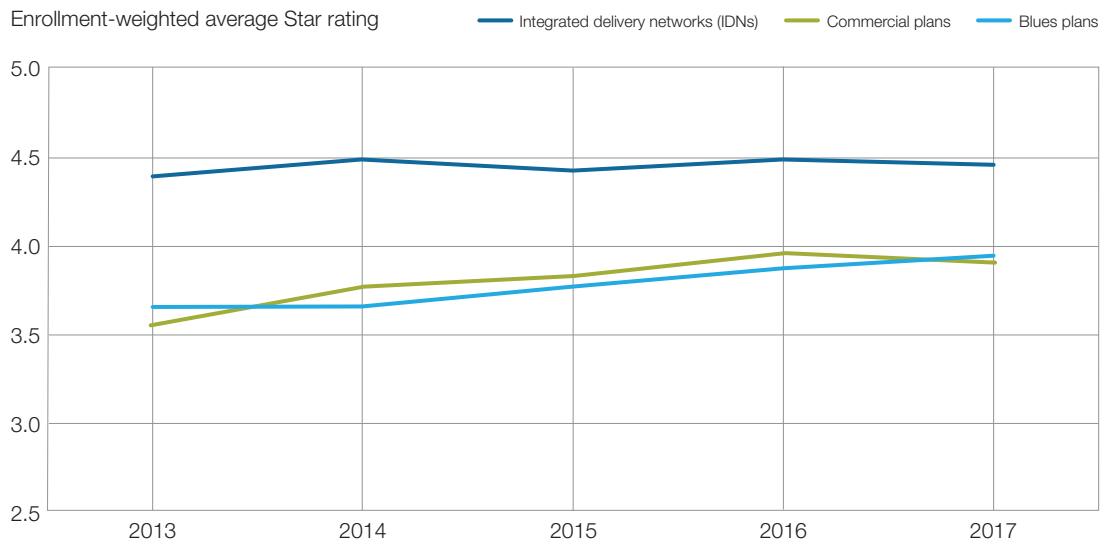
HMO, health maintenance organization; PFFS, private fee for service; POS, point of service; PPO, preferred provider organization.

Source: McKinsey analysis of CMS Medicare Star ratings data (2013–17); CMS April enrollment files (2012–16)

#### EXHIBIT 5 Blues performed on par with commercial plans, but IDNs remain dominant

##### Medicare Advantage Star rating by plan category

Enrollment-weighted average Star rating



Source: McKinsey analysis of CMS Medicare Star ratings data (2013–17); CMS April enrollment files (2012–16)

One factor contributing to the Blues' performance improvement was the rating given to Aware's (BCBS Minnesota's) 1876 contract, which was too new to be rated last year. Aware, which received a rating of 4.5 Stars, includes 7% of all Blues enrollment this year. If that contract is excluded, the Blues' enrollment-weighted average score would be 3.89, on par with the rating for commercial plans. The slight improvement from last year's 3.86 was driven primarily by the higher ratings given this year to

three of Anthem's HMO plans and two of GuideWell's plans (one HMO and one regional PPO).

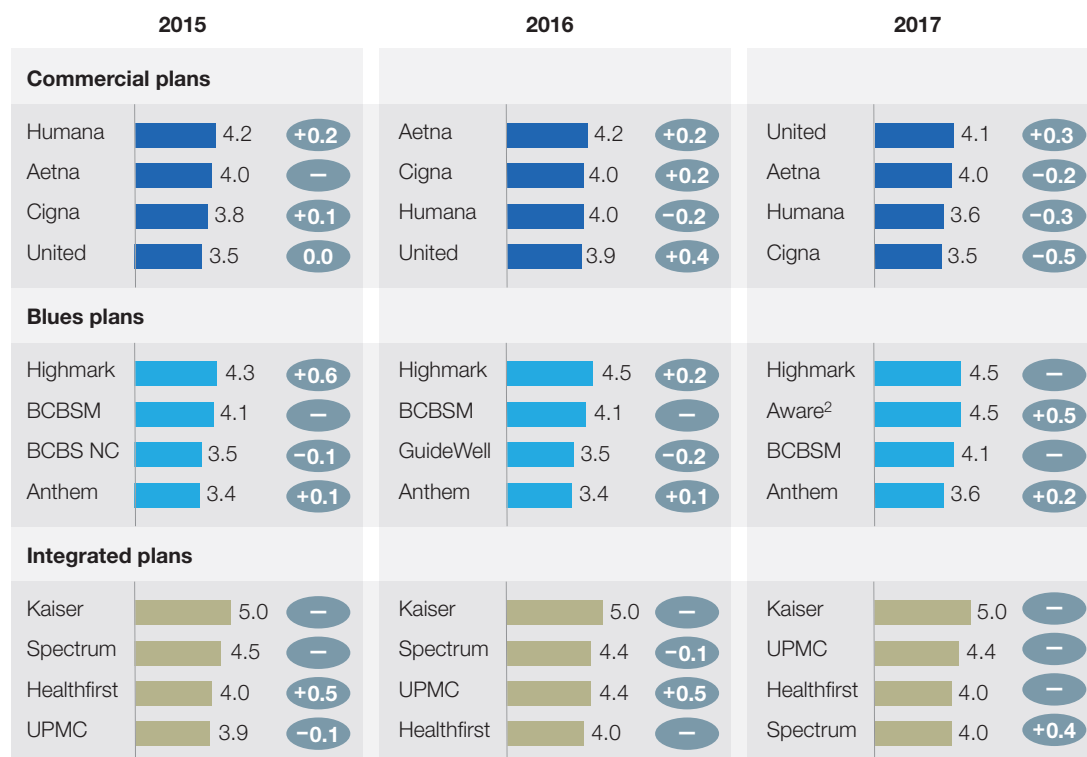
The small decline in performance for commercial plans can be partially explained by the large drops in the enrollment-weighted Star ratings from top payors (Exhibit 6). If the payors affected most this year (Cigna and Humana) are excluded, the enrollment-weighted average Star rating for commercial plans would have been 4.05 in 2017 and 3.94 in 2016.

## EXHIBIT 6 Top carriers show consistent performance, except for commercial plans

### Top 4 carriers by enrollment, ranked by Star ratings 2015–17

Enrollment-weighted average Star rating

● Year-on-year change,<sup>1</sup> points



BCBSM, Blue Cross and Blue Shield of Michigan; BCBS NC, Blue Cross and Blue Shield of North Carolina; UPMC, University of Pittsburgh Medical Center.

<sup>1</sup>Year-on-year changes reflect actual differences, not rounded differences.

<sup>2</sup>Includes 1876 cost contract.

Source: McKinsey analysis of CMS Medicare Star ratings data (2014–17); CMS April enrollment files (2013–16)



## Ratings appear to affect member attraction more than retention

Since last year, MA market membership has grown to 16.7 million, from 15.5 million, an almost 8% increase.<sup>6</sup> Although the percentage of all MA members who are enrolled in contracts with 4+ Stars decreased from 71% last year to 68% this year, the change does not reflect a decrease in the number of people who enrolled in the higher-rated contracts. Rather, its primary cause is the high volume of members retained by contracts that dropped from 4+ Stars to lower ratings (Exhibit 7).

To better understand the potential implications of rating changes on future enrollment, we first analyzed the association between the 2016 Star ratings (issued in October 2015) and 2016 enrollment. The analysis revealed that contracts with 4+ Stars saw a 13.1% increase in enrollment between October 2015 and October 2016, whereas contracts with fewer than 4 Stars saw only a 5.9% increase. The difference in enrollment cannot entirely be attributed to consumer awareness of the

ratings, however. Our research has shown that only about one in five consumers are aware of the significance of plan ratings.<sup>7</sup> Other factors probably also contribute, including the ability of higher-rated contracts to lower premiums and increase benefits because of their bonus payments and rebate dollars. Thus, it appears likely that contracts receiving fewer than 4 Stars in 2017 will have relatively slower enrollment growth than plans with 4+ Stars.

In addition, we analyzed enrollment changes between 2014 and 2016 to further understand the impact over time of losing a 4+ rating. We found that over those two years, contracts that lost a 4+ rating experienced only 7.8% membership growth, while contracts that retained the high rating saw 40.9% growth in membership. (Exhibit 8).

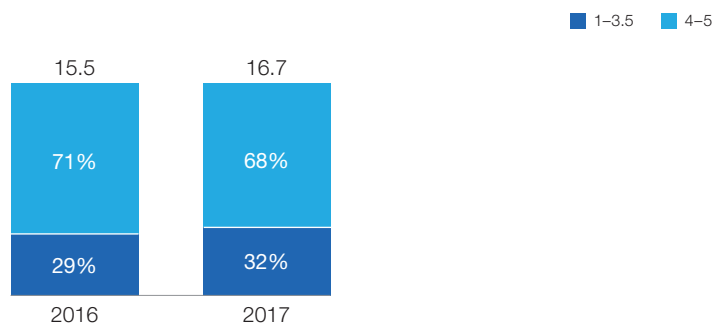
## Contracts that left the market have low Stars ratings

We also wanted to understand the correlation between low Star ratings and the likelihood that contracts remain in the market. To investigate this, we analyzed all contracts that have left the market since 2013, either because coverage was

### EXHIBIT 7 Percentage of enrollees in 4+ Star MA plans fell slightly

#### Membership by Medicare Advantage (MA) Star summary score<sup>1</sup>

Millions of enrollees



<sup>6</sup>Based on April 2016 and 2017 enrollment figures. Totals exclude people in plans that were too new to be rated.

<sup>7</sup>Based on McKinsey's 2015 Medicare Advantage consumer insights survey.

<sup>1</sup>Excludes MA prescription drug (PD) contracts that were not rated, PD-only contracts, and MA-only contracts. Source: McKinsey analysis of CMS Medicare Star ratings data (2016–17); CMS April enrollment files (2015–16)

terminated or contracts were consolidated.<sup>8</sup> On a member-weighted basis, over 90% of the contracts that left each year had fewer than 4 Stars. Furthermore, of the 320 contracts that had fewer than 4 Star ratings in 2013, 46% had been terminated or were consolidated into other contracts by 2017.

Exhibit 9 provides more detailed insights into the impact of low ratings. For example, 7% of the contracts offered in 2013 had been terminated or consolidated by 2014, and 98% of the people enrolled in those contracts had been in contracts with fewer than 4 Stars. Furthermore, the weighted average score of the terminated/consolidated contracts was 2.98.

Among the contracts that left the market, termination was more common initially, but consolidation predominated in the last two years. For example, consolidated contracts accounted for 41% of the enrollees whose contract left the market in 2014 but 95% of those enrollees in 2016. Among the large commercial payors, consolidation accounted for close to 100% of the enrollees whose contract left the market in 2016, compared with 72% in 2014.

## Plan maturity is associated with higher Star ratings

Plans with more experience in the MA program tend to have higher enrollment-weighted average 2017 Star ratings (Exhibit 10), a pattern consistent with previous years' results. This appears to be true even for IDNs. Integrated plans accounted for 33% of the market entrants in the past five years (31% on an enrollment basis), and those new entrants had a weighted average score of 3.43. Another 33% of the entrants were commercial plans, whose average rating was 3.43. The remaining 34% of the entrants were Blues plans, with an average score of 3.41. Thus, it appears that all new entrants need time to reach higher performance levels.

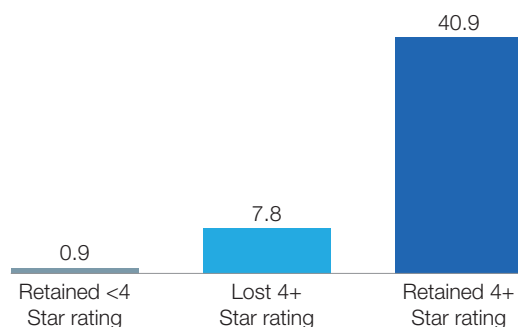
## Some performance factors correlate with positive Star performance

To identify where MA plans should target their improvement efforts, we ran a regression analysis to determine how performance on specific measure domains affected the plans' overall Star ratings.

### EXHIBIT 8 Enrollment changes favor plans that retained 4+ Star ratings

#### Change in enrollment 2014–16 by Star status<sup>1</sup>

% change in enrollment



<sup>1</sup> Change in overall Star ratings 2014–15.

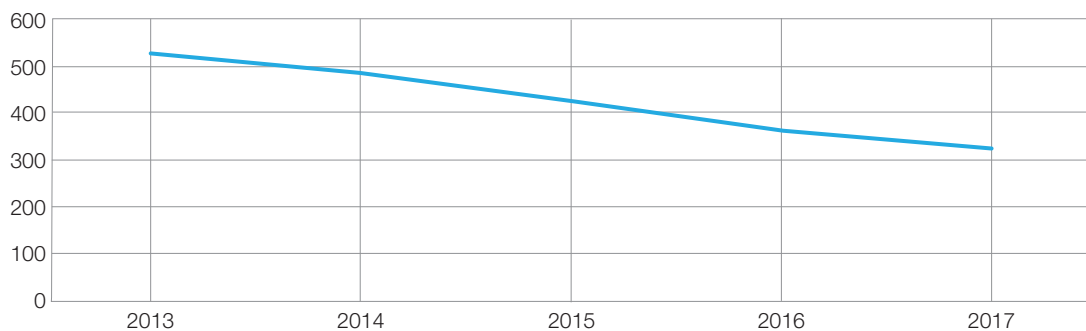
Source: McKinsey analysis of CMS Medicare Star ratings data (2014–16); CMS October enrollment files (2014–16)

<sup>8</sup> We considered a plan to be terminated if it was no longer offered or its contract was not renewed. We defined plans as consolidated whenever two or more plans were combined into one.

## EXHIBIT 9 The vast majority of plans that left the market scored below 4 Stars

### Contract survivorship

Number of plans remaining in market



### For plans that left the market<sup>1</sup>

Transition year	2013–14	2014–15	2015–16	2016–17
Percentage of all plans	7	12	15	10
Percentage of affected enrollees in <4 Star plans	98	91	95	100
Weighted average Star score	2.93	3.37	3.43	3.35

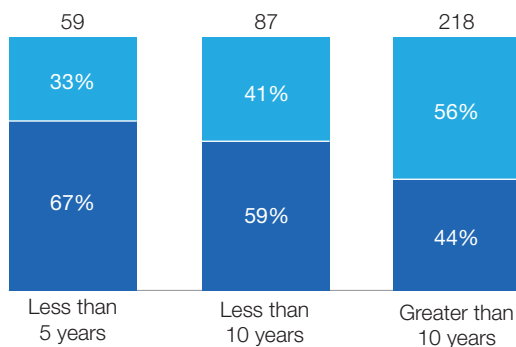
<sup>1</sup>Includes plans that were consolidated into other plans and plans that were terminated.

Source: McKinsey analysis of CMS Medicare Star ratings data (2013–17); CMS April enrollment files (2012–16)

## EXHIBIT 10 Length of time in the MA program is associated with higher Star ratings

### Ratings by length of time in Medicare Advantage (MA) program

Plans by average 2017 Star rating, %



Source: McKinsey analysis of CMS Medicare Star ratings data (2017); CMS April enrollment data (2016)

CMS groups the measures into nine domains. The top three domains that influenced scores (ranked in order of correlation with positive Star performance) are:

- HD4: Member Complaints and Changes in the Health Plan's Performance
- HD2: Managing Chronic (Long-term) Conditions
- HD1: Staying Healthy: Screenings, Tests, and Vaccines

Exhibit 11 lists, in order, all nine domains. An explanation of which metrics fall within these domains is provided in the methodology section.



The findings in this article provide a perspective on how CMS is rating the performance of the

MA plans offered for 2017. The information is based on publicly reported data released on October 12, 2016. [O](#)

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## EXHIBIT 11 Certain domains affect Star ratings more than others

### Domains ranked by their impact on average Star rating<sup>1,2</sup>

- 1 HD4: Member Complaints and Changes in the Health Plan's Performance
- 2 HD2: Managing Chronic (Long-term) Conditions
- 3 HD1: Staying Healthy: Screenings, Tests, and Vaccines
- 4 DD3: Member Experience with the Drug Plan
- 5 DD1: Drug Plan Customer Service
- 6 DD4: Drug Safety and Accuracy of Drug Pricing
- 7 HD5: Health Plan Customer Service
- 8 HD3: Member Experience with Health Plan
- 9 DD2: Member Complaints and Changes in the Drug Plan's Performance

<sup>1</sup> Ordered in terms of impact on overall Star ratings based on a regression analysis comparing the change in domain score with the change in overall Star rating.

<sup>2</sup> See the methodology section for a list of measures included in each domain.

Source: McKinsey analysis of CMS Medicare Star ratings data (2016–17)

## Methodology

**Enrollment-weighted average.** On October 12, 2016, CMS released data on Medicare Advantage contracts and plans offered for 2017, in advance of the annual enrollment period. McKinsey calculated enrollment-weighted averages by taking the total number of enrollees in contracts and plans for 2016, assigning higher weights to plans with higher enrollment.

The results were used to calculate the enrollment-weighted averages for 2017 Star ratings. The enrollment-weighted average demonstrates Stars performance among carriers and products with the highest level of participation and thus allows us to understand overall trends.

**Enrollment.** The October 2016 summary Star rating data from CMS was used as a filter for the April 2016 CMS Medicare Advantage enrollment by state, county, and contract.

Therefore, enrollment in contracts that did not exist in the October 2016 ratings file are not included in the enrollment data in this Intelligence Brief.

**Sanctioned plans.** Sanctioned plans (e.g., Cigna) were included in the analysis because they received ratings and were included in CMS's overall figures.

**Domain measures.** Exhibit 12 (on the next page) includes a full list of the measures included in each domain.

### Glossary

**Integrated delivery network (IDN).** A health plan model, either provider-led or payor-led, with close alignment between the payor and provider functions.

**Health maintenance organization (HMO).** A plan model centered on a primary care physician who acts as gatekeeper to other services and referrals; it provides no coverage for out-of-network services except in emergency or urgent-care situations.

**Preferred provider organization (PPO).** A health plan model that allows members to see physicians and receive services that are not part of a network, but the out-of-network services require a higher copayment. Local PPOs serve specific counties that the plan chose to include in its service areas. Regional PPOs serve one of twenty-six regions decided by Medicare, usually one or more states.

**1876 contract.** A plan that is operated by an HMO or competitive medical plan (CMP) based on a cost-reimbursement contract. Enrollees are not restricted to the HMO or CMP network, and can receive coverage through original Medicare as well. Medicare payments to the HMO/CMP are based on the reasonable cost of providing services to the Medicare beneficiaries.

## EXHIBIT 12 Certain domains affect Star ratings more than others

### Domains ranked by impact of rating changes on average Star rating<sup>1</sup>

<b>1 HD4: Member Complaints and Changes in the Health Plan's Performance</b> <ul style="list-style-type: none"> <li>• C26: Complaints about the Health Plan</li> <li>• C27: Members Choosing to Leave the Plan</li> <li>• C28: Beneficiary Access and Performance Problems</li> <li>• C29: Health Plan Quality Improvement</li> </ul>	<b>5 DD1: Drug Plan Customer Service</b> <ul style="list-style-type: none"> <li>• D01: Call Center – Foreign Language Interpreter and TTY Availability</li> <li>• D02: Appeals Auto-Forward</li> <li>• D03: Appeals Upheld</li> </ul>
<b>2 HD2: Managing Chronic (Long-term) Conditions</b> <ul style="list-style-type: none"> <li>• C08: Special Needs Plan (SNP) Care Management</li> <li>• C09: Care for Older Adults – Medication Review</li> <li>• C10: Care for Older Adults – Functional Status Assessment</li> <li>• C11: Care for Older Adults – Pain Assessment</li> <li>• C12: Osteoporosis Management in Women Who had a Fracture</li> <li>• C13: Diabetes Care – Eye Exam</li> <li>• C14: Diabetes Care – Kidney Disease Monitoring</li> <li>• C15: Diabetes Care – Blood Sugar Controlled</li> <li>• C16: Controlling Blood Pressure</li> <li>• C17: Rheumatoid Arthritis Management</li> <li>• C18: Reducing the Risk of Falling</li> <li>• C19: Plan All-Cause Readmissions</li> </ul>	<b>6 DD4: Drug Safety and Accuracy of Drug Pricing</b> <ul style="list-style-type: none"> <li>• D10: MPF Price Accuracy</li> <li>• D11: High Risk Medication</li> <li>• D12: Medication Adherence for Diabetes Medications</li> <li>• D13: Medication Adherence for Hypertension (RAS antagonists)</li> <li>• D14: Medication Adherence for Cholesterol (Statins)</li> <li>• D15: MTM Program Completion Rate for CMR</li> </ul>
<b>3 HD1: Staying Healthy: Screenings, Tests, and Vaccines</b> <ul style="list-style-type: none"> <li>• C01: Breast Cancer Screening</li> <li>• C02: Colorectal Cancer Screening</li> <li>• C03: Annual Flu Vaccine</li> <li>• C04: Improving or Maintaining Physical Health</li> <li>• C05: Improving or Maintaining Mental Health</li> <li>• C06: Monitoring Physical Activity</li> <li>• C07: Adult BMI Assessment</li> </ul>	<b>7 HD5: Health Plan Customer Service</b> <ul style="list-style-type: none"> <li>• C30: Plan Makes Timely Decisions about Appeals</li> <li>• C31: Reviewing Appeals Decisions</li> <li>• C32: Call Center – Foreign Language Interpreter and TTY Availability</li> </ul>
<b>4 DD3: Member Experience with the Drug Plan</b> <ul style="list-style-type: none"> <li>• D08: Rating of Drug Plan</li> <li>• D09: Getting Needed Prescription Drugs</li> </ul>	<b>8 HD3: Member Experience with Health Plan</b> <ul style="list-style-type: none"> <li>• C20: Getting Needed Care</li> <li>• C21: Getting Appointments and Care Quickly</li> <li>• C22: Customer Service</li> <li>• C23: Rating of Health Care Quality</li> <li>• C24: Rating of Health Plan</li> <li>• C25: Care Coordination</li> </ul>
	<b>9 DD2: Member Complaints and Changes in the Drug Plan's Performance</b> <ul style="list-style-type: none"> <li>• D04: Complaints about the Drug Plan</li> <li>• D05: Members Choosing to Leave the Plan</li> <li>• D06: Beneficiary Access and Performance Problems</li> <li>• D07: Drug Plan Quality Improvement</li> </ul>

<sup>1</sup> Ordered in terms of impact on overall Star ratings based on a regression analysis comparing the change in domain score with the change in overall Star rating.

Note: Sub-metrics are not ranked by impact. They are listed as context for the measures that make up the domain.

Source: McKinsey analysis of CMS Medicare Star ratings data (2016–17)

# CMS's final ruling on the Quality Payment Program under MACRA: Strategic implications for stakeholders

*Performance measurement for the Quality Payment Program (QPP) has begun. Although 2017 is a transition year, the QPP already has important implications for payors.*

**Dan Fields;  
Deepali Narula;  
Seema Parmar;  
Mithun Patel, MD;  
and Maria Sodini**

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 effectively ended the Medicare Sustainable Growth Rate (SGR) methodology that had previously been used to manage Medicare physician expenditures. The SGR methodology often resulted in significant reductions in physician payments, and Congress would regularly pass “doc fixes” to avert these cuts. MACRA replaced the SGR methodology with flat updates to the fee schedule and introduced a redesigned reimbursement framework known as the Quality Payment Program (QPP). The QPP will consolidate previous quality and cost programs under a single program designed to encourage clinicians to take on risk through alternative, value-based payment models.

On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) published the final rule for the QPP, and the first QPP performance measurement period began on January 1, 2017. Below, we provide a brief summary of the program's key elements and discuss their implications for stakeholders. Note: Although MACRA was developed with bipartisan support, it is possible that changes to healthcare policy made by the new administration could affect how the QPP is rolled out.

(MDs, DOs, chiropractors, podiatrists, dentists, and optometrists), physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.<sup>1</sup> These clinicians will be exempt from the QPP if they are in their first year of Medicare participation or meet the Medicare low-volume threshold (no more than either 100 Medicare Part B patients or \$30,000 in allowed Medicare Part B charges). CMS estimates that as a result of these exemptions, approximately one-third of the clinicians in the groups listed above will be excluded from the QPP in 2017.

In 2017 and future calendar years, clinicians can choose to participate in one of two tracks under the QPP:

## [Merit-based Incentive Payment System.](#)

MIPS is a pay-for-value program that combines three existing initiatives—the Physician Quality Reporting System, value-based payment modifiers, and meaningful use incentives—into a single program with four components of performance: quality, resource use (cost), clinical practice improvement, and “advancing care information” (certified electronic health record, or EHR, use). It is the provisions concerning MIPS that pertain only to certain clinicians in 2017 and 2018.

## [Advanced Alternative Payment Model track.](#)

Clinicians will be exempt from MIPS if they participate in alternative payment models (APMs) that meet certain CMS criteria: for

## Overview

The QPP will eventually affect nearly all clinicians, but in 2017 and 2018 some of its provisions will pertain only to physicians

<sup>1</sup>Providers can choose to have reporting and financial bonuses/penalties assessed at the individual clinician level or at the entity level (based on taxpayer identification number).



example, the clinicians must be willing to accept downside risk and meet specified participation thresholds based on volume and payments. The APMs that meet these criteria are considered Advanced APMs. For the first two years of the QPP, a clinician's eligibility to participate in the Advanced APM track will be based solely on participation in Medicare Advanced APMs. From the 2019 performance period onward, clinicians that meet CMS's other criteria for the Advanced APM track will be able to count participation in both Medicare APMs and value-based payment arrangements with non-Medicare payors (including Medicare Advantage payors) as a way to achieve the required thresholds.

Participation and performance will be measured within each calendar year, with payment adjustments disbursed two years later (i.e., 2017 performance will determine 2019 adjustments). Between 2017 and 2019, the increase to the base Medicare physician fee schedule will be 0.5% annually. Between 2020 and 2025, the base Medicare physician fee schedule will be held constant (0% increase to the base rate); adjustments to reimbursement during that time will come exclusively from payments made through the QPP. Starting in 2026, MIPS participants will receive a 0.25% annual increase in the base rate, and Advanced APM participants will receive 0.75%. In addition, both groups will receive payment adjustments through their participation in either MIPS or an Advanced APM.

## MIPS

CMS describes 2017 as a "transition year," during which it is offering clinicians the option to "pick your pace." Clinicians have four participation options and can avoid penalties

*Participation and performance [in an advanced APM] will be measured within each calendar year, with payment adjustments disbursed two years later.*

by meeting minimal reporting requirements. (Starting in 2018, non-exempt clinicians will be required to participate in MIPS for the full year.) In 2017, the participation options are:

- Participate for the full year to be eligible for the full bonus payment.
- Participate for a minimum of 90 days to be eligible for a neutral or slightly positive payment.
- Meet the minimal reporting requirements (one quality measure, one improvement measure, or the basic metrics within the advancing-care-information category) to avoid penalties.
- Do not report at all and automatically face the maximum 4% penalty.

Clinicians will receive a score in each of the four performance categories (quality, resource use, clinical practice improvement, and advancing care information); the scores will then be aggregated into a composite score. In year 1, CMS will not be factoring cost into the MIPS score. However, it will evaluate resource-use performance and give clinicians reports to help them understand how the resource-use category will be evaluated in the future. As shown in Exhibit 1, the scores in each area are weighted, and the weighting will change over time. The specific metrics included in each area and their weighting are adjusted for different groups of clinicians. For example, specialists have their own specific quality metrics. Hosp-

ital-based physicians are excluded from the advancing-care-information category. Physicians who do not interact directly with patients are excluded from both the resource-use and advancing-care-information categories and are required to report on only two, rather than four,

clinical improvement measures (they will still be evaluated on quality, however).

The data to be submitted is a mix of self-reported and claims-based information.

Clinicians are required to use a certified EHR

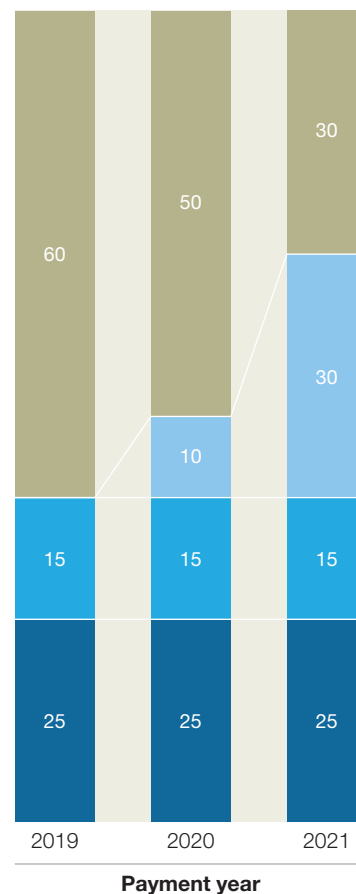
## EXHIBIT 1 MIPS measures four performance categories

Quality Resource use (cost) Clinical practice improvement Advancing care information

### Categories

<b>Quality</b>	<ul style="list-style-type: none"> <li>Replaces PQRS</li> <li>Provider must choose 6 measures from 271 possible measures,<sup>1</sup> including 1 outcome measure</li> <li>Specialists choose from specific specialty sets</li> <li>Bonus points for high-priority and additional outcome measures and for electronic reporting</li> </ul>
<b>Resource use (cost)</b>	<ul style="list-style-type: none"> <li>Replaces value-based payment modifiers; automatically evaluated using claims data</li> <li>Measures include total (annual) per-capita costs for all attributed beneficiaries, Medicare spending per beneficiary during any inpatient admission, and 10 episodes cost measures</li> </ul>
<b>Clinical practice improvement</b>	<ul style="list-style-type: none"> <li>Provider must choose 2–4 activities from 92 activities<sup>1</sup> in 8 categories (health equity, beneficiary engagement, behavioral health, care coordination, expanded practice access, emergency preparedness, practice safety, population management); can choose either A) 2 high-priority activities, B) 1 high-priority and 2 medium-priority activities, or C) 4 medium-priority activities</li> </ul>
<b>Advancing care information</b>	<ul style="list-style-type: none"> <li>Similar to meaningful use requirements; specific QPP requirements for 2017 vary based on certified EHR technology edition used (2014 or 2015)</li> <li>5 required measures include security risk analysis, e-prescribing, provide patient access, send summary of care, and request/accept summary of care<sup>2</sup></li> <li>Bonus points for performance and submission of additional measures</li> </ul>

### Change score weighting over time



EHR, electronic health record; MIPS, Merit-based Incentive Payment System; PQRS, Physician Quality Reporting System; QPP, Quality Payment Program.

<sup>1</sup>The 271 measures and 92 activities were specified in the final rule.

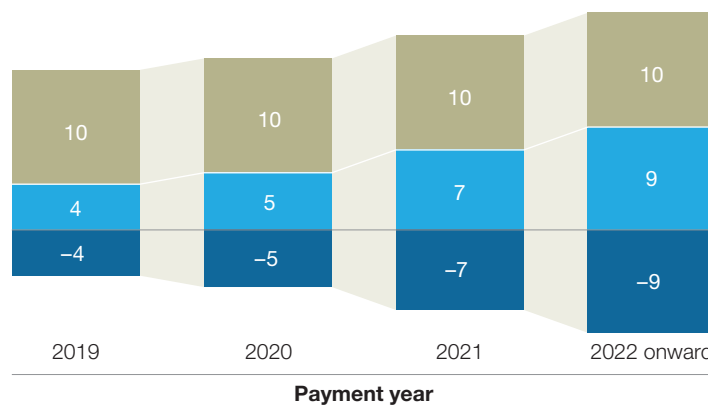
<sup>2</sup>The number of measures that need to be reported depends on the clinician's certified EHR technology edition; for certain editions, clinicians may only need to report on four measures (security risk analysis, e-prescribing, provide patient access, health information exchange).

Source: CMS Quality Payment Program Final Rule

## EXHIBIT 2 Range of adjustments to Medicare Part B clinician payments under MIPS<sup>1</sup>

### % increase or decrease per clinician<sup>2</sup>

■ Maximum potential bonus for "exceptional" performers (in top 25th percentile) between 2019 and 2024 ■ Potential performance bonus ■ Maximum potential performance penalty for those in bottom 25th percentile



MIPS, Merit-based Incentive Payment System.

<sup>1</sup> The Centers for Medicare and Medicaid Services (CMS) assumes that there will be more negative payment adjustments than positive ones. Thus, to ensure budget neutrality, it has proposed that positive payment adjustments may be scaled up (to up to three times their current level) in the event the total amount of negative payment adjustments is less than the total amount of positive payment adjustments.

<sup>2</sup> Percentage increases and decreases were proposed by CMS.

Source: CMS Quality Payment Program Final Rule

system for the advancing-care-information category and can receive bonus points in the quality category by using electronic clinical quality measure (eCQM) reporting. Clinicians may also submit data with support from approved third-party intermediaries, such as health IT vendors, that are able to meet CMS's data submission requirements. However, clinicians will not have to submit data for the resource-use category, because it will be evaluated through claims data.

A performance threshold for the composite score will be established prior to each year. This score will reset annually and will be based on either the mean or median of the composite scores for the previous performance period. Clinicians who score above the threshold will

earn bonuses; those who score below it will face penalties. Bonus and penalty amounts will align with the scores (e.g., the higher the score, the greater the bonus), but the maximum penalties will be imposed on those who do not report at all. Disbursements will be calculated annually. The bonuses and penalties issued in 2019 (based on 2017 performance) will be a maximum of 4% of the Medicare Part B charges allowed in 2018. They will then gradually increase to 9% in 2022 and later. In each year between 2019 and 2024, exceptional performers can receive additional bonus payments of up to 10% (Exhibit 2).

Clinicians participating in certain CMS APMs that do not meet the criteria for an Advanced APM (as defined below) are required to

participate in MIPS.<sup>2</sup> These clinicians have been given a separate APM scoring standard to reduce the burden of reporting to multiple programs and to reward the quality, cost, practice, and EHR improvements achieved through these APMs.

## Advanced APMs

Under the QPP, only certain alternative payment models qualify as an Advanced APM. These models must meet certain criteria:

- A defined percentage of their practitioners must use certified EHR technology.
- The models must base payments on quality metrics comparable to those used in the MIPS quality category.
- The models must either bear more than nominal financial risk (including downside risk) or qualify as a medical home model.

Advanced APM participants for 2017 include clinicians in Medicare Shared Savings Program (MSSP) Tracks 2 and 3 accountable care organizations (ACOs), Next Generation ACOs, and any of the following models: Comprehensive Primary Care Plus, Comprehensive End-Stage Renal Disease, or Oncology Care (two-sided risk).

Clinicians in these programs who meet certain payment and patient volume thresholds are considered “qualifying APM participants” and are exempt from MIPS. During the 2019 to 2024 payment years, these clinicians will receive a lump-sum bonus payment of 5% of Medicare Part B-allowed charges from the year preceding the payment years. (This lump-sum bonus is in addition to any performance-based payment the clinicians receive directly through the APM.) Clinicians who meet lower payment and patient volume thresholds are defined as

“partial qualifying APM participants” and will not be eligible for the lump-sum payments. However, they can choose to opt out of MIPS.

In December 2016, CMS announced additional programs that would allow clinicians to qualify for the Advanced APM track, starting January 1, 2018. These programs include the updated Comprehensive Care for Joint Replacement Episode program, the new Cardiac Care Episode program (which will begin on October 1, 2017), and the new MSSP Track 1+ program (which requires ACOs to accept downside risk, albeit at a lower level than is specified in Tracks 2 and 3).

## QPP financing and costs

CMS estimates that in 2019 (the first payment year), about 600,000 individual clinicians will receive payment adjustments through MIPS, and that clinicians in smaller practices are more likely to receive negative adjustments than clinicians in larger practices (Exhibit 3).<sup>3</sup> If there is an equal split between clinicians earning bonuses and those facing penalties, the average impact per clinician could be about \$4,000 per year, or 1% to 2% of gross income.

The 70,000 to 120,000 clinicians who CMS estimates will participate in Advanced APMs in 2017 are expected to earn, on average, between \$4,000 and \$5,000 in APM incentive payments (in addition to earnings or penalties from the APM itself).

## Early implications for payors

Although MACRA primarily affects providers, it has important implications for payors as well. At present, however, it is unclear whether

<sup>2</sup>Medicare Shared Savings Program (MSSP) Track 1 accountable care organizations, which are eligible for shared savings but do not accept financial risk, are an example of such APMs.

<sup>3</sup>Based on the historical performance of smaller practices in quality programs and the difficulties such practices often face in affording the investments needed for performance improvements and reporting requirements under MIPS.

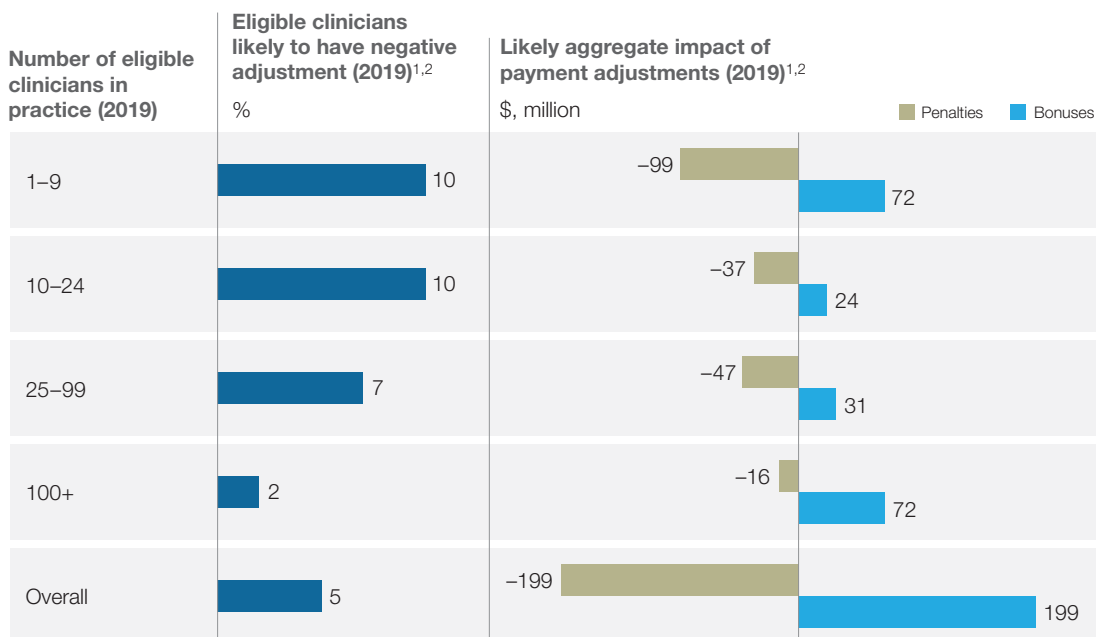
MACRA will present payors with a significant opportunity—or disruption. Under the new administration, the biggest adjustment that could affect the QPP (other than complete dismantling of MACRA) would likely be changes to the current focus on Advanced APMs introduced by Center for Medicare and Medicaid Innovation. At present, private payors have the option of piggy-backing on these models when entering into negotiations with providers. This approach is designed to give providers a greater incentive to invest in the necessary infrastructure and increase their willingness to

enter into value-based arrangements with private payors. If the Advanced APMs are not in place, the payors could potentially have both the freedom and burden of designing their own value-based models for providers.

**Medicare Advantage (MA).** Shifts in the base Medicare physician fee schedule could slow growth in MA physician reimbursement. Potential provider consolidation (as smaller, under-performing providers look to align with larger, more capable systems) could affect network structure and pricing. Providers at

### EXHIBIT 3 CMS's estimated range of Medicare Part B clinician payment adjustments under MIPS

Estimated range, excluding additional bonus payments for exceptional performers



MIPS, Merit-based Incentive Payment System.

<sup>1</sup> The Centers for Medicare and Medicaid Services (CMS) used 2015 data to estimate 2017 performance and then used those estimates to gauge the potential payment bonuses and penalties in 2019.

<sup>2</sup> CMS has noted that use of historical data as a basis for calculation and the use of a standard set of participation assumptions may over-estimate the negative impact on small practices.

<sup>3</sup> Payments estimated using 2014 dollars.

Source: CMS Quality Payment Program Final Rule

risk of penalties under MIPS may look to shift patients into MA plans, where they can negotiate contract terms and are better able to meet reporting requirements and, in some cases, performance expectations. Overlaps between QPP and Stars metrics could create positive momentum, encouraging both payors and providers to work on quality and cost management efforts systematically. Payors may consider how to structure their MA value-based reimbursement plans to meet CMS criteria for Advanced APMs under the QPP.

#### Value-based models across all segments.

Clinicians who do not have the necessary payments or patient volume in Medicare Advanced APMs to meet the participation thresholds for the QPP's Advanced APM track may show a greater appetite for participating in value-based models with non-Medicare payors, given that in 2019 participation in non-Medicare models could count toward those thresholds and help them qualify for the Advanced APM track.

Contrary to historical norms, some providers may move ahead of their payor partners on value-based reimbursement—it is possible that providers participating in Advanced APMs could try to leverage their investments in QPP capabilities to enter into value-based arrangements and secure patient volume across payors.

The sidebar below describes potential actions payors can consider taking in response to MACRA.

## Early implications for providers

**Financial implications.** In the near term, actual bonus and penalty amounts may be relatively small (e.g., 2% to 4%) and will affect only a moderate subset of most providers' book of

business, given that Medicare fee-for-service patients are often only 15% to 20% of a typical clinician's volume. Nevertheless, the combined impact of the penalties on margin and the reduction in the fee schedule annual growth rate make the opportunity cost of not performing well under the QPP more substantial.

**Physician alignment.** Small practices exempt from the QPP will still be affected by the removal of rate increases. Thus, they may look to align with health systems or larger physician groups that could potentially enable them to receive MIPS or Advanced APM bonuses. Mid-sized practices at risk of being penalized through MIPS may also seek alignment with larger systems able to offer them the capabilities needed to optimize MIPS or Advanced APM performance. Management services providers (or possibly some payors) might be able to lighten the burden on these practices by providing additional data gathering and reporting services.

**Clinician behavior.** The QPP places growing emphasis on behavior change to focus on cost and quality, not just productivity. Clinician leadership and governance among employed practitioners will become increasingly important, especially as specialists and other groups not typically in pay-for-value programs enter MIPS or Advanced APMs.

**Care patterns.** Over the long term, care patterns may change as clinicians become more aggregated, use of EHR becomes more prevalent, and care protocols become more standardized for quality and cost purposes.

**Post-acute care.** Clinicians participating in Advanced APMs who are responsible for a patient's total cost of care will likely show

## Potential actions payors could take in response to MACRA

### Medicare Advantage (MA)

- Analyze potential network configurations based on anticipated changes.
- Move to solidify and protect relationships with high-quality, high-value providers through longer-term, potentially exclusive contracts; develop an MA strategy that will also boost provider performance in MACRA.
- Support high-value providers who are willing to enter into longer-term MA contracts to fill capability gaps, which could mean sharing the cost of investments required to improve performance on Medicare Star ratings and in the QPP.
- Launch more robust cost-of-care capabilities to prevent over-utilization in MA, which could potentially occur as a response to constraints on fee-for-service utilization.

