RECESSION AND RESILIENCE: OPPORTUNITIES FOR HEALTHCARE LEADERS IN THE NEXT ECONOMIC DOWNTURN

Economic ebbs and flows are called “cycles” for a reason. It has been over 10 years since the last recession began. The challenge for today’s healthcare leaders is not whether the next downturn will occur—it’s whether you are ready for it. Consider:

The structure of the healthcare industry has fundamentally changed since 2008, making previous experience in understanding the impact of a recession less relevant

Many industry leaders have not experienced a recession in their current roles because of the long period of economic growth

The gap between industry leaders and laggards widens during and after a recession, driven by actions taken by leaders before and throughout the downturn

Healthcare leaders need to consider the implications of an economic slowdown and build a resilience plan—not only to weather the impact, but also to enable their companies to emerge financially and strategically stronger

Impact of a recession on healthcare: The next time could be different

MAJOR CHANGES IN THE HEALTHCARE INDUSTRY SINCE THE 2008–09 RECESSION		POTENTIAL IMPLICATIONS OF THE NEXT RECESSION
34	states[1] expanded Medicaid, extending eligibility to ~13M adults as of 2018	Increased Medicaid enrollment could create budgetary pressure for states: 13 of the