### Broader value-based strategy

- Decide on how to reconcile programs: should you be a leader—or take a back seat to CMS design? If the new administration decides to slow down CMS's push to value-based care, will you continue to push forward?
- Develop scenario plans, including financial, organizational, network, and governance implications between the two options.
- Consider if/how programs can be designed or updated to align with the provider risk levels and capabilities required to succeed in the QPP.
- Consider initiatives that focus on building patient loyalty (to both providers and payors) while offering patients tools and incentives to better manage their care and make decisions to improve their health.

greater interest in aligning with high-performing post-acute systems to better coordinate care so they can improve quality and outcomes while reducing the total cost of care. However, there may be increased pressure on post-acute utilization if APMs become more widely used and physician incentives are geared toward ensuring appropriate utilization in the post-acute setting.



Now that performance measurement for the QPP has started, payors can begin to determine how MACRA is likely to affect them. In particular, changes in the current focus on Advanced APMs and shifts in the base Medicare

physician fee schedule could present payors with a significant opportunity—or disruption. ○

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INSIGHTS ON SPECIFIC MARKETS:  
**Medicaid**





# Improving healthcare for people with special or supportive care needs

*Certain individuals have especially complex medical and supportive care needs. State governments, private payors, providers, and technology companies are innovating to address these needs.*

Three groups of individuals often have especially complex medical and supportive care needs: those with behavioral health (BH) conditions, including substance abuse; those with intellectual or developmental disabilities (I/DDs); and those requiring long-term services and support (LTSS) because of chronic, complicated medical conditions or physical disabilities.

For simplicity's sake, we use the term *special or supportive care needs* to refer to the combination of services these three groups require. Although the groups constitute less than 20% of the US population, they account for more—perhaps far more—than 35% of the country's total annual health expenditures (Exhibit 1).

Most individuals in the three groups require a combination of medical and supportive services, usually for prolonged periods. However, the needed care is not always available; even when it is, coordination among service providers is often inadequate. Historically, the care has been delivered by a variety of providers, overseen by a number of different public and private entities. Too often, the structural incentives for collaboration among these entities are weak.

As a result, the amount spent on special or supportive care needs often bears little relationship to the severity of a person's condition or the quality of care delivered. McKinsey research has found, for example, that the

correlation between the level of need of individuals with I/DDs and the amount payors spend annually for their care is frequently poor.

Unless better ways are found to coordinate care delivery, spending on the three groups will rise significantly (without any improvement in the quality of care), in part because the number of affected individuals is growing. Population aging accounts for some of the growth—estimates suggest that the number of Americans above age 65 will be 60% higher in 2030 than in 2010, and that 70% or more of those over 65 will eventually need LTSS. However, increased awareness of the underlying conditions and improved diagnostic criteria that make it easier to identify affected individuals are also contributing to the rising prevalence.

In recent years, state governments, private payors, and providers have undertaken a number of innovations to improve care delivery to these groups. Technological advances are supporting many of the innovations.

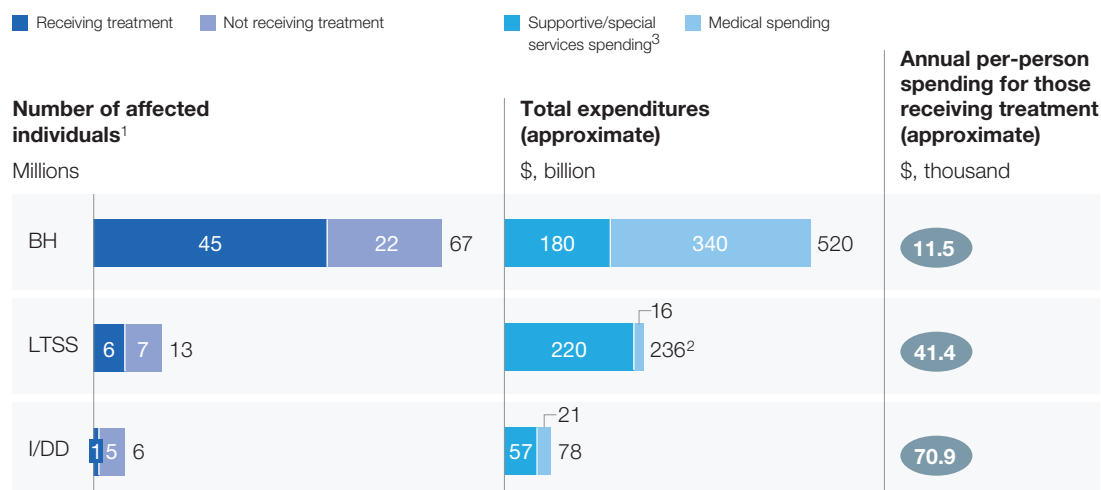
## State governments

States have been at the forefront of innovation because of their involvement with Medicaid. Individuals with special or supportive care needs constitute roughly one-third of all Medicaid patients but account for almost two-thirds of the program's spending. Not only do states administer the Medicaid program, they also shoulder, on average, about 40% of its costs.

**Kara Carter,  
Razili Lewis,  
and Tim Ward**

This article provides an overview of a much longer report on care delivery for individuals with special or supportive care needs. The longer report, which was released in August 2016, can be found on the McKinsey on Healthcare website.

## EXHIBIT 1 Cost of care for individuals with special or supportive care needs



BH, behavioral health; LTSS, long-term services and support; I/DD, intellectual or developmental disabilities.

<sup>1</sup>Populations are not mutually exclusive (e.g., the I/DD population has significant overlap with the LTSS population).

<sup>2</sup>Likely a significant underestimate.

<sup>3</sup>For the LTSS and I/DD populations, the category "supportive/special services" includes all services that help individuals perform activities of daily life, such as bathing, dressing, and preparing meals. For the BH population, the category includes both the services described previously and the care required for the BH conditions (e.g., therapy, rehabilitation).

Source: The data in this exhibit was drawn from more than a dozen reports. A complete list can be found in the appendix to a longer report McKinsey produced on care delivery to individuals with special or supportive care needs. The report is available on the McKinsey on Healthcare website.

States have been changing the Medicaid services they provide to these groups in four primary ways: increasingly shifting the groups and the services they need to managed care, implementing models to integrate care more effectively, adopting new payment methods, and standardizing how the quality of care is measured. However, states vary considerably with respect to which approaches they are using and which populations they are focusing on.

Because most of the innovations states have adopted are comparatively new, they have not yet produced conclusive evidence of impact, but preliminary results are promising. Arizona (in addition to several others), for example, has structured its payment rates to influence the setting where individuals requiring LTSS

receive care; through this program, the percentage of these individuals cared for at home or in community-based settings has increased to 70%, from 5%.

States are also increasingly using advanced analytics to tailor programs to specific subsets of patients. For example, many patients have both medical and BH conditions. In some cases, the medical problems are far more severe than the BH conditions; in other cases, the reverse is true. By using advanced analytics to evaluate Medicaid claims data, a state can determine whether a given patient is better treated by a primary-care practice with in-house BH support or by a BH-care provider that partners closely with a primary care practice (Exhibit 2). Advanced analytics can also be



used to identify patients who are not properly adhering to their treatment plan.

## Payors

To date, private-payor involvement with most individuals with special or supportive care needs has largely been through Medicaid managed-care programs. The pace at which private payors have been building the required capabilities largely reflects the pace at which states have been introducing managed care for the relevant populations. For this reason, most payors have focused on individuals with BH conditions or those in need of LTSS care. Only recently have states—and hence payors—begun to focus on individuals with I/DDs.

Many payors are gaining capabilities through acquisitions or by subcontracting with specialty

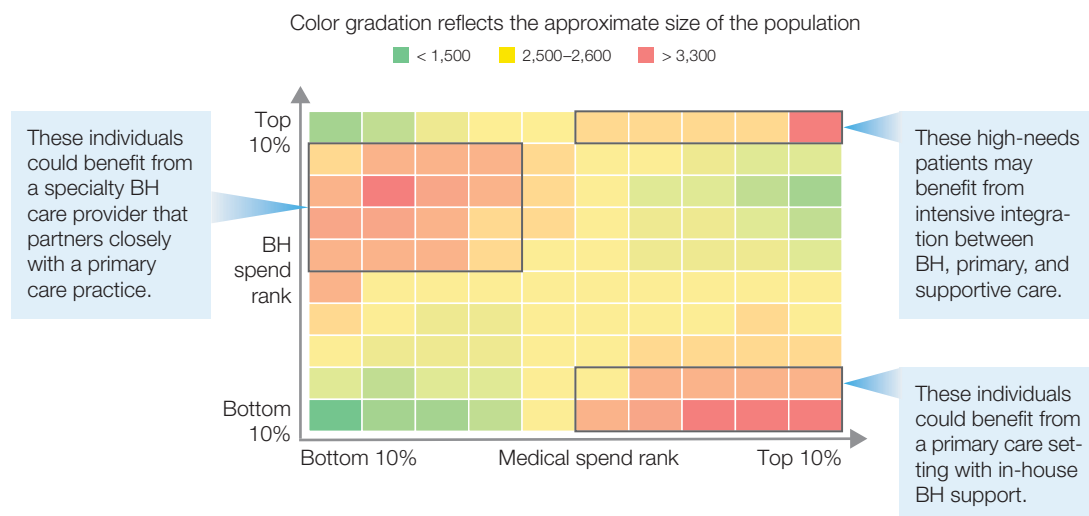
vendors, a trend likely to continue. Many payors see the states' managed-care programs for individuals with LTSS needs (especially “dual eligibles”—those covered under both Medicaid and Medicare) as critical strategic areas for investment. Furthermore, the increasing nationwide emphasis on BH care (as indicated by such actions as the introduction of mental-health parity laws) may encourage payors to continue investing in BH capabilities.

## Providers

Historically, most of the providers offering services to individuals with special or supportive care needs were not-for-profits or small, independently owned businesses. However, the industry has started to consolidate, primarily for three reasons. First, consolidation makes it easier for the providers to invest

### EXHIBIT 2 Advanced analytics makes it possible to tailor treatment to specific patient profiles

#### Heat map of behavioral health (BH) patients based on their BH and medical care costs



Source: Blinded claims data analysis from one state; McKinsey Healthcare Analytics's proprietary Behavioral Health Diagnostic Tool

in the back-office infrastructure necessary to improve operations, decrease costs, and measure and report care quality. Second, the payment innovations states are implementing could compress provider margins if the providers do not respond effectively (for example, by taking steps to improve operational efficiency). Third, the providers must build contracting capabilities if they are to respond to the growing adoption of managed care for individuals in need of BH, LTSS, or I/DD services.

At the same time, some providers are differentiating themselves in other ways. For example, a few LTSS providers are offering smaller, more home-like environments. Some individuals prefer these settings to traditional nursing homes because of the personalized attention they receive, and many of these providers have been shown to deliver better outcomes at lower cost.

## Technology companies

At present, more than \$5 billion is being invested annually in new healthcare technologies, many of which could improve care delivery to individuals with special or supportive care

needs. New administrative tools are making it possible for smaller providers to automate many aspects of practice management. New remote-monitoring devices are making it easier to deliver services at home and to detect gaps in care. Other technologies with considerable promise include remote medical consultations, decision-support tools, and devices that objectively assess a patient's functional status.



Only time will tell whether the evolution of care delivery for individuals with special or supportive care needs lives up to its promise. Emerging evidence suggests, however, that there is reason to hope. [O](#)

*The more detailed report on how care delivery is changing for individuals with special or supportive care needs is available on the McKinsey on Healthcare website.*

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# Next-generation contracting: Managed Medicaid for individuals with special or supportive care needs

*Individuals with special or supportive care needs require complex and highly diverse types of care, and accordingly account for a high proportion of Medicaid spending. This new framework can help states improve their ability to design and contract for managed Medicaid programs for these individuals—and maximize the programs’ likelihood of success.*

The past decade has seen considerable innovation in how specialty services are provided to individuals with special or supportive care needs—those with behavioral health (BH) conditions or intellectual or developmental disabilities (I/DD), as well as those who require long-term services and supports (LTSS) because of medical conditions or physical disabilities.<sup>1</sup> Many state Medicaid programs, for example, are increasingly using managed care to provide these services while keeping costs under control (Exhibit 1). We expect this trend to be resilient regardless of other changes to the Medicaid program that may be considered in the coming years.

Our experience suggests that a structured approach to contracting can help states maximize the potential of a managed Medicaid program for one or more of these groups. The first step is basic: a state should determine what its objectives are and how much potential managed care has for achieving those objectives. It should then consider 15 questions related to the program’s scope, market structure, partnership approach, and terms of agreement. There is no single “right” set of answers to these questions. Each state should base its decisions on the objectives it wants to achieve.

In this paper, we describe the structured approach we recommend, highlighting the 15 key questions. We also discuss several related issues states should bear in mind as they begin to define their approach to managed care contracting.

## Context

Individuals with special or supportive care needs represent some of the most vulnerable populations in today’s healthcare system. These individuals often require a combination of medical treatment and supportive services, either in an institutional, home-based, or community-based setting, and can require prolonged assistance performing activities of daily living (e.g., bathing, cooking). As a result, they often require intensive care coordination activities in addition to a higher overall volume of services, and can be subject to detrimental gaps in care.

As McKinsey’s recent report<sup>2</sup> makes clear, the three groups with special or supportive care needs present unique challenges. Although they constitute only 20% to 25% of the population, they account for 35% of national healthcare expenditures. Each year, the United States spends over \$800 billion on care delivery to these individuals, including more than \$450 billion for non-medical services. The Medicaid program bears about two-thirds of these costs.<sup>3</sup> About 40% of Medicaid funding comes from state budgets. However, the amount spent does not always correlate well with the quality of care delivered, level of care coordination, or ease with which care can be accessed.

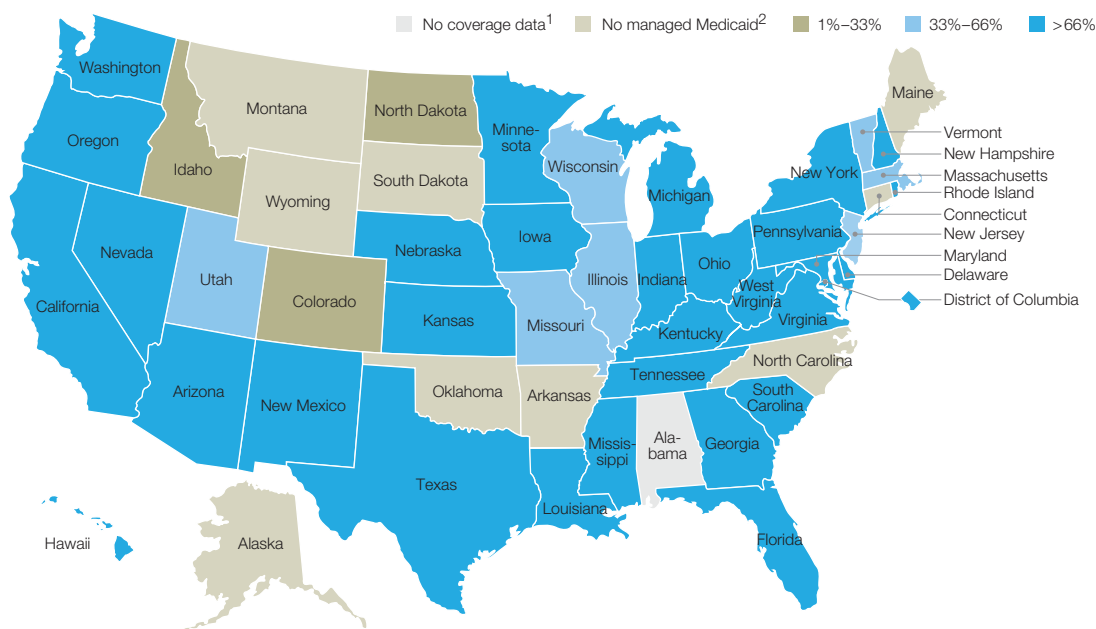
Several economic trends have prompted an increasing number of states to consider alternative approaches to managing their Medicaid populations as a whole—not just those with

**Brian Latko,  
Katherine Linzer,  
Bryony Winn,  
and Dan Fields**

The footnotes for this article appear on p. 136.

## EXHIBIT 1 Most states have adopted managed Medicaid programs, with varying degrees of coverage

### % of Medicaid population covered by managed care



<sup>1</sup>Alabama began its managed care plan in the middle of 2016 and has not yet reported enrollment figures for the new program.

<sup>2</sup>Includes states with less than 1% of the population covered by managed Medicaid.

Source: Medicaid.gov state profiles; Medicaid state managed care overviews; state Department of Human Services (DHS) and Medicaid websites; press search

special or supportive care needs. For years, national healthcare expenditures have been increasing at a rate above GDP growth, and spending levels are projected to rise further because of the aging population, the increasing prevalence of chronic conditions, and other factors. In many states, the number of people eligible for Medicaid has risen because of the Affordable Care Act. Cost concerns have prompted states to innovate in how they deliver care to their general pool of Medicaid beneficiaries and, more recently, to individuals with special or supportive care needs.

State Medicaid programs have therefore been introducing new approaches for serving their beneficiaries, including those with special or

supportive care needs. One of the approaches being used most often is managed care, in the belief that it can achieve multiple aims:

- Improve care quality, outcomes, and patient experience
- Enhance the overall performance of state health systems, especially in such areas as access to care and population health
- Slow spending growth

In addition, states may be attracted by the increased budget predictability, program flexibility, and accountability that managed care can provide.

Because managed care programs for Medicaid beneficiaries with special or supportive care

needs are comparatively new, empirical evidence for their effectiveness is still limited. However, studies have shown that total health-care costs for Medicaid beneficiaries with BH conditions can be reduced by 5% to 10% within four years through improved integration of behavioral and physical health services.<sup>4</sup> Another study has shown that states can achieve cost savings of 10% to 15% by rebalancing their LTSS services toward home- and community-based offerings.<sup>5</sup> Evidence is also emerging that managed care programs for individuals with special or supportive needs can improve care quality, outcomes, and patient experience.

In 2005, 23 states offered managed care to one or more of the groups requiring special or supportive care through their Medicaid program. Today, 38 states do (Exhibit 2).<sup>6</sup> BH programs are the most established; managed care services for individuals with I/DDs are still uncommon. Only seven states currently offer managed care programs to all three populations (Exhibit 3).

Many managed care organizations (MCOs) have responded to the opportunity states have created to provide programs for Medicaid beneficiaries with special or supportive care needs and have demonstrated willingness to invest in new services and new markets, sometimes even before a formal solicitation is announced. The long-term nature of these contracts is attractive to MCOs because they can provide financial stability. Furthermore, well-run managed Medicaid programs for individuals with special or supportive care needs can give MCOs exposure, affording opportunities for footprint expansion. A structured approach to contracting can increase the effectiveness of a state's and MCO's joint efforts, ensuring that the programs are well run and beneficiaries receive the care they deserve.

## Evaluating the potential for managed care

When considering whether to transition to a managed care program for one or more of the groups with special or supportive care needs, a state should begin by identifying its objectives for these groups. It should then evaluate managed care's ability, compared with alternatives, to meet those objectives.

### Setting objectives

A managed care program for Medicaid beneficiaries with special or supportive care needs can, potentially, achieve several goals, but managed care may not be the only available path to meeting those goals. Clarifying and prioritizing the state's objectives through a fact-based performance diagnostic is an important first step in assessing the available options, including managed care (Exhibit 4). The diagnostic can be structured in a variety of ways, but in all cases, it should include analyses of claims-based data (to identify performance gaps and areas of high-cost growth) and the state's performance compared with that of its peers.

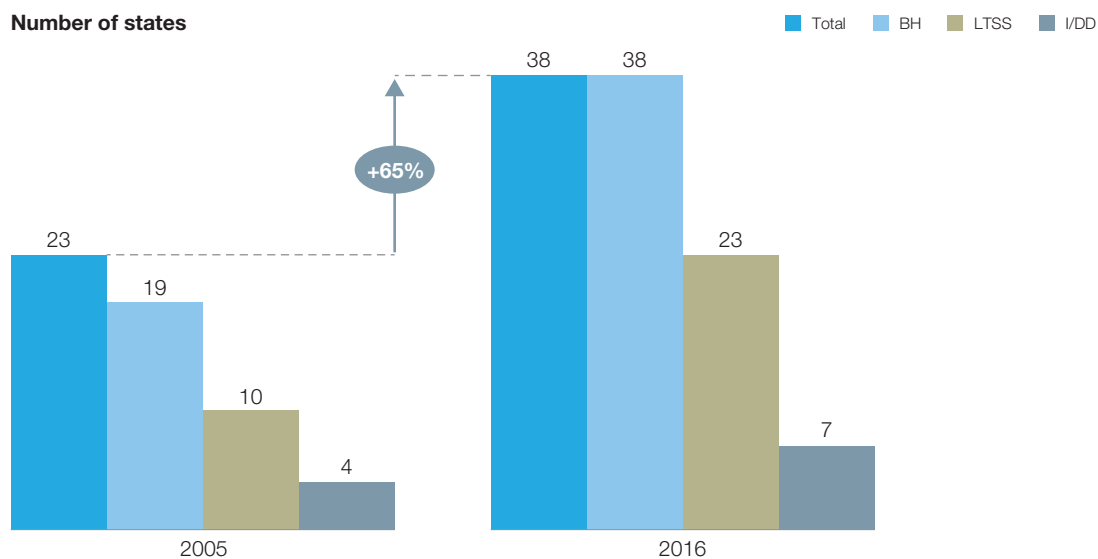
The claims-based analysis should address these questions:

- What is the breakdown of services currently being provided to the individuals with special or supportive care needs?
- For each group, what is the best way to segment beneficiaries, services, and programs?
- What are the trends in core medical and pharmacy spending for each group?
- What providers currently, or could potentially, serve each group?

Exhibit 5 offers a selection of national benchmarks that can be used for state-by-state comparisons.

## EXHIBIT 2 Growth in Medicaid managed care coverage for individuals with special or supportive care needs

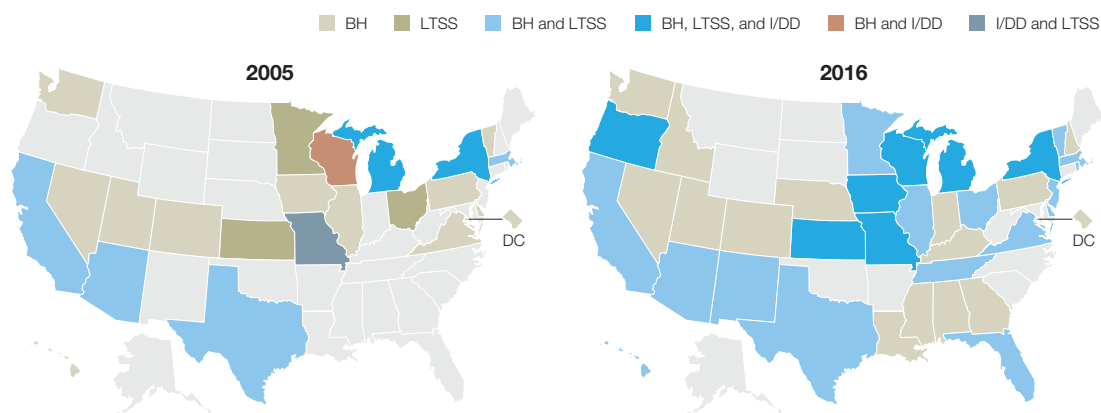
### Number of states



BH, behavioral health; I/DD, intellectual or developmental disabilities; LTSS, long-term services and supports.

Source: Medicaid.gov state profiles; Medicaid state managed care overviews; state DHS and Medicaid websites; press search

## EXHIBIT 3 Use of managed Medicaid programs for individuals with special or supportive care needs<sup>1</sup>



BH, behavioral health; I/DD, intellectual or developmental disabilities; LTSS, long-term services and supports.

<sup>1</sup>Shading indicates that a state has at least one capitated, risk-based managed care program for a given population. This exhibit does not take into account specific types of program design or the administrative decisions covered elsewhere in the article (e.g., whether coverage for multiple populations is integrated into a single program or what the geographic scope or structure of the programs is).

Source: Medicaid.gov state profiles; Medicaid state managed care overviews; state DHS and Medicaid websites; press search

## Evaluating managed care against alternatives

States generally have a number of options for achieving their objectives for Medicaid beneficiaries with special or supportive care needs. A fully capitated, risk-based managed care

program is one. Other options include implementing new provider payment methodologies within the current fee-for-service delivery system (e.g., by using case-mix groups) or making wholesale changes to provider reimbursement rates. States can also introduce new technolo-

### EXHIBIT 4 Potential diagnostic analyses for BH managed care programs

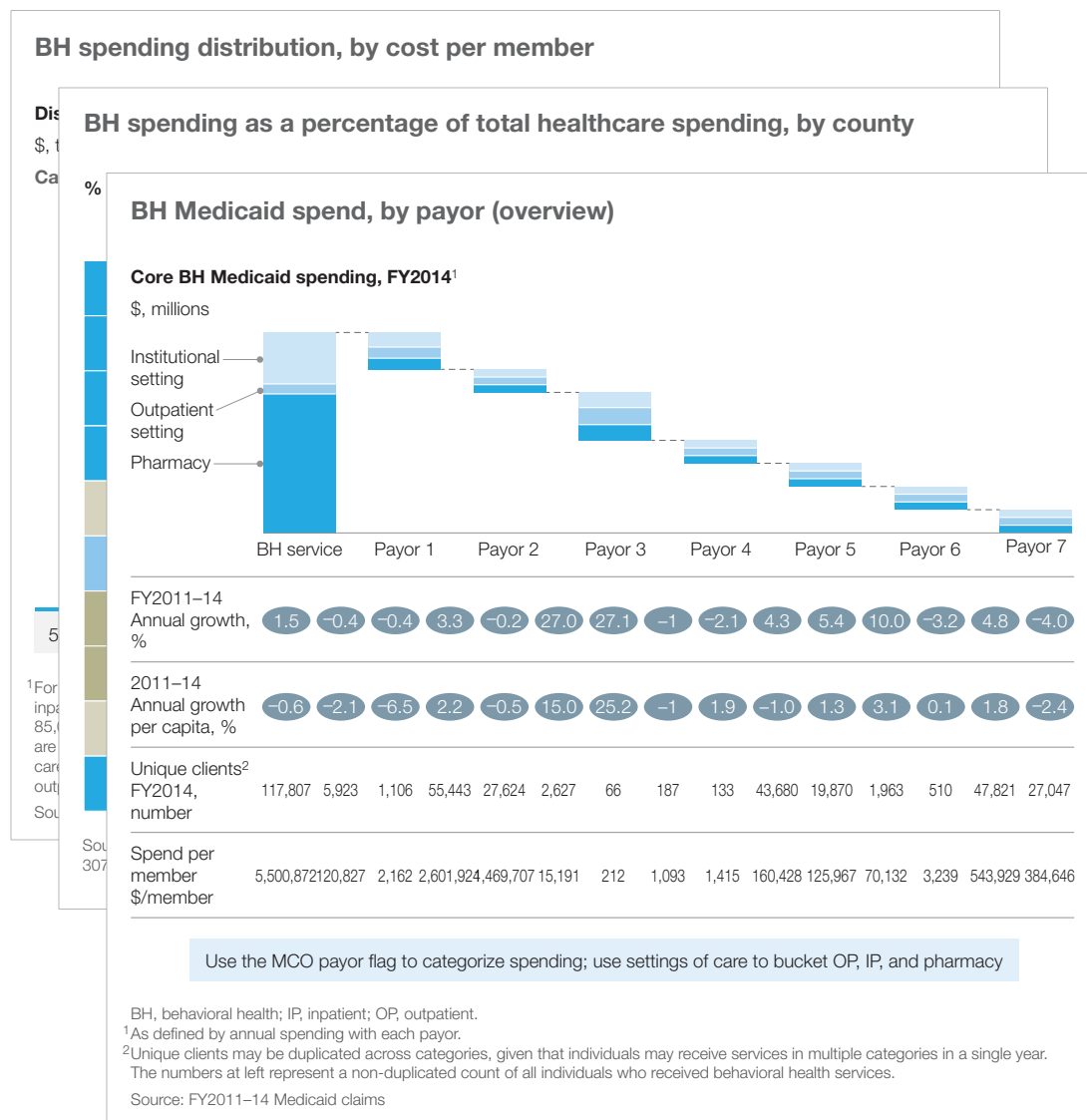


EXHIBIT 5 **Benchmarking metrics to gauge state performance**

	Metric description	National benchmark
<b>BH</b>	1. Total annual medication spending for people with a mental disorder	\$850 per person
	2. Residential psychiatric program utilization among Medicaid-eligible adults and children	<b>Children</b> <ul style="list-style-type: none"> <li>• Admissions: 2.0 per 100,000 Medicaid-eligible individuals</li> <li>• Length of stay: 83 days</li> </ul> <b>Adults</b> <ul style="list-style-type: none"> <li>• Admissions: 17.4 per 100,000 Medicaid-eligible individuals</li> <li>• Length of stay: 58 days</li> </ul>
	3. Percentage of children ages 4–17 receiving ADHD medication treatment	6.1%
	4. Overall percentage of inpatient discharges with a principle mental health diagnosis	5.7% of total discharges
	5. Suicide rate	12.6 people per 100,000 individuals
<b>I/DD</b>	1. Overall utilization of HCBS waivers among the US population	<b>Birth to age 21:</b> 156 per 100,000 people <b>Age 22 or older:</b> 181 per 100,000 people
	2. Overall utilization of inpatient ICF/IID facilities among the US population	<b>Birth to age 21:</b> 6 per 100,000 people <b>Age 22 or older:</b> 35 per 100,000 people
	3. Percentage of all individuals with I/DDs living in large state I/DD facilities	~26,500 people (~3% of the I/DD population)
	4. Number of individuals with I/DD on a waiting list for residential services	558 per 100,000 Medicaid beneficiaries
	5. Percentage of all individuals with I/DDs living in their own home or a family home	64%
<b>LTSS</b>	1. HCBS share of total LTSS spending	40.2% of Medicaid LTSS spending for the aged and physically disabled
	2. Percentage of nursing facilities with a 4+ Medicare Stars rating	46.1% of facilities
	3. Number of aged or physically disabled individuals on a waiting list for HCBS services	<b>Aged:</b> 10% <b>Aged/disabled:</b> 26%
	4. Percentage of individuals receiving home health care who require an acute hospital admission or unplanned care in the emergency room (without being admitted)	<b>Acute care:</b> 25% of home health care recipients <b>Emergency department visit:</b> 12% of home health care recipients

ADHD, attention deficit hyperactivity disorder; BH, behavioral health; HCBS, home- and community-based care; ICF/IID, intermediate care facilities for individuals with intellectual disabilities; I/DD, intellectual or developmental disabilities; LTSS, long-term services and supports.

Source: The sources of all statistics in this exhibit are listed in the sidebar on p. 137

gies or vendors to enhance existing capabilities for managing complex beneficiaries (e.g., through independent assessments). Yet another option is changing the groups' medical or payment policies, or the application of those policies, within the current system (e.g., by introducing new prior authorization requirements).

Nevertheless, certain elements specific to a capitated, risk-based managed care approach make it an attractive way to achieve a state's objectives. First, a capitated managed care model can give the state greater predictability for budgeting purposes than is possible in fee-for-service models. Second, a managed care approach can bring in new capabilities, resources, and experience if the contracts are with MCOs that have experience in other states. Third, well-designed MCO contracts can increase the system's flexibility and accountability. Finally, managed care programs that include multiple vendors can introduce competition between health plans, enhancing client choice and driving innovation.

## Design and execution decisions

Should a state decide to pursue managed care for one or more groups with special or supportive care needs, it will have to consider a number of design and execution decisions in four areas: program scope, market structure, partnership approach, and terms of agreement. Although each of these decisions needs to be thought about early in the process, most decisions do not have to be made until contracts are awarded. In fact, it is likely that many of these decisions will evolve during the process.

Exhibit 6 describes all 15 decisions and outlines when they should be made. In the sections that

follow, we discuss several of these decisions in detail to illustrate the specificity with which each one needs to be considered.

### Program scope

States first need to define the new program's scope and determine how well it would fit with existing managed Medicaid programs. Selecting which population(s) to include and deciding how programs will be integrated are among the most important components of program scope.

**Choice of population(s).** The results of the diagnostic should determine which groups with special or supportive care needs should be prioritized. For example, if a state discovered that the proportion of its LTSS Medicaid beneficiaries being cared for in institutional settings is much higher than in other states, a managed care LTSS program that shifts beneficiaries to home- and community-based settings could provide a cost-reduction opportunity.

When deciding whether to pursue one, two, or all three program areas simultaneously, states should consider their capacity for managing change.

**Integration across programs.** States with existing managed Medicaid programs need to determine whether to integrate the new effort into an existing plan (Exhibit 7). For example, BH benefits could be "carved in" to an existing managed Medicaid program. Carve-ins can simplify vendor management by reducing the number of MCO relationships and create opportunities for improved care coordination. However, stand-alone programs enable states to select vendors with specialized expertise.

States selecting a stand-alone approach should decide whether to integrate coverage for the



## EXHIBIT 6 The 15 core design decisions

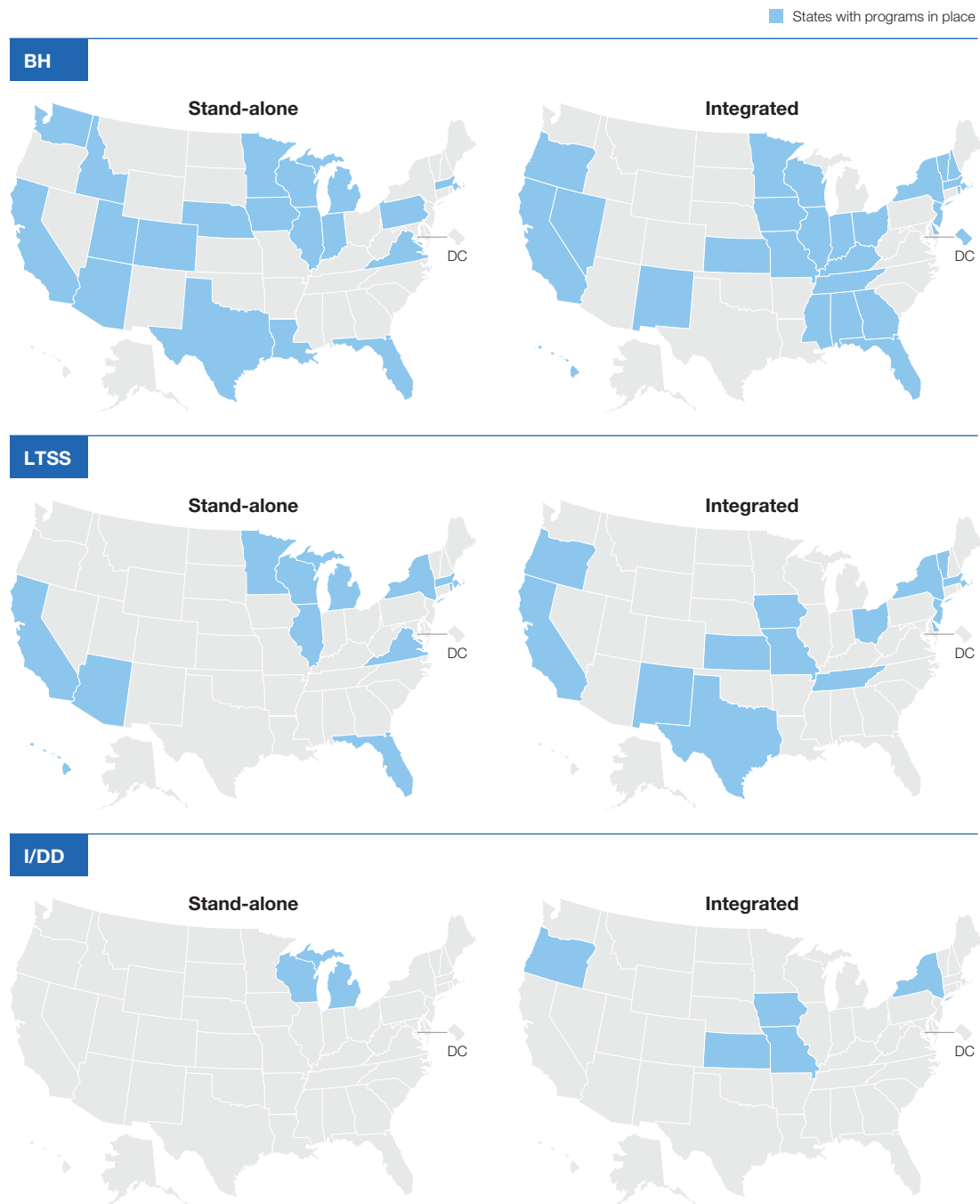
Additional details are included in the text

Decision	Question(s) to answer	Decision timing
<b>Program scope</b>		
Choice of population(s) to address	Which groups with special or supportive care needs—BH, I/DD, and/or LTSS—are under consideration?	Final decision prior to request for proposal (RFP) release
Integration across programs	Should BH, I/DD, LTSS programs be integrated with existing managed programs, and/or with one another?	Initial perspective by RFP; final decision by contract award
Coverage model	Should contracts be structured by service or by population?	Initial perspective by RFP; final decision by contract award
Integration with Medicare	How should care for the dual-eligible population be managed?	Final decision by RFP release
Regulatory framework	What regulatory vehicle best supports this transition?	Final decision by RFP release
<b>Market structure</b>		
Geographic reach	Should contracts be statewide or structured by region?	Initial perspective by RFP; final decision by contract award
Member choice	Should a single MCO or set of MCOs take on all services to be managed for a given program area?	Initial perspective by RFP; final decision by contract award
Enrollment model	Should the enrollment policy for managed care be mandatory or voluntary? What should the enrollment process look like if there are multiple options?	Initial perspective by RFP; final decision by contract award
<b>Partnership approach</b>		
Responsible party	Which state agency should be the responsible party?	Final decision by RFP release
Performance management approach	What is the approach to vendor and performance management?	Final decision by RFP release
Payor profile	What factors are important in vendor selection (e.g., balance of national scale and experience vs. local capabilities, specialist vs. multi-line payor)?	Initial perspective by RFP; final decision by contract award
<b>Terms of agreement</b>		
Contract length	What should be the duration of MCO contracts? What is the approach for contract renewal or exit?	Final decision by RFP release
Rate structure	Should rates be set at full capitation? How should rates be managed over time?	Final decision by RFP release
Rate-setting approach	What mechanism should be used for contractual rate setting?	Final decision by RFP release
Quality terms	What quality incentives and metrics should be used?	Final decision by RFP release

BH, behavioral health; I/DD, intellectual or developmental disabilities; LTSS, long-term services and supports; MCO, managed care organization.

Source: McKinsey Healthcare Systems and Services Practice

## EXHIBIT 7 Integration of managed Medicaid programs, by state



BH, behavioral health; I/DD, intellectual or developmental disabilities; LTSS, long-term services and supports.

Source: Medicaid.gov state profiles; Medicaid state managed care overviews; state DHS and Medicaid websites



Legend:

- No choice
- Choice for some
- Choice for all

Map Labels:

- Washington
- Oregon
- Idaho
- Montana
- North Dakota
- South Dakota
- Wyoming
- Nebraska
- Colorado
- Utah
- Nevada
- California
- Arizona
- New Mexico
- Oklahoma
- Texas
- Alaska
- Hawaii
- Minnesota
- Wisconsin
- Michigan
- Illinois
- Indiana
- Ohio
- Pennsylvania
- New York
- Maine
- Vermont
- New Hampshire
- Massachusetts
- Rhode Island
- Connecticut
- New Jersey
- Maryland
- Delaware
- District of Columbia
- West Virginia
- Kentucky
- Tennessee
- North Carolina
- South Carolina
- Georgia
- Alabama
- Mississippi
- Louisiana
- Florida

ments to stakeholders. Nevertheless, states may find it useful to subdivide geographically so they can partner with multiple regional MCOs, or to limit the areas served to a select subpopulation.

Many states report they find value in contracting with multiple MCOs; this approach creates competition for beneficiaries and provides greater latitude in managing MCO performance.<sup>8</sup> However, the value of MCO choice to the state may exceed its value to beneficiaries, because members typically view other factors—such as ability to retain their physician—as more important than the choice of an MCO.<sup>9</sup>

States also need to give early attention to the types of relationships they aspire to develop with MCOs. A key decision here is which group(s) within state government will have responsibility for overseeing the program.

**Responsible party.** The responsible party within state government typically sets the tone for the

partnership(s) and manages vendor performance. In many states, responsibility for each of the groups with special or supportive care needs is shared between the Medicaid program and a separate division or agency (e.g., a division of developmental disabilities services). In transitioning to managed care, states have taken a variety of approaches: giving sole responsibility to the Medicaid program, sole responsibility to the relevant division, or a hybrid. When making this decision, states need to consider internal factors—such as where talent and capabilities reside—and the fit with other program design choices.

### Terms of agreement

States should also consider the intended terms of agreement, starting with contract length, before they begin the contracting process.

**Contract length.** The length of contracts is likely to influence the level of investment MCOs will make and set the tone of the partnership(s). Today, many states opt for three- to five-year contracts, with options for extension.<sup>10</sup> However, states are increasingly using longer contracts to form long-term partnerships, encourage innovation, and provide attractive terms to MCOs.

States also need to determine who will hold options for extension or exit. In some cases, a state may decide on a short initial contract but give itself the option to extend the contract. In other cases, the state agrees to a longer contract but builds in exit clauses that either side can exercise. It is likely that many states may eventually use both extension and exit options.

### Other factors to consider

The design decisions described above give states a range of market-specific options for a managed Medicaid program. In all cases,

however, states may want to take four steps before asking MCOs for proposals:

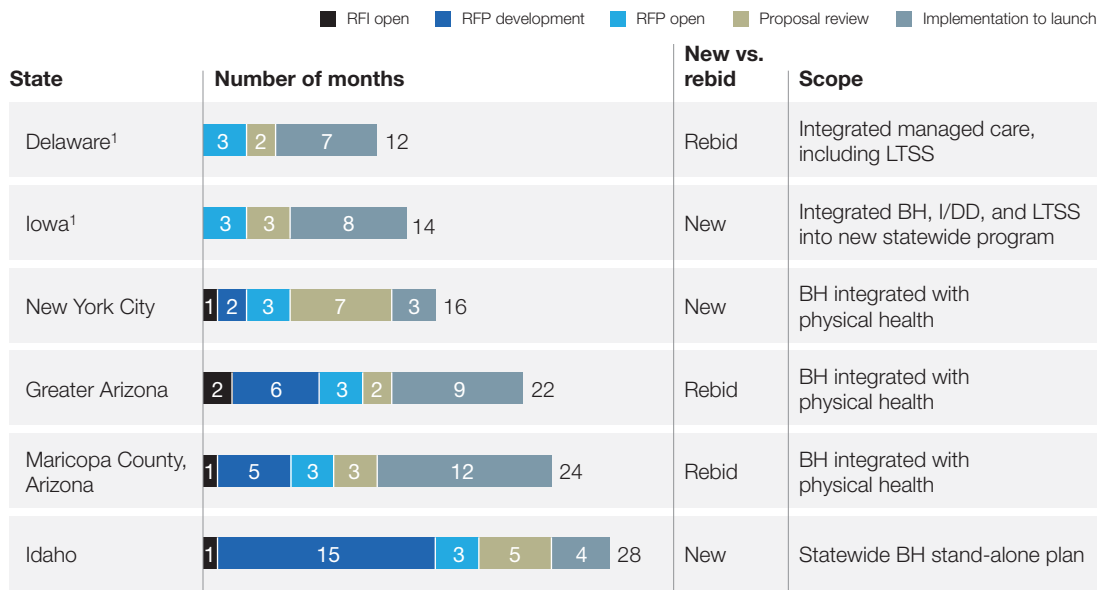
**Design the program around desired partnerships.** States should begin engaging MCOs early, bringing a range of potential partners to the table to generate ideas. Structuring these conversations to allow for substantive dialogue is important. Throughout the contracting process, states and MCOs should jointly define goals, such as quality improvement or desired changes to the delivery system.

**Build in competition.** States should communicate the planned market structure early on. MCOs typically value knowing the number of likely vendors and regions so they can develop a competitive strategy. Allowing sufficient time for new entrants to prepare a bid is important for widening the set of potential MCOs. States should develop contract terms that encourage innovation, such as member auto-enrollment based on achievement of quality and cost goals, and contract extensions based on performance.

**Encourage continuous innovation.** States should define the particular areas in which ongoing innovation will be needed and, early in the process, seek partners with relevant expertise in those areas. Interaction with MCOs can be tailored to encourage continuous innovation through incentive programs and shared savings.

**Adhere to an ambitious yet realistic time frame.** A sample of recent state procurements suggests that the process, including implementation, can take anywhere from 12 to 28 months (Exhibit 10). Exhibit 11 outlines the steps states need to take, which generally happen over a two-year period, to move from initial consideration of managed care for one or more of the groups with special or supportive care needs to program launch.

### EXHIBIT 10 Timing of recent state managed Medicaid procurement efforts for individuals with special or supportive care needs

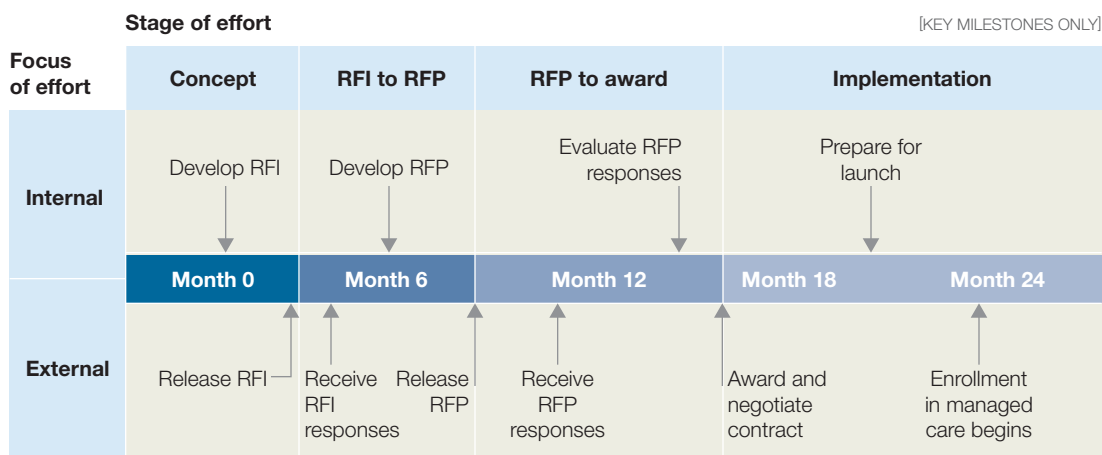


BH, behavioral health; I/DD, intellectual or developmental disabilities; LTSS, long-term services and support

<sup>1</sup>No request for information (RFI) was conducted and, therefore, no request for proposal (RFP) development timeline could be established.

Source: State Departments of Health; state Medicaid and procurement agencies; press announcements

### EXHIBIT 11 Overview of the process for adopting a managed Medicaid program for individuals with special or supportive care needs



RFI, request for information; RFP, request for proposal.

Source: State and managed care organization expert interviews

Implementation time is especially important to consider. Although a few states have been able to launch managed Medicaid programs within three or four months of the contract award, most states require more time. Among the factors that most strongly influence the implementation timeline are the state's level of experience with managed Medicaid, the infrastructure and experience of the MCOs already present in the state, and the degree to which the Centers for Medicare and Medicaid Services and other important stakeholders have been actively engaged throughout the process. An overly ambitious timeline can be counterproductive if it impedes the transparency and engagement required for a successful launch.



Managed care programs present an opportunity for states to serve populations with complex

needs in a new and effective way. MCOs, in turn, can benefit from the opportunity for strategic expansion. In designing these programs, each state should carefully consider a number of specific factors that will ensure the delivery of sustainable value for MCOs and the state, while improving quality and outcomes of care delivered for beneficiaries. ○

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#### FOOTNOTES

- <sup>1</sup> Behavioral health issues include mental health and substance abuse conditions, which can range from mild disorders to severe illnesses (e.g., schizophrenia). Individuals with intellectual or developmental disabilities (I/DDs) require help performing activities of daily living (e.g., bathing, cooking) for a prolonged period and thus need long-term services and supports (LTSS). The other individuals needing LTSS have chronic, complex medical conditions or physical disabilities, and thus require extended care in home, community, or institutional settings. Because the services needed by individuals with I/DDs are often more highly specialized than those required by other people needing LTSS, we have categorized the two groups separately in this paper.
- <sup>2</sup> Carter K, Lewis R, Ward T. Improving care delivery to individuals with special or supportive care needs. McKinsey report. August 2016. A summary of the report's findings begins on p. 119.
- <sup>3</sup> Kaiser Family Foundation. Federal and state share of Medicaid spending.
- <sup>4</sup> Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Milliman American Psychiatric Association Report. April 2014.

- <sup>5</sup> Kaye HS. Gradual rebalancing of Medicaid long-term services and supports saves money and serves more people, statistical model shows. *Health Affairs*. 2012;31(6):1195-1203.
- <sup>6</sup> The count of 38 states includes Washington, DC.
- <sup>7</sup> Arizona, Illinois, and Wisconsin are examples of states that have taken this approach. Arizona's Regional Behavioral Health Authority program is stand-alone, but the Arizona Long-term Care System runs an integrated LTSS and I/DD program. Illinois' Integrated Care Program serves the state's aged and disabled populations, but BH coverage is provided through a separate, managed care program. Wisconsin's BadgerCare includes BH services, but its Family Care program covers all three areas. Some states, like Wisconsin, have multiple programs for one or more of the groups because of legacy effects or differences in the subpopulations being served.
- <sup>8</sup> Based on interviews with state Medicaid leaders.
- <sup>9</sup> Based on interviews with state Medicaid leaders and MCO executives.
- <sup>10</sup> Based on interviews with state Medicaid leaders and MCO executives.



## Statistical sources

The statistics shown in Exhibit 5 were obtained from the following sources:

### Behavioral health

1. Medical Expenditure Panel Survey. Table 3a: Mean expenses per person with care for selected conditions by type of service, United States, 2012.
2. Substance Abuse and Mental Health Services Administration. Behavioral Health, United States, 2012. Table 62. December 2013.
3. Centers for Disease Control and Prevention. State-based prevalence data for parent-reported ADHD medication treatment. January 2014.
4. Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality. National statistics on mental health admissions and national statistics on all stays, 2013.
5. American Foundation for Suicide Prevention. Suicide statistics.

### Intellectual or developmental disabilities

1. Residential Information Systems Project (RISP). In-home and Residential Long-term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and Trends through 2012. University of Minnesota. 2014.

2. Kaiser Family Foundation. Waiting list enrollment for Medicaid section 1915(c) home- and community-based service waivers.

3. United Cerebral Palsy. The Case for Inclusion. 2014 Report.

### Long-term services and supports

1. Eiken S, et al. Medicaid expenditures for long-term services and supports in FY 2013. (Note: This benchmark indicates that HCBS represents a higher percentage of spending because it attributes the entire “personal care” and “home health” categories of service to the aged and physically disabled populations.)
2. Data.medicare.gov. Nursing Home Compare.
3. Kaiser Family Foundation. Waiting list enrollment for Medicaid section 1915(c) home and community-based services waivers, by type of waiver.
4. Centers for Medicare and Medicaid Services. OASIS C based home health agency patient outcome, process and potentially avoidable event reports.
5. Centers for Medicare and Medicaid Services. Home health care national data.

# The granularity of Medicaid MCO growth

*Despite present uncertainties, MCO leaders can still aspire to grow—and make decisions to support that aspiration. Our research shows that the key sources of growth for Medicaid MCOs are strategic, not operational.*

**Deborah Hsieh,  
David G. Knott,  
and Tim Ward**

Medicaid enrollment in the United States has grown swiftly in recent years. More than 16 million people who were ineligible for the program in 2014, or had not yet enrolled in it, now have Medicaid coverage,<sup>1</sup> in large part because 31 states and the District of Columbia expanded Medicaid eligibility under the Affordable Care Act.<sup>2</sup> As a result, many public and private institutions have seen a large, rapid influx of Medicaid enrollees. In particular, managed care organizations (MCOs)—health insurers that sign contracts with state Medicaid agencies to deliver care to members for a set fee per month—have grown quickly. Between 2010 and 2014, MCO enrollment surged by 9% per year.<sup>3</sup>

At present, the future pace of Medicaid enrollment growth is uncertain. Because most newly eligible beneficiaries in expansion states have already signed up for coverage, growth from expanded eligibility may be slowing. Also, at the time of this writing, it is unclear whether expansion will be kept as is, extended, or rolled back. However, as discussions about alternative funding mechanisms for Medicaid continue, the possibility has arisen that some states may decide to introduce or enlarge Medicaid managed care programs, given the budgetary certainty such programs can bring. Should this occur, Medicaid managed care enrollment would rise.

In this uncertain environment, MCO leaders can still aspire to grow—and make strategic decisions to support that aspiration. To identify actions MCO leaders might consider to spur and sustain growth, we studied the factors that contributed to enrollment growth at 120 MCOs to analyze the

strategies that yielded the best results. The granular perspective we developed revealed three key insights:

- The markets in which MCOs choose to compete are more important than taking market share from competitors
- Building scale is critical to growth
- Geographical detail matters

Admittedly, the Medicaid MCO market is a highly dynamic one, and so we plan to revisit our analysis of the sources of growth regularly.

## Breaking down MCO growth

In 2008, the authors of *The Granularity of Growth*, a book that discusses McKinsey's research on corporate growth, described how leaders can push through the "tyranny of the average" by using a detailed approach to understand and capture pockets of opportunity.<sup>4</sup> This method enables leaders to isolate specific, actionable factors that can stimulate growth.

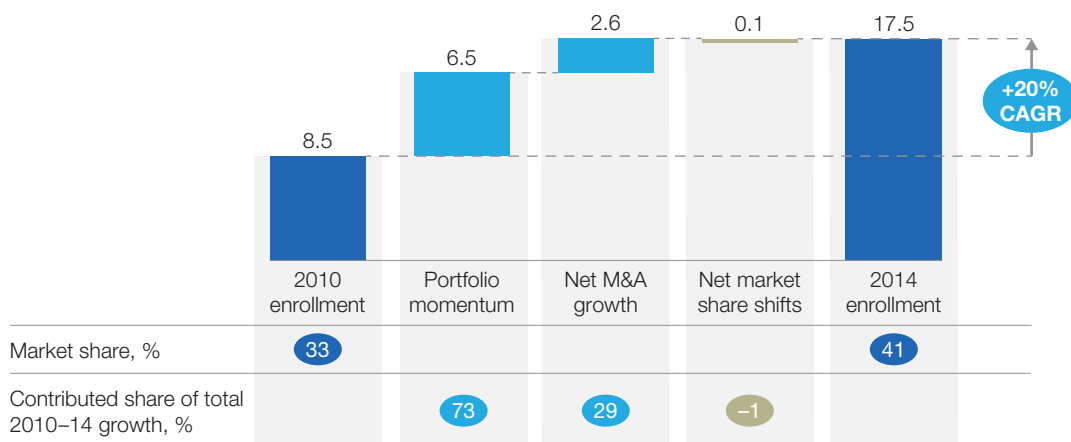
To understand the factors that spur growth for Medicaid MCOs, we took the same approach by disaggregating the three sources of growth. The first two—portfolio momentum and mergers/acquisitions (M&A)—largely reflect a company's strategy. (Portfolio momentum reflects how the company's existing markets are growing and what new markets it enters.) The third type—share gain in existing markets—relates primarily to operational execution. The sidebar, "Three sources of growth," provides fuller descriptions of these growth drivers.

The footnotes for this article appear on p. 144.

## EXHIBIT 1 Portfolio momentum and M&A enabled the five largest MCOs in 2014 to markedly increase enrollment<sup>1</sup>

### Sources of Medicaid MCO enrollment growth for five largest MCOs, 2010–14

Number of enrollees, millions



CAGR, compound annual growth rate; M&A, mergers and acquisitions; MCO, managed care organization.

<sup>1</sup> Definition of "largest" is based on 2014 enrollment; excludes special-needs-only plans and US territories.

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

Using data from the Centers for Medicare and Medicaid Services, the National Association of Insurance Commissioners, and state agencies, we studied the performance of 120 MCOs in 39 states between 2010 and 2014. The sample included MCOs of all sizes and was broadly representative of the total US market.

Our research confirms the relatively unsurprising point that the most successful MCOs pursue multiple sources of growth and, as a direct result, perform better. Companies that achieved top-quartile performance in all three areas saw a compound annual growth rate (CAGR) in enrollment of 63% during the years we studied. The MCOs in the bottom quartile of overall performance (those that did not perform in the top quartile in any area) saw a CAGR of just 7%.

The less obvious finding is that it matters which sources of growth MCOs focus on. According to the authors of *The Granularity of Growth*, portfolio momentum and M&A together account for 95% of growth across industries. Our results confirm that this holds true for MCOs as well: in most cases, the two strategic components generated much more impact than the operational one did. However, only 32% of the MCOs we studied performed well in both strategic areas.<sup>5</sup> This finding suggests that MCOs should be focusing more actively on the strategic sources of growth, especially now that states may be revising their approaches to Medicaid. (It is worth noting, however, that if overall Medicaid MCO growth decreases, winning market share may become more important.)

### “Where” and “what” beat “how”

For most MCOs, sustained enrollment growth comes more from “where to compete” choices (e.g., “which markets do I focus on?” and “what should I acquire?”) than from “how to compete” actions to improve market share. Portfolio momentum was the key driver of growth for the Medicaid MCOs we studied, as it has been in other industries. At an aggregate level, M&A ranked second as a source of growth. However, some MCOs did achieve significant share gain. Our analysis showed that the MCOs that had the highest absolute growth from share gain were more likely to operate in a single, local market.

For the five MCOs that had the largest membership in 2014—Anthem, Centene, WellCare,

Molina, and UnitedHealth Group—virtually all growth between 2010 and 2014 resulted from portfolio momentum and M&A, with the former accounting for almost three-quarters of the total growth (Exhibit 1).

Given the extent to which portfolio momentum drives growth at large MCOs, it should remain a top strategic priority. We believe that MCO leaders should pay particular attention to three factors that can spur MCO enrollment growth at the state level:

- Changes in eligibility
- The movement from fee-for-service reimbursement to managed care
- Underlying changes in the demographics of the population (e.g., population growth or broad changes in average income)

## Three sources of growth

Disaggregating growth into three areas can help MCO leaders better understand and evaluate their company’s performance.

**Portfolio momentum.** Growth an MCO achieves when its overall market enlarges (e.g., because the states it operates in decide to increase their use of managed Medicaid, or because the MCO expands into new states).

**M&A.** Growth from acquiring another MCO, minus any contraction from divesting assets.

**Share gain in existing markets.** Growth from gaining market share from competitors in a state in which the MCO already participates.

### Bigger is usually better

Nationally, the overall Medicaid market grew at a 14% CAGR between 2010 and 2014, but large MCOs grew faster than smaller ones did (Exhibit 2). During those years, aggregate growth for the five largest MCOs in 2014 reached a CAGR of 20%, and the companies increased total market share. In contrast, aggregate growth for the smaller MCOs that year—those not in the top 15—was just 5% CAGR; these companies lost market share. Part of the explanation for the difference in performance is that scale increases an organization’s ability to execute its strategies, particularly M&A, successfully. Our results show that it was mainly the larger MCOs that participated in and experienced growth as a result of M&A.<sup>6</sup>

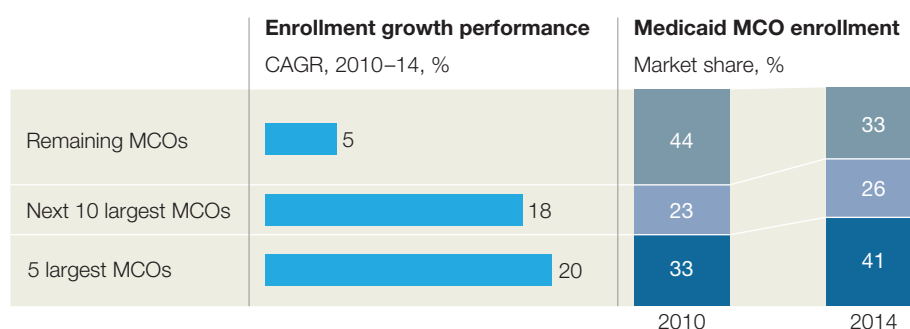
Between 2010 and 2014, all MCO size categories lost share in their existing markets (i.e., markets in which they participated in 2010 or, for brand-new players, the first market entered between

2010 and 2014). In many cases, however, the market share losses were offset by growth from portfolio momentum and M&A. In fact, the smaller MCOs that achieved high membership growth did so through portfolio momentum.

### Location, location, location

The details of geographical mix matter. Although some MCOs are constrained by mission or other considerations to a single geographical market, others can—and do—choose where to compete.

## EXHIBIT 2 Medicaid MCO enrollment growth varied widely across states



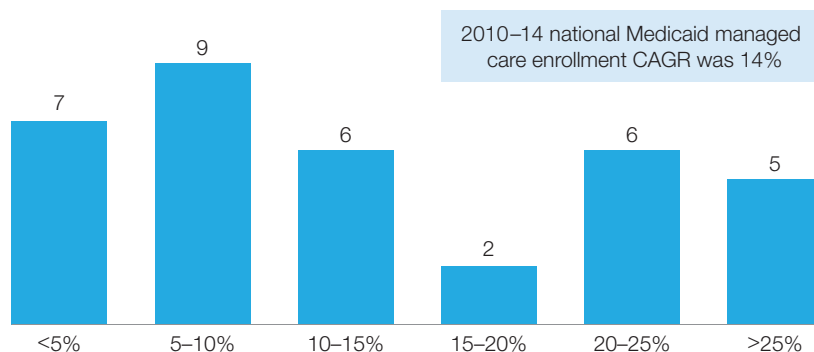
CAGR, compound annual growth rate; MCO, managed care organization.

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

## EXHIBIT 3 Medicaid MCO enrollment growth varied widely across states

### CAGRs for 2010–14 state Medicaid MCO enrollment growth<sup>1</sup>

Number of states



CAGR, compound annual growth rate; MCO, managed care organization.

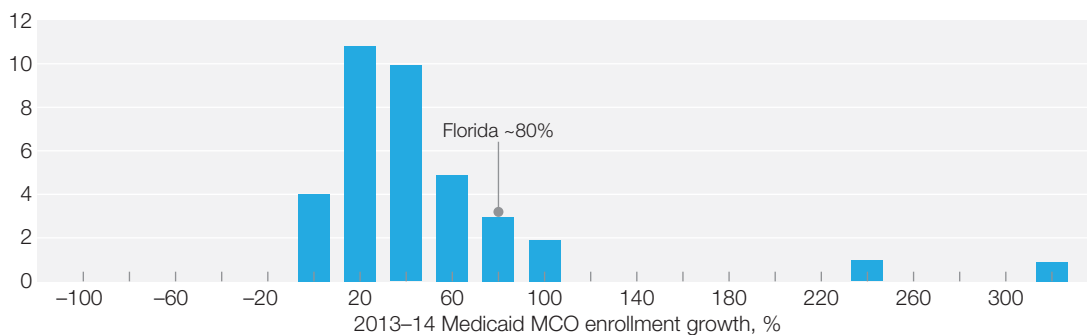
<sup>1</sup>Excludes special-needs-only plans; for states with comprehensive managed care programs each year from 2010 to 2014 (N = 35).

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

## EXHIBIT 4 Breaking down growth into micromarkets can reveal new, actionable insights

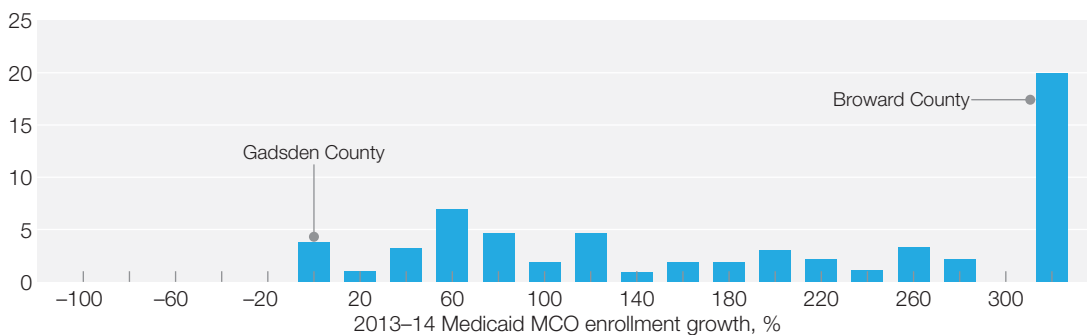
### State-level enrollment growth

Number of states



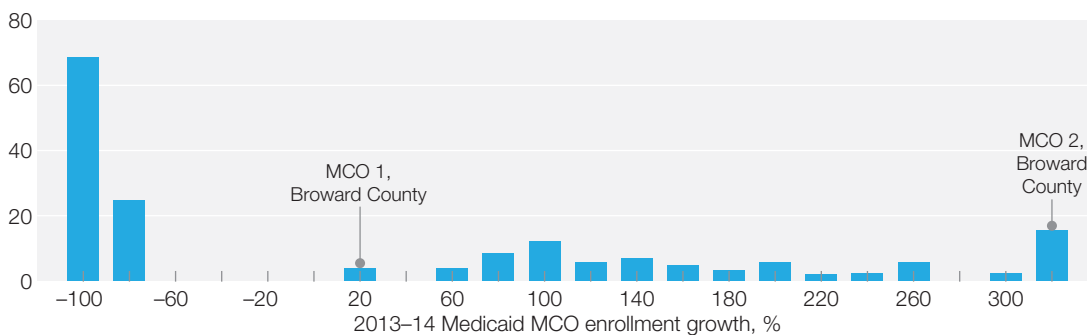
### County-level enrollment growth

Number of Florida counties



### Company-level enrollment growth

Number of individual MCOs in Florida county



MCO, managed care organization.

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

Our results demonstrate that growth in managed Medicaid has not been evenly distributed. In five states (Kansas, Kentucky, Illinois, Utah, and Oregon), the number of enrolled beneficiaries grew at a CAGR of over 25%. However, in seven other states, enrollment grew by less than 5% per year (Exhibit 3).

Growth varied significantly at the micromarket level as well. In Florida, for example, the number

of Medicaid beneficiaries in managed care grew by 83% from 2013 to 2014. Not all Florida MCOs benefited from that membership growth, though. Some saw their membership rise by almost 400%; others exited the market.

Geography helps explain these results. When we re-examined membership changes in Florida at a more granular level, it became clear that both overall growth rates and the performance

#### EXHIBIT 5 Medicaid MCO companies by enrollment growth, 2010–14

	2010–14 enrollment growth, members <sup>1</sup>	2010–14 enrollment growth, CAGR	Growth from each source, %		
			Portfolio momentum	M&A	Share gain
Anthem	3,500,000	37.7	51.5	68.1	–19.6
Centene	2,600,000	22.1	104.0	0.0	–4.0
WellCare	1,000,000	18.2	103.1	16.0	–19.1
Molina	1,000,000	14.4	120.2	5.5	–25.7
UnitedHealth Group	900,000	7.0	94.8	–4.1	9.2
Aetna	800,000	14.7	66.9	63.2	–30.1
LA Care <sup>2</sup>	600,000	77.6	12.8	0.0	87.2
Fidelis	500,000	20.8	47.4	0.0	52.6
Inland Empire Health Plan	500,000	24.2	83.4	0.0	16.6
HealthFirst	500,000	21.3	46.0	40.9	13.1
AmeriHealth Caritas	400,000	9.7	129.7	7.3	–37.0
CareSource	400,000	10.0	104.0	0.0	–4.0
Humana	300,000	58.4	31.6	0.0	68.4
Kaiser	300,000	28.8	66.1	0.0	33.9
Meridian Health Plan	300,000	20.7	63.0	0.0	37.0

CAGR, compound annual growth rate; MCO, managed care organization.

<sup>1</sup>2010–14 membership enrollment growth is rounded to the nearest 100,000.

<sup>2</sup>Enrollment figures for California are based on California Department of Managed Health Care reports and estimates of subcontracting to other plans. California data also exclude prepaid health plan enrollment.

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.



of individual MCOs differed significantly among counties. Between 2013 and 2014, for example, managed Medicaid membership decreased in Gadsden County but rose substantially in Broward County (Exhibit 4). However, most of the growth in Broward County was driven by a single MCO; other MCOs lost members there.

Granular geographical analysis at the county level or deeper can help MCOs identify specific pockets of likely future growth (often, a result of demographic or policy changes). The variations in potential growth that can be detected increase as granularity rises, and so choosing where to play must be done at a micromarket level.

Our research also indicates that geography is not the only dimension to consider on a granular basis when investigating growth opportunities. Within a single state or county,

growth can also vary widely between program types and eligibility categories.



Our results indicate that for Medicaid MCOs, as for companies in other industries, the keys to growth at present are portfolio momentum (especially at a granular market level) and M&A (Exhibit 5). It is important for MCO leaders to give these factors sufficient weight in decisions about where to compete. ○

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The authors would like to thank Matt Carey and Nina Jacobi for their contributions to this article.

#### FOOTNOTES

<sup>1</sup>CMS. November 2016 Medicaid and CHIP application, eligibility determination, and enrollment report. November 2016.

<sup>2</sup>Kaiser Family Foundation. Status of state action on Medicaid expansion decision. Data as of January 1, 2017.

<sup>3</sup>McKinsey analysis of data from the Kaiser Family Foundation. Total managed Medicaid managed care enrollment. Data as of January 1, 2017.

<sup>4</sup>Viguerie P, Smit S, Baghai M. The Granularity of Growth: How to Identify the Sources of Growth and Drive Enduring Company Performance. John Wiley & Sons. 2008.

<sup>5</sup>We considered an MCO to be executing well in a given area if its growth performance was in the top quartile of all MCOs.

<sup>6</sup>Few MCOs outside the top 10, by either 2014 enrollment or 2010–14 enrollment growth, participated in and experienced growth from M&A. Note that for mergers that occurred after 2014, we calculated growth independently for each of the MCOs and then added the results to the acquirers' data (i.e., Health Net and Trillium acquisitions are not included in the category M&A growth; rather, the growth each of these companies achieved between 2010 and 2014 was calculated separately and then added to Centene's performance in each of the three sources of growth. The same calculation was used for Preferred Medical Plan and Molina and for Simply Healthcare and Anthem.)

# Transitions in coverage type are the norm for most consumers over time

*We are learning more about how income fluctuations over a lifetime affect a consumer's choice of healthcare coverage. Payors should think more deeply about how these transitions will affect their business.*

Transitions in health insurance coverage appear to be the norm for most Americans over time. Our analysis of point-in-time coverage data reveals striking age- and income-related patterns that imply changes over time in both the types of coverage people are most likely to have and their probability of being uninsured. As the quality and availability of the data needed to track individuals across coverage programs improve, a more complete picture of these lifetime dynamics is emerging. Analysis of the data by age and income, as well as recent studies of lifetime income dynamics, suggest that coverage transitions over the course of an individual's lifetime are common. As a result, payors may want to view short-term fluctuations in coverage, as well as long-term transitions of their members, as interrelated phenomena, which has implications for how they think about their business.

## Quantifying transitions

We undertook our exploration initially because of questions about the rate of coverage transitions between Medicaid and the individual market. Given Medicaid expansion and the introduction of income-related subsidies in the individual market, many experts<sup>1</sup> had predicted that income volatility—associated with common life events such as marriages, divorces, family formation, income growth, and job loss—would cause a high percentage of low-income adults to move between Medicaid and individual market

coverage each year.<sup>2</sup> Any changes to health-care programs the new administration decides to make could influence these dynamics. Nonetheless, we believe that transitions among coverage types, including lack of coverage, will remain relevant even if the Affordable Care Act is repealed and/or replaced.

To understand transitions between Medicaid and the individual market, we first reviewed external literature. For example, researchers from UC Berkeley, using a simulation model,<sup>3</sup> studied expected coverage transitions in light of policy changes under the Affordable Care Act. They estimated that, of the non-elderly enrolled in Medi-Cal (California Medicaid) at the beginning of a year, 25% would no longer be enrolled at the end of that year.<sup>4</sup> Our analysis of enrollment reports from the Centers for Medicare and Medicaid Services (CMS) indicates that the nationwide annual Medicaid disenrollment rate may be even higher—as much as 37% per year.<sup>5</sup> Given that many eligibility categories (e.g., aged, blind, or disabled) are not based solely on income, the populations susceptible to income-driven coverage transitions (e.g., parents and single adults) would experience even higher exit rates than this average rate would imply. A recent study of income dynamics using data from the Social Security Administration confirmed that those with low incomes, compared with higher-income cohorts, experience not only overall income growth trends but also greater income volatility.<sup>6</sup> Both persistent and short-term increases in income would contribute to a loss

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The footnotes for this article appear on p. 149.

of Medicaid coverage for individuals, should their incomes rise above eligibility thresholds.

At present, little is known about what happens to individuals who exit the Medicaid program. The UC Berkeley researchers estimated that more than one-third of these Californians would switch to employer-sponsored insurance (ESI); the remainder would become eligible for a qualified health plan (QHP). However, the researchers did not determine the percentage of individuals who actually enrolled in a QHP once eligible. An analysis of Washington State data suggests that about 1% of all Medicaid enrollees in that state transitioned to a QHP between October 2014 and September 2015.<sup>7</sup> This point estimate of movement between Medicaid and QHPs is smaller than one may have expected, but it also does not capture transitions out of Medicaid to other coverage types—whether ESI, a temporary gap in coverage, or a long-term lack of insurance. A broader picture of the complete set of coverage transitions Medicaid individuals undergo is needed to fully understand the long-term movements of these individuals.

To further understand this broader set of coverage transitions, we used the McKinsey Predictive Agent-based Coverage Tool (MPACT) to examine the overall 2014 US health insurance market. Results reveal that coverage patterns vary within each age cohort and income level (Exhibit 1).<sup>8</sup> Nevertheless, certain trends based on age and income begin to emerge.

The patterns in coverage by age cohort are highlighted in Exhibit 2. Before age 18, Medicaid and ESI are the dominant coverage types. Between the ages of 18 and 34, the rate of ESI coverage increases, but the proportion of

people without health insurance spikes.

Between 35 and 65 (the peak earning years for most people<sup>9</sup>), the uninsured rate decreases and ESI predominates. After the age of 65, most people have Medicare coverage, but only a minority rely on that program alone for coverage.

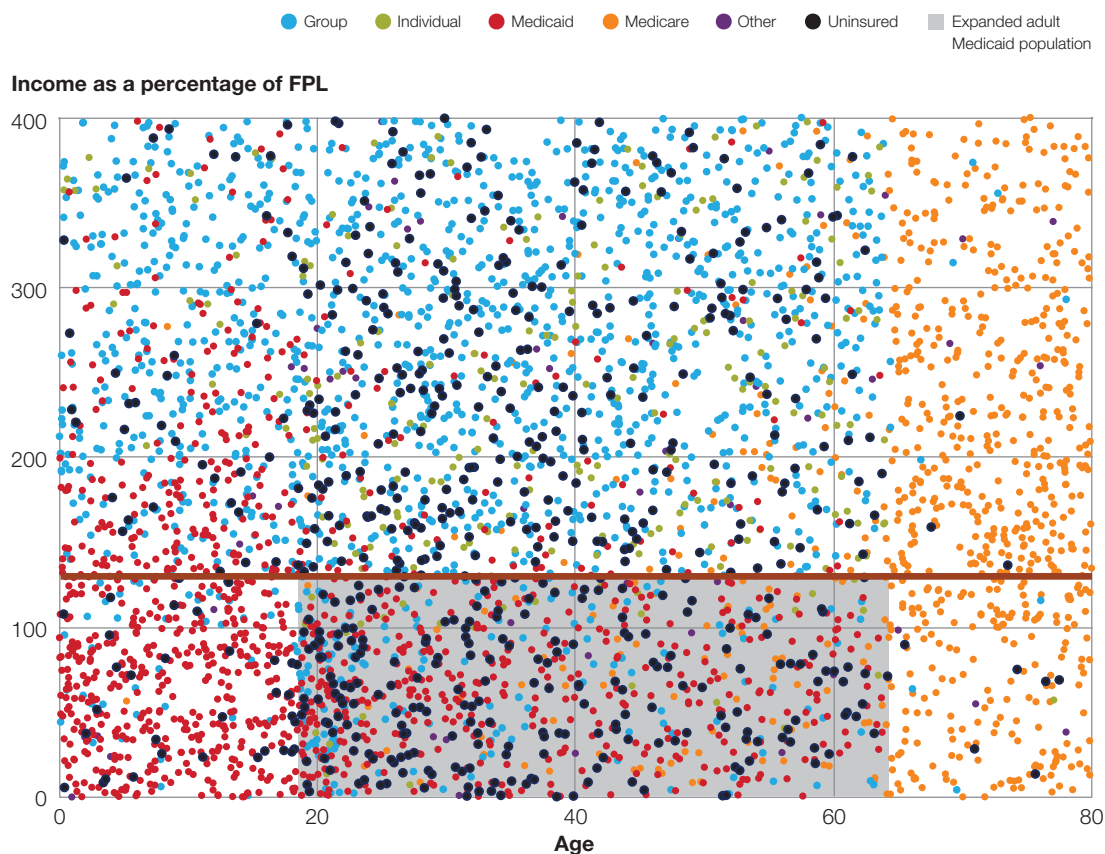
This point-in-time analysis of insurance coverage is consistent with the longitudinal income dynamics study referenced above, which confirms that short-term income volatility occurs within the context of long-term upward trends in income. Although volatility declines as individuals' ages and incomes increase, large negative income shocks remain a real possibility.<sup>10</sup> As more data becomes available to characterize the longitudinal coverage movements of individuals, we may likewise be able to link the point-in-time insurance snapshots outlined above more directly to coverage transition patterns.

In short, the patterns underscore that coverage transitions—both short-term fluctuations and long-term trends—are common. For example, many middle-aged, commercially insured individuals may have been on Medicaid at one time, and most of them will be on Medicare in the future. Similarly, an individual may move between Medicaid coverage, a QHP, and uninsured status over the course of a couple of years. Importantly, these are not isolated phenomena. In other words, individuals may experience short-term coverage transitions in the context of a longer-term path through different types of coverage.

## Implications for payors

Our findings suggest that payors might benefit from better understanding how consumers transition among coverage types over time (in both the short and long term), since these

## EXHIBIT 1 Influence of age and income on health insurance coverage



FPL, federal poverty level.

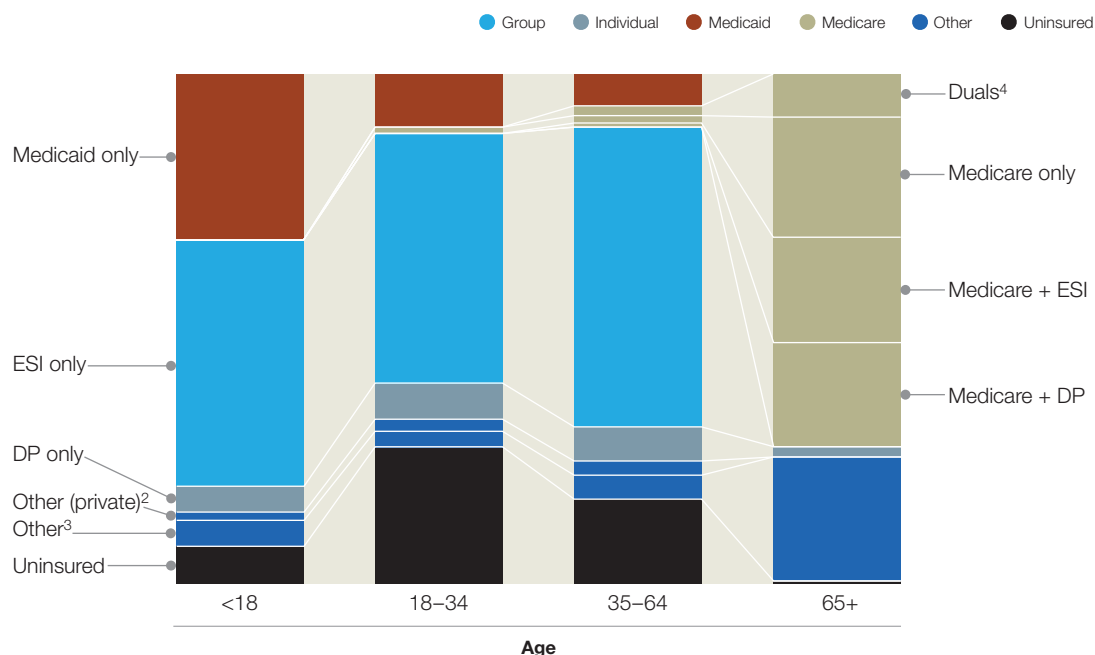
Note: Each dot represents 50,000 people. Medicaid figures exclude dual eligibles, who are counted in the Medicare category in MPACT. Medicaid enrollees above 138% FPL include children in the Children's Health Insurance Program, pregnant women, higher-income parents in some states, and blind and disabled beneficiaries.

Source: MPACT 7.5 model with data from the 2014 American Community Survey

transitions have important business implications. In general, coverage transitions represent opportunities for payors to either retain, gain, or lose members as consumers switch from one form of coverage to another (e.g., they become ineligible for Medicaid or lose ESI but become eligible for individual insurance or Medicare Advantage). Engagement strategies could have the potential to increase retention across coverage types in these scenarios. For instance, the Medicaid managed

care regulations from CMS allow exchange carriers to reach out to Medicaid beneficiaries, potentially building relationships before a coverage transition becomes necessary.

More immediately, understanding coverage transitions can help payors identify commonalities that transcend coverage type—commonalities that could help them realize efficiencies within their organizations. Our research shows, for example, that the behaviors and

EXHIBIT 2 Breakdown of insurance types by age cohorts<sup>1</sup>

ESI, employer-sponsored insurance; DP, direct-purchase private insurance.

<sup>1</sup> Coloring matches MPACT categories in Exhibit 1, which assigns individuals to a single coverage type. The subcategories listed are taken from the American Community Survey.

<sup>2</sup> "Other (private)" includes "employer-sponsored/direct-purchase coverage" and "other private-only combinations."

<sup>3</sup> "Other" includes "TRICARE/military health coverage," "VA healthcare," "other public-only combinations," and "other coverage combinations."

<sup>4</sup> "Duals" are individuals with both Medicare and Medicaid coverage.

Source: American Community Survey, five-year estimates, 2013

preferences of consumers covered by Medicaid, individual insurance, and ESI are notably similar in certain ways. In our surveys, 19% of Medicaid enrollees and 22% of those with ESI coverage said they exchanged text messages with a healthcare provider.<sup>11</sup> Use of a mobile app to enhance prescription drug compliance was reported by 16% and 14%, respectively. These similarities (often defined around a consumer's health, income, education, or other demographics, independent of coverage type) suggest that the patient-engagement apps and other mobile tools payors are developing may appeal to consumers in multiple lines of business. Other

strategies to engage consumers could also appeal to consumers across coverage types.

Another example: Medicaid beneficiaries and consumers with individual coverage have similar preferences when their primary care physician (PCP) no longer accepts their insurance. When asked about this scenario in our surveys, 56% of Medicaid beneficiaries and 57% of consumers with individual coverage said they would choose a new PCP; only 10% of both groups said they would go out of network to see their original PCP.<sup>11</sup> This finding suggests that lines of business might be able to take similar approaches

to network and plan design—but further research is needed to better understand the underlying drivers of individuals' provider preferences when covered under different insurance types.



Of course, coverage type will remain a critical criterion for payors that want to attract, retain, and manage members, and thus many elements of the enrollment and renewal processes will remain within separate lines of business. And, certainly, differences in the health risk profiles of different coverage types cannot be ignored. For example, our research indicates that adult Medicaid enrollees have a higher rate of chronic illness than do those with individual or ESI coverage

and may be helped by care-management programs tailored to their needs.

Nevertheless, by understanding coverage transitions, payors may be better able to serve the needs of their members efficiently and effectively. They could also help reduce the number of people who fall into coverage gaps and become uninsured. More broadly, opportunities exist to improve data availability and further analyze coverage transitions to better understand their causes and impacts. ○

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#### FOOTNOTES

<sup>1</sup>Examples include:

- Sommers BD, Rosenbaum S. Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and Individual Exchanges. Health Affairs. 2011.
- Buettgens et al. Churning under the ACA and state policy options for mitigation. Urban Institute: Timely analysis of immediate health policy issues. 2012.
- Sommers et al. Medicaid and Marketplace eligibility changes will occur often in all states; Policy options can ease impact. Health Affairs. 2014.
- For potential transitions under a Medicaid/Basic Health Program arrangement: Curtis R, Neuschler E. Income volatility creates uncertainty about the state fiscal impact of a Basic Health Program (BHP) in California. Institute for Health Policy Solutions. 2011.

<sup>2</sup>It is important to note that issues related to coverage transitions and continuity are most relevant where coverage rates among younger and lower-income adults are high. Some populations (e.g., low-income individuals in states that opted not to expand Medicaid) may be more likely to lose coverage than to transition between coverage types when common life events occur.

<sup>3</sup>A combination of the California Simulation of Insurance Markets (CalSIM) model version 1.7 and data from the Survey of Income and Program Participation were used to estimate steady-state coverage transitions (e.g., in 2019).

<sup>4</sup>Dietz et al. The ongoing importance of enrollment:

Churn in Covered California and Medi-Cal. UC Berkeley Labor Center. April 1, 2014.

<sup>5</sup>This 37% annual disenrollment is likely an upper bound as disruptions during the redetermination process may force individuals to disenroll for a short period of time.

<sup>6</sup>Güvenen F et al. What do data on millions of US workers reveal about life-cycle earnings risk? Federal Reserve Bank of New York Staff Reports. February 2015.

<sup>7</sup>Washington Health Benefit Exchange. September enrollment data. Enrollment Reports & Data. Washington Healthplanfinder, 2015.

<sup>8</sup>The McKinsey Predictive Agent-based Coverage Tool (MPACT) is a behavioral micro-simulation model that projects the post-reform health insurance coverage landscape under different scenarios from 2013 to 2022. The model is built upon a granular demographic database that brings together multiple public data sources such as the Census, American Community Survey, Small Area Health Insurance Estimates, and many others.

<sup>9</sup>US Census Bureau, Current Population Survey.

<sup>10</sup>Güvenen F et al. What do data on millions of US workers reveal about life-cycle earnings risk? Federal Reserve Bank of New York Staff Reports. February 2015.

<sup>11</sup>McKinsey Consumer Health Insights survey, 2015; McKinsey Consumer Health Insights Medicaid survey, 2015.





INSIGHTS ON SPECIFIC MARKETS:  
Provider-led health plans





# The market evolution of provider-led health plans

*Offering a health plan can give health systems an opportunity for growth, but it is not without financial risk. To benefit from this move, health systems should use a different lens to understand both consumers and risk, know where the best growth opportunities are, rethink their payor-provider interactions, and take advantage of integrated claims and clinical data.*

As US providers adapt their business models in response to the transition from fee-for-service reimbursement to different forms of value-based payment, they are increasingly exploring the benefits of vertical integration. In some cases, they have chosen to offer their own health plans.

Many of the health systems that first took this step focused on the Medicaid market. More recently, health systems have been offering a growing number of Medicare Advantage (MA) and public exchange plans. Interest in the exchange market seems to be especially keen. Furthermore, shutdown of 12 of the 23 CO-OPs (Consumer Operated and Oriented Plans) has created a set of exchange enrollees looking for another health plan, and recent losses may cause some large payors to put less emphasis on the exchange market.

Nevertheless, available (although early) financial data suggests that the performance of provider-led health plans (PLHPs) remains mixed in all markets. More than 40 of the 89 PLHPs we analyzed have had negative margins in some or all of the past three years. Empirical data suggests, however, that scale (in terms of the number of lives) can help.

Health systems that are already offering a health plan or are considering adopting this approach must therefore carefully think through how they can take advantage of having an integrated

delivery system. Success will require them to have—or develop—a range of skills. For example, they should be able to use product design to develop products that meet consumers' needs, undertake sophisticated actuarial analyses to price appropriately, and take advantage of integrated claims and clinical data to spot opportunities for better medical management. In addition, they must have a deep knowledge of competitive dynamics to identify regions with strong growth potential and be willing to adopt new administrative approaches to reduce costs.

In this paper, we will review both the growth trajectory and financial performance of PLHPs. In addition, we will discuss the four questions health systems should ask themselves if they are considering offering a PLHP or want to re-evaluate their plan's market differentiation.

## Market growth<sup>1</sup>

Provider ownership of health plans has been increasing steadily. Between 2010 and 2014 (the most recent year for which most data is available), the number of providers offering one or more health plans grew to 106, from 94 (Exhibit 1). Furthermore, many providers expanded into additional lines of business (Exhibit 2). In 2010, only 47 (50%) of the providers owning health plans operated in more than one line of business; four years later, 65 (61%) did. As a result, PLHPs were available in 43 states in 2014

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<sup>1</sup> Detailed explanations for how all market growth and financial performance calculations were done can be found in the methodology section, which begins on p. 163.

(Exhibit 3), and enrollment in the plans had surged to 15.3 million, from 12.4 million in 2010.

Most of the enrollment growth in PLHPs occurred in the Medicaid, MA, and individual markets (Exhibit 4). However, the small-group market also increased slightly from 2010 to 2014 (2.6% CAGR). In contrast, enrollment decreased in the large-group and administrative-services-only (ASO) markets (CAGRs were -4.7% and -2.4%, respectively). The large-group and ASO markets are difficult for most PLHPs to serve, and the opportunities for growth in the other markets are more favorable.

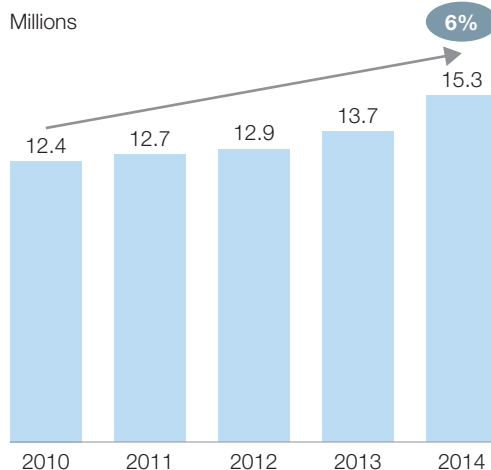
Between 2010 and 2014, the largest enrollment growth in percentage terms occurred in the individual market, primarily because many providers introduced public exchange plans as a way

to drive volume. During that time, enrollment increased at a CAGR of approximately 25%, from about 270,000 to 670,000 lives. The number of providers offering health plans in the individual market rose to 55, from 36. For PLHPs, further growth in this market is likely not only because of the CO-OP shutdowns and losses incurred by large insurers, but also because the penalty for being uninsured reaches its full amount in the 2016 tax year.

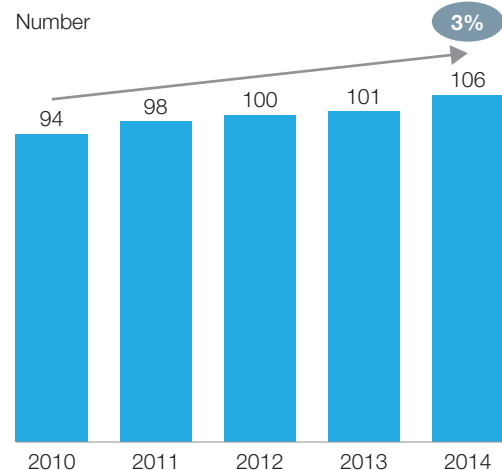
The largest enrollment growth in absolute terms occurred in the managed Medicaid market, from about 6.1 million lives in 2010 to 8.8 million lives in 2014 (a CAGR of more than 9%). The number of providers offering Medicaid plans rose to 51, from 43. Although PLHPs already have high penetration in managed Medicaid (they currently cover

#### EXHIBIT 1 Overall PLHP enrollment has grown faster than the number of plans

##### Growth in PLHP enrollment<sup>1,2</sup>



##### Growth in number of PLHPs<sup>2,3</sup>



PLHP, provider-led health plan.

<sup>1</sup>Count of Medicare lives does not include cost products.

<sup>2</sup>Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

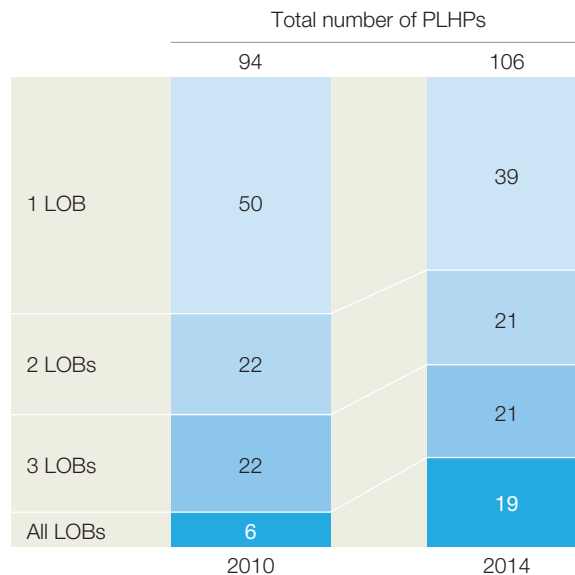
<sup>3</sup>Health plans with fewer than 25 lives are excluded.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premiums, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

## EXHIBIT 2 PLHPs are diversifying across lines of business

### PLHPs by line of business (LOB)<sup>1,2,3,4</sup>

% of total PLHPs



PLHP, provider-led health plan.

<sup>1</sup>Count of Medicare lives does not include cost products.

<sup>2</sup>Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

<sup>3</sup>Health plans with fewer than 25 lives are excluded.

<sup>4</sup>LOBs counted are individual, Medicare, Medicaid, and other commercial (large-group, small-group, and administrative-services-only).

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premiums, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

about 22% of the people in that market), several factors suggest that significant room for market-share growth remains. For example, Medicaid expansion is continuing across the states. (The 27 states that had expanded Medicaid by November of 2015 included about 60% of all enrollees in that program.) In addition, the shift to value-based payments is amplifying the need for population health management skills, and state regulations for managed Medicaid programs are favorable for PLHPs.

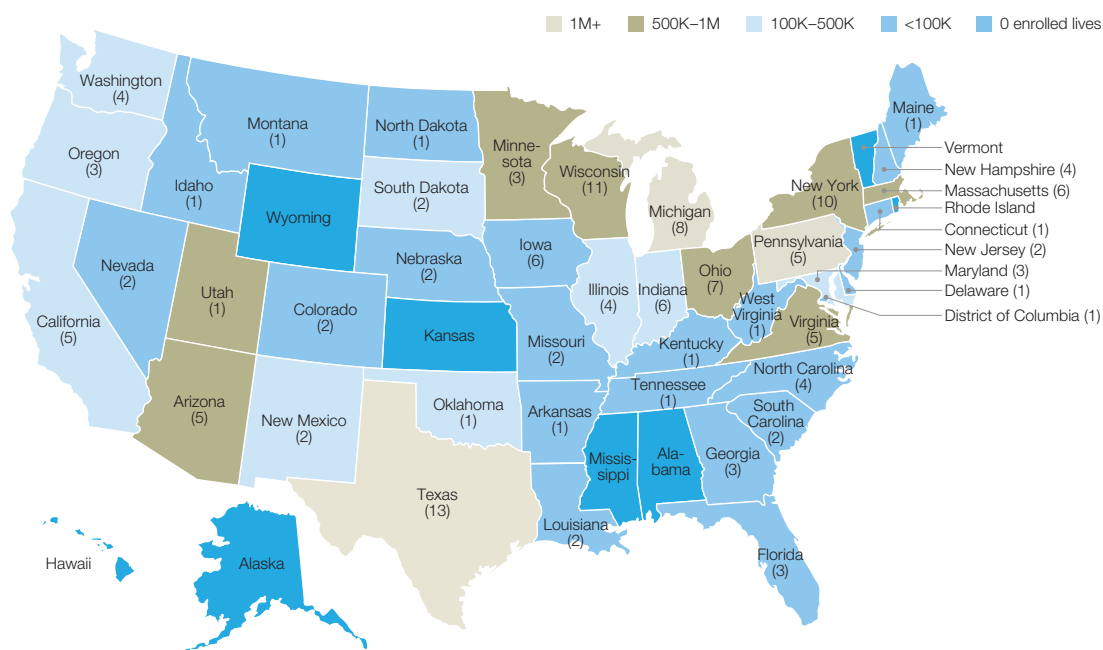
In the MA market, enrollment in PLHPs grew at a CAGR of about 17% between 2010 and 2014, to 1.1 million lives, from approximately 600,000.

The number of providers offering MA plans increased to 69, from 47. Enrollment in provider-sponsored MA plans is expected to continue to grow given the favorable conditions (e.g., the adoption of risk-bearing and other innovative payment models and the heightened focus on reducing inpatient utilization rates). Nevertheless, many providers appear to view the MA market as having less opportunity for growth than either the individual or Medicaid markets. The number of MA enrollees is low (in comparison with the size of the individual and Medicaid markets), and these consumers are typically well served by payors, leaving limited opportunity for PLHPs.



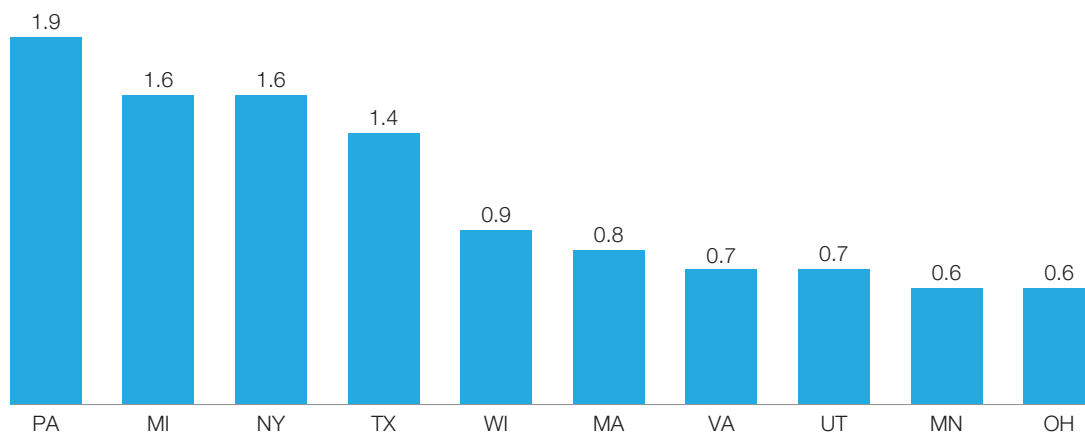
### EXHIBIT 3 About 15 million people are covered by 106 PLHPs in 43 states

#### Number of PLHPs by state (2014)<sup>1,2,3</sup>



#### States with the highest PLHP enrollment

Total members, millions



PLHP, provider-led health plan.

<sup>1</sup>Count of Medicare lives does not include cost products.

<sup>2</sup>Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

<sup>3</sup>Health plans with fewer than 25 lives are excluded.

Source: NAIC 2010-14 end-of-year Supplementary Health Care Exhibits and its 2010-14 end-of-year Premiums, Enrollment, and Utilization Exhibits; CMS August 2010-14 enrollment by county; McKinsey Provider Plan Database

Despite the significant increase in overall enrollment, most PLHPs remain comparatively small. In 2014, only five providers had plans that cover more than 500,000 lives. In the aggregate, however, these plans had a fairly large market share (from about 16% in the total MA market to 31% in the total managed Medicaid market). Enrollment is also concentrated at the state level. More than 40% of all people covered by PLHPs live in Pennsylvania, Michigan, New York, or Texas (see Exhibit 3).

## Financial performance

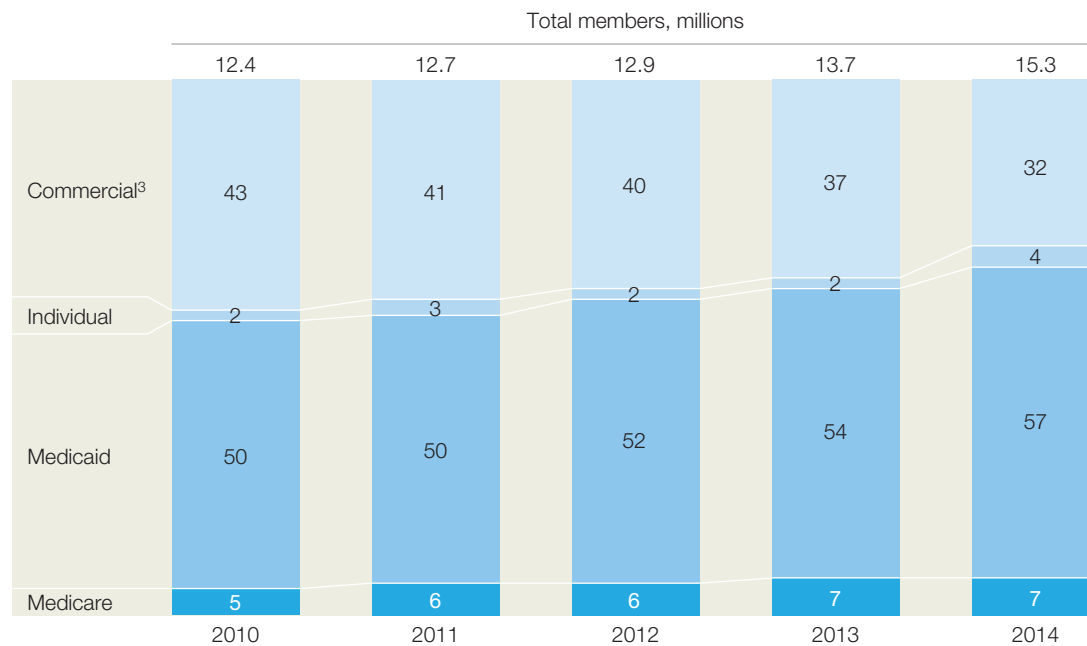
Between 2010 and 2014, average medical loss ratios (MLRs) for PLHPs increased steadily in most lines of business (Exhibit 5). In the Medicaid market, for example, the average MLR rose to 89%, from 86%. The exception was the large-group market; the average MLR there decreased to 87%, from 89%.

During those years, average administrative loss ratios (ALRs) in most lines of business

### EXHIBIT 4 PLHP enrollment has increased in all markets except large-group commercial

#### PLHP enrollment by line of business<sup>1,2</sup>

% of total PLHP members



PLHP, provider-led health plan.

<sup>1</sup> Medicare lives do not include cost products.

<sup>2</sup> Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

<sup>3</sup> Commercial including non-individual commercial plans: large-group, small-group, and administrative-services-only plans.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premiums, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database



were often slightly higher (usually, by no more than 1% of premiums) among PLHPs than in the rest of the market. Exceptions did occur, though. In 2014, for example, both Medicaid and Medicare PLHPs had ALRs slightly below the industry average.

The comparatively high MLRs and ALRs narrowed the operating margins on the health plans but, in some cases, may have had a more favorable effect on the health systems as a whole. Only by considering the economic impact across the entire integrated system can providers understand the full impact of owning a health plan.

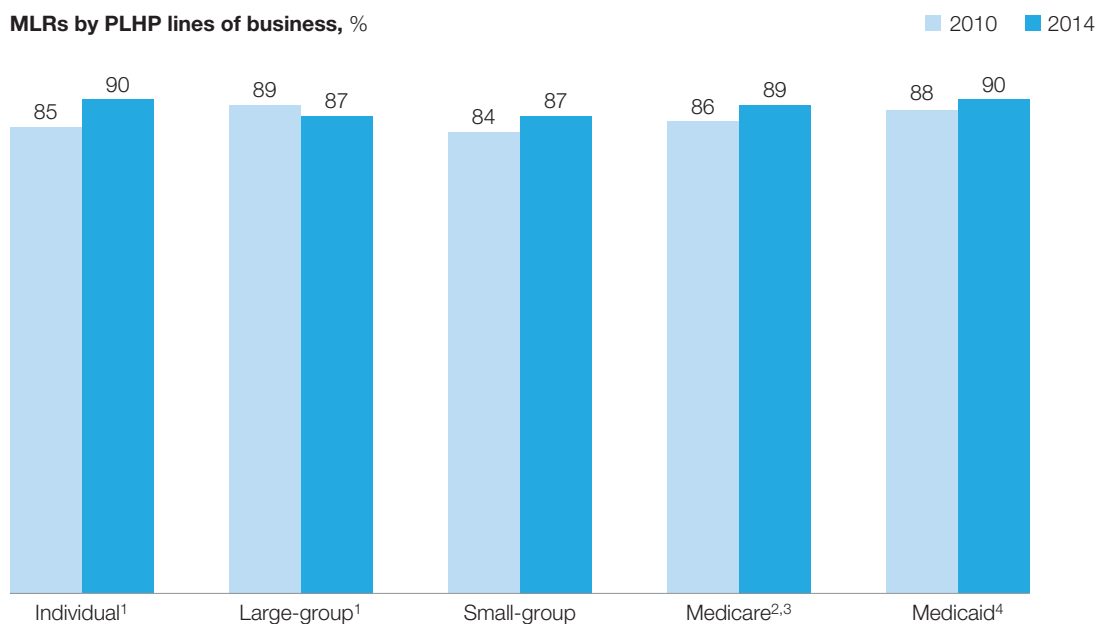
To look more closely at the economics of a PLHP, we conducted deep dives on the two areas with the strongest current growth: managed Medicaid and the individual market.

### Managed Medicaid

Among the 51 providers offering managed Medicaid plans, operating margins varied significantly in 2014 (Exhibit 6). The average was about 1.3%. Among the PLHPs with less than 100,000 lives, operating margins averaged 1.58%, compared with 0.53% for plans covering 100,000 to 500,000 lives and 2.95% for plans with more than 500,000 lives. However, within each of these three subsets,

## EXHIBIT 5 PLHPs have higher MLRs in most lines of business

MLRs by PLHP lines of business, %



PLHP, provider-led health plan.

<sup>1</sup>Medical loss ratios (MLRs) reflect payments and receivables from ACA risk programs.

<sup>2</sup>Financials include claims and premiums from cost products.

<sup>3</sup>Because NAIC Supplementary Healthcare Exhibits were not always submitted, MLRs are known only for about 80% of the Medicare line of business.

<sup>4</sup>Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premiums, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

there was significant variation in operating margins, indicating an opportunity for many provider-led managed Medicaid plans to better manage profitability. That aggregate profits as a percentage of premiums were highest among carriers with more than 500,000 lives suggests that scale is important.

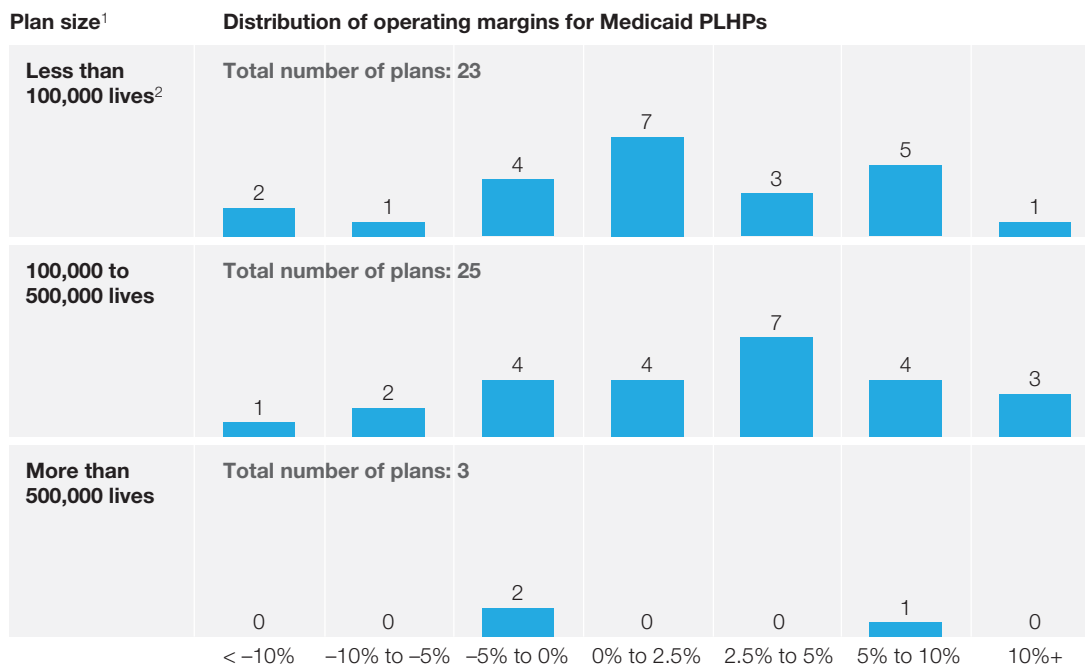
At least four providers focusing on children's health are currently offering Medicaid PLHPs. Together, these PLHPs covered 9% of total Medicaid enrollees in 2014. Before 2013, these plans tended to have lower MLRs than other PLHPs did. Since then, their MLRs have risen and now exceed those of other PLHPs.

### Individual market

Although the performance of the PLHPs present on the public exchanges has varied, most have struggled to achieve profitability in the individual market (as have many other carriers). In the aggregate, these plans had an operating margin loss of 10.5% post-tax in 2014 after the 3Rs (reinsurance, risk corridors, and risk adjustment) were factored in.<sup>2</sup> Nevertheless, 29% of the PLHPs in the individual market had positive margins that year.

In general, the PLHPs received better results than most other carrier types did if the 3R payments are calculated as a percentage of

## EXHIBIT 6 Scale appears to benefit PLHPs in the Medicaid market



PLHP, provider-led health plan.

<sup>1</sup>Plans with fewer than 25 lives were not included.

<sup>2</sup>Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits (SHCE) and its 2010–14 end-of-year Premiums, Enrollment, and Utilization Exhibits; IRS 990 forms (when SHCE is missing); CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

<sup>2</sup>Kaiser Permanente was excluded from this and all other analyses of market growth and financial performance. Given its origins as an insurer and atypical structure, we have not included it in the set of PLHPs.

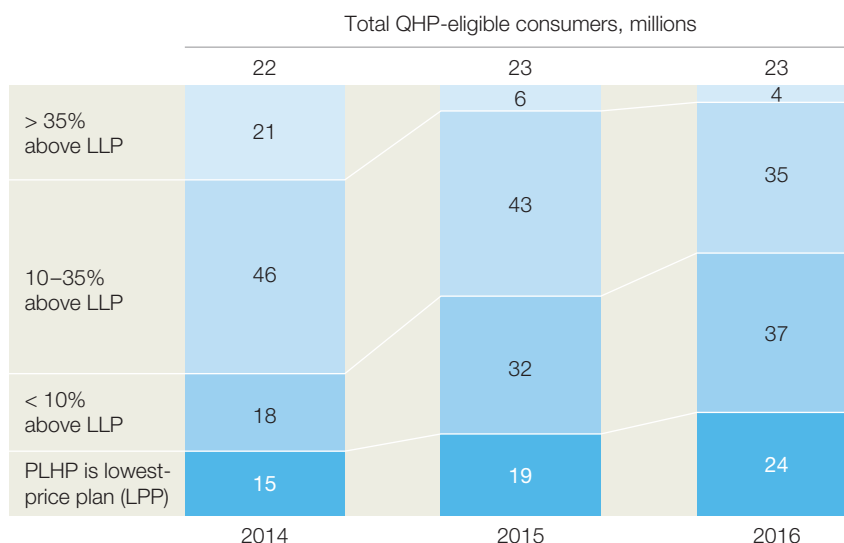
premiums (the exception was the CO-OPs, which usually received significant amounts in reinsurance). As a group, the PLHPs received the equivalent of about 17% of premiums as 3R payments for 2014, but individual payments varied, especially among the smaller plans: some providers had to pay more than 70%, but others were given more than 150%. Almost all of the 3R money came from reinsurance funds because risk corridor and risk adjustment payments to the PLHPs did not amount to more than 1% of premiums.<sup>3</sup> The reinsurance program will terminate in 2016, which could apply further pressure on margins unless plan pricing is done carefully.

Since 2014, PLHPs have become more price competitive on the public exchanges (Exhibit 7). In the first open enrollment period (OEP), they were the price leader—the carrier offering the lowest-priced silver plan—in 15% of the counties where one or more PLHPs were available. That percentage rose to 19% in the 2015 OEP and then to 26% in 2016. PLHPs were especially likely to become price leaders in areas where CO-OPs exited the 2016 exchanges. It is not yet clear, however, whether the competitive pricing is a sustainable strategy for many exchange PLHPs, given their large losses to date and the upcoming termination of some of the transitional programs (especially reinsurance).

## EXHIBIT 7 PLHPs are becoming more price competitive on the public exchanges

### Cost of lowest-price PLHPs relative to the lowest-price silver plans<sup>1</sup>

Total QHP-eligible consumers, millions



<sup>3</sup>In 2014, PLHPs, like other carrier types, were affected by the change in risk corridor rules to make the program revenue-neutral. Of the risk corridor receivables all carriers booked, only 12.6% was actually paid out to them.

PLHP, provider-led health plan.

<sup>1</sup>In counties where PLHPs are available, the premium for the lowest-price PLHP was compared with the cost of the lowest-price silver plan. The lowest-price PLHPs were then grouped into categories based on the size of the pricing differential. This information was combined with the number of QHP-eligible consumers in each county to determine how many of those consumers could be placed into each category.

Source: McKinsey Exchange Offerings Database; McKinsey Provider Plan Database

The proportion of preferred provider organization (PPO) plans offered by providers on the public exchanges decreased from 22% in the 2014 OEP to 20% in 2016. (Most other carriers have been making a similar move.) The change may reflect an attempt to manage utilization more tightly given the financial pressures all payors are facing. In contrast, there was a small increase in the number of broad-network plans offered by providers.

## Design choices for a PLHP

There are four essential questions a health system should ask itself if it is considering offering a PLHP. These questions are also helpful for providers already offering plans that want to re-evaluate their differentiation in the market.

**How can consumerism benefit a PLHP?** As healthcare consumerism rises, what many people want from providers and health insurers is changing—in ways that could put PLHPs at an advantage. If providers want to use health plans to increase volume, however, they must understand consumers' price sensitivity and benefits preferences.

Data from the public exchanges demonstrates that people who buy health insurance for themselves tend to prefer low-cost plans—but not necessarily the lowest-cost product. For example, in a survey of exchange participants we conducted after the close of the 2015 OEP, 49% of the respondents who had purchased exchange plans and remembered the plans' pricing said that they had selected products with premiums that were average or above average relative to other plans within the comparable metal tier.<sup>4</sup>

Furthermore, consumers appear to be willing to pay for convenience. In a broader consumer

survey we conducted in 2015, we explained to the more than 2,200 participants what an integrated delivery network (IDN) was and then asked them to tell us which features they would be willing to pay up to \$20 per month for if they joined this kind of network.<sup>5</sup> The features selected most often were guaranteed appointments, after-hours appointments, and weekend appointments.

We also asked the participants to tell us how much they would want some of the features that typically characterize an IDN if those features were offered to them. Two of the features chosen most often indicate that consumers are willing to let their health information be shared between insurers and providers. Specifically, 76% said they would want their providers and health insurer to have a single, up-to-date view of their care history and future care needs. And, 75% said that they would want technology that allows all their providers to access their health and treatment information, and to coordinate care.

Thus, there is an opportunity for PLHPs to consider pricing and product benefits in a new way. The product benefits should be tailored to the strengths of the care management offered by the underlying health system.

### When is growth through a PLHP most likely?

If a health system is looking for growth through a PLHP, it should consider carefully which regions are suitable and which are not. The most suitable place for a PLHP is a region where the health system has a large share of a consolidated provider market and the level of payor consolidation is low. Even in this situation, however, the health system should make certain that its physician alignment skills are as strong as possible if it is to maximize the benefit of owning a health plan. In addition, it should be

<sup>4</sup>McKinsey's 2015 Post-Open Enrollment Survey.

<sup>5</sup>McKinsey's 2015 Consumer Health Insights Survey.

sure to have solid capabilities in both population health management (to contain medical costs) and the necessary actuarial analyses (to price products accurately). PLHPs also need to account for existing third-party payor relationships.

**Is an alternative type of administrative infrastructure possible?** Often, the administrative infrastructure used to set up a PLHP is similar to that of a stand-alone health plan (granular claims requirements, extensive prior authorization lists, utilization management and care management prerequisites, etc.). If most health plans led by providers are going to cover fewer than 100,000 or 150,000 lives, however, then achieving benefits of scale through this type of infrastructure will be next to impossible. Health systems have an opportunity to depart from this approach by establishing a radically different administrative infrastructure—for example, one that aligns clinical policies between the health system and the health plan’s business units to minimize the need for utilization management, strives for an auto-adjudication rate of 90% or higher, establishes a common care-management infrastructure, and makes claim submissions an exception rather than a necessity. We recognize that the administrative infrastructure must take into consideration the health system’s relationship with third-party providers and other payors in the market. Nevertheless, we believe that all PLHPs have—and should take advantage of—the chance to rethink the traditional payor administrative infrastructure.

**What can be gained through granular analytics?** Health systems with their own health plans have an important advantage: integrated claims and clinical data that can allow them to undertake sophisticated analytics. As a result, they should be able to make the most of opportunities for better medical management by identifying at-risk

patients, offering them appropriate preventive care, and, when necessary, intervening early. For example, the health systems can use the claims and clinical data to accurately determine the end-to-end cost of managing their high-risk patients and then change their approach to managing these patients (e.g., by directing them to the right care settings and offering timely interventions). Integrated data can also give health systems unique insights into the health plan’s performance in the different channels they are using to attract members to gain an end-to-end view of the lifetime value of a member within an IDN. The traditional payor or provider approach to calculating lifetime value will lead to conflicting results for an IDN; hence, a unique, comprehensive approach informed by deep analytics is critical.



Offering a health plan may be an attractive growth opportunity for many health systems, but it is not without risk (as current financial data attests). Health systems, if they are to benefit from offering a health plan, will need to be able to understand how they can use consumerism to their advantage and where the best opportunities for growth exist. In addition, they must be willing to rethink the administrative infrastructure they want to use and take advantage of the integrated claims and clinical data at their disposal. ○

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The authors would like to thank Martina Miskufova, Brendan Murphy, and Ellen Rosen for their support and assistance.

## Methodology

### Data used

- Some data about the products offered on the 2015 and 2016 public exchanges has now been made public, but financial results are available only through 2014. Thus, all calculations are based on 2014 data unless otherwise stated.
- The **McKinsey Provider Plan Database** includes detailed information about the 106 health systems currently offering one or more health plans in the United States. Among other things, the database provides details about 2010 to 2015 plan financial data, including (by state and entity) covered lives, health premiums earned, claims, and G&A expenses. It also describes the associated provider organization, the state(s) in which the plan operates, the states where it is offered on public exchanges, and the year(s) of opening and termination (2010 to 2014). Thus, the database contains information valuable to payors, providers, pharmaceutical companies, and medical device manufacturers.
- The **McKinsey Exchange Offerings Database** offers a granular view of all individual exchange products across the country offered in 2014 through 2016, as well as pre-reform benchmarks. It includes details on more than 340,000 ACA-compliant on-exchange products (from all 3,143 US counties), such as premiums, benefit design, and network design. In addition, it includes carrier and pricing details for all new entrants and incumbents (including 315 carriers participating on the 2016 exchanges), as well as hospital network data (including more than 2,000 unique exchange networks in 2014 and over 2,500 such networks in both 2015 and 2016, as well as network participation data for all US acute care hospitals).
- The primary sources of external data used in the article were the National Association of Insurance Commissioners' (NAIC's) Supplemental Health Care Exhibits; its Premiums, Enrollment and Utilization Exhibits; and its Analysis of Operations Exhibits (for G&A expenses). Additional data was obtained from the August 2015 enrollment report by county released by the Center for Medicare and Medicaid Services (CMS); Internal Revenue Service (IRS) 990 forms; and financial reports from the California Department of Health Care (DMHC).

### Calculations

- **Number of health plans.** Calculating the number of health plans offered by providers (or other insurers) in all lines of business is difficult because the available sources differ in their method of reporting (e.g., by legal entity, company, or organizations within companies). Comparisons between sources are therefore often inexact. For that reason, we have focused in this paper on the number of providers offering health plans rather than the aggregate number of plans being offered.
- **Enrollment.** The enrollment calculations in this paper are based on data from the NAIC's Supplemental Health Care Exhibits

## Methodology *(continued)*

and its Premiums, Enrollment and Utilization Exhibits, as well as CMS's August 2015 enrollment report by county. This approach is somewhat different from the one used in our last paper on PLHPs.<sup>1</sup> In that paper, we used national InterStudy lives data which, in some cases, included covered individuals in US territories. Also, the InterStudy calculations employed a wider definition of fully insured commercial lives. As a result, its estimates of overall market size are significantly larger.

- **Growth estimates.** The estimates of growth in the Medicaid market are based on the fact that as of February 2016, 32 states (including the District of Columbia) had expanded Medicaid. The calculations of Medicare enrollment growth include only members in MA plans, not Medicare cost plans.
- **Financial performance.** Financial data was taken from the NAIC's Supplemental Health Care; Premiums, Enrollment and Utilization; and Analysis of Operations Exhibits. For those carriers that did not submit this information to the NAIC, we supplemented the financial data with information from IRS 990 forms and DMHC financial reports.

—The Visiting Nurse Service of New York and the Universal Care Medical Group are not included in the estimates of financial performance among Medicaid PLHPs because of differences in their financial reporting.

—The estimates of MA financial performance cover about 80% of the total Medicare market and include cost products.

- **Aggregate margin loss.** The aggregate margin loss was calculated by taking the sum of all margins (positive or negative) reported by PLHPs and then dividing that amount by the sum of all premiums.
- **Operating margins.** For all lines of business, operating margins were calculated as premiums paid minus SG&A expenses, claims, taxes, licenses, and fees.
  - For commercial lines and Medicare, this information was derived from the NAIC's Supplemental Health Care Exhibit.
  - For Medicaid, it was taken from the NAIC's Premiums, Enrollment and Utilization Exhibit as well as the Analysis of Operations Exhibit (for G&A expenses).

<sup>1</sup>Khanna G, Smith E, Sutaria S. Provider-led health plans: The next frontier—or the 1990s all over again? McKinsey white paper. January 2015.



CAPABILITIES FOR SUCCESS:

# Consumer sales and marketing





# Enabling healthcare consumerism

*Companies that can learn to understand, guide, and engage healthcare consumers, while inspiring their loyalty, have a significant opportunity to change the healthcare landscape.*

**Jenny Cordina,  
Rohit Kumar,  
and Erin Olson**

In the United States, the ongoing growth of cost-sharing levels has given consumers greater influence over healthcare delivery. Between 2006 and 2015, for example, the average deductible for employees with employer-sponsored insurance grew by more than 120%.<sup>1</sup> Consumers now directly control \$330 billion annually in out-of-pocket healthcare expenses,<sup>2</sup> and the choices they make have the potential to affect 61% of all healthcare spending.<sup>3</sup>

Although true healthcare consumerism is still growing slowly, there are pockets in which it has taken hold. For example, consumers are beginning to actively engage in making decisions about their health and healthcare. Also, consumer preferences are becoming more sophisticated. Since the launch of the public insurance exchanges, for example, a growing number of consumers have been selecting their health insurance plans for reasons other than price alone.<sup>4</sup> Similarly, we have seen Medicare Advantage (MA) purchase patterns shift as consumers make more sophisticated trade-offs among up-front premiums, total costs, and network configurations.<sup>5</sup>

Both payors and providers could benefit by more deeply engaging healthcare consumers. Greater consumer engagement could help them improve customer acquisition and retention, strengthen brand premium, lower administrative costs, and develop competitive advantages. Perhaps most important, enhanced consumer engagement has the potential to improve health outcomes.

To enable healthcare consumers to fully emerge, payors and providers must deliver in four areas:

- **Know** consumers and what drives their behaviors
- **Guide** consumers toward the information they need to make better decisions
- **Engage** consumers to help prepare them for and enable behavior change
- **Inspire** consumers to build loyalty

Admittedly, the journey from education to engagement to behavior change is not always a straight line. But mastering these four actions will go a long way to increase the likelihood that consumers will change their behavior.

## Know consumers

*Develop a more nuanced understanding of consumers' needs, preferences, and values*

We often hear several common refrains about healthcare consumers—who they are, what they're looking for, and how they act. Indeed, a number of myths about healthcare consumers are widely cited (see “Debunking common myths about healthcare consumerism,” p. 175).<sup>6</sup>

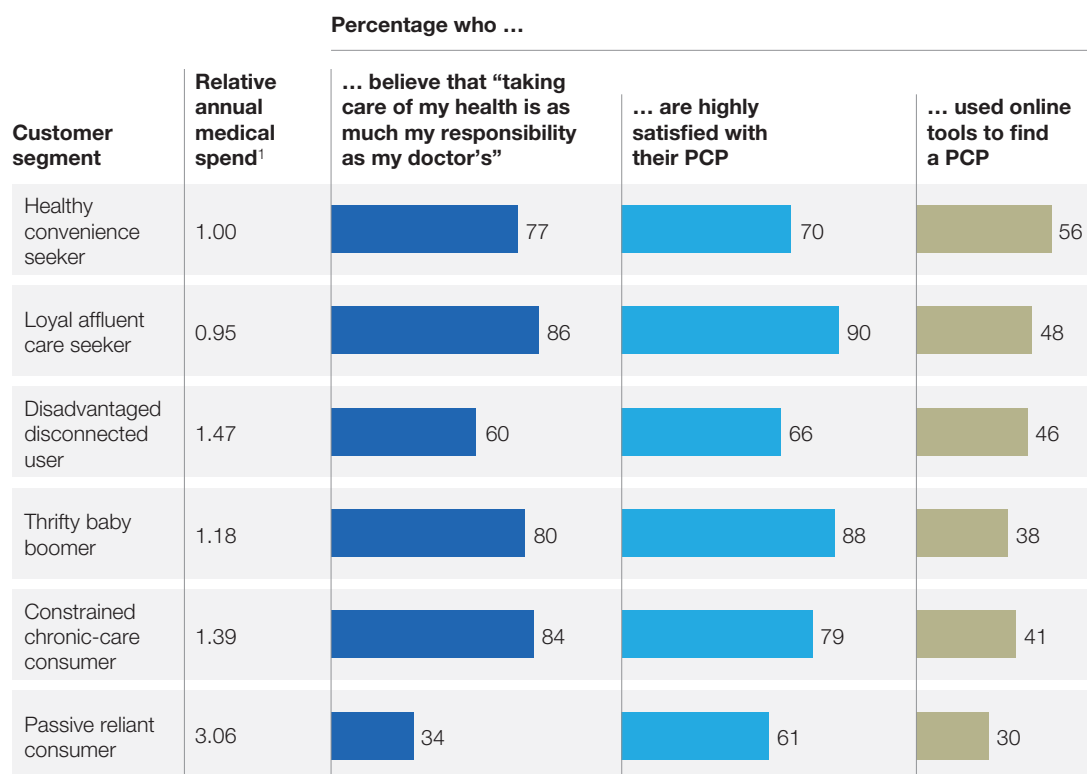
The reality is different; there is no “average” healthcare consumer. Rather, consumers come from a wide range of backgrounds, have differing clinical and lifestyle needs, and hold a variety of attitudes and expectations about healthcare. Thus, understanding the *average healthcare consumer* provides limited

The footnotes for this article appear on p. 174.

information. Segmentation can provide greater insights, but segmentation without a discrete goal can waste time and energy. For game-changing insights, payors and providers must determine their objectives and then segment consumers accordingly so they can develop practical actions to address the needs of those segments. For example, we built a segmentation model to understand how consumers' beliefs, attitudes, and values influence how they interact with the healthcare system at large. The results enabled us to divide the US population into six archetypes of healthcare engagement (Exhibit 1).

This segmented view of healthcare consumers can allow industry participants to design an “ecosystem” around what consumers need and want—whether it be certain types of insurance products or alternative settings for care delivery. Segmentation can also make it easier to engage with consumers and guide them toward appropriate treatment choices or levels of insurance coverage. It is important, however, that the segments be seen as starting points, not endpoints, because consumers in all segments have the potential to take a more active role in healthcare decision making. (Some segments, such as healthy convenience

#### EXHIBIT 1 Consumers vary in their attitudes and healthcare spending



PCP, primary care provider.

<sup>1</sup> Index is relative; annual medical spending by healthy convenience seekers is indexed at 1.00.

Source: 2016 McKinsey Consumer Health Insights Survey



seekers, may be more open to change than others are, though.) Thus, any strategy to engage consumers and serve them well must be predicated on a nuanced understanding of them, since it is the nuances that often influence the likelihood of success. Payors and providers need to know which segments to engage (and when), how those consumers can and want to be reached, and what engagement approaches they will respond to best.

## Guide consumers

*Connect them with the information they need to make better healthcare decisions*

Knowing consumers is not enough. They often need—and in many situations want—guidance to make better decisions. The first step in guidance is to ensure that consumers have the right type of information (e.g., information that is personalized, easy to understand, and from a source they trust), something they often lack today. For example, consumers consistently report that both cost and quality of care are important to them, yet our surveys show that only about 15% of respondents research costs and 18% investigate care quality before making healthcare decisions.<sup>7</sup> Why is this? Consumers often struggle to get the information they need to navigate their healthcare options. Of the consumers in our 2016 Consumer Health Insights (CHI) survey who said they researched the price of care ahead of time, more than half reported that they needed to check more than one source (e.g., by visiting a payor's website or calling a payor or provider). In a different study, three out of five respondents said they are confused by the benefit design of their health plan (especially the treatment options available to them).<sup>8</sup> (These findings highlight the need to improve not only consumers' awareness

*Any strategy to engage consumers and serve them well must be predicated on a nuanced understanding of them, since it is the nuances that often influence the likelihood of success.*

of available resources and information, but also the quality of that information.)

To effectively guide consumers, payors and providers should be prepared to heighten consumer awareness by giving them the right information at the right time at each stop along the consumer-decision journey. However, guiding consumers is more than simply making high-quality information available; thus, the second step in guidance is to ensure that consumers can easily connect with the information they need. Despite some improvements in consumers' awareness, most consumers are often still in the dark about ways to improve their care. For example, many consumers are unaware of the free or low-cost preventive health options available to them.<sup>9</sup> And although 98% of health plans offer tools to help consumers navigate their healthcare decisions, only 31% of consumers seem to know about them.<sup>10</sup>

Thus, payors and providers must make sure that consumers are aware of the information available to them, and building awareness may take time. Our survey of Medicare beneficiaries has shown, for example, that fewer than 20% of MA members are aware of the Star ratings given annually to MA plans; however, awareness is slowly building, and almost all the respondents who said they

knew about Star ratings reported having purchased a plan with three or more stars.<sup>11</sup>

How information is delivered affects consumer understanding, and consumers have clear expectations in this area. In our CHI survey, 64% of the consumers said they expected their provider to have an online presence. Respondents also made it clear that they want online information from their payors, especially about whether a treatment is covered, whether a care facility or provider is in network, and what the cost of treatment is likely to be. Most payors today offer this information—including estimated out-of-pocket treatment costs—to their members.<sup>12</sup> However, if the estimates are inaccurate or inconsistent with other sources, the information becomes meaningless to consumers. Providing consumers with accurate, meaningful, and accessible information is the first step in empowering their decision making and enlisting them as partners in managing their health and the cost of their healthcare.

## Engage consumers

*Prepare them for behavior change*

Once knowledge-driven guidance is delivered to consumers, it becomes possible to engage them and, often, change their behavior. Payors and providers can use several approaches to engage consumers—for example, focusing on what drives consumer behavior, improving their experience, and/or holistically supporting their health goals.

**Focusing on drivers of behavior.** As part of our 2016 CHI survey, we developed a detailed model of patient utilization. We paired self-reported utilization data with consumers' attitudinal responses to tease out the factors influencing high utilization and costs, while controlling for key variables such as chronic disease status. We found that a leading indicator of whether consumers were high utilizers was surprisingly simple: whether they strongly agreed that they “need help to be healthy.”

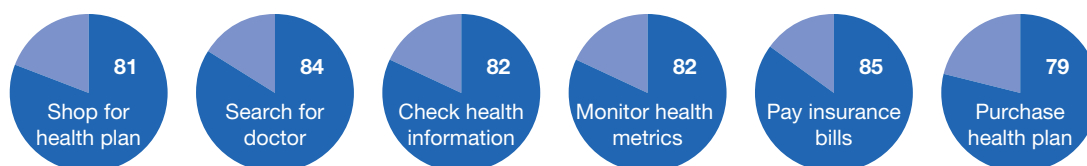
### EXHIBIT 2 Many consumers view digital solutions as the most effective way to meet healthcare needs

% of respondents who view digital solutions as the most effective way to perform healthcare activities

#### Consumer journeys



#### Example of a step within each journey



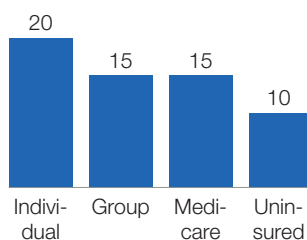
Source: 2016 McKinsey Consumer Health Insights Survey

### EXHIBIT 3 Consumers are showing increasing interest in nontraditional healthcare partners

% of respondents who preferred a nontraditional partner as their top choice to help keep them healthy

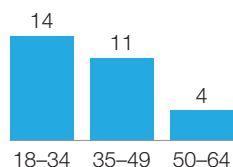
#### Health insurance company

**15%** of respondents overall chose a health insurer; however, this preference varied by type of insurance



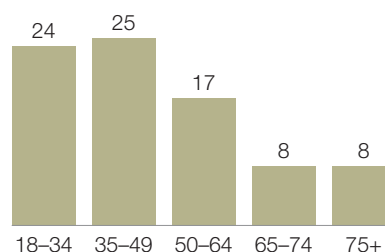
#### Employer

**8%** of respondents overall chose their employer; however, this preference varied by age



#### Family

**19%** of respondents overall chose a family member; however, this preference varied by age



Source: 2016 McKinsey Consumer Health Insights Survey

When we dug further into why consumers with chronic conditions believe they need help, “lack of motivation” appeared as a leading factor. “Motivation” describes both reasons for action (i.e., what’s your motive?) and enthusiasm for change. More broadly, motivation includes all thoughts and feelings that converge to influence behavior. As a result, a patient’s report of “lack of motivation” can sometimes point to something deeper, such as a lack of confidence or fear of failure.<sup>13</sup> Insights such as these create opportunities for payors and providers—by understanding what actually drives motivation (or the lack thereof) in patients with chronic conditions, healthcare stakeholders can develop effective strategies to improve outcomes and lower the cost of care.

**Improving customer experience.** Another way to engage consumers is to improve their healthcare experiences. Consumers value

ease—in our CHI survey, for example, the top two reasons why respondents said they are interested in online appointment scheduling were “convenience” and “saves time.”

One way to increase consumers’ convenience is to provide effective digital healthcare tools. In our CHI survey, an overwhelming majority of respondents made it clear that they want digital solutions at each step in their healthcare journey (Exhibit 2)—they perceived digital tools as often more effective than phone or in-person communication. For example, 90% of those who had ordered prescriptions online thought that doing so was useful, and 91% of those who had online access to their electronic health information found that having such access was useful.

However, providing digital healthcare tools does not guarantee that consumers will use them. Last year, more than 165,000 mHealth



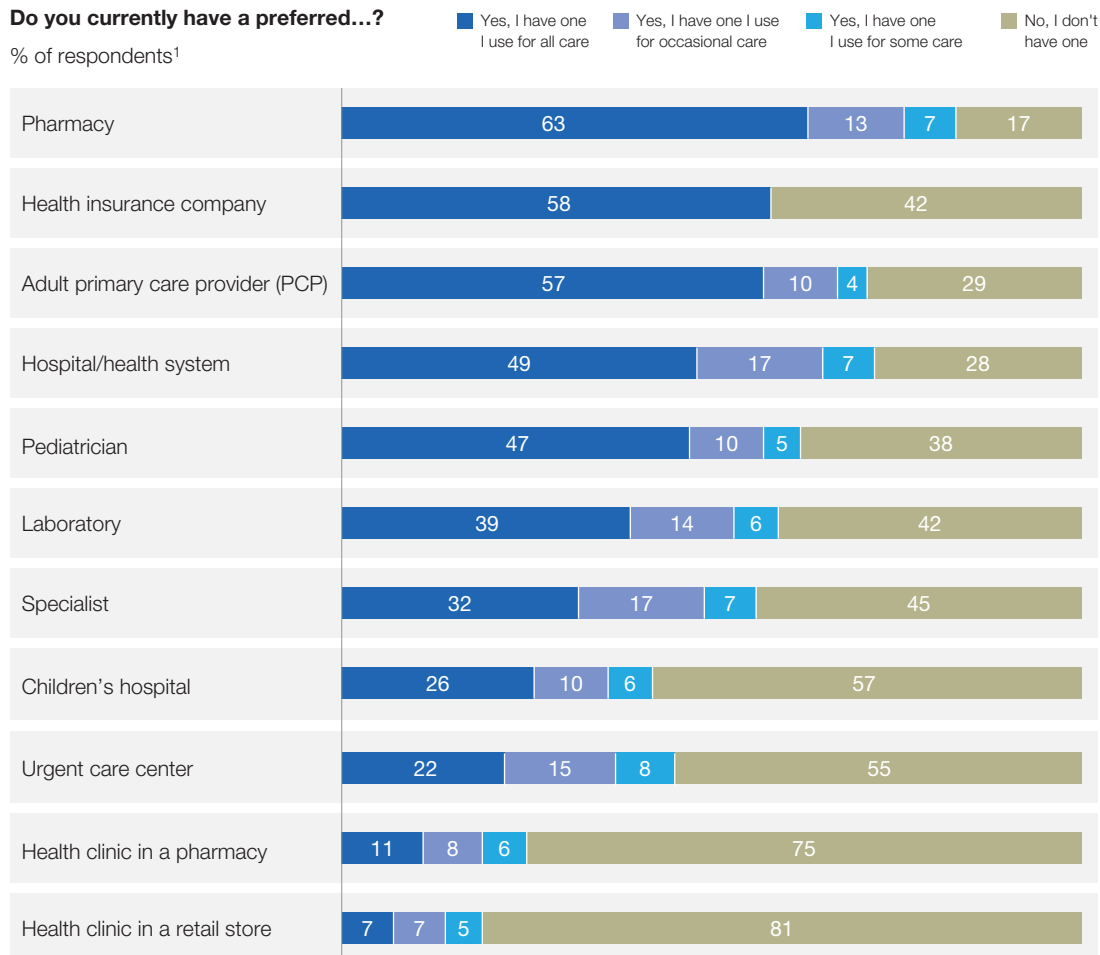
apps were available in the iTunes app store; thus, building awareness of a specific app is a crucial first step in getting consumers to use it. (The difficulty in building awareness helps explain why only 12% of the apps accounted for 90% of the downloads.<sup>14</sup>) However, awareness, although necessary, is not sufficient for adoption. Consumers are looking for value and ease—if digital tools do not deliver value and are not easy to use, consumers won't continue

to use them.<sup>15</sup> At present, many consumers are disappointed by the digital healthcare tools available to them. For example, less than one-third of our CHI survey respondents said they were highly satisfied with the digital tools offered by their primary care providers—the lowest satisfaction rating reported for any aspect of care (other aspects included quality of care, length of wait time, coordination with other physicians, and time with physician).

#### EXHIBIT 4 Many consumers have few, if any, preferred healthcare partners

##### Do you currently have a preferred...?

% of respondents<sup>1</sup>



<sup>1</sup> Numbers shown do not always sum to 100 because of rounding.

Source: 2016 McKinsey Consumer Health Insights Survey

### Supporting consumers' healthcare goals.

Payors and providers can also engage consumers by helping them reach their health goals in a more holistic way. On average, Americans spend only a small proportion of each day explicitly focused on their health and healthcare.<sup>16</sup> Yet at multiple points in each day—whether shopping at the grocery store, going to school, or interacting with colleagues—they are making decisions that affect their health. And they are seeking support for their healthcare goals from increasingly diverse sources (Exhibit 3).

As consumer preferences shift toward integrated healthcare support from stakeholders outside the exam room, an opportunity is growing to use nontraditional partnerships to promote health in ways other than an explicitly medical context. Key relationships in a consumer's life can be leveraged to keep the consumer healthy, decrease system costs, and improve customer satisfaction and loyalty.

## Inspire consumers

### *Build trust and loyalty*

Our research suggests that there is under-realized opportunity to build loyalty by developing preferred relationships with consumers, because many of them do not have specific preferred healthcare partners (Exhibit 4). In our CHI survey, for example, 12% of the respondents said they would be willing to receive primary care services from their health insurer, and 11% said they would be willing to receive health insurance from their provider.

Consumer loyalty, retention rates, and profitability can be increased by engaging consumers in their healthcare decisions (both insurance plan selection and care consump-

tion), and then ensuring that customer satisfaction levels are high. Customer satisfaction is important because of its strong influence on shopping behavior. In our CHI survey, for example, we asked patients what they would do if their primary care provider were no longer included in network. Respondents who reported high satisfaction levels were 20% less likely to say they would switch providers than those with low satisfaction levels. Similarly, in our survey of Medicare beneficiaries, 67% of those who said they had renewed without shopping were highly satisfied with their plan, compared with 1% of those who were highly dissatisfied. Despite the complexity of the healthcare system, a consistent set of factors helps ensure high satisfaction levels: high quality, good customer service, and reasonable cost.<sup>17</sup>

By focusing on building consumer loyalty, payors and providers have an opportunity to cultivate an important source of competitive advantage.



Healthcare consumerism is emerging. All healthcare companies need to determine how they want to adapt to the evolving environment and how they can better understand, guide, and engage consumers while inspiring loyalty among them. For those companies that choose to take on the challenge and can successfully meet consumers' needs, a significant opportunity awaits. ○

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## FOOTNOTES

- <sup>1</sup> Flavelle C. Next health-care fight? Out-of-pocket costs. Bloomberg View. September 22, 2015.
- <sup>2</sup> World Health Organization. Global Health Expenditures Database.
- <sup>3</sup> McKinsey analyses have found that catastrophic care (something consumers have little or no influence over) accounts for 39% of healthcare costs. However, the other categories of care (e.g., preventive, routine, discretionary) are subject to consumer choices, at least to some degree. (See Singhal S, Coe E. The next imperatives for US healthcare. p. 11.)
- <sup>4</sup> Anand P, Coe E, Cordina J, Rivera S. Understanding consumer preferences can help capture value in the individual market. p. 81.
- <sup>5</sup> Cordina J, Jamieson D, Kumar R, Machado-Pereira M. Improving acquisition and retention in Medicare. p. 95.
- <sup>6</sup> Cordina J, Kumar R, Moss C. Debunking common myths about healthcare consumerism. p. 175.
- <sup>7</sup> McKinsey regularly conducts detailed surveys of healthcare consumers, including surveys focused specifically on Medicare beneficiaries and people eligible to purchase health insurance on the individual exchanges. More details about the surveys can be found in the appendix.
- <sup>8</sup> Collective Health. People love their health benefits. But do they understand them? (2015 survey results).
- <sup>9</sup> Reed ME et al. In consumer-directed health plans, the majority of patients were unaware of free or low-cost preventive care. *Health Affairs*. 2012;31:2641-8.
- <sup>10</sup> HealthSparq. Creating savvy health care consumers ... it takes more than offering online tools. (2015 survey results).
- <sup>11</sup> Cordina J, Kumar R, Moss C. Debunking common myths about healthcare consumerism. p. 175.
- <sup>12</sup> Sweeney E. Survey: Majority of healthcare plans offer price transparency tools. *FierceHealthcare*. February 19, 2016.
- <sup>13</sup> Dixon A. Motivation and confidence: What does it take to change behaviour? *The King's Fund*. 2008.
- <sup>14</sup> Terry K. Number of healthcare apps soars, but use does not always follow. *Medscape*. September 18, 2015.
- <sup>15</sup> 2016 Consumer Health Insights survey.
- <sup>16</sup> Bureau of Labor Statistics. American Time Use Survey.
- <sup>17</sup> Cordina J, Kumar R, Moss C. Debunking common myths about healthcare consumerism. p. 175.

# Debunking common myths about healthcare consumerism

*Payors and providers need an accurate understanding of how healthcare consumerism is playing out. Using data from surveys of thousands of people across the US, we debunk eight of the most common myths circulating in the industry.*

Until recently, consumerism in the US healthcare industry has moved slowly. However, several converging forces are likely to change the situation soon and result in a more dynamic market. Higher deductibles and co-payments, greater transparency into provider performance and costs, and the rise of network narrowing and provider-led health plans are prodding patients to become more involved in healthcare decision making than ever before. As yet, most payors and providers have comparatively little data to assess how consumerism is likely to affect them. As a consequence, they can neither confirm nor refute a number of assumptions about healthcare consumerism that are often stated as fact.

Over the past eight years, we have conducted extensive research into healthcare consumerism. This year alone, we surveyed more than 11,000 people across the country about how they perceive their healthcare needs and wants, how they select providers, and how they make other healthcare decisions. Our results suggest that many of the assumptions currently being made about healthcare consumerism are no more than myths.

## Myth #1

*Healthcare is different from other industries. Consumers don't bring the same expectations about customer experience to healthcare that they bring to retail or technology companies.*

Our findings indicate that consumers want the same qualities in healthcare companies that

they value in non-healthcare settings. In this year's Consumer Health Insights (CHI) Survey, we asked participants to identify the non-healthcare companies with the strongest consumer focus. Apple and Amazon led the list. We then asked the participants to tell us what qualities gave such companies a strong customer focus, as well as what they valued in a consumer-focused healthcare company. The answers to the two questions were surprisingly similar (Exhibit 1). For example, more than half the participants cited great customer service as important for non-healthcare and healthcare companies alike. Other qualities that the participants identified as important for both sets of companies were delivering on expectations, making life easier, and offering great value.

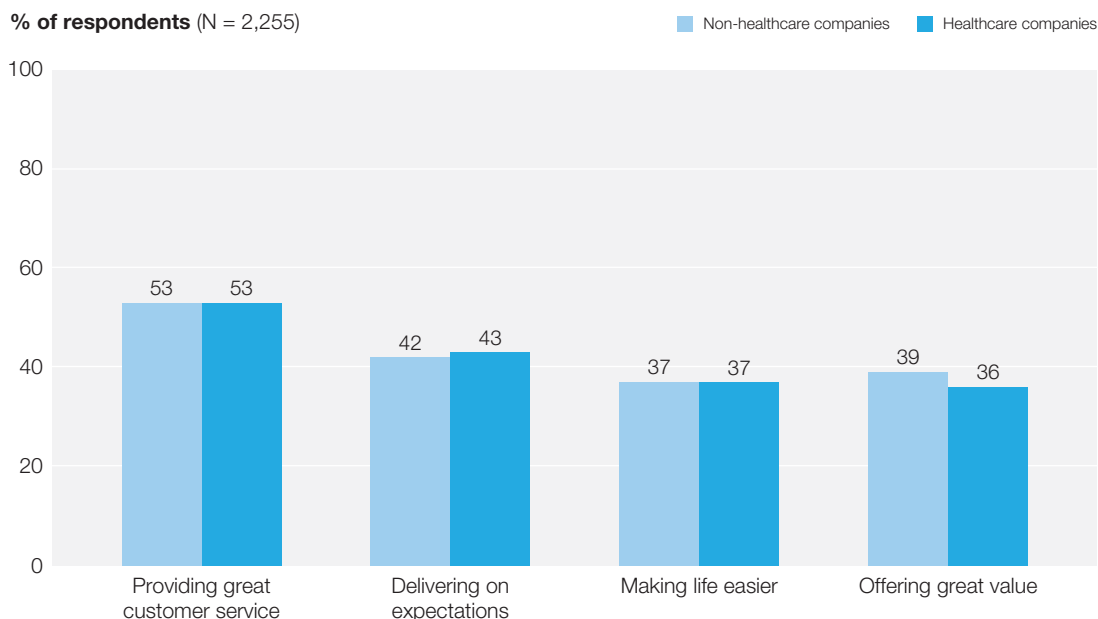
Whether healthcare companies need to perform as well as Apple and Amazon on customer experience remains to be seen. However, the evidence suggests that just performing better than other current healthcare competitors will not be sufficient. Customer expectations are being set by non-healthcare industries, and meeting those expectations is likely to be critical to ensure satisfaction and loyalty.

## Myth #2

*Consumers know what they want from healthcare companies and what drives their decisions.*

Most consumers have strong opinions about what matters to them when they make healthcare decisions or receive healthcare services.

**Jenny Cordina,  
Rohit Kumar,  
and Christa Moss**

EXHIBIT 1 Qualities consumers value in companies<sup>1</sup>

<sup>1</sup>Participants were offered 10 qualities and asked to select the 3 they thought mattered most.

Source: McKinsey 2015 Consumer Health Insights Survey

The evidence suggests, however, that there is often a disconnect between what consumers believe matters most and what influences their opinions most strongly. Given the intangible nature of health insurance and health-care provision, it appears that some factors play a much greater role than most consumers realize. For example, as part of our 2014 CHI Survey, we posed two questions about patient satisfaction to the participants who reported having been hospitalized within the previous three years. First, we asked them how satisfied they were with their hospital experience. Second, we asked them to rank the importance of various factors that might have influenced their satisfaction levels.

More than 90% of these participants said they had been at least somewhat satisfied

with the care they received, and most of them rated the outcome achieved as the most important influence on their satisfaction. However, when we mapped the factors that participants said influenced their satisfaction against their reported levels of satisfaction, we found that the empathy and support provided by health professionals (especially nurses) had a stronger impact than outcomes did (Exhibit 2). Satisfaction levels were also strongly influenced by the information the participants had been given during and after treatment.

In general, our results suggest that people tend to overstate tangible factors (e.g., parking, pain management) and understate factors that are more emotional (e.g., empathy) or abstract (e.g., value).

### Myth #3

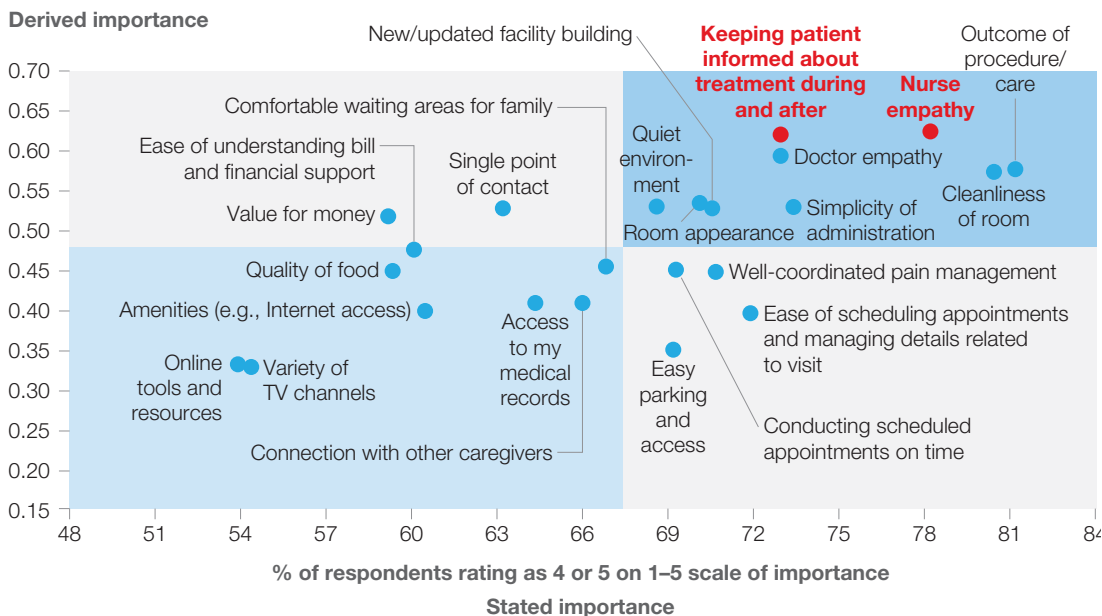
*Most consumers research their health-care choices before making important decisions and then make fact-based choices based on their research.*

Five different surveys we conducted recently suggest that many, if not most, healthcare consumers are not yet making research-based decisions. Our findings indicate, for example, that only a few consumers are currently researching provider costs or even the number of providers they can choose among. Although some (but far from most) consumers are beginning to research their health plan choices, many of them are not yet aware of key factors they should consider before selecting coverage.

**Provider choices.** In this year's CHI Survey, only 22% of the participants said that they always ask about cost before going to a doctor or other healthcare provider. We also asked participants whether they had received certain services in the past year and, if so, whether they had researched costs in advance. Exhibit 3 shows the results. The participants who received maternity care were most likely to report that they had researched costs prospectively. In all cases, the participants were much more likely to say that they had "talked to someone" (e.g., a provider or insurance representative) to investigate costs than to look at websites. Furthermore, even among the subset of consumers who reported doing research on costs before undergoing an expensive, invasive procedure (e.g., cardiac or

## EXHIBIT 2 What consumers say is most important does not always correlate with their actual satisfaction levels<sup>1</sup>

Correlation coefficient in relation to overall inpatient satisfaction score (N = 1,160)



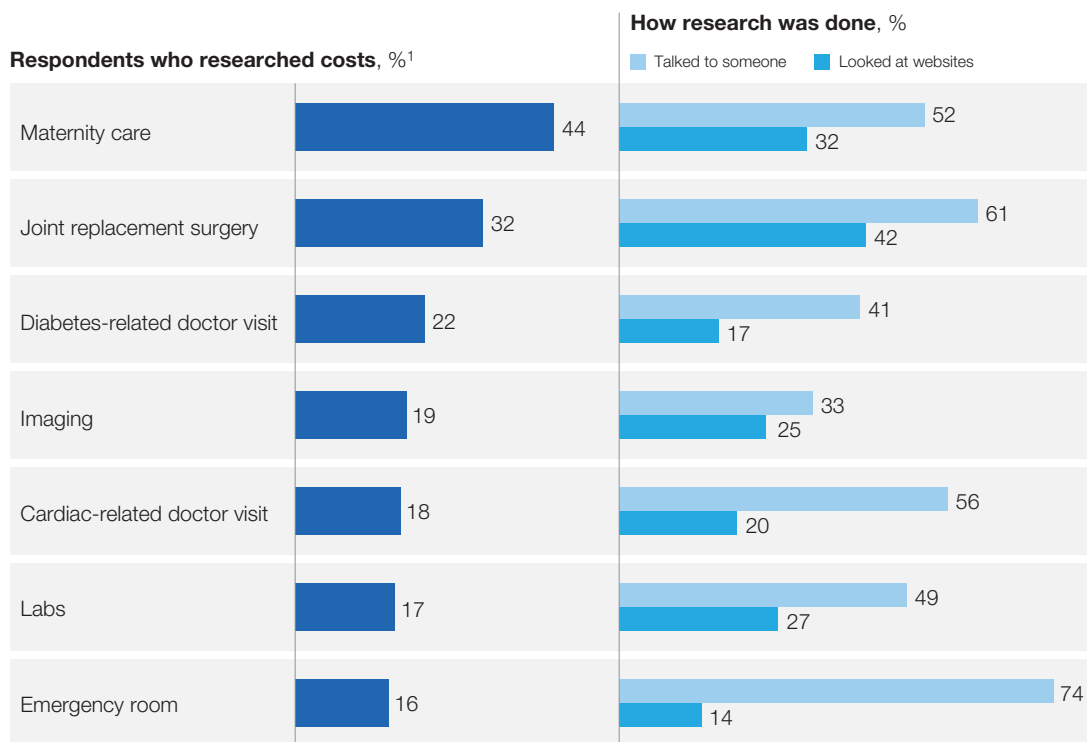
Source: McKinsey 2014 Consumer Health Insights Survey

joint surgery), half still said that their doctor's recommendation was the key factor that influenced their decision about where to seek care.

Cost is not the only factor most consumers are not yet actively investigating. In last year's CHI Survey, we asked the participants who reported having been hospitalized in the previous three years to tell us how many hospitals there were in their local area. More than half said there was only one local hospital when, in fact, there were a median of three hospitals within a 10-mile radius of their home and ten hospitals within a 20-mile radius.

**Health plan choices.** Soon after the close of the 2015 open enrollment period (OEP), we surveyed consumers who were eligible to purchase exchange plans to investigate the decisions they made about health insurance during the OEP.<sup>1</sup> Forty-four percent of those who said they have bought an exchange plan for the first time indicated that they did not understand the type of provider network included in their plan. Nineteen percent of those who had purchased an exchange plan last year also indicated they were unaware of their plan's provider network. Only 12% of those who remained

### EXHIBIT 3 Some consumers are beginning to research the cost of healthcare services



<sup>1</sup>Bauman N, et al. Hospital networks: Evolution of the configurations on the 2015 exchanges. McKinsey Center for US Health System Reform Intelligence Brief. April 2015.

<sup>1</sup>The question about researching costs was asked only of participants who said they had received a given type of care in recent years. Thus, the N value differed depending on the type of treatment.  
Source: McKinsey 2015 Consumer Health Insights Survey



uninsured knew the size of the subsidy they were eligible for, and only 59% were aware of the penalty for not obtaining coverage.

Similarly, in our survey this year of Medicare members, we found that only 21% of those who had enrolled in a Medicare Advantage (MA) plan knew their plan's Star rating. However, almost all of those who knew their plan's rating had purchased a plan that had three or more Stars.

Moreover, in a survey we conducted this year of Medicaid-eligible recipients, only 32% of those who were enrolled in a managed care program and did not have dual Medicare coverage indicated that they had done any research before selecting a carrier, even though they had the option of choosing among multiple carriers.

## Myth #4

*Now that consumers are paying more for their healthcare, premium price is the only truly important factor in purchase decisions.*

During both the 2014 and 2015 OEPs, premium price was, indeed, an important factor for many consumers. However, a sizeable percentage of people did not buy the cheapest plan available to them.

In our 2015 post-OEP survey, for example, 49% of the participants who had purchased exchange plans and remembered the plans' pricing said that they had selected products with premiums that were average or above-average relative to the other plans within the comparable metal tier. The higher-premium products these participants bought (in comparison with the less-expensive plans pur-

chased by other respondents) were more likely to be based on preferred provider organizations, to include pharmacy benefit add-ons, or to cover alternative types of care (e.g., acupuncture, chiropractic).

A subsequent report released by the Department of Health and Human Services confirms that price is not the only factor that many people shopping for individual coverage consider.<sup>2</sup> It found that 66% of the 8.84 million people who bought health insurance through the federally facilitated marketplace during the 2015 OEP could have purchased a health plan with a monthly premium of \$50 or less (after the advanced premium tax credit was applied). However, only about half of these people bought the very-low-cost plans.

In our Medicare study, we asked participants to design their own plan, giving them trade-offs between premium prices and various cost-sharing and benefit options (e.g., premiums went up as deductibles went down). Only 15% of the participants selected a \$0 premium plan. In contrast, almost two-thirds of them said they would be willing to pay a \$50 premium per month if it would reduce their medical deductible to \$0. Thirty percent of the participants said that they would be willing to pay more than they were currently paying if it would help them hold their deductible down or enabled them to buy ancillary products. The feature cited most often by those willing to pay higher premiums was having a \$0 deductible for prescription drugs.

Similarly, in this year's CHI Survey, one-third of the participants said they were willing or very willing to pay up to 20% more for health

<sup>2</sup>Health insurance marketplaces 2015 open enrollment period: March enrollment report. ASPE Issue Brief. March 10, 2015.

insurance if it gave them more choices about where to seek care. Furthermore, in a private exchange simulation we conducted recently with individuals covered by employer-sponsored insurance, the participants spent, on average, 40% above the employer-contribution level to obtain ancillary benefits, such as vision, life, and critical illness insurance. In fact, many of the private exchange simulation participants were willing to trade down on medical benefits so they could trade up on ancillary benefits (Exhibit 4).

## Myth #5

*Almost all consumers have a primary care provider (PCP) and are highly reluctant to change doctors.*

In this year's CHI Survey, 82% of participants said that they had a regular PCP. However, the likelihood of having a PCP was age-related: 96% of the participants above age 65 reported having a PCP, compared with only 65% of those ages 18 to 34. The likelihood of

### EXHIBIT 4 In private exchange simulations, consumers showed a willingness to trade medical for ancillary benefits

#### Medical benefits

**In simulation, participants bought down on medical benefits...**

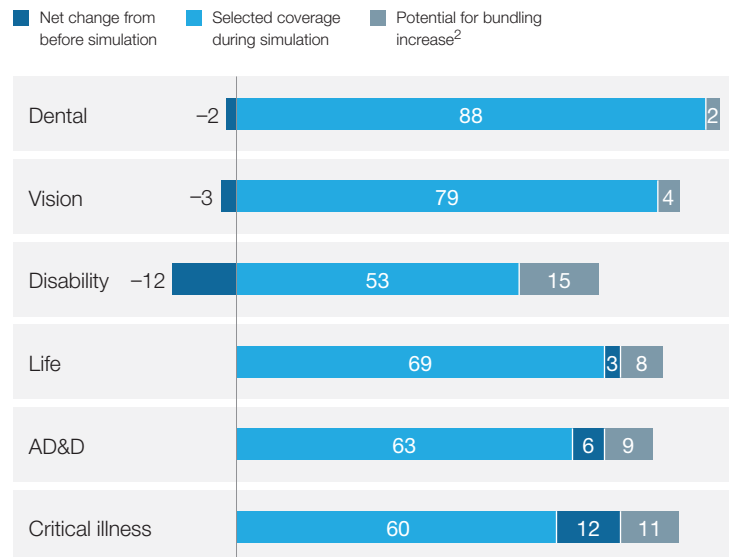
Average actuarial value, %  
(N = 2,406)<sup>1</sup>



#### Ancillary benefits

**... but purchased ancillary products not offered by their employers**

% of participants given a base level of funding who purchased ancillary products (N = 804)<sup>1</sup>



AD&D, accidental death and dismemberment.

<sup>1</sup>Samples are weighted to match the profile of employees in the four states studied.

<sup>2</sup>During the simulation, participants were not given the option of purchasing products in bundles. However, they were asked whether they would be interested in purchasing certain products in a bundle. The percentages given here reflect the likely increase in products sold based on participants' responses to that question.

Source: McKinsey 2015 Private Exchange Simulation

## *The chief reason for using pharmacies and retail clinics was ... accessibility (convenient locations, not needing an appointment, convenient hours).*

having a PCP was also influenced by income (89% of those with incomes above \$100,000 said that they had a PCP) and health status (90% of those with one or more chronic conditions had a PCP).

Among all of the participants who did have a regular PCP, 66% said that they would not change providers unless they or their doctor moved. However, 57% of them also indicated that they would be willing to switch doctors if their health plan no longer covered their PCP. Among this 57%, willingness to switch was influenced by the length of a participant's relationship with the PCP: 72% of those who had been using that doctor for only one or two years were willing to make the change, compared with 53% of those who had been with their doctor for five or more years.

Other evidence from this year's CHI suggests that many consumers are willing to consult providers other than a regular PCP. For example, 71% of all of the participants agreed with the statement: "There are many good primary care physicians that I would be satisfied seeing." Forty-five percent of the participants said that they had made an appointment at least once with any available doctor within the same practice or facility as their regular PCP. Of those who had not done so, only 18% indicated that they were unwilling to consult any doctor but their PCP.

In addition, 16% of the participants said that they receive routine care from a multi-doctor primary care clinic rather than an individual PCP. When asked why, nearly half of these participants cited accessibility (e.g., convenient locations, shorter waiting times, easier scheduling). Among the 84% of participants who did not receive care from a primary care clinic, 55% said they would be willing to do so if it cost no more than or less than what they currently pay (Exhibit 5).

### Myth #6

*Retail clinics will remain a niche health solution.*

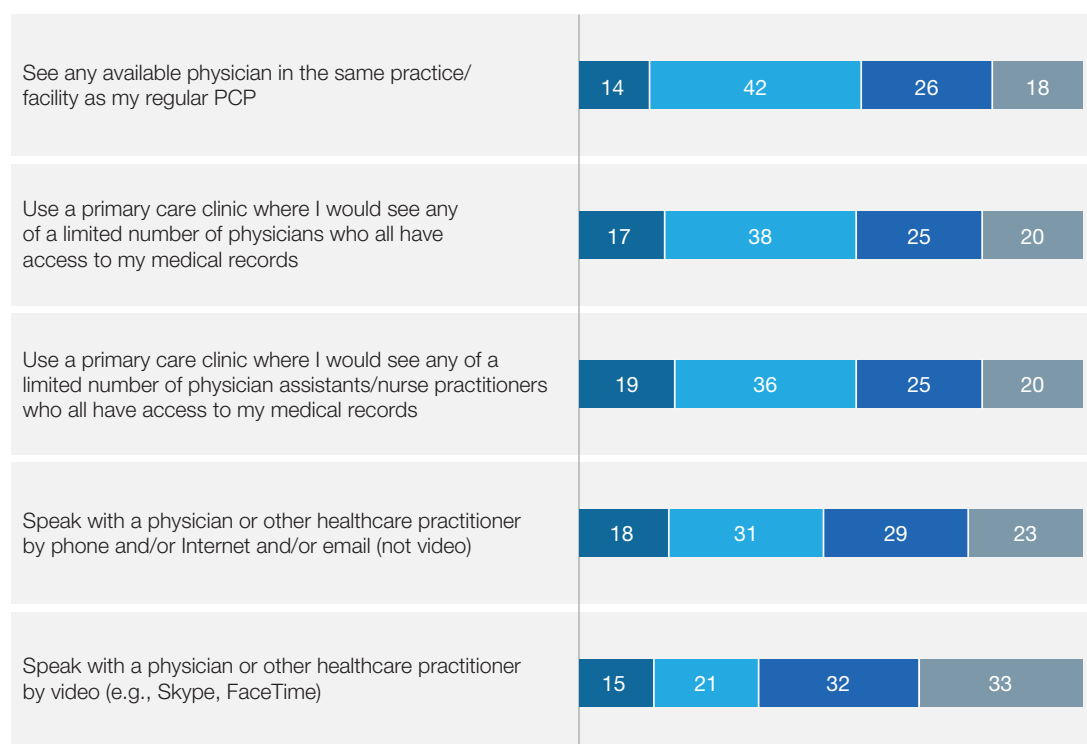
Awareness and utilization of other alternative-care options are also rising. In this year's CHI Survey, more than 80% of the participants were aware of healthcare services being offered through pharmacies and retail stores. About half of these participants, however, were unsure of the specific services being offered.

About two-thirds of the participants said they are willing to use healthcare services offered by a pharmacy or retail store. Twenty percent reported having already sought care in these settings within the past two years (up from 10% in our 2013 CHI survey). The chief reason given for using pharmacies and retail clinics for care was, once again, accessibility (convenient locations, not needing an appointment, convenient hours). More than three-quarters of the 2015 participants who

## EXHIBIT 5 Many consumers are willing to use alternative provider arrangements

% of respondents willing to use alternative arrangements (N = 1,881)

■ I am willing to do this if it costs me less than what I currently pay
 ■ I am not sure
 ■ I am willing to do this if it doesn't cost me more than what I currently pay
 ■ I am not willing to do this in the future



PCP, primary care provider.

Source: McKinsey 2015 Consumer Health Insights Survey

had used these alternative-care options said they plan to do so again. Just over half (51%) of those who reported having received healthcare services at a pharmacy or retail clinic indicated that they had done so for immunizations; 26% said they had sought treatment for a minor illness. Of the participants who said they had not yet used one of these alternative-care options, more than 60% indicated they were willing to do so for immunizations, minor illnesses, or nutritional/weight loss support (Exhibit 6).

Use of these alternative care options could grow substantially in the next few years, given their increasing numbers and expanding offerings. The number of retail clinic locations across the United States rose from 1,183 in 2010 to 1,866 in 2015.<sup>3</sup> CVS, which operates about half of the retail clinics, has announced that it plans to have 1,500 clinics by 2017. Growth among other the major players is likely to accelerate now that Walmart is putting primary care practices within its stores.

<sup>3</sup>Tabuchi H. How CVS quit smoking and grew into a health care giant. New York Times. July 11, 2015.

## Myth #7

*Only young people are using technology to manage their health and healthcare needs.*

In both this year's and last year's CHI surveys, we also asked participants about using technology to manage their health and healthcare needs. Not surprisingly, millennials (those between the ages of 18 and 34) were more likely to report using technology for these purposes,

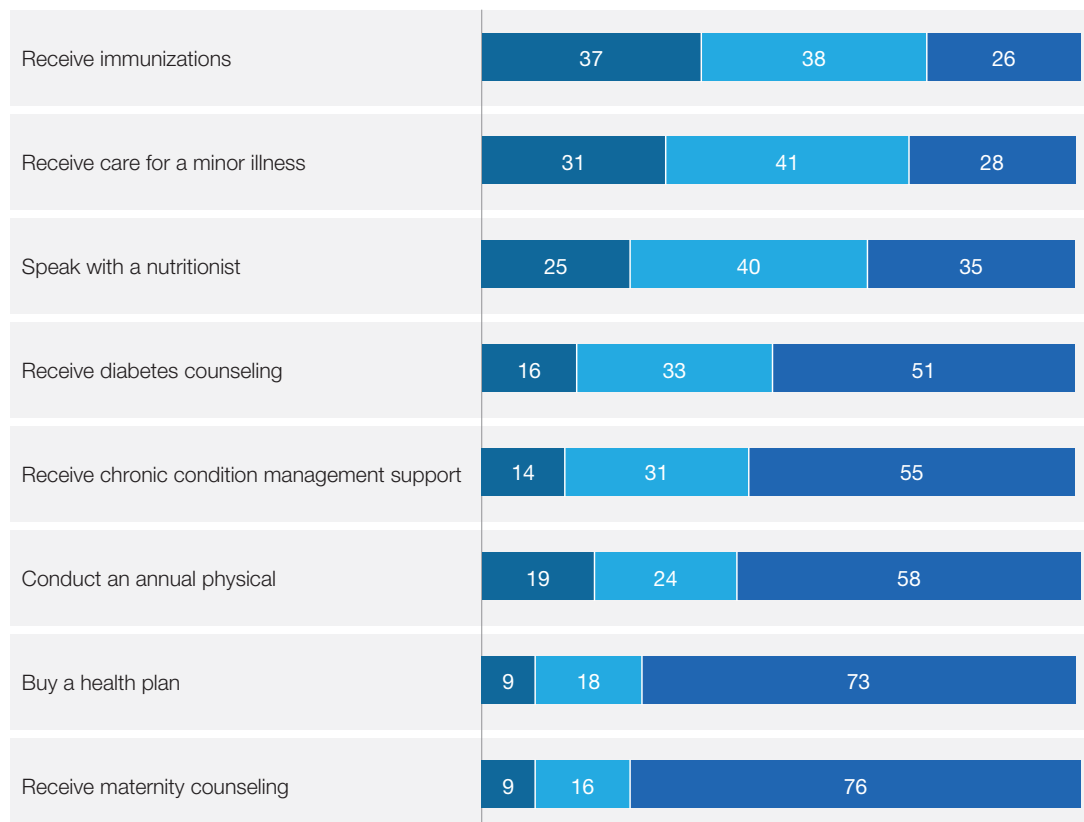
but a considerable number of the older participants were doing so as well (Exhibit 7). In all age groups, the top two activities were communicating with doctors and scheduling appointments. However, millennials were much more likely than older participants were to say that they were using social media to share wellness ideas and participate in online wellness groups.

We also asked participants about whether they had used websites or apps for a number of

### EXHIBIT 6 Many consumers are willing to receive some healthcare services in retail settings

% of respondents willing to do these things at a pharmacy or retail clinic (N = 1,849)

■ I am very willing to do this ■ I am somewhat willing to do this ■ I would not do this



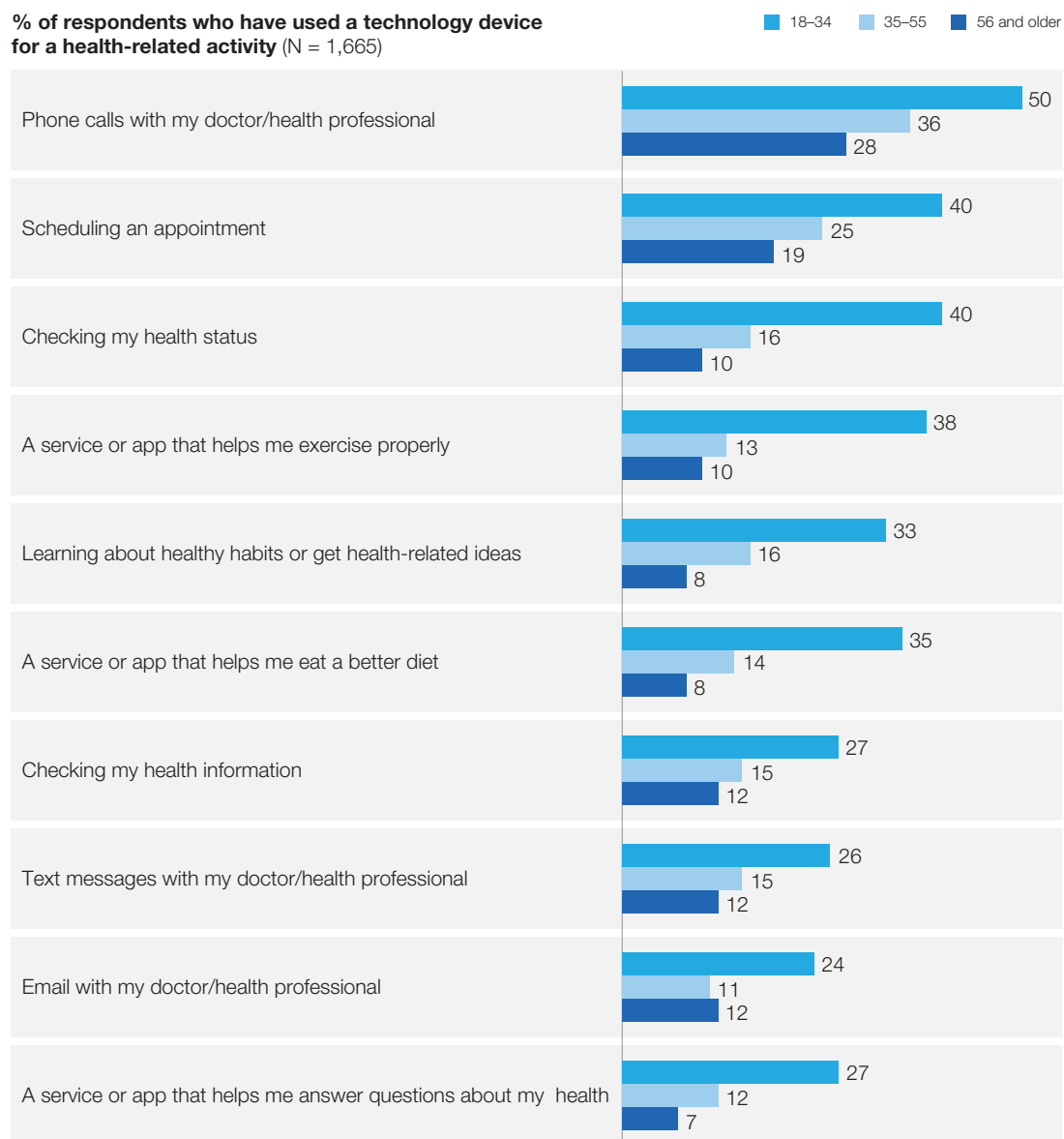
Source: McKinsey 2015 Consumer Health Insights Survey

health-related activities, and, if so, whether they thought those resources were more or less effective than phone or in-person communication. For two of the most common activities—

communicating with a physician and scheduling appointments—the majority of participants ages 65 and older (65% and 78%, respectively) thought that websites and apps were more effective.

### EXHIBIT 7 Many consumers are willing to use technology for health-related activities

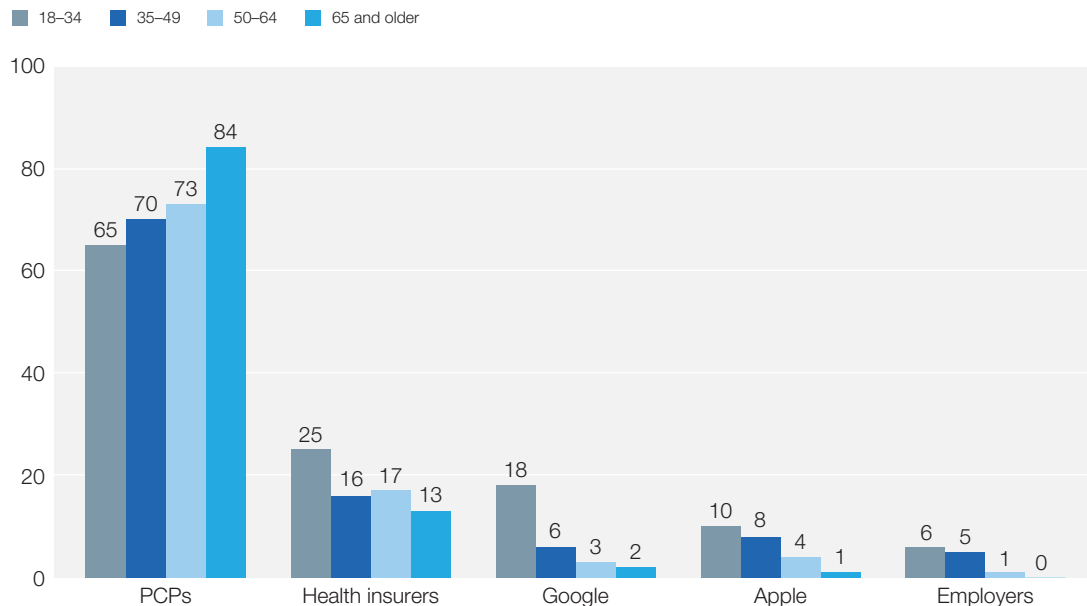
% of respondents who have used a technology device for a health-related activity (N = 1,665)



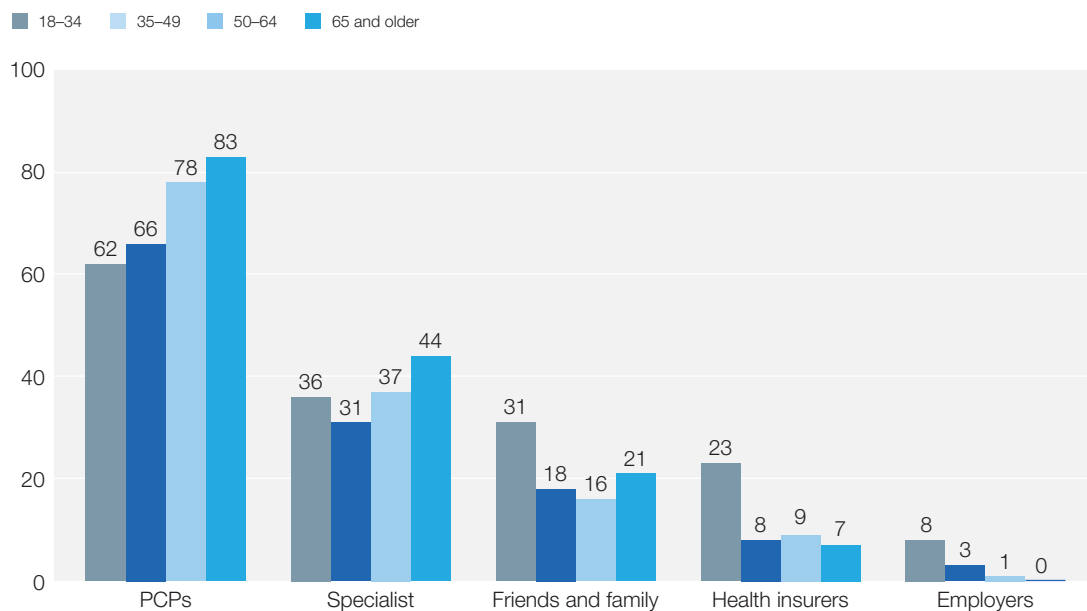
Source: McKinsey 2015 Consumer Health Insights Survey

## EXHIBIT 8 Consumers trust PCPs most with their health data

% of respondents willing to store data from a health monitoring device with... (N = 871)



% of respondents willing to share their health data with... (N = 973)



PCPs, primary care providers.

Source: McKinsey 2014 Consumer Health Insights Survey



## Myth #8

*Most people are willing to trust insurers to store their health records.*

In our 2014 CHI Survey, we asked the participants to imagine having some sort of health-monitoring device. We then asked them two questions: Where would they be comfortable storing information from that device? And with whom would they be willing to share the data?

Apropos storage, the participants overwhelmingly chose PCPs (Exhibit 8). Only a minority of them said they were comfortable having health insurers, Google, or Apple store their health data, and even fewer people chose employers. Participants also named PCPs as the group with whom they were most comfortable sharing the data (Exhibit 8). In both cases, age had only a small impact on the answers received.




We believe that healthcare consumerism will soon enter the steep slope of the innovation S-curve and become a much more significant force. Payors and providers need to begin making plans now if they want to be ready to respond to, and perhaps shape the evolution of, healthcare consumerism.

The data and insights we have amassed can help them do that. Our findings suggest, for example, that payors should think about what value proposition they want to offer to consumers. That value proposition can be, but doesn't have to be, price related—consumers are open to other enticements. And payors should not assume they are the natural owners of consumers' health records; they will have to find a way to earn greater consumer trust if they want to

do that. Providers should not take patient loyalty for granted or underestimate the role that experience-related factors such as convenience and empathy play in consumer satisfaction and loyalty.

The results described in this article are only a fraction of the information we have amassed. Our findings also reveal important attitudinal differences based on age, gender, ethnicity, income, health status, and geography—differences that have important implications for both payors and providers. These findings have convinced us that both payors and providers need to better understand what really drives consumer decision making and focus on that (rather than just on what consumers say). This understanding must be based on very granular data to ensure its relevance to local healthcare players.

In addition, both payors and providers should think about the evolving role of new healthcare technologies in shaping consumer behaviors so they can take advantage—and not become victims—of them. Perhaps most important, both payors and providers should realize that consumers' expectations are no different in healthcare than in any other industry. In fact, other industries will continue to shape these expectations—healthcare companies need to catch up, or they risk being disrupted. 

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# Great customer experience: A win-win for consumers and health insurers

*For payors, stronger consumer engagement can lead to stronger financial performance. By mapping the “journeys” consumers take as they buy and use health insurance, payors can better deliver what customers want and need—and help them better manage their healthcare. However, a nuanced approach by line of business and consumer segment is required.*

As consumers' role in healthcare continues to expand, so does the importance for payors of direct-to-consumer capabilities and member engagement. Consumers are taking a more active part in healthcare decision making, and they have multiple interactions with payors that strongly affect those decisions—including which health plans to select, what types of providers to consult, what treatments to use (and where to receive them), and how to get the most from their healthcare dollars.

Our research and experience suggest that improving the consumer experience and member engagement can strengthen a payor's financial performance in multiple ways, including:

**Lower churn rates.** McKinsey's Cross-Industry Customer Experience Survey found that the likelihood consumers would renew their current health insurance coverage increased with their level of satisfaction.<sup>1</sup> In the survey, the link held true among the participants with Medicare Advantage (MA) or individual insurance coverage as well as the large number of respondents who had group coverage but were able to select their own plans (Exhibit 1). Satisfied customers were five times more likely than dissatisfied customers to report that they had renewed their plan. Evidence also suggests that customer satisfaction increases the likelihood that people will stay with the same insurer when switching between segments.

**Trend-bending innovations for commercial accounts.** By establishing solid relationships with members, payors are likely to find it easier to convince employers—both those with full-risk coverage and those with administrative-services-only accounts—to adopt innovative benefit approaches designed to bend medical cost trends.

**Administrative cost savings.** High customer satisfaction (CSAT) scores can improve the ease of doing business and reduce the administrative burden. Satisfied customers are more likely to be well informed about plan terms, such as services covered, and to make decisions that follow plan requirements (e.g., by staying in network). In addition, they are usually better able to handle routine administrative tasks on their own and are less likely to call service centers or file complaints.

**Total cost-of-care optimization.** Payors with especially strong consumer capabilities may be able to use member engagement to lower medical costs while improving outcomes. For example, these payors may be better positioned to guide members to appropriate sites of care and encourage them to take control of their health (e.g., by entering a care management program or adhering to proper medication use).

**Avoiding disintermediation by new entrants.** Strong member engagement may also prove helpful for payors as they increasingly compete

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<sup>1</sup> McKinsey's Cross-Industry Customer Experience Survey is an ongoing survey that monitors customer satisfaction with six major industries, including health insurance. In addition, it identifies the factors that influence satisfaction levels by mapping customer journeys and pain points, both across and within industries. More than 22,000 people across the United States participated this year, including almost 6,000 people who answered detailed questions about health insurers. More details about this survey can be found in the appendix, which begins on p. 239.

with either technology disruptors or providers attempting to build direct relationships with consumers to influence where the consumers seek care.

Our research and experience indicate that payor performance is improving; however, significant opportunity remains. In our Cross-Industry Customer Experience Survey, payors outranked utility and pay TV companies in terms of consumer satisfaction (Exhibit 2).<sup>2</sup> We also found that reported satisfaction levels were considerably higher among MA plan participants (8.5) than among consumers with individual (7.6) or group (7.8) coverage.

To address this opportunity, we outline specific steps—many drawn from the experience of leading consumer companies—payors can take to increase consumer engagement.

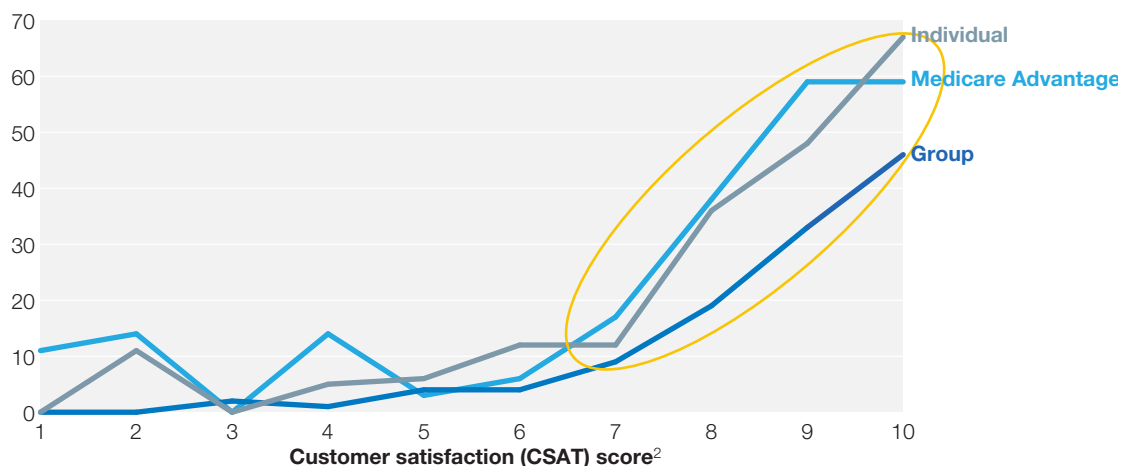
## Understanding the consumer “journey”

Payors can effectively and efficiently improve their customer experience only if they can identify how consumers interact with them and other healthcare stakeholders, as well as what elements of those interactions are most important to various customer segments. In our experience, a payor can do this by mapping the “journeys” consumers take as they research, obtain, and use health insurance.

Simply put, a journey is the end-to-end experience a consumer has as he or she navigates a given activity. In the case of a payor’s members, for example, the “find-a-doctor” journey begins as soon as someone decides he or she needs a doctor and ends once the first doctor visit is made. During this journey, the member often

### EXHIBIT 1 Renewal likelihood increases with consumer satisfaction

Likelihood of renewal,<sup>1</sup> % (N = 5,837)



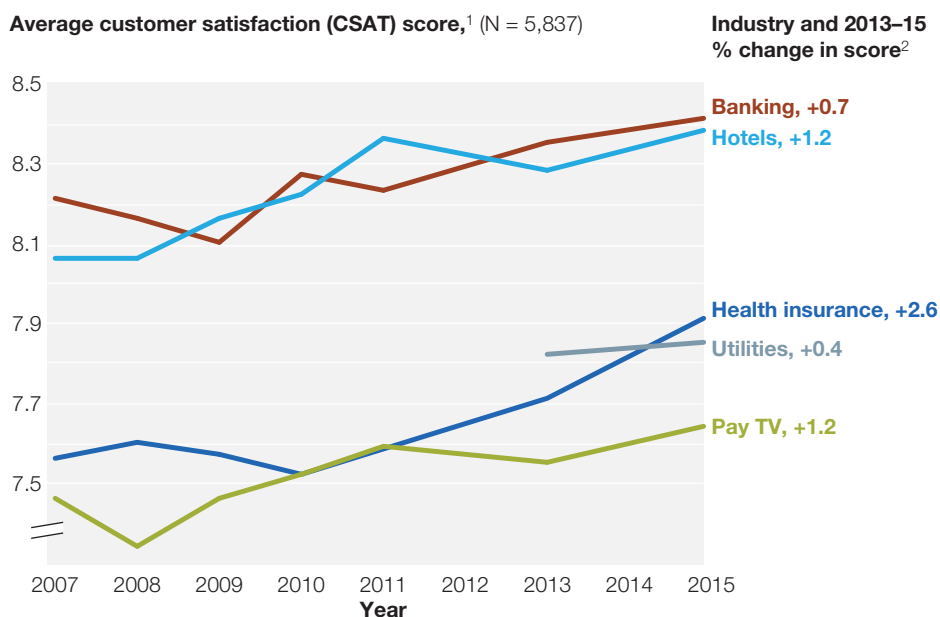
<sup>2</sup>Note: Changes made to the survey between 2013 and 2015 might have influenced results for all sectors.

<sup>1</sup>We asked consumers how likely they were to make these changes in the next 12 months. Those who said 9 or 10 on a scale of 1–10 were defined as “likely to renew.”

<sup>2</sup>Customer satisfaction was measured on a scale of 1–10.

Source: 2015 McKinsey Cross-Industry Customer Experience Survey, June and July 2015

## EXHIBIT 2 Customer satisfaction has improved in most industries



<sup>1</sup>Customer satisfaction was measured on a scale of 1–10; survey included up to three companies per industry per respondent.

<sup>2</sup>Survey was not conducted in 2012 and 2014. Data on utilities were not collected before 2013.

Source: 2015 McKinsey Cross-Industry Customer Experience Survey, June and July 2015

has multiple interactions—also described as touchpoints—with the payor, using different channels (e.g., calls to customer service, visits to the provider directory).

In our experience, a member's interactions with a payor typically include seven key journeys (Exhibit 3). In addition to finding a doctor, they include the sign-up process, receiving care, and getting answers to questions. The final journey is coverage renewal.

Measuring satisfaction along each end-to-end journey, rather than at discrete touchpoints only, gives a payor a more comprehensive understanding of its members' experience and of what matters most to which customers. Our research in multiple industries shows that

journey satisfaction scores are twice as good as touchpoint satisfaction scores in predicting business outcomes. Armed with this understanding, the payor can assess its current performance, identify improvement opportunities, and prioritize improvement efforts based on value potential and strategy.

## Increasing consumer engagement

Leading consumer companies excel at using their understanding of what their customers want to advance their financial goals. Their aim is not simply to enhance their customers' experience, but also to shape that experience by pinpointing the improvements that produce the greatest financial return.

Payors can learn from their example. To achieve the financial results that stronger consumer engagement can produce, a payor should:

- Analyze and segment the customer base
- Determine which journeys matter most to key segments
- Link the most important journeys to current financial performance
- Redesign the journeys and build the cross-functional capabilities needed to design and implement new journeys that deliver on the experience
- Track performance across journeys
- Institute cultural change and continuous improvement to sustain the transformation at scale

### **Analyze and segment the customer base**

To ensure value capture from targeted efforts to improve the consumer experience, a payor must begin by understanding the profitability of its membership base and the drivers of profitability by line of business. Thus, a “tear-down” that looks at profitability across demographic segments, regions, channels, and products is necessary. To round out these internal insights, the payor should create durational curves to map the evolution of performance over time. With this fact base in hand, the payor can determine which customer segments to focus its improvement

## **EXHIBIT 3 Consumers take seven journeys when buying and using health insurance**

Journeys	Major elements of journey
<b>I sign up and join</b>	<ul style="list-style-type: none"> <li>• Finding, evaluating, applying, and purchasing plans across channels, including specialty</li> <li>• Establishing financial arrangements with the plan</li> </ul>
<b>I select a provider</b>	<ul style="list-style-type: none"> <li>• Choosing/accessing the type and site of care for my health needs</li> <li>• Ensuring that I understand network inclusion and its impact on out-of-pocket costs</li> </ul>
<b>I receive care</b>	<ul style="list-style-type: none"> <li>• Ensuring access to care needs, including filling prescriptions, getting referrals to specialists, and meeting pre-certification requirements</li> </ul>
<b>I take control of my health</b>	<ul style="list-style-type: none"> <li>• Enabling long-term health and wellness</li> <li>• Establishing/managing the use of clinical/nonclinical care for chronic conditions</li> <li>• Budgeting/managing financial aspects of chronic care</li> </ul>
<b>I manage my finances</b>	<ul style="list-style-type: none"> <li>• Simplifying the processes for claims submission and adjudication, receiving monthly statements, and making premium payments</li> </ul>
<b>I have a question or problem</b>	<ul style="list-style-type: none"> <li>• Updating contact information</li> <li>• Adding/removing dependent(s)</li> <li>• Resolving premium billing/payment issues</li> <li>• Reconciling claims/billing and replacing ID cards</li> </ul>
<b>I renew my coverage</b>	<ul style="list-style-type: none"> <li>• Renewing my existing plan or migrating to a new plan</li> <li>• Migrating to a new segment (e.g., to Medicare from employer-sponsored group coverage)</li> <li>• Adding specialty/voluntary products</li> </ul>

efforts on (the specific segments often vary from company to company).

In addition, the payor should review its operational data and other available information to identify the pain points those customer segments commonly encounter. The data collected can range from the major reasons for call-backs to customer service to comments new members make on social media. This information provides initial insights into those customers' underlying needs and preferences.

Understanding profitability typically requires a cross-functional effort, involving actuarial, marketing, operations, and analytics teams. The analyses will differ substantially by line of business because of differences in the factors that influence profitability (e.g., risk adjustment). However, this step provides a quantitative foundation essential for measuring the success of any change program.

### **Determine which journeys matter most**

Once the payor has a portrait of its high-priority customers, the next step is to determine which journeys matter most to both those customers and the company's financial performance. Our Cross-Industry Customer Experience Survey shows that four journeys have the strongest impact on customer satisfaction overall (Exhibit 4). Deeper analysis reveals, however, significant variations among consumer segments. In our survey, for example, MA beneficiaries placed greater emphasis on filling prescriptions and submitting claims than did those with individual or group coverage. In contrast, respondents with individual coverage indicated that the provider selection and sign-up journeys were most important to them. Health status (especially the presence or

absence of multiple chronic conditions) frequently also had a strong impact on journey importance.

### **Link journeys to financial performance**

Especially for a payor facing significant financial challenges, the real power of journey analysis comes from linking insights to company economics. Thus, along with identifying what matters most to high-priority members, the payor should assess the potential value of each improvement effort. This requires three steps for each journey and member segment. First, the payor should estimate the value at stake by rigorously dissecting corresponding claims and operational data. This kind of analysis can determine, for example, whether change could lead to medical cost reductions (e.g., those that would result from lower emergency room and urgent care center utilization), decreased churn rates, or other results with positive financial impact. Second, the payor should consider the cost and feasibility of implementing each change. Third, the payor should develop a close understanding of both consumer expectations and competitors' performance to assess the impact each change would have on relative market performance. The trick is to find the changes that improve both the consumer's experience and the company's economics at the same time.

### **Redesign the most important journeys**

Once the focus journeys have been identified, they should be redesigned using a "customer-back" approach; the goal is to encourage desired behaviors (e.g., undergoing health assessments). Consumer surveys, focus groups, and employee interviews can help the payor understand what a given journey is like for members today and where the key pain points are.

For each of the prioritized journeys, the payor should create a map of what that journey should ideally look like in the future. This idealized version should be based on a deep understanding of pain points and should not be constrained by current operations. The payor can then determine what improvements to test with consumers. The redesign process should be iterative, with multiple test-and-learn pilots that include different mem-

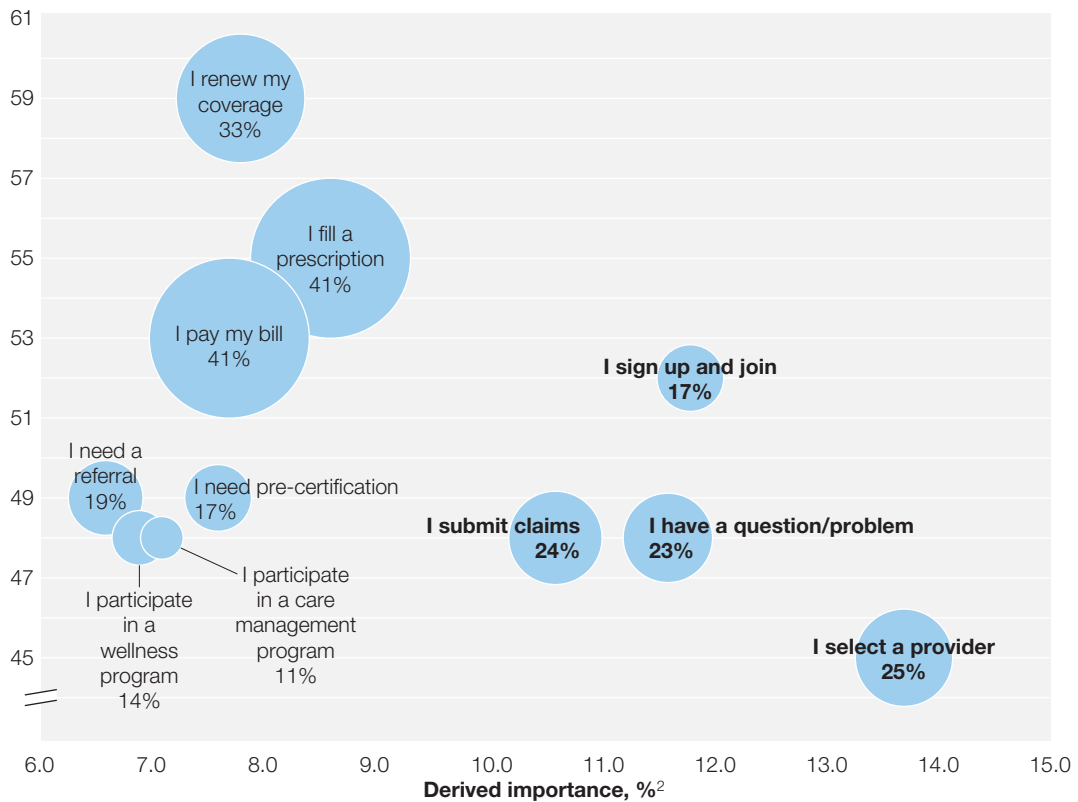
ber cohorts. Results should be rigorously tracked to determine what works before scaling. This type of rapid prototyping helps assess members' responses to the various initiatives, validate each initiative's value proposition, and demonstrate the business objectives achieved.

In our experience, two parallel approaches are needed to produce superior outcomes. First,

#### EXHIBIT 4 Four health insurance journeys matter most to consumers

Journey satisfaction, % highly satisfied<sup>1</sup> (N = 5,837)

● % of members experiencing journey in last 12 months  
(labels in bold are the ones that matter most to consumers)



<sup>1</sup>Highly satisfied was defined as a score of 9 or 10 on a scale of 1–10.

<sup>2</sup>"Derived importance" (as opposed to "stated importance") is calculated using a statistical technique that examines the relationship between the value individuals place on various factors of an experience and how they rate the overall experience. The individual factors that correlate most strongly with the overall rating are thought to have the greatest impact on the experience and thus have the highest derived importance. In consumer research, derived importance is considered superior to stated importance because many people lack insight into what drives their perceptions and behaviors.



sophisticated design thinking should be used to create experiences that customers will think are significantly more compelling and drive the desired behaviors (e.g., by making it easier to schedule a health assessment). Second, analytical tools such as ClickFox should be used to better understand current consumer behaviors, patterns, and bottlenecks—information necessary for both designing and testing the new experiences.

### Track performance across journeys

To sustain the value captured in the pilots, the payor should determine the anticipated financial impact of each initiative and then set up rigorous tracking mechanisms and governance processes. The payor should sequence each initiative and translate its economic impact into annual, and also three-to-five-year, budget implications. Doing this will require alignment within the organization on such issues as incremental vs. baseline impact in business budgets, as well as a thoughtful split of the roles different units (e.g., business segments, central consumer office, supporting operations) will play in delivering the impact.

Once the goals are set, the payor should establish tracking mechanisms and governance for the initiatives to measure their progress. Typically, we see companies use a common metric (e.g., CSAT scores) that cascades across lines of business and is meaningful to frontline employees. The metric itself is less important than how it is used—the metric must be tied directly to the improvement efforts and financial implications so that the organization understands what it is aiming at—and how.

### Institute cultural change and continuous improvement

In addition to improving specific journeys, payors need to enhance their consumer

capabilities if they want these efforts to be sustained. Accomplishing this usually entails changes in the organization's culture, particularly at the front line. These employees have the most direct impact on the consumer experience, and they often generate the best improvement ideas. Keeping frontline employees engaged in the transformation can yield disproportionate benefits.

McKinsey has identified six hallmarks that define the companies that perform best in consumer experience.

**Have a compelling value proposition.** The companies have defined a clear, compelling value proposition for their customers and ensure that all parts of the organization deliver consistently on it.

**Disseminate broad consumer-focused communications.** The companies have not simply identified the consumer journeys that are most important in supporting that value proposition—they make certain that everyone in the organization knows why those journeys are important.

**Reinforce frontline culture.** The companies use the key journeys to reinforce frontline culture. Because many journeys are cross-functional in nature, effective redesign usually requires better collaboration and proactive problem-solving across silos.


**Define performance metrics.** In addition, the companies use the journeys to define performance metrics and governance systems.

**Stress continuous improvement.** The companies continuously innovate to find ways to improve how their customers experience the consumer journeys.

**Manage expectations.** The companies also leverage the journeys to manage members' expectations. For example, a customer service call center might let members know how long the wait time to speak to a representative is likely to be and explain when the call center is less busy in case members want to call back later.



As consumerism becomes more deeply entrenched in the healthcare industry, payors have the opportunity to capture value and increase

margins by improving their customers' experience. By mapping the journeys their key customers take, linking those journeys to financial impact, and then making changes to eliminate pain points and make the journey more enjoyable, payors can achieve those goals. 

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CAPABILITIES FOR SUCCESS:  
Digital





# How tech-enabled consumers are reordering the healthcare landscape

*Consumers' accountability for healthcare spending is increasing, and more than a thousand companies are developing new digital/mobile technologies that should allow consumers to take greater control over their healthcare choices. This combination may disrupt the industry's migration toward larger, more integrated systems and put almost \$300 billion—primarily, incumbent revenues—into play.*

Four convergent forces are reordering the healthcare landscape in the United States. Largely in response to two of them—reform and the reallocation of financial risk between providers and health insurers—the industry has been consolidating at record pace (more than 80 deals in each of the past four years). However, two other forces—rising consumerism and the spread of digital/mobile technologies—could lead the industry in a different direction.

Consumers are paying a growing portion of their healthcare costs out of pocket, and they are well aware of the convenience and simplicity provided by online banking, shopping, and travel reservations. As a consequence, they are starting to alter their attitudes about healthcare costs, choices, and accessibility, as well as who should control their clinical information and how much administrative complexity they should endure. These changes will likely accelerate as consumers' financial accountability for healthcare costs continues to increase.

Technology companies—many of which are new entrants to the healthcare sector—are hastening the changes by offering consumers a growing array of health-related applications, programs, monitors, and devices. Although these technologies currently pose little risk to incumbents, they could create considerable disruption in the not-distant future.

Our research suggests a growing divergence between how providers and insurers are integrating and reconstituting their organizations and how tech-enabled, financially accountable consumers want to interact with them. Consumers may increasingly resist incumbent-imposed restrictions precluding them from deciding where, when, how, and from whom to seek care. Consider a world in which:

- Pricing transparency applications and online scheduling tools permit consumers to identify and use discrete, best-in-breed health services from a range of providers (some of whom are consulted remotely via mobile e-visits), rather than accept the limitations in benefits or access restrictions imposed by narrow networks, health maintenance organizations, or integrated provider systems.
- By enabling people to own, and control access to, their health data, digital/mobile health technologies eliminate the information asymmetry that has long benefited healthcare system incumbents and inhibited the creation of an informed healthcare consumer.
- Consumers can create their own personal health management “ecosystems,” quite literally in the palms of their hands, based on individual preferences for how they wish

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to monitor and manage their health and healthcare, as well as how they choose to manage their health benefits and payments. (Admittedly, this last scenario requires development of an IT platform that would allow data from different technologies to connect, but such a platform is likely to be built within five to ten years.)

We cannot yet predict the rate at which these developments will occur. Evidence verifying the effectiveness of some of the technologies has not yet emerged. Furthermore, the healthcare sector has confounded many prior predictions of technological evolution (in part because of the typically inverse relationship between age and need—younger people tend to adopt new technologies more rapidly, but older people usually have greater health-care needs). Nevertheless, the pace of change has often been extremely rapid when digital/mobile technologies are involved (think BlackBerry versus iPhone, or CD versus MP3). If the changes become widespread, up to about \$270 billion of incumbents' current revenue and another \$13 billion to \$24 billion in new revenues could be contested due to price compression and shifting demand and supply dynamics. Furthermore, the conventional wisdom—that vertical and horizontal integration, and the risk management and information advantages resulting from them, are preconditions for competitive success in healthcare—may become invalid or will apply only to those market segments forced or willing to trade personal choice and access for very low cost.

In short, the rise of financially accountable, technology-enabled consumers could splinter today's healthcare value chain. Incumbents must decide how they want to respond.

## Key findings

We conducted extensive research to understand the impact digital/mobile health technologies could have on providers and health insurers, especially when they are used by financially accountable consumers. We interviewed technology innovators, investors, and healthcare industry incumbents. We also surveyed thousands of US consumers to learn how their perceptions about and use of the technologies are evolving. In addition, we analyzed the business models of scores of new entrants and other industry shapers (e.g., venture capitalists, technology incubators, and existing IT companies serving incumbents in other ways) to understand their strategic intent and impact potential. This research revealed five key findings:

### **Consumers are starting to replace traditional healthcare services with digital ones**

Consumers' awareness of digital/mobile health technologies is growing rapidly. Between 2014 and 2015 alone, awareness of many of these technologies more than doubled. However, utilization of the technologies lags awareness. For example, 86% of our survey respondents indicated that they knew it was possible to fill prescriptions or order health supplies online, but only 29% had actually done so. Yet even low utilization rates can translate to high real-world numbers. Executives at Zocdoc, an online scheduling service, told us that more than six million Americans use it each month.<sup>1</sup> Nearly 80% of the consultations occurred within 72 hours of the appointment request. Eighty-five percent of the appointments were with providers the consumers had not previously consulted, suggesting that many people view conveni-

<sup>1</sup>Interview with Oliver Kharraz, MD (then COO and now CEO of Zocdoc), April 2015.

ence and easy access as more important than loyalty to a physician.

Consumers are adopting digital/mobile health technologies not just to manage prescriptions

or schedule appointments, but also to interact directly with physicians, monitor their health and physical activity, learn about their medical conditions, rate providers, and more (Exhibit 1). Not surprisingly, utilization rates are currently

## EXHIBIT 1 Consumers are using a broad set of digital health tools

### Health-related activities consumers report having used technology for

% of respondents

Activities	Smartphone/tablet	Laptop/desktop
Text messages with my doctor	16	N/A
Emails with my doctor	16	30
Help eat better	19	10
Help exercise properly	20	9
Answer questions about health	15	15
Schedule an appointment	26	25
Check health information (e.g., test results)	17	36
Check health status (e.g., calories burned)	22	15
Information about doctor/hospital ratings	15	33
Review or rate my experience	11	19
Information about doctor costs	11	21
Information about hospital costs	10	22

Source: Consumer Health Insights Digital Survey, April 2015

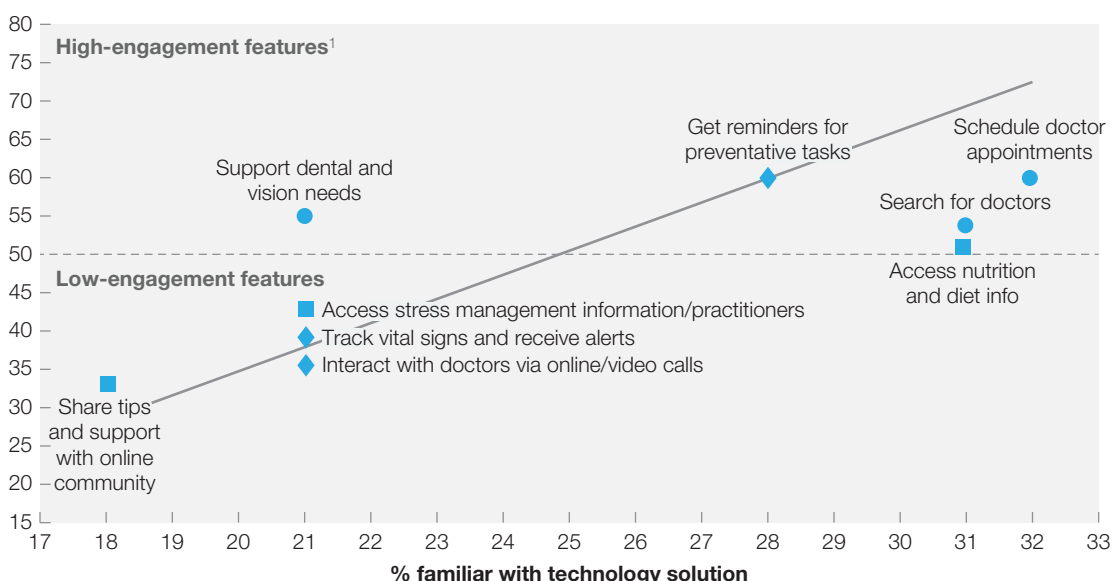


## EXHIBIT 2 Utilization increases once awareness grows

## Utilization among aware users

% currently using solution

● Clinical scheduling   ■ Search and share   ◆ Personalizing health

<sup>1</sup>Defined as features with usage rates above 50% among those familiar with the technology.

Source: Consumer Health Insights Digital Survey, April 2015

<sup>2</sup>Use of mobile technologies also depends on smartphone ownership, something that is still far more common among younger Americans. However, older adults are catching up. Between 2014 and 2015, overall smartphone use in the United States rose by about 10%. Among those over 65, it increased more than 40%. (Smith A. U.S. smartphone use in 2015. Pew Research Center. April 1, 2015.)

<sup>3</sup>According to the Agency for Healthcare Research and Quality (AHRQ), annual healthcare expenditures average about \$3,000 for patients with one chronic condition and more than \$7,000 for patients with multiple chronic conditions. Patients with one or more chronic conditions account for more than 80% of total annual healthcare spending in the United States. (AHRQ. Multiple Chronic Conditions Chartbook. April 2014.)

highest among younger Americans. For example, millennials are twice as likely as baby boomers, and three times as likely as seniors, to use email or text messages to communicate with physicians. However, use does correlate with awareness (Exhibit 2). Once a high awareness level is reached, generational differences often diminish significantly.<sup>2</sup> For example, among the respondents who knew about online appointment-scheduling services, utilization rates were similar among millennials and seniors.

While awareness can drive initial uptake of a technology, long-term use requires that consumers understand the value the technology provides and perceive it as

better than what more traditional approaches may deliver (Exhibit 3). Among the survey respondents who had tried one or more digital/mobile health technologies, three-quarters thought they were more effective than traditional approaches.

Digital/mobile health technologies could be especially helpful for patients with chronic conditions, given the difficulty and high cost of managing those conditions.<sup>3</sup> Here again, a growing number of consumers appear to prefer technology to more traditional approaches. In our survey, we asked respondents whether they had a chronic condition and, if so, whether they wanted a health coach. Of those who wanted one, 48% favored an online solution. Only 28%

wanted an in-person coach, and 18% preferred telephone interactions.

If awareness of digital/mobile health technologies continues to rise rapidly and their adoption curves are similar to those other digital/mobile applications followed, we anticipate that 60% to 65% of all consumers will be using common digital/mobile healthcare technologies (e.g., e-visits) within five to ten years. To understand the significance of this percentage, consider: at present, about 68% of Americans have smartphones.<sup>4</sup>

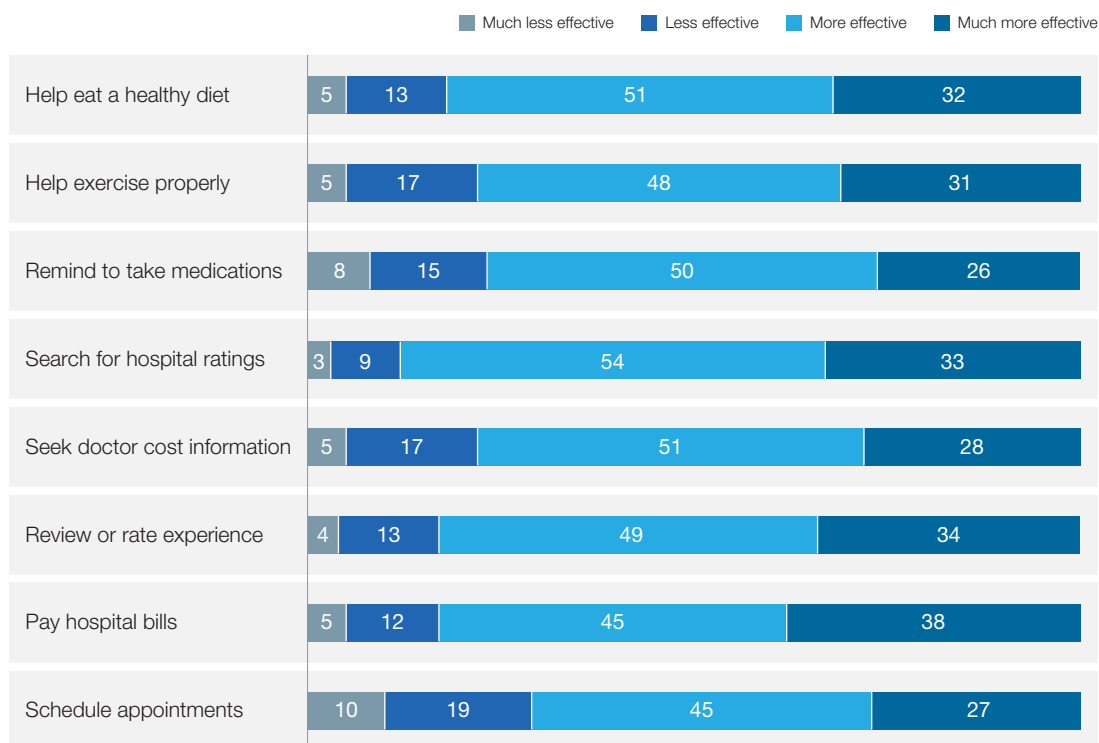
### Investment in these technologies is robust and growing

Since 2011, venture capitalists have invested over \$14 billion (cumulatively) in more than 1,200 companies developing consumer-centric digital/mobile health and related healthcare technologies in the United States.<sup>5</sup> However, the actual amount being invested in the technologies is much higher, because the \$14 billion does not include the internal innovation dollars companies have committed to digital transformation (including the creation of a foundation for advanced analytics).

## EXHIBIT 3 Technology is viewed as more effective for a range of healthcare uses

**Do you think that websites and apps are a more—or less—effective way to perform each of these activities than phone or in-person communication?**

% of all respondents who said they own a digital device



Source: Consumer Health Insights Digital Survey, April 2015

<sup>4</sup>Anderson M. Technology device ownership: 2015. Pew Research Center. October 29, 2015.

<sup>5</sup>Wang T et al. Digital health funding: 2015 year in review. Rock Health. December 2015.

## *Investors appear to be equally interested in direct-to-consumer and intermediated technologies, but for very different reasons.*

The consumer-centric, digital/mobile technologies fall into three categories. About half are aimed directly at consumers (e.g., wearables, scheduling applications, and e-visit tools). Our estimates suggest these technologies received roughly 40% of the more than \$4.5 billion invested in the sector during 2015. Another 40% of the funding focused on technologies consumers would use after a recommendation or prescription from a physician. Examples include medical devices (e.g., remote diagnostic equipment) and personalized medicine enablers (e.g., micro-devices that must be ingested). These technologies are typically more complex than those aimed directly at consumers and need to achieve a higher standard of performance before providers will use them or insurers will pay for them.<sup>6</sup> The remaining 20% of the funding was invested in electronic health records, data analytics, and other technologies beyond the scope of this article.

Thus, investors appear to be equally interested in direct-to-consumer and intermediated technologies, but for very different reasons. Technologies directly addressing consumers' concerns about costs and convenience, and requiring little or no physician involvement, currently have higher awareness and adoption rates, and they are likely to have a less challenging path to

achieving scale. Intermediated technologies present greater cost-reduction potential, given that many of them are designed for patients with chronic conditions. The likelihood these technologies could produce savings sufficient to offset their cost is therefore much higher. Once the value of intermediated technologies is proved, consumers may begin to demand them through their providers.

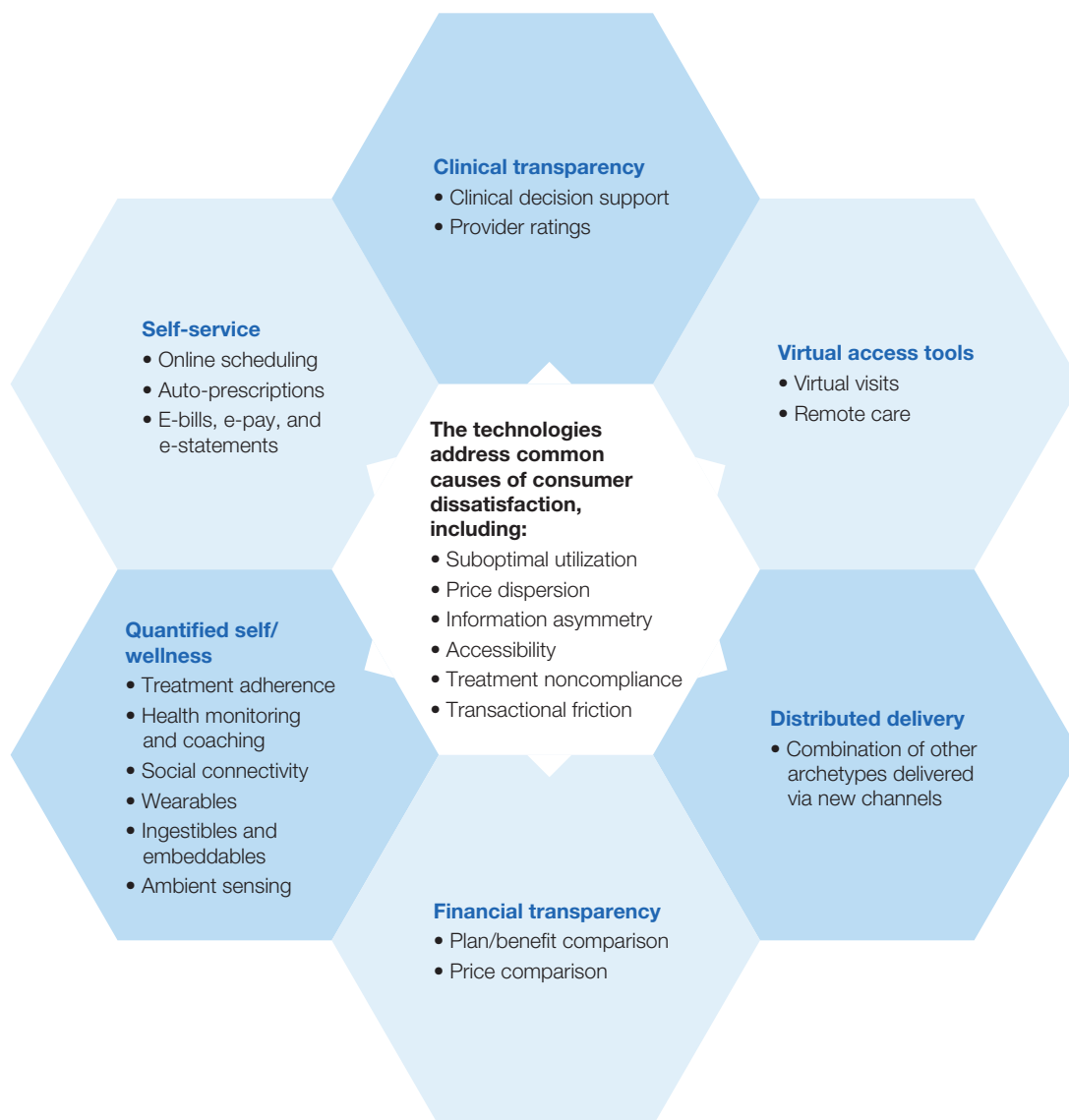
### **New technologies address consumer dissatisfaction**

Consumer-centric digital/mobile health technologies can be grouped into six categories, each of which addresses one or more of the top consumer points of dissatisfaction with the current healthcare system (Exhibit 4). These categories provide a more nuanced way to analyze the technologies' likely impact on health system economics.

- **Self-service tools**, such as online appointment scheduling, prescription auto-renewal, and electronic payment, reduce the transactional friction frequently associated with administrative tasks. At present, about 15% of the companies focusing on direct-to-consumer and intermediated healthcare technologies fall into the category. These companies are likely to see accelerated adoption levels, given consumers' familiarity with the similar tools used in other sectors (e.g., transportation and retail).
- **Quantified self/wellness tools** include technologies that monitor health status or treatment adherence, enable coaching, or provide social connectivity, as well as devices that can be worn, ingested, or embedded in the human body. These technologies have the potential to reduce over- or under-utilization of healthcare services and increase compliance with

<sup>6</sup>For example, the intermediated technologies usually require medical-grade data to support evidence of efficacy, in many cases must undergo peer review, and frequently require regulatory approval.

**EXHIBIT 4 Digital/mobile healthcare technologies can be grouped into six categories**



appropriate treatments. About 20% of the companies concentrate on this area.

- **Clinical transparency tools** decrease information asymmetry and could help consumers use healthcare services more appro-

priately because they offer support for clinical decision making as well as insights into provider performance (e.g., outcomes achieved, adherence to evidenced-based standards). This category includes 25% to 30% of the companies.

- **Financial transparency tools** allow consumers to compare the prices and benefits offered by different insurance plans, as well as the prices charged by different providers for the same service. This information could help direct consumers to lower-cost plans and services and, over the longer term, reduce price dispersion. About 8% to 10% of the companies are active here.
- **Virtual access tools**, which enable remote monitoring and care, as well as e-visits with providers, make healthcare services more accessible and thus have the potential to decrease suboptimal utilization and reduce readmission rates. This category is the focus of 25% to 30% of the companies.
- **Distributed delivery tools** permit the other technologies to be delivered to consumers through multiple channels. Examples include interfacing, messaging, and interoperability-related tools. About 5% to 7% of the companies focus here.

During our interviews, many venture capitalists expressed particular enthusiasm for transparency solutions and virtual access tools. In their opinion, these technologies are the most likely to scale because of their potential value in terms of cost, convenience, or ease of use. Virtual access tools do hold considerable promise—but at present there is little consistent evidence to show they can

sustainably reduce costs or improve patient outcomes at scale.

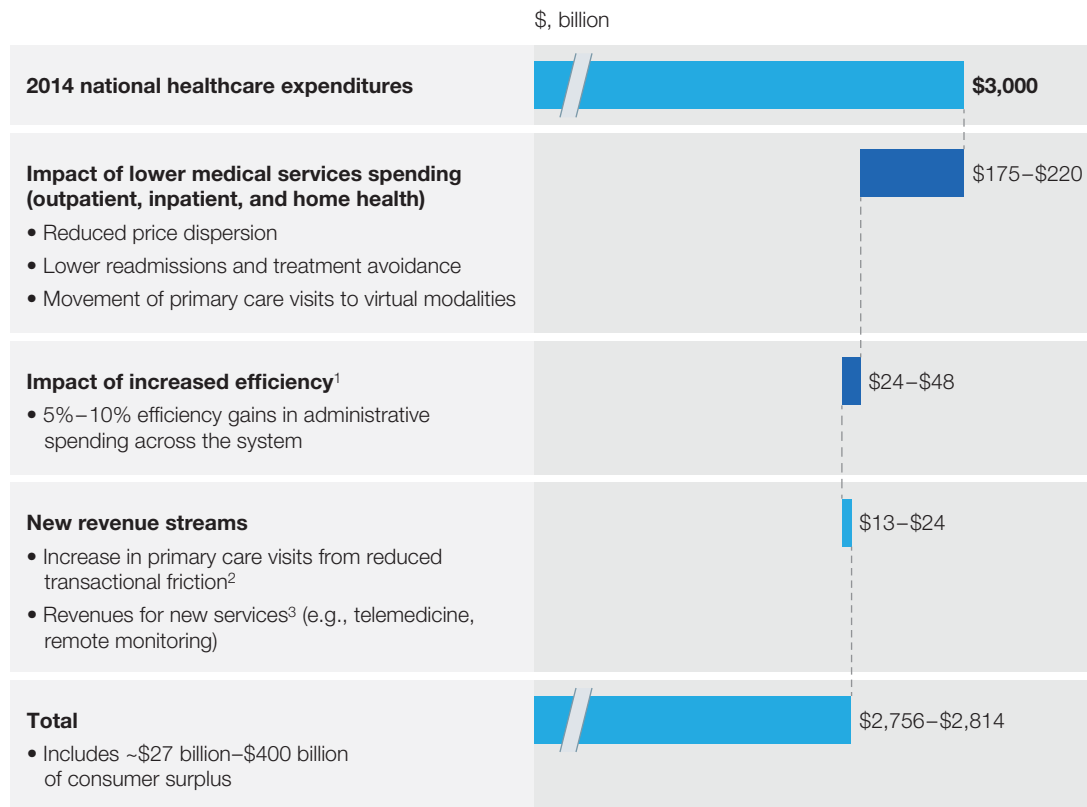
### **Who will pay remains unclear**

The venture capitalists and industry experts we interviewed believe employers, insurers, and providers—not consumers—are likely to pay for most of the technologies. They noted that employers still underwrite a material portion of healthcare spending and are adversely affected by health-related absenteeism and workers' compensation (all of which would decrease if the technologies show a return on investment). Furthermore, employer support would be consistent with a growing trend: companies are giving employees help to make better-informed, more cost-effective decisions while shifting an increased proportion of healthcare costs to them.

The venture capitalists and industry experts also believe that health insurers and providers will pay for some of these technologies. In their opinion, insurers will see the technologies as a way to speed the path to value-based reimbursement. Providers will view them as a way to reduce costs and enhance quality in a fee-for-service world, and to optimize risk and medical utilization under value-based reimbursement arrangements.

In our consumer survey, respondents were more interested in getting digital/mobile health technologies from their health insurers than from their employers or providers.

*The venture capitalists and industry experts we interviewed believe employers, insurers, and providers—not consumers—are likely to pay for most of the technologies.*

**EXHIBIT 5 Almost \$300 billion of healthcare spending could be up for grabs**

<sup>1</sup> Assumes that 5%–10% of total administrative cost (\$480 billion) can be eliminated through greater use of digital.

<sup>2</sup> Assumes that ~60% of currently underserved patients will increase primary care use (in-person or virtual consultations); cost estimates include both the increased primary care use and the incremental utilization (a small proportion of the new patients will need complex treatments or inpatient care).

<sup>3</sup> Includes revenue to companies developing telemedicine services, new monitoring and wellness devices, transparency solutions, and self-service solutions.

Source: McKinsey analysis

However, many respondents said they were willing to pay for the technologies themselves.

### Up to \$292 billion of health sector revenue could be in play

To understand the economic impact the new technologies could have on providers and insurers, we analyzed how each of the six categories could affect three things: demand for and pricing of existing healthcare services; new revenues the technologies

might bring in; and operational efficiencies they might create (Exhibit 5). Our findings are summarized below (for more detail, see the methodology section, “Calculating the financial impact of digital technologies,” which begins on p. 211).

- **Demand and pricing.** The new technologies are not likely to lower demand for primary care services, but they should make it possible to deliver many of those

## Barriers that must be overcome

Before consumers can fully create their own healthcare ecosystems, several barriers need to be overcome. First, consumers' understanding of the overall health system is low, as is their awareness of many digital/mobile health technologies and the value they can provide. However, consumers' awareness of the technologies, at least, is rising rapidly. Second, consumers' concerns about information security remain high; it is the reason cited most frequently by consumers for rejecting digital/mobile health technologies (or for not trusting the entities offering them). Third, many of the technologies are likely to require FDA approval. Clear definitions of which of them do—and do not—require approval must be developed, and streamlined approaches for securing approval must be created (especially for technologies that administer or involve changes in medication). Fourth, providers have to become willing to share the information in patients' electronic health records with other digital record-keeping solutions. (If they refuse to do this, though, consumers may simply opt to find new providers.)

Another barrier is technological. More than 70% of the new entrants we interviewed agreed that before consumers can create their own digitally enabled healthcare ecosystems, one or more integrated solutions are needed: IT platforms that can aggregate the data from various technologies and applications into a single, seamless personal health record enabling consumers to share

their data with providers and insurers when appropriate. No such platform yet exists, but a number of industry players, as well as nontraditional entrants, are vying to develop one.

Within healthcare, we have already seen a comparable platform evolution occur: the emergence of public and private health insurance exchanges. A few years ago, it would have been nearly impossible for consumers to go to a single online marketplace to compare and contrast health plans and select their own coverage options.

During our interviews, most of the new entrants and investors said they expect such platforms to emerge within three to five years. They cited the growing breadth of information aggregation and the consumer engagement capabilities offered by several at-scale players (e.g., health information systems vendors, super-scale revenue cycle management companies, population health managers, healthcare data and analytics organizations, and even telecommunications companies) as evidence of each group's potential to emerge as a platform. The diversity of these players also helps explain why the new entrants and investors believe it is unlikely a single platform winner will appear. Rather, a set of winning platforms will probably be used to address discrete opportunities, such as virtual care, financial transparency and decision support, and information aggregation and sharing.



services less expensively. For example, the average cost of an outpatient physician visit is currently about \$100 to \$150, whereas most e-visits are priced at about \$40. Better monitoring and real-time communication should improve care quality, which could reduce inpatient volumes. By revealing price differences, transparency solutions should lower both inpatient and outpatient costs. As a result, we expect overall healthcare spending to decrease by \$175 billion to \$220 billion. A significant portion of the decrease is likely to accrue to consumers as surplus. How providers and insurers will be affected by the decline in spending will likely depend on how they prepare for the changes ahead.

- **Increased efficiency and productivity.** Administrative costs account for about 16% of total healthcare spending. The increased automation and self-service enabled by new digital/mobile technologies should reduce labor costs and transactional complexities, lowering overall administrative costs by 5% to 10% (\$24 billion to \$48 billion annually). The pervasive use of digital/mobile technologies should also help drive down the current friction associated with healthcare workflows and enhance productivity at the unit level. Most of the savings and productivity gains should accrue to incumbents.
- **New revenue streams.** Although some of the new technologies will be substitutes for more expensive services, others will be new services with new revenue streams. In addition, demand for primary care services is likely to rise once transactional friction is reduced, access is easier, and consumers take a more active role in monitoring their

health status. As a result, \$13 billion to \$24 billion of new revenue could enter the health system. How much of this will accrue to incumbents and how much to technology companies remains to be seen.

## Implications for industry participants

Exactly when consumers will be able to build their own, personal health management ecosystems is unclear; the barriers remain significant (see the sidebar on p. 206, “Barriers that must be overcome”). However, even relatively modest adoption could have enormous implications for insurers and providers. Consider what would happen if benefit designs continue migrating toward greater cost sharing and most consumers eventually pay the majority of their healthcare expenses out of pocket. If these consumers decide to take control of their clinical information, organize their provider networks based on what they value most (e.g., convenience, quality, price), and select their preferred service delivery channels (which could render geographic proximity much less relevant), what would a large, integrated health system offer them, especially if it is perceived as more administratively complex, less responsive, and more expensive? And what value would a traditional insurer offer them, especially one that limits access to certain providers?

*Exactly when consumers will be able to build their own, personal health management ecosystems is unclear; the barriers remain significant.*

In short, more engaged consumers enabled by new digital/mobile health technologies could potentially cause three shifts in industry dynamics:

### **Change in the basis for competitive advantage**

The basis for competitive advantage (and competitive models) could be fundamentally different. In a world of engaged, enabled healthcare consumers, the geographic scope of competition, historically concentrated in metropolitan service areas, would broaden—especially once price and quality transparency tools alert consumers to the existence of higher-value alternatives elsewhere. Greater transparency would also make it easier for disruptors (e.g., retail clinics) to gain market share by making their advantages known to consumers.<sup>7</sup> Consumers seeking greater convenience, superior value, and an enhanced experience will likely want to utilize different service providers at each step in the care continuum, challenging the value proposition of the “fully wired,” yet still not fully integrated, health system.

### **Consumers become clinical data integrators**

Consumers may increasingly own and manage their clinical data, which would allow them to decide for themselves who should be given access to that information (and when) in clinical, transactional, and administrative settings. It would also make it easier for consumers to select and utilize providers they view as more accessible, convenient, and lower cost.

### **Incumbents’ roles shift**

Today, insurers and providers largely control the healthcare experience for consumers. In the future, their control is apt to diminish, which would change the roles they play. Insurers would become holistic risk managers, helping consumers navigate competitive alternatives by advising them on how best to manage their financial accountability and risk preferences. However, new intermediaries may emerge to compete with insurers attempting to play this role. For example, retirement and wealth advisers could integrate health risk assessment and health cost estimation into the advice they give clients.

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## **EXHIBIT 6 Seven steps are needed to prepare for the digital future**

- Boldly reimagine your business model (don’t use technology just to make your current model more efficient)
- Use a comprehensive, integrated approach—not piecemeal initiatives—to develop your connected health strategy
- Restructure your business and consumer value propositions; compete on more than just price
- Build the capabilities to serve “segments of one”
- Structure and manage strategic alliances carefully
- Use dynamic portfolio management mechanisms, especially rapid (three- to six-month) reviews
- Invest not only in technology (e.g., integration platforms and flexible technology architectures), but also in operational and organizational redesign

<sup>7</sup>Retail clinics, which are offering a growing array of primary care and diagnostic services, have experienced a 12% CAGR over the past three years. Their spread could accelerate in a quality- and price-transparent world.

Providers, especially physicians, would become trusted health advisers. They would spend much less time gathering information and performing diagnostic tests and procedures. Instead, they would rebalance some of their time to serve as healing counselors by coaching consumers, helping them make sense of the information already gathered, and when necessary, helping them orchestrate and select among potential treatment options.

## Actions players should contemplate

All industry players will need to evolve their business and operational models to navigate the coming disruption. They will also have to place a premium on strategic audacity and organizational agility—incumbency could shift in a matter of months, not years, in the new digitally enabled healthcare landscape. (Consider: several prominent social media sites have already become obsolete in the personal messaging realm.) We believe seven actions are required (Exhibit 6).

First, the entire business model should be boldly reimaged—digital/mobile technologies should not be deployed just to make the current model marginally more efficient. Without a bold aspiration, any changes made could simply reinforce the status quo. Companies in other industries adapting to digital successfully have taken the opportunity to rethink and reinvent the core principles of their business.

Second, the approach used to create an effective connected health strategy should be comprehensive and integrated, accounting for all stages of the patients' health journey—not a series of random, disconnected

*Winners will be defined by their ability to “know their customers” on a more intimate level than standard market segmentation models allow.*

initiatives. For instance, many health systems are starting to let patients schedule appointments online or track their health vitals through wearables. However, they still don't allow patients to preregister, complete a health risk assessment online, integrate their data into their personal health records, or make payments electronically.

Third, business and consumer value propositions should be restructured to adapt to the new basis of competition. It will become increasingly critical to compete on more than just price in a world where mobile is the dominant source of Internet traffic. Many companies have already found that consumers are often willing to spend more for a superior customer experience.

Fourth, winners will be defined by their ability to “know their customers” on a more intimate level than standard market segmentation models allow. Understanding context is critical for understanding how consumers may behave in a particular health scenario. For example, a physically active consumer who strongly values his or her ability to exercise may behave as a price seeker when shopping for primary care services but could be completely price indifferent, and highly attuned to care quality and outcomes, when looking for an orthopedic surgeon. Assumptions based on traditional consumer demo-

graphic or psychographic profiles will not suffice in a world where “segments of one” are the norm.

Fifth, if incumbents are to take part in the healthcare ecosystems consumers create for themselves, they will need external alliances to ensure they are present where consumers are. Consumers will be easier to influence when the “right choice” for them correlates strongly with their convenience and self-interest. (More than 40 health systems are already affiliated with CVS to make certain both sides have a complete picture of consumers’ health activity and can proactively address their health needs.) Thus, incumbents must have processes for structuring and managing broad alliances.

Sixth, incumbents will need to make frequent trade-offs between physical and digital assets, and the bets they place on new technologies will likely require frequent resource reallocation decisions (three- to six-month review cycles). In a world where technology companies can provide budding entrepreneurs with curated healthcare data, computing infrastructure, and the business intelligence tools needed to launch new businesses “out of the box” in ten days or less and test the viability of their business models at lightning pace, organizations cannot afford to fund digital projects on an annual basis and then sit back and wait for results.

Finally, all industry players will need to think comprehensively about the magnitude of change required to be successful in a digital age. This will require investments not just in technology (resilient and secure systems), but also in operational redesign, culture (including frontline culture), organizational restructuring, governance and oversight mod-

els, and performance management measurements and incentives. Ultimately, technology, in and of itself, is not likely to serve as a sustainable source of competitive advantage. Rather, advantage will come from the ability to create and seamlessly integrate “open” systems of record, systems of insight, and systems engagement.



The healthcare industry is already shifting toward increased consumer control, and new digital/mobile health technologies are likely to hasten the trend. At least \$200 billion of incumbents’ revenue could be at risk, and the healthcare industry’s current emphasis on consolidation could become much less relevant. However, up to \$24 billion in new revenue could enter the healthcare system as well, and much of this money could flow to incumbents if they are agile enough to capture it. We believe the time for incumbent providers and insurers to act is now, because many of their current sources of advantages (e.g., local presence, information asymmetry) may disappear. The impact of engaged, tech-enabled healthcare consumers may not be felt for five to ten years, but by then it may be too late. In other industries, many of the companies that failed to prepare in advance for the impact of digital/mobile technologies lost out to more nimble new entrants. ○

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## Methodology: Calculating the financial impact of digital technologies

To estimate the impact digital/mobile health technologies could have on payor and provider economics, we analyzed three variables: demand for and pricing of existing healthcare services; new revenues the technologies could bring in; and operational efficiencies the technologies might create. We then calculated how much of the potential savings would be achieved through the different technology categories.

### IMPACT ON OVERALL HEALTHCARE SPENDING

#### Demand and pricing

Digital technologies will likely intensify the shift to lower-cost sites of care, and in many cases may replace in-person consultations with virtual modalities. As a result, inpatient and outpatient healthcare spending could decline by as much as \$175 billion to \$220 billion. We anticipate that roughly \$27 billion to \$40 billion of this decline will accrue to consumers as surplus. How much of the remaining decrease will be absorbed by providers, and how much by insurers, is less clear, in part because it will depend on the types of risk-based arrangements used in the future. Three factors will likely account for the majority of the spending decrease:

- **Reduced price dispersion.** Widespread adoption of clinical and financial transparency solutions could narrow price dispersion for both inpatient and outpatient services (similar to the impact online travel platforms have had on airline and hotel pricing). Today, prices for the same health-

care service often vary considerably among providers in the same market—often, by 15% to 60%, but sometimes by 100% or more.<sup>1,2</sup> Admittedly, some of the price dispersion is linked to care setting. However, reducing the dispersion by bringing prices in the top two quartiles for most health services to the 50-percentile price could lower healthcare spending by \$100 billion to \$120 billion.<sup>3</sup>

- **Primary care shifting to virtual modalities.** As awareness of and demand for telemedicine and other virtual services grows, an increasing number of outpatient consultations and home-health visits could be delivered through these modalities. Currently, an average outpatient physician visit costs \$100 to \$150. An average home-health visit is approximately \$100. Most e-visits are offered at about \$40. If 15% to 20% of current outpatient consultations and home-health visits were to occur electronically, healthcare spending could potentially be cut by \$25 billion to \$40 billion.
- **Reduced readmissions and enhanced care quality.** Virtual access technologies that enable remote monitoring and better real-time communication with physicians have the potential to lower the need for outpatient consultations and, especially, inpatient care for high-cost conditions such as diabetes and heart disease. For example, about 20% of patients hospitalized for diabetes are currently readmitted within 30 days<sup>4</sup>; lowering the readmission rate could produce considerable savings.

<sup>1</sup>Castlight Health. Costliest cities 2015.

<sup>2</sup>Health Care Pricing Project. The price ain't right? Hospital prices and healthcare spending on the privately insured.

<sup>3</sup>We excluded emergency room, acute inpatient, and high-intensity chronic care services from this analysis because it is unlikely that the price dispersion for these very costly services could be reduced as significantly.

<sup>4</sup>Robbins JM, Webb DA. Diagnosing diabetes and preventing re-hospitalizations: the urban diabetes study. *Medical Care*. 2006; 44:292–296.

## Methodology *(continued)*

At present, few studies have been able to show that remote monitoring tools can reduce hospitalization rates, but the field is developing rapidly. If the data from these tools can be easily integrated with clinical records, it should be possible to offer proactive interventions that might prevent the need for many admissions and readmissions. How soon this will occur and how effective the interventions will be remain unknown, however. Thus, we took a conservative approach to estimate impact but acknowledge that actual impact could prove to be much higher. We analyzed the 20 conditions that together account for about 80% of the total healthcare spending (as identified through the Medical Expenditures Panel Survey),<sup>5</sup> and we assumed that the effect the technologies could have on treatment avoidance and inpatient volumes is likely to vary by condition. Our findings suggest that in the near to medium term, the aggregate reduction in spending could be between \$50 billion and \$60 billion, driven primarily by a 5% to 15% reduction in inpatient volumes.

### Increased efficiency across the system

Administrative costs are currently estimated to account for about 16% of total healthcare spend annually (i.e., \$480 billion). Digital/mobile technologies could allow some processes to be automated and help increase the use of self-service, thereby reducing labor costs and transactional complexities. For example, we have found that the average cost to a health system

of sending and processing a paper statement is about \$5 to \$6. Electronic bill presentment and self-pay solutions targeted to consumers can lower this cost by more than 50% while giving consumers a superior payment experience and helping providers get paid faster. At the system level, the increased efficiency could lower administrative costs by 5% to 10% and generate \$24 billion to \$48 billion in efficiency gains.

### New revenue streams

Offsetting the reduction in inpatient and outpatient spending will be the costs associated with the new, digitally enabled health services, which will likely result in \$13 billion to \$24 billion in new consumption. Two factors will account for most of the spending:

- Increase in primary care visits from reduced transactional friction.** Healthcare utilization is likely to grow as self-service tools become more widely available, digital marketing campaigns raise awareness, and consumers find it easier to locate and access health services digitally. For example, the availability of e-visits for basic health consultations would give consumers greater choice and make possible services that previously were difficult or, in some cases, impossible to obtain. Online scheduling solutions would further increase choice and convenience. Although this trend will affect all consumers, the greatest impact will likely be seen among the 50 million Americans who currently do not seek healthcare services<sup>6</sup> and, to a lesser extent, the

<sup>5</sup>Cohen SB. The concentration of health care expenditures and related expenses for costly medical conditions, 2012. AHRQ Medical Expenditures Panel Survey. October 2014.

<sup>6</sup>Defined as those who have not visited a physician within the past 12 months.

150 million people who use those services at a lower-than-average rate for their age group.<sup>7</sup> If digital/mobile health technologies encourage 20% to 30% of these two groups to increase just their primary care utilization to the mean level, about \$8 billion in incremental healthcare spending will result. If we further assume that 3% to 5% of this subset will need additional healthcare services (e.g., complex treatments delivered by specialists or inpatient care), incremental spending could reach \$10 billion to \$20 billion.

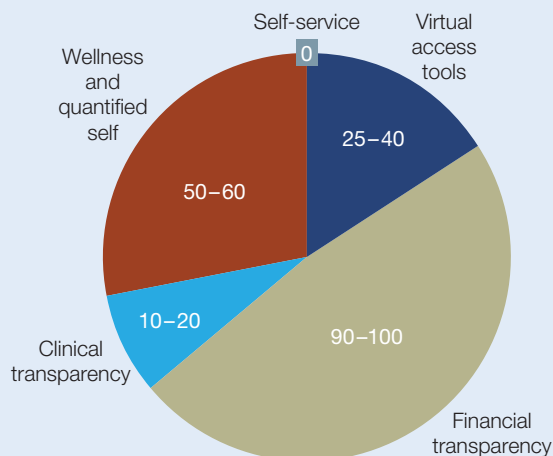
• **Revenue from new services.** As adoption rates for digital/mobile health technologies grow and revenue models mature, new classes of services—including telemedicine, self-service, and personal diagnostic and medical devices—will likely produce new revenue streams. We estimate that these services could generate between \$20 billion and \$25 billion in annual spending. Much of this money will not be new revenue but rather substitute spending for money saved elsewhere (e.g., the cost of a remote monitoring system would

## EXHIBIT Digital/mobile health technologies differ in their likely economic impact

### Types of technologies that will likely account for...

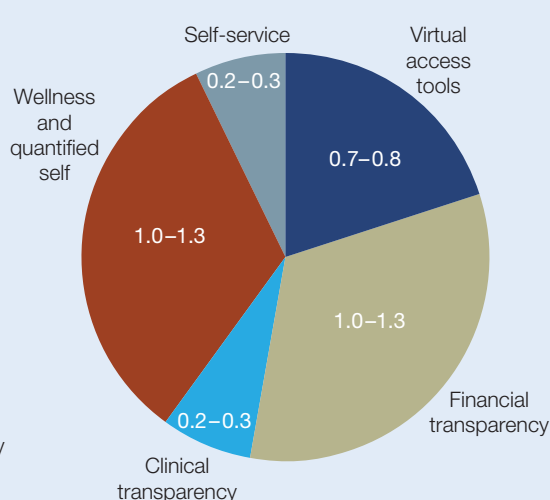
... \$175 billion–\$220 billion reduction in health expenditures

\$, billion



... \$3 billion–\$4 billion of new revenue that could go to technology companies

\$, billion



Source: McKinsey analysis

<sup>7</sup>Centers for Disease Control and Prevention. Health, United States, 2014. Table 71.



## Methodology *(continued)*

partially offset any savings achieved from remote monitoring). We estimate, however, that about 15% of the money—perhaps \$3 billion to \$4 billion—will be new revenue that will likely accrue to new digital/mobile service providers (unless they are wholly owned by incumbent health systems). Where the remainder will go will depend on a number of factors, most notably what amount of risk is transferred to providers.

### IMPACT BY TECHNOLOGY CATEGORY

The exhibit on p. 213 illustrates which of the six categories of digital/mobile health technologies are likely to have the greatest impact on the revenue of healthcare industry incumbents, as well as where the \$3 billion to \$4 billion that is likely to accrue to new technology players is likely to go.

- **Financial transparency tools** (and, to a lesser extent, clinical transparency tools) are likely to produce the largest shifts in

incumbent revenues, since they could reduce price dispersion. They would not have any significant impact on how healthcare is delivered, however.

- **Quantified-self/wellness and virtual access tools** could encourage many consumers to better manage their own health, which has the potential to reduce the need for expensive and often unnecessary health services (e.g., emergency room visits for common health conditions) and lower the readmission rate. At the same time, the heightened awareness of health status these tools give consumers will likely increase demand for primary care services.
- **Accessibility and self-service tools** could accelerate primary care demand by making it easier and quicker to obtain care. Self-service technologies could also help reduce administrative costs, bringing healthcare closer to other mature industry sectors that employ similar technologies.

# Why digital transformation should be a strategic priority for health insurers

*Digital technologies and applications have the potential to markedly enhance a health insurer's profits. Leadership from the top is necessary to overcome the organizational resistance to change that can make a digital transformation difficult.*

Why should senior health insurance leaders make “digital” a strategic priority? Many leaders may be tempted to relegate digital initiatives to their IT departments, or to small teams that have historically dealt with topics like digital marketing, but this would be a mistake. When executed well, these initiatives can achieve substantial, near-term SG&A cost savings and give payors a much more solid footing from which to face the future. Over the longer term, they may also be able to decrease spending on medical services. In addition, digital initiatives can serve as a catalyst to organizational transformation. Given current margin pressures and ongoing industry changes, payors face a strategic imperative to consider fundamental changes to their operating model. Digital initiatives can help payors reimagine their business processes and customer engagement techniques, and enable them to make the needed changes.

By “digital,” we mean the broad range of technologies and applications that enable more efficient automation, better decision making, stronger connectivity with customers and other external stakeholders, and more advanced data-driven innovations. These technologies, together with business process redesign, make possible a new way of working that can fundamentally transform a payor organization. For decades, productivity has improved far more slowly in the healthcare industry than in other sectors. Most payors are only begin-

ning to adopt customer-centric thinking, prompted by the consumerization of health insurance. New, highly agile, digitally native firms are entering the market and could significantly disrupt existing business models.

To understand how severe the disruption could be, consider the music industry (Exhibit 1). Revenues have plummeted as distribution has shifted to downloads and streaming, and much of the remaining revenues have gone to new players. What may be most interesting about this example is that it took about five years from the time Napster was launched until industry revenues were cut in half, which gave some incumbent record label executives a false sense of security.

Other sectors are being affected by digital disruption. Uber is upending the taxi industry. Airbnb is threatening hotel revenues. Netflix, Hulu, and similar services have radically changed TV industry dynamics.

Furthermore, we have seen digital disrupt heavily regulated industries that are more analogous to health insurance, including financial services. For example, property and casualty insurance (P&C) has seen the rise of digital disruptors such as Progressive and Geico, which have driven what had traditionally been a broker-led sale to a much more direct-distribution industry (about 40% of P&C insurance purchases are now made online without human inter-

**Basel Kayyali,  
Steve Kelly, and  
Madhu Pawar**

vention). Similarly, personal/retail finance has been disrupted by digital. Many digitally native companies (e.g., Voya, previously known as ING Direct) have gained significant market share despite not having traditional “brick and mortar” assets. In the process, they have fundamentally changed consumer buying behaviors—for example, 34% of consumers now use mobile apps for personal finance. As the US healthcare industry makes the B2B to B2C transition driven by healthcare reform and aging demographics, is there any reason to think that health insurance will be different?

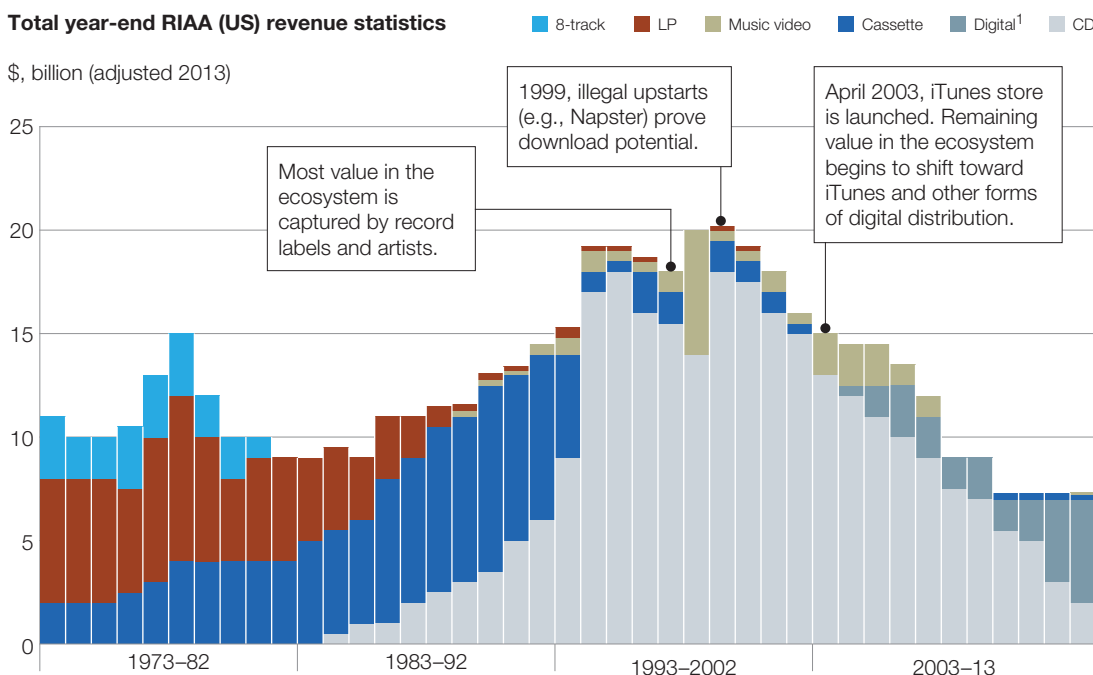
Some senior payor executives are beginning to grasp the significance of digital for their

organizations. McKinsey’s recent Digital Enablement Survey, for example, shows that they are devoting an increasing proportion of the IT budget to building digital capabilities rather than supporting core IT infrastructure (e.g., claims processing systems). Our forecasts suggest that digital transformation will account for more than 50% of their strategic IT budgets within the next three to five years.

We believe, however, that most payor executives need to think bigger and move faster. Digital should be at or near the top of their strategic priorities, and CEOs should proactively champion digital transformation. We also believe that the time

## EXHIBIT 1 Digital dramatically shifted value among music industry participants

### Total year-end RIAA (US) revenue statistics



<sup>1</sup>Includes synchronization, on-demand streaming (ad-supported and paid subscription), ringtones, kiosks, downloaded music videos, downloaded albums, and downloaded singles.

Source: Recording Industry Association of America (RIAA)

is right to take significant action. In many industries (not just music), there has been a delay of about four or five years from the time a new digital technology is launched to the time its disruptive effects become apparent. The delay results largely from two factors: the speed at which consumer behavior changes and the time until the huge scale advantages that digital can provide take hold (not only economies of scale but also the impact of having a large participant network). Both factors eventually reach a tipping point, and the subsequent changes can be dramatic. As many other industries have discovered, incumbents that can get ahead of the changes can create a strong competitive advantage and gain considerable value. Most of the other incumbents are significantly disadvantaged; some may have to exit the market. Thus, the delay in impact should not lull payor executives into a false sense of security. If they wait until the disruptive effects of digital are more noticeable, it may be too late to change course.

## How digital can help payors

To derive maximum benefit from digital, payors should learn to view it not as a *thing* but as a *way of working*—that is, as a way of thinking about and running their businesses. Digital can have a significant positive impact on payor economics, primarily through four levers:

**Stronger connectivity.** Digital gives payors new ways to engage with all stakeholders. For example, it can be used to improve the *consumer* experience by simplifying the buying process and making it easier for consumers to select the right product.

In addition, it can provide tools to help steer consumers to the lowest-cost high-quality provider, thereby optimizing the care setting for their needs and enabling them to better manage their health. In today's world, any payor that wants to connect with consumers must include social media and online channels as a core part of its strategy. In addition, payors must accept that the expectations of today's consumers are increasingly being set by their experiences in other sectors.

However, digital also enables payors to engage more effectively with *providers*. For example, payors can give the providers more sophisticated, digitally enabled tools to manage the population health of their patient panel, as well as clearer methods for gauging the quality of care delivery. Digital also enables better collaboration and data sharing with providers, which supports more effective care coordination.

**Greater efficiency and automation.** Digital can do far more than enable payors to optimize their current processes. It makes possible automations that allow them to radically reimagine workflows. Think of all the things that digital can do today that it could not do even five years ago—and then think about how you might build new, vastly more efficient workflows using a clean-sheet design approach. Many of the processes payors currently use have resulted from a series of small decisions made over many years. There is no reason most of those processes need to be that complicated. Digital makes it feasible to design minimally viable processes based on the end-to-end journeys taken by external stakeholders (see below for more details).

**Better decision making.** Digital also includes advanced analytics and big data insights. Without digital, it becomes far more difficult—if not impossible—to implement value-based reimbursements and other payment innovations. Population health management also depends on advanced analytics. In addition, digital enables payors to optimize their networks at a highly atomized level and to design more attractive (and profitable) products that cater to the needs of a given demographic, area, or segment. To understand the impact advanced analytics can have, consider the auto insurance industry. Years ago, a few companies (e.g., Progressive, GEICO) gave themselves a source of advantage by using advanced analytics and segmentation to better understand customers and risks. As a result, these companies outperformed the industry and took significant share from competitors.

**More advanced innovation.** Finally, digital enables payors to think more broadly about business model and care delivery innovations. For example, it can help payors envision new approaches to care delivery that have the potential to hold down costs (e.g., wearables that monitor the health status of patients with chronic conditions, telemedicine “virtual visits” that reduce the need for in-person physician consultations). Digital can also make healthcare more accessible by giving patients easy access to their medical history and help them locate nearby clinicians, specialists, and facilities.

By combining these four levers, payors can achieve significant impact. One large payor, for example, decided to completely

“clean sheet” its member sign-up process/ journey after it discovered that it was swamped dealing with enrollments in the individual market. The payor began by using customer-centric design (supported by advanced analytics) to permit consumers to start and complete the sign-up process online. Thanks to digital automation, the new process entails considerably fewer steps than the old one did. The payor also used advanced analytics to predict when human intervention was likely to be needed during auto-enrollment so that customers were not inadvertently lost. The result: the defect escape rate was reduced by 80%, and the cycle time by 50%. Overall spending on customer sign-up was lowered by 30% to 50%.

## Financial impact of digital transformation

Payors that employ the four levers could achieve a large near-term reduction in SG&A costs. The exact amount would vary from payor to payor, given the broad dispersion in individual carriers’ per-member administrative spending. We estimate that, on average, payors would save roughly 10% to 15% of their SG&A costs—\$15 billion to \$25 billion industry-wide.<sup>1</sup>

Over the longer term, we believe that digital could significantly decrease spending on medical services. Most of the savings would come from the substitution of lower-cost services for more expensive alternatives. (Remote monitoring and virtual visits, for example, could decrease the need for in-person consultations.) In addition, digital transparency tools that inform consumers about variations in provider pricing could

<sup>1</sup> Payors’ administrative savings were calculated as follows: About half of the US’s \$3 trillion in annual spending on healthcare flows through non-governmental payors. Administrative expenses account for 10% to 11% of that \$1,500 billion, or \$150 billion to \$165 billion. If that amount, in turn, is reduced by 10% to 15%, the savings would be between \$15 billion and \$25 billion.

encourage them to seek out lower-cost providers. Utilization of primary care services is likely to rise (as would spending for those services), but we estimate that the increase in costs would be more than offset by lower utilization of more expensive services. (For example, by making it easier for patients to access healthcare, digital technologies could improve patient outcomes and lower the rate of hospital admissions and readmissions.) Consumers will be the primary beneficiaries of the lower spending, but some of the savings will accrue to payors and providers.

The size of the potential prize helps explain why venture capital investments in digital health more than quadrupled between 2011 and 2015 (from \$1.1 billion annually to \$4.5 billion).<sup>2</sup> No other investment category has seen an increase of this magnitude since the dot-com era in the late 1990s. At present, more than 1,200 companies are working on innovations for the healthcare industry. Many of these companies are looking to partner with incumbent payors and providers—but many are also targeting pure-play disruption.

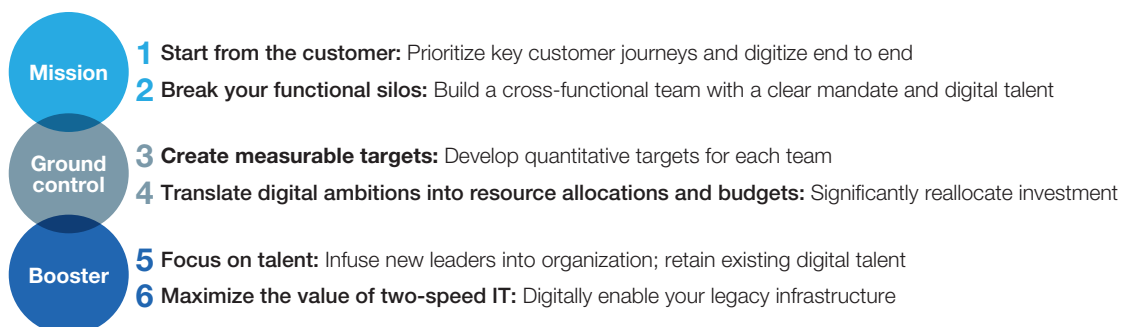
## Using digital for organizational transformation

Today, most health insurance companies are siloed organizations that have been optimized for specialization and efficiency in performing current processes (in essence, the companies use a divide-and-conquer approach). As a result, most employees find it very hard to challenge the status quo and suggest new ways of working. All too often, business unit leaders are highly resistant to innovation and cross-functional collaboration is difficult.

Only very senior leaders—especially the CEO—can ensure that the new way of working enabled by digital is embedded across the organization, a prerequisite for achieving maximum impact. And only very senior leaders can decide what the ultimate goals should be. Do they want to use digital to diversify their company? Completely transform the core organization? Something else?

Once senior leaders have prioritized their goals, six specific actions can help them get the effort going (Exhibit 2).

### EXHIBIT 2 Six steps help get the digital transformation going



Source: McKinsey Healthcare Technology Practice

<sup>2</sup>Wang T et al. Digital health funding: 2015 year in review. Rock Health. December 2015.

### Start from the customer

Senior leaders should begin by understanding the key journeys taken by their external stakeholders—consumers, providers, employers, and brokers (Exhibit 3). A journey is the end-to-end experience someone has as she or he navigates a particular activity. Journeys that can be digitized for health insurance consumers include enrollment, billing, claims submissions/processing, and issue resolution. For both payors and providers, digital analytics can enhance care management, value-based reimbursement, and performance evaluations. Digital approaches can also make it easier for payors to credential providers, design networks, and improve reporting to providers, employers, and brokers.

Once leaders have identified the journeys their customers take, they should determine which of those journeys should be prioritized. Prioritization helps keep the entire organization focused on a limited set of crucial changes. It also helps ensure that important projects are funded adequately. To prioritize, start by considering two variables: which journey redesigns are likely to produce the most value and which ones are most likely to succeed. (The success of one project helps break down resistance to other redesigns.) Then, consider which managers are open to change and where resistance is highest in the organization. Once the prioritized journeys have been selected, all steps within them should be digitized to the fullest extent possible.

### EXHIBIT 3 Eight customer journeys matter most for payors

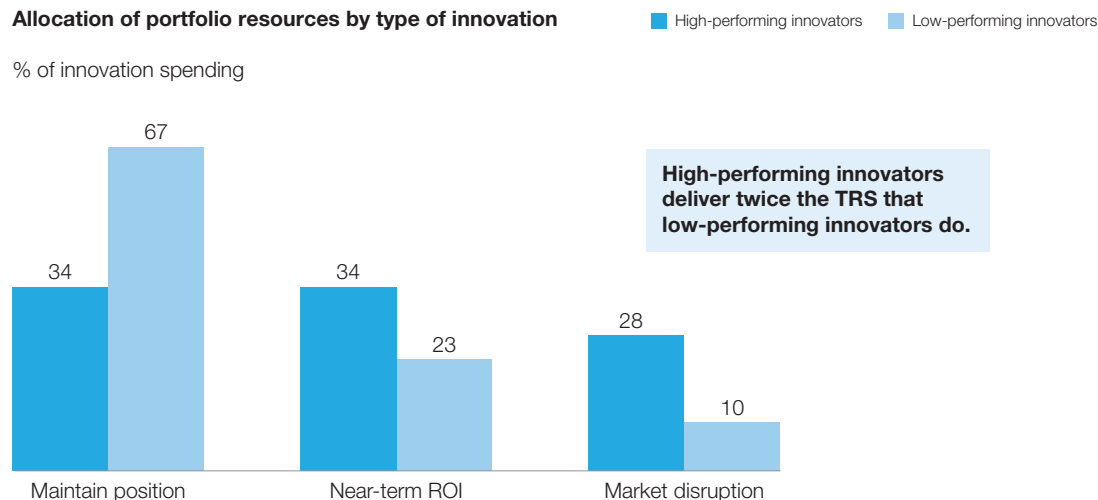
Journey	Activities
Increase consumer awareness	Product education, consideration, and evaluation
Enroll consumers	Inquiry, quote-to-card, and billing
Solve problems	Customer/broker issue resolution, provider servicing
Pay what's owed	Claims processing, broker commissions
Analyze and report data	Employer and broker reporting/analytics
Help members take control	Member care management and wellness initiatives
Help providers deliver better care	Provider healthcare value programs and performance review
Optimize the provider network	Provider credentialing and network design

Source: McKinsey Healthcare Technology Practice



#### EXHIBIT 4 High-performing innovators shift spending to capitalize on market disruptions

##### Allocation of portfolio resources by type of innovation



ROI, return on investment; TRS, total return to shareholders.

Source: McKinsey Global Survey on Innovation 2014

#### Break your functional silos

The next step is to build a cross-functional team for each prioritized customer journey and encourage an extraordinary level of cross-functional collaboration. In most cases, the team will include representatives from multiple divisions. Google, for example, built Google Drive, its cloud storage service, by staffing a team with representatives from marketing and sales as well as engineering and IT.

The cross-functional teams should have a clear mandate for change. These teams are important for redesigning the prioritized journeys, and they are also a key element in changing organizational mind-sets. For a typical payor journey, up to five or six different groups within the organization, including operations, IT, sales operations, and business segments, should collaborate on a clean-sheet redesign.

#### Create measurable targets

Once the teams are set up, senior leaders should challenge them by setting goals that, at face value, may appear to be inconsistent. Stress that the overall goal for each team is a complete redesign of all steps in the journey, but also emphasize that the redesign should result in a minimally viable product. In other words, both the journey and product should be kept as simple as possible and focused on customers' most important needs.

In addition, senior leaders should set bold quantitative targets (e.g., a 30% to 40% improvement in productivity or a 50% or greater improvement in cycle time and quality) for each team to push the possibilities of what a clean-sheet design can accomplish. They can then measure progress against those targets on a quarterly basis. Progress should have a strong influence on resource allocations.

### **Translate digital ambitions into resource allocations**

Most companies establish their capital budgets each year by adding similar percentage increases to each line of the previous year's budget. This approach is not compatible with true digital transformation. This is not to say, however, that the IT budget needs to increase dramatically. Rather, money in the existing budget should be shifted toward the prioritized digital investments.

A global survey McKinsey recently conducted showed that high-performing innovators devoted about two-thirds of their innovation budgets to market disruptions and near-term ROI (Exhibit 4).<sup>3</sup> In contrast, low-performing innovators spent two-thirds of those budgets on maintaining their current processes. The high-performing innovators produced twice the total return to shareholders as the low performers did.

The implications are clear: to reap maximum benefits from digital, companies have to reallocate a significant portion of their budgets to digital innovations focused on a small number of the highest-priority journeys.

### **Focus on talent**

Digital transformation involves new ways of working and thinking. Senior leaders should take concrete steps to ensure that their organizations have the necessary digital talent by identifying and retaining existing talent and bringing new talent in the door. As in most transformations, there will be some nay-sayers and blockers who resist the changes; these people should not remain on the digital transformation team.

### **Maximize the value of two-speed IT**

It is not realistic—or appropriate—for a payor to jettison all of its legacy IT infrastructure when beginning the move toward digital transformation. Two goals should be pursued instead: to adapt as much of that infrastructure as possible so it can support new digital approaches, and to find methods that would allow new projects to “fail fast” (within months, not years). This way, unsuccessful innovations are abandoned rapidly and successful innovations are identified and scaled up. A staged approach can be used to achieve both goals.

First, payors should build a digital foundation by designing new services for easy consumption. These new services should standardize the existing data models within the company's fragmented legacy infrastructure. In addition, the services should make it possible to quickly integrate new applications with the legacy infrastructure by creating standard services-based interfaces. (These interfaces can avoid point-to-point integrations between the applications and legacy infrastructure.) This approach would dramatically increase the speed with which new digital capabilities can be embedded into the IT environment while reducing the integration and testing costs that can make it cost-prohibitive to experiment and fail fast. Investments will still be needed, but development time and resource requirements can be reduced by creating minimal viable products initially. (Using a minimal-viable-product approach and services-based architecture, Amazon was able to take Prime from concept to launch in six weeks.) Additional investments can then be made to improve products that show

<sup>3</sup>McKinsey Global Survey on Innovation 2014.

solid signs of success. At the same time, companies should leverage their legacy infrastructure wherever possible to maximize the ROI on those systems, but start cutting back on new investments in the legacy infrastructure.

Next, companies should accelerate the shift from old to new by increasing the amount of money allocated to new systems and services. Continuing investments in old systems should be made only if those systems can be upgraded or modernized (at reasonable cost) to meet the needs of the new digital approaches. Eventually, older systems can be retired if they cannot be made capable of changing at the speed digital transformation requires.



For payors, the business case for digitization is strong. Not only can it improve financial performance in the short term, but over the long term it holds the key to increasing consumer satisfaction and fending off attacks from new entrants. The payor industry's net promoter scores (which gauge customer satisfaction) have historically been poor, but there is no reason these scores cannot

equal or exceed those of leading consumer companies. What is the danger of not focusing on these goals? Innovators saw that the cable/pay TV industry had high revenues but very poor customer satisfaction ratings. They used digital not only to design new products but to reimagine how those products could be delivered. The result: direct TV companies are experiencing a rapid rise in market share and valuation. Cable and pay TV companies are scrambling to respond.

The attention of senior leaders can help payors avoid the same fate. The six steps described above can enable payors to embrace digital transformation and move down a path toward a successful future. ○

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CAPABILITIES FOR SUCCESS:  
Organization







# Why agility is imperative for healthcare organizations

*A new concept, organizational agility, can help healthcare companies adapt more quickly to changing customer needs, competitor responses, and regulatory guidelines—without requiring a full-scale restructuring.*

*Imagine this scenario: your organization needs to adhere to new regulatory requirements, and you have been asked to join a meeting to discuss immediate action plans. Soon after the meeting begins, you sense it will be similar to a conversation many of you have had before—yet key perspectives are missing from the room, and there is no clarity on who is driving the decision making or who will be responsible for implementation. Even worse, you anticipate having a similar discussion in a different meeting with another group (with some overlap of members) in the near future.*

*Now imagine walking into a meeting where all relevant stakeholders are present. As you sit down, you are confident that all prior decisions will be considered and built upon. You are also sure that all participants will know from the outset which decisions the group can make, who specifically will be driving decision making, who has accountability for the overall project, and which individuals across the organization will be responsible for implementing key near-term actions.*

*The contrast between these scenarios demonstrates the power of agility, an approach that enables organizations to be responsive, nimble, and better able to seize opportunities in a rapidly changing external environment. While few healthcare organizations are truly agile today, agility will be an increasingly*

*critical capability moving forward, given the industry's turbulence, complexity, and accelerating speed of change. In this environment, healthcare leaders must choose: spearhead the pursuit of greater agility or risk being left behind.*



Many payors and providers have struggled to keep pace with an ever-changing business landscape. Thus, the pursuit of agility—an organization's ability to adapt quickly and successfully in the face of rapid change—has taken on increased importance.<sup>1</sup> In numerous industries, the companies thriving most have managed to crack the paradox of agility, balancing a stable foundation of core processes and capabilities with the ability to dynamically redeploy those capabilities to address emerging challenges and opportunities. Both stability and dynamism are needed to excel—companies that get the mix wrong can find themselves either drowning in chaos or saddled with a bureaucracy that leaves them unable to respond to changing market conditions.

The concept of agility is especially relevant to healthcare, which has endured tremendous upheaval in recent years. The industry continues to see strong growth in M&A, the ownership of physician practices by healthcare organizations, and the adoption of value-based care arrangements. Consumers have become increasingly empowered in making care

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<sup>1</sup>For more information about agility and how businesses are adapting their organizations to become more agile, see these two articles: Aghina W, De Smet A, Weerda K. Agility: It rhymes with stability. McKinsey Quarterly. December 2015. Bazigos M, De Smet A, Gagnon C. Why agility pays. McKinsey Quarterly. December 2015.



*Although the healthcare industry has been slower than many of its counterparts to embrace agility, payors and providers are particularly well suited to benefit from it.*

decisions. Financial and regulatory pressures have grown. And further changes are likely given the outcome of the 2016 election.

Although the healthcare industry has been slower than many of its counterparts to embrace agility, payors and providers are particularly well suited to benefit from it. An examination of how companies in other industries have transformed their operations demonstrates the far-reaching advantages. Healthcare organizations can begin unlocking this potential by assessing their current degree of agility and then creating a road map to integrate agility throughout their enterprise. By building the capacity to respond to change more effectively, both payors and providers will be better positioned to survive in the years ahead.

### Why agility is critical for healthcare

The concept of agility stretches back more than a century, with organizations from the US military to Japanese manufacturers serving as evangelists. More recently, the software development industry grasped the power of agility, and the concept has spread to application development functions within more traditional industries. In some companies, bureaucracy had so slowed product development cycles that businesses were investing hundreds of millions on major IT applications only to find that evolving cus-

tomers' needs had rendered the applications obsolete by the time of release. An agile development process, as espoused by Jim Highsmith in his 2000 book *Adaptive Software Development*, has enabled companies to work faster and more collaboratively to reduce the time to market for new products.<sup>2</sup>

Research by McKinsey's Organization Practice has shown that agility combines a stable backbone with dynamism. Truly agile companies (those in the upper right quadrant in Exhibit 1) are characterized by resilience, quick decision making, and empowerment to act. The other three quadrants reflect varying imbalances between stability and dynamism. Companies that are weak on both attributes typically lack the coordination and leadership to seize opportunities. Bureaucratic organizations are often so slow to adapt to changes that they find they must pursue a fairly disruptive organizational restructuring every two or three years, just to keep up with changes in the market.<sup>3</sup>

Agility can help payors and providers take on not only the industry's ongoing uncertainties, but also more tactical challenges, such as:

- Pursuing new alignment models and innovative partnerships to foster growth
- Investing in functions or products that enable market differentiation
- Increasing efficiency and reducing costs by improving productivity, without losing local responsiveness to customer needs

<sup>2</sup>Highsmith J. *Adaptive Software Development: A Collaborative Approach to Managing Complex Systems*. Dorset House Publishing. 2000.

<sup>3</sup>Aronowitz S, De Smet A, McGinty D. Getting organizational redesign right. *McKinsey Quarterly*. June 2015.

- Improving performance transparency in both clinical and nonclinical areas
- Empowering frontline staff to meet evolving consumer preferences and needs more readily

In short, agility can enable healthcare companies to adapt quickly without requiring a full-scale redesign. Change becomes part

of the norm (rather than a disruption that seems to crop up randomly every other year), and it evolves fluidly and naturally—often bottom-up, without intervention from the top. By developing the ongoing capacity to change, healthcare companies can acquire the flexibility and dynamism needed to respond as the landscape shifts.

### EXHIBIT 1 Organizational agility is the right balance of stable backbone and dynamic capabilities

Place a check mark by every word that describes how it currently feels to work at your company. Total the number checked in each quadrant to see where your company falls.

Dynamic capability	Strong	<b>“Start-up”</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Start-up</li> <li><input type="checkbox"/> Chaos</li> <li><input type="checkbox"/> Creative</li> <li><input type="checkbox"/> Frenetic</li> <li><input type="checkbox"/> “Free for all”</li> <li><input type="checkbox"/> Ad hoc</li> <li><input type="checkbox"/> Reinventing the wheel</li> <li><input type="checkbox"/> No boundaries</li> <li><input type="checkbox"/> Constantly shifting focus</li> <li><input type="checkbox"/> Unpredictable</li> <li><input type="checkbox"/> Total</li> </ul>	<b>Agility</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Quick to mobilize</li> <li><input type="checkbox"/> Nimble</li> <li><input type="checkbox"/> Collaborative</li> <li><input type="checkbox"/> Easy to get things done</li> <li><input type="checkbox"/> Responsive</li> <li><input type="checkbox"/> Free flow of information</li> <li><input type="checkbox"/> Quick decision making</li> <li><input type="checkbox"/> Empowered to act</li> <li><input type="checkbox"/> Resilient</li> <li><input type="checkbox"/> Learn from failures</li> <li><input type="checkbox"/> Total</li> </ul>	
		<b>Trapped</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Uncoordinated</li> <li><input type="checkbox"/> Stuck</li> <li><input type="checkbox"/> Empire building</li> <li><input type="checkbox"/> Fighting fires</li> <li><input type="checkbox"/> Local tribes</li> <li><input type="checkbox"/> Finger pointing</li> <li><input type="checkbox"/> Under attack</li> <li><input type="checkbox"/> Rigid</li> <li><input type="checkbox"/> Politics</li> <li><input type="checkbox"/> Protecting “turf”</li> <li><input type="checkbox"/> Total</li> </ul>	<b>Bureaucracy</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Risk averse</li> <li><input type="checkbox"/> Efficient</li> <li><input type="checkbox"/> Slow</li> <li><input type="checkbox"/> Bureaucratic</li> <li><input type="checkbox"/> Standard ways of working</li> <li><input type="checkbox"/> Siloed</li> <li><input type="checkbox"/> Decision escalation</li> <li><input type="checkbox"/> Reliable</li> <li><input type="checkbox"/> Centralized</li> <li><input type="checkbox"/> Established</li> <li><input type="checkbox"/> Total</li> </ul>	
		Weak	Weak	Strong
		Stable backbone		

Source: McKinsey Organization Practice

## What healthcare can learn from other industries

Truly agile organizations have a core set of processes and capabilities (e.g., working norms, centers of excellence) that are located centrally and managed consistently throughout the organization. However, they are able to adapt those processes and capabilities quickly so they can respond to a wide range of new challenges, often through a cross-functional approach. To accomplish this, some companies have “de-coupled” the managerial hierarchy from how day-to-day work is directed. For instance, a strong functional group might hire, train, evaluate, and promote a large team of people, but team members may be “rented” to businesses or projects, often on a temporary basis. By creating efficient internal talent markets, the organizations ensure that people can then be quickly redeployed to new challenges and opportunities. With this approach, a key enabler of agility is the fact that the business/project leaders set priorities and direct day-to-day work, but may not be “the boss” according to the organizational chart.

Similarly, in an agile organization, objectives, metrics, targets, and decision rights tend to be organized horizontally across end-to-end processes focused on value creation and customer experience. In non-agile organizations, by contrast, these activities strictly follow the managerial hierarchy, with targets cascaded down and decision making escalating up the formal chain of command.

In an agile organization, the end-to-end processes tend to be stable, as are the functional “homes” where most people

officially report on the org chart. Similarly, at least some of the cultural norms required to empower the flexible, cross-functional teams are stable. These features undergo only slow, incremental changes over time. However, decision making, daily priorities, the allocation and re-allocation of resources, and the company’s collective response to customers and market demands are set up to be extremely fast, fluid, and dynamic.

Most healthcare organizations have a stable set of processes and capabilities because such a backbone is essential for effective operations. Payors, for example, must be able to execute a range of core operational processes, such as claims handling, provider contract negotiations, and regulatory compliance. Providers must follow formal procedures to promote high-quality patient care, handle patient data properly, ensure compliance with health information requirements, and execute timely claims submissions. The few healthcare organizations that lack a stable backbone typically experience calamitous results.

However, few payors and providers are agile. At most of these organizations, agility exists in pockets of the enterprise but is not a foundational element of the whole. Payors and providers that want to become agile must learn how to build on their backbone so they can shift from practices that inadvertently promote undesired behavior (e.g., siloed decision making) to those that enhance their organization’s dynamic capabilities.

Two recent examples of agility adoption, in banking and home nursing, illustrate its potential benefits for payors and providers.

### **ING: Cross-functional teams and increased collaboration**

The financial company ING restructured several of its head office departments, moving away from hierarchical silos to cross-functional teams, which it calls squads.<sup>4</sup> The squads are autonomous, dynamic groups responsible for the end-to-end execution of specific customer-related missions, such as streamlining mortgage applications. A designated product owner (a member of the squad) is responsible for the squad's activities and for managing backlog and priorities. Squads are composed of colleagues with different areas of expertise and disciplines, such as marketing, product management, and IT, depending on the mission. The squads are inherently small and fully empowered within their scope of accountability. They are co-located to maximize collaboration and can be ramped up, ramped down, added to, or reconfigured quickly based on the needs of the moment.

The concept of “squads” borrows the idea of a “sprint” in software development; it is also similar to the agile “scrum” methods often used in application development. The cross-functional resources are 100% dedicated to a specific objective or project, and must deliver it within short period of time (often, a fraction of traditional timetables, perhaps two or three weeks rather than five or six months). It is important to note that not *all* resources are organized this way—some people perform more predictable work in more traditional, less dynamic contexts. However, some agile models can be used for work that is more repetitive and less project-based (these models are similar to the self-managed, high-performing work teams used in lean manufacturing) or for highly dynamic but less cross-functional work (the “flow-to-the-work” models for applying

deep technical or functional expertise are examples of the latter approach).

At ING, squads with similar missions are connected and coordinated through “tribes” (e.g., mortgage services)—essentially, focused performance cells within a business unit that often include up to a dozen squads. The tribe leader is responsible for budget allocation, coordination, and best-practice sharing. A set of rules (e.g., squads have a limit of nine people, and a tribe can include no more than 150 people) supports this structure.

Employees within the same function coordinate with each other through “chapters”—functional competence groups that form the company's stable backbone. A chapter leader decides how jobs should be tackled, represents to hierarchy for squad members, and is responsible for coaching, development, and performance management.

Companies like ING that successfully adopt these approaches often find that product release cycle times shrink by 50% to 80% and costs decrease by 20% or more. In addition, organizational capabilities improve. Since summer of 2015, ING's adoption of agility has increased employee engagement by 20 points even as the company cut its total full-time equivalents by 30%. What's more, the company reduced its time to market for new products by nearly tenfold, and its customer satisfaction has risen significantly.

### **Buurtzorg: Greater agility through a flat organizational structure**

Buurtzorg, a home health nursing organization headquartered in the Netherlands, uses a rather extreme form of agility.<sup>5</sup> The organization is completely flat: every employee—

<sup>4</sup>Jacobs P, Schlattmann B. ING's agile transformation. McKinsey Quarterly. January 2017.

<sup>5</sup>Interviews with company executives.

including approximately 9,000 nurses and 40 central office staff—“reports” directly to the CEO. Most employees are grouped into pods, which are self-managing teams of 12 or fewer nurses; each pod covers a defined geographic area and set of patients. This approach enables flexible working hours for nurses, supports the sharing of best practices among teams (organically and through an online forum), and produces innovative patient solutions (such as better approaches for teaching patients how to conduct basic tasks). Pods even manage all of their own hiring. In addition, coaches (not managers) are available to help the pods solve problems and function optimally, as well as spread best practices.

Within the company, a set of defined processes form a limited but effective stable backbone. Pods have a minimum utilization rate of 60%, and all nurses are expected to participate in team decision making and meetings. Pods can also request the help of their coach from the central office, with one coach employed for every 40 teams.

This agile model has enabled Buurtzorg to improve the efficiency of its service delivery so that patients are able to regain autonomy more quickly and has helped the company capture 70% of the Dutch market over the past ten years.

## How healthcare organizations can become more agile

As payors and providers embark on the journey to become agile, they will need to communicate their vision to all managers and employees throughout the enterprise.

Our Organization Practice colleagues have found that a useful method is to liken the company to a smartphone. The company's structure, core processes, culture, and basic capabilities are, in essence, the smartphone's hardware and operating system<sup>6</sup>—a platform upon which a more dynamic set of capabilities (the organizational version of “apps”) can be built. The platform provides the foundation, framework, and skills needed to permit employees to perform effectively, and to move quickly as the business environment changes. However, the company's core processes and basic capabilities must be sufficiently open and flexible so that the “apps” (the tailored, dynamic capabilities needed for a given initiative) can easily and quickly be added or reconfigured.

A common approach used by companies seeking agility is to move some of their employees into centralized functions designed to serve and support the organization as a whole. The business lines are left “owning” fewer people, but they retain budget authority and, when necessary, can rent the resources they need from the functions. The result is more nimble allocation of resources to high-priority areas, the ability to operate more dynamically, and often the creation of centers of excellence in different skill areas.

Although an agile organization may still have a matrix-like feel with dotted-line reporting, the approach to work and collaboration is typically much less disruptive, for two reasons. First, the reporting line to the core function is stable. Second, the dynamic aspects of objective setting and decision making are largely de-coupled from the hierarchy, allowing much greater flexibility and speed (assuming that senior leaders

<sup>6</sup>Aghina W, De Smet A, Weerda K. Agility: It rhymes with stability. McKinsey Quarterly. December 2015.

**EXHIBIT 2 A five-step journey can allow companies to achieve greater agility**

<b>Define where you want to be</b>	<ul style="list-style-type: none"> <li>• Agree on your strategic objectives and how agility can help you get there (e.g., targeted segment/market growth, enhanced value-based care models and reimbursement capabilities)</li> </ul>
<b>Understand where you are today</b>	<ul style="list-style-type: none"> <li>• Assess where pockets of agility may exist within your current organization (e.g., discrete business units focused on healthcare innovation, IT departments)</li> <li>• Chart the proposed journey and two-pronged approach (i.e., identify pilots for agility concept, as well as system-wide priorities to build agility capabilities)</li> </ul>
<b>Draft the new model</b>	<ul style="list-style-type: none"> <li>• Define and detail the specific aspects of the stable backbone for your organization (e.g., decision-making processes and rights, core functions that can be drawn upon as needed)</li> <li>• Overlay the dynamic capabilities and model for agile units and teams</li> </ul>
<b>Use agile to become agile</b>	<ul style="list-style-type: none"> <li>• Launch agile prototypes, then iterate and refine via defined feedback loops</li> <li>• Allow learning and local adaptation in the dynamic elements; transformation happens most effectively by moving quickly toward an agile model in selected areas for the business</li> <li>• Build scale by shifting targeted areas to a more fully agile model, rather than attempting to shift a broad set of teams at once</li> </ul>
<b>Use agile as a source to learn and improve</b>	<ul style="list-style-type: none"> <li>• Scale agility and formalize the new model</li> <li>• By moving area by area to implement agility, your organization can reach a tipping point at which the model becomes self-sustaining</li> </ul>

Source: McKinsey Organization Practice

can learn to give up control of their fiefdoms). This structure is similar to the one used by many project-based organizations that seek to avoid the disruption that can result from a continuously evolving portfolio of initiatives.

Because agility is still a new concept, there are only a few examples of truly agile healthcare organizations to date (see the sidebar for two examples, p. 234). However, the concept is taking hold quickly in other turbulent and complex industries, and it is up to healthcare leaders to decide if they want to lead in this space or risk falling behind.

Based on our experience and what we have learned from other industries, we propose a five-step journey that payors and providers

could use to pursue agility (Exhibit 2). As with any strategic road map, the starting point is a clear definition of objectives and an evaluation of the organization's existing capabilities.

As the organization begins to implement agility, it should do two things simultaneously: conduct discrete pilots to test and prove the agility concept within the organization, and solidify the stable backbone (e.g., core processes and reporting structures) to lay the foundation for broader implementation. This method is analogous to the approach ING took when it embarked on its agility journey. It ensures that the pilots can show what is possible and the organization will be able to support and scale up the successful pilots. Continuous learning and

## Organizational health, agility, and healthcare

To gauge the level of agility within the health-care industry, as well as how it relates to overall organizational health, we conducted an outside-in assessment of nine payors and providers. In each case, we evaluated the organization based on both its level of overall agility and the presence of agile components within parts of the enterprise. This proprietary research has helped us identify effective strategies that healthcare companies can use to gain speed without losing stability.<sup>1</sup>

Our analysis found that the more agile health-care companies demonstrate better organizational health, as measured by McKinsey's Organizational Health Index, and stronger performance, as reflected in higher patient satisfaction scores, better outcomes, and healthier financial results. Two companies, one that has already achieved a high degree of agility and one that is still in transition, shed light on the impact of becoming more agile.

### Harnessing agility to optimize clinical quality and innovation

Company A, a regional healthcare provider, embarked on its agility journey about a decade ago. As part of this process, the company transformed its operating model from a decentralized, nonstandardized structure to one with substantial stability and consistency. In particular, it instituted rigorous standards for patient care, as well as a system to measure and track performance against those standards. As a result, Company A now has a stable backbone centered on clinical quality, which has enabled it to pursue more innovative care delivery and payment models.

The journey began when the company's CEO said to the CMO, "Deliver a plan for clinical excellence, and I'll give you the resources you need." Once the plan was approved, the CMO put in place a number of teams, each of which was tasked with building stable, translatable processes to establish consistent clinical standards across the organization. The teams consist of self-directed physicians who choose the areas they want to focus on based on their expertise and interests. The teams are supported by a centralized group of permanent, dedicated resources, including a research team (to help gather data and identify best practices) and an implementation team (to assist with putting the standards into practice and then measuring and tracking results).

Today, Company A has more than 20 of these clinical excellence groups in place. Each develops new standards and processes for quality and innovation annually, along with corresponding measurement and tracking systems. For example, if an employee came across an aspect of clinical practice that isn't adequately addressed, a clinical excellence team is deployed against this area. Although the initial clinical excellence teams focused on acute care, the company is currently extending the teams' scope to consider ambulatory care settings as well.

This infrastructure—the combination of a stable backbone and the ability to react dynamically as the need arises—has instilled a company-wide ethic of high clinical standards and evidence-based practice. It also helps ensure that the company's core business is preserved

<sup>1</sup>McKinsey's Organizational Health Index (OHI) includes a series of specific questions that assess an organization's speed (its ability to act quickly in the face of challenges and adapt to new ways of doing things) and stability (baseline structures, processes, and systems in place to simplify day-to-day work and eliminate reinvention).



and runs smoothly as the organization begins to implement different care delivery and payment models. In addition, it has enabled the company to achieve top-decile clinical outcomes and solid financial performance.

### Using centers of excellence to scale agility

Company B, a national payor organization, is shifting toward an agile matrix structure by establishing several shared services for functional areas (e.g., HR, claims) and “centers of excellence” in specialized areas (e.g., quality, compliance). The business lines can draw on these shared services as necessary for resource-intensive but infrequent efforts, and then set priorities and direct activities for the shared staff assigned to their projects. (An example of such an effort would be the need to develop the approach for responding to a large request for proposal.) This agile setup allows the company to quickly develop and scale capabilities that can then be rapidly deployed as needed.

Company B is in the process of expanding this approach to tackle a wider range of business issues beyond resource-intensive, one-off efforts. For example, the business lines can now call on a central team when they need to answer particularly challenging or time-sensitive analytics questions. The company is also experimenting with expanding agility in a few areas with high strategic priority by creating working teams staffed with dedicated employees from a range of functional homes, such as IT and medical management.

follow-on improvements are vital characteristics of agility—the key to embedding the concept into an organization’s DNA.



The healthcare landscape has changed meaningfully in the past several years, and more changes are ahead. Both payors and providers need to better organize themselves so they can respond effectively. Many healthcare organizations have struggled in this regard; too often, they either continue to operate with an antiquated organizational structure or undergo frequent “transformations” that are obsolete before they are fully implemented.

Agility can help payors and providers adapt more quickly to changing customer needs, competitor responses, and regulatory guidelines without requiring a full-scale restructuring and reallocation of resources. Moreover, agility can enable healthcare organizations to innovate and lead, and not be confined to reactive responses. These capabilities are likely to prove even more crucial in the coming years. ○

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APPENDIX:

# Our research and tools





## Appendix: Our research and tools

The articles in this compendium leverage proprietary research and analyses that McKinsey's Healthcare Systems and Services Practice, the McKinsey Center for US Health System Reform, McKinsey Healthcare Analytics, and other groups within McKinsey have conducted over the past several years. This appendix describes the major tools and data sources used in these articles.

### **BEHAVIORAL HEALTH DIAGNOSTIC TOOL**

The Behavioral Health Diagnostic Tool, developed by McKinsey Healthcare Analytics, uses information from healthcare claims (including professional, facility, and prescription claims) to identify, analyze, and segment differences in the behavioral health populations and patterns in their treatment and care. These analyses can be performed on any claims data set to reveal opportunities for improved care of this population. The analyses were created with significant clinician input, validated across multiple data sets, and syndicated with leaders in behavioral health population management. Examples of questions that can be answered through the use of this proprietary tool include:

- What percentage of the overall population has a diagnosed and treated behavioral health condition?
- What is the profile of the individuals with behavioral health conditions that have the highest needs, and what percentage of total spending is concentrated on them?
- How does the severity of behavioral health needs exacerbate medical conditions?

### **CONSUMER HEALTH INSIGHTS SURVEY**

McKinsey's annual Consumer Health Insights (CHI) Survey provides information on the opinions, preferences, and behaviors of more than 3,300 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 about the choices and trade-offs consumers are likely to make.

Since the survey was implemented in 2007, McKinsey has collected descriptive information from over 22,000 individuals and their households. The survey assesses customer experience with healthcare and non-healthcare companies; attitudes regarding health, healthcare, and the purchase and use of healthcare services; experience and satisfaction with current and past healthcare insurance carriers; attitudes about a broad range of related supplemental insurance products; opinions, use, and loyalty levels regarding healthcare providers and pharmacies; and experience of individuals with chronic conditions.

We supplement the information from the CHI with data from other sources, such as information on a consumer's estimated lifetime value to a health insurer, 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. We expect that health insurers



## Appendix: Our research and tools *(continued)*

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.

### **CROSS-INDUSTRY CUSTOMER EXPERIENCE SURVEY**

This unique survey, which McKinsey has conducted since 2007, explores how satisfied US consumers are with six industries: banking, health insurers, healthcare providers, hotels, pay television, and utilities. (Future iterations of this survey will include additional industries.) The survey also assesses the link between customer satisfaction and business outcomes, including renewals. About 22,000 consumers took part in the most recent survey, which uses the journeys framework in each sector to understand what matters most to consumers and why. The framework also enables comparisons across industries. For example, the sign-up journey is relevant to both banks and health insurers. To measure consumer satisfaction, the survey uses customer satisfaction (CSAT) scores. Although this metric differs somewhat from the net promoter score, which is also sometimes used to assess consumer satisfaction, the two approaches produce comparable results.

### **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.

### **EXCHANGE OFFERING DATABASE**

The Exchange Offering Database offers a granular view of all individual exchange products across the country that were offered from 2014 through 2017, as well as pre-reform benchmarks. It includes details on more than 400,000 county-level ACA-compliant exchange plans, such as premiums, benefits design, and network design. Specifically, the database includes:

- Data for all 3,143 counties in the United States.

- Carrier and pricing details for all new entrants and incumbents since 2014, including 236 carriers participating on the 2017 exchanges.
- Hospital network data, including more than 2,000 unique exchange networks in 2014, over 2,500 networks in 2015 and 2016, and more than 1,700 networks in 2017, as well as network participation data for all acute-care hospitals in the United States (over 4,500), including 373 health systems.
- Cost-sharing benefits design details for all products; drug formulary data for select markets.
- Pre-reform (2013) comparison data for incumbents' market presence and offerings.

#### **INDIVIDUAL MARKET OPEN ENROLLMENT PERIOD CONSUMER SURVEY**

Through a collaboration between McKinsey's Center for US Health System Reform and its Marketing Practice, we survey a national sample of uninsured and individually insured consumers each year, shortly after the close of the individual-market open enrollment period (OEP). The 2016 survey, conducted February 2–18, 2016, had a sample size of 2,763. Of these respondents, 1,187 had ACA plans, 500 had non-ACA plans, and 1,076 were uninsured.

The survey aimed to understand respondents' demographics and descriptive characteristics, and to assess their shopping behaviors, attitudes regarding health and healthcare, purchase and use of healthcare services, awareness of health reform, opinions about—

and experience shopping for—individual health insurance, and preferences for specific plan designs.

Sample sizes for the seven market segments we identified were: non-ACA insured, 500; carrier renewers, 568; carrier switchers, 130; new to individual coverage, 263; new to insurance, 56; payment stoppers, 169; and uninsured, 1,076.

At the time of publication, the 2017 OEP survey was underway.

#### **MCKINSEY PREDICTIVE AGENT-BASED COVERAGE TOOL (MPACT)**

The McKinsey Predictive Agent-based Coverage Tool (MPACT) is a micro-simulation model that uses a comprehensive set of inputs to project how health insurance coverage may shift over time. This tool helps inform strategic decisions by simulating the impact of health-care reform over time based on the decisions of individual consumers, health insurers, and employers.

MPACT projects granular health insurance enrollment changes at a county level from 2013 to 2022 across key demographics (e.g., age, race/ethnicity) and coverage groups (e.g., individual, group, Medicaid, Medicare, uninsured). MPACT contains approximately 70 million discrete geo-demographic cells based on granular demographic categorization. This level of granularity allows insight into insurance coverage patterns for specific demographic segments in any US geography.



## Appendix: Our research and tools *(continued)*

### MEDICAID CONSUMER SURVEY

Quantitative consumer insights about the current Medicaid population and potential new entrants to the program have been difficult to come by. To help address this gap, McKinsey surveyed more than 1,419 consumers across the United States in 2015, focusing on current Medicaid members (both dual eligibles and non-dual enrollees) and people who are currently eligible for Medicaid but not enrolled. The results, weighted to reflect the age, gender, ethnicity, education, and income of each of the groups, revealed important insights about the current and future Medicaid population.

### MEDICAID MCO DATABASE

McKinsey's Medicaid Managed Care Organization (MCO) Database provides comprehensive information on state-level MCO programs—not just MCOs but also prepaid ambulatory health plans, prepaid insurance health plans, and programs of all-inclusive care for the elderly. The database includes county-level enrollment, market share, parent company, and company type (e.g., national, Blue, provider, etc.). It also includes information on contract-level enrollment, use of waivers, and shared savings or quality incentives. MCO offerings are also mapped to exchange carriers.

In addition, the database identifies the MCOs that offer coverage for individuals with special or supportive needs. It also tracks which populations are included (e.g., dual eligibles; those who are aged, blind, or disabled; and those with intellectual or developmental disabilities) and what types of services are carved

in or carved out (e.g., medical, behavioral health, prescription drug coverage, long-term services and support, care needed for individuals with intellectual or developmental disabilities).

### MEDICARE ADVANTAGE DATABASE

McKinsey's Medicare Advantage (MA) Database compiles monthly enrollment at the plan, contract, and county levels. This information can be combined with a health insurer's financials as well as MPACT data to create a comprehensive view of participation and performance in the MA market at the county and/or state level. Overall Star ratings and domain-level ratings are available to generate granular insights into carrier performance. In addition, the MA Database tracks monthly capitation and bonus rates for Parts A–C.

### MEDICARE CONSUMER SURVEY

This national survey included 2,208 seniors covered by Medicare Advantage, Medicare fee-for-service, or Medicare supplement plans. It sought to understand what matters to these consumers and their decision-making process for both coverage- and care-related decisions.

### ORGANIZATIONAL HEALTH INDEX

McKinsey's Organizational Health Index (OHI) helps business executives understand the underlying mind-sets and behaviors that drive performance within their company. Based on survey responses from senior leaders, managers, and frontline employees, the executives can identify areas in need of improvement, prioritize initiatives to address them, and map them to one of McKinsey's proven recipes for success.

Distinct modules of the OHI provide flexibility to customize organizational health management to an organization's evolving needs. The OHI enables companies to:

- Measure organizational health using an online survey to diagnose strengths and weaknesses that directly affect performance.
- Define “signature” combinations of organizational health management practices tailored to strategy and prioritize key areas for improvement.
- Develop interventions and define road maps in action-planning workshops.
- Implement targeted actions to improve organizational health in key areas.
- Embed organizational health optimization into performance management cycles through “pulse checks” and interactive course-correction sessions.

A company's OHI score provides the single best predictor of its future performance capacity. In addition, specific elements within the overall score can help a company identify specific changes that will enable it to improve its organizational health relative to its peers.

### **PAYOR FINANCIAL DATABASE**

McKinsey's Payor Financial Database (PFD) aggregates and verifies information from the National Association of Insurance Commissioners (as supplied by SNL Financial), and other public sources, to create a consolidated set of P&L data by carrier, state, and line of business. At present, data is available for the individual, small-group, and large-group risk markets, as well as Medicaid, Medicare Advantage (national level only), and Medicare Supplemental markets.

The PFD includes granular data at the state and/or national levels from 2010 through 2015. The data is validated and adjusted to account for reporting and other errors, as well as to ensure comparability. Outputs include covered lives, premiums, claims, expenses, and profits. Claims are split into medical claims and prescription drug claims.

### **PRIVATE EXCHANGE SIMULATION**

McKinsey's Private Exchange Simulation investigates what might happen if individuals currently covered under employer-sponsored insurance were given the option of selecting their own coverage (and other benefits) on a private online exchange. It assesses participants' interest in private exchanges and tests their buying behavior given a range of plan options and ancillary benefits. Recently, more than 2,400 consumers participated in these online simulations.

### **PROVIDER-LED PLAN DATABASE**

The Provider-led Plan Database offers a comprehensive, up-to-date list of 106 providers with associated provider-led health plans and respective covered lives (approximately 15 million) by line of business, including individual, group, administrative-services-only (ASO), Medicaid, and Medicare. Specifically, the database includes:

- Covered lives, revenues, and losses at a state level across individual, small-group, large-group, ASO, Medicaid, and Medicare Advantage from 2010 through 2015.
- Provider-led plan participation in the marketplaces, as well as product, pricing, and network information for all exchange years (2014 to 2017).
- Financial performance across lines of business. ○





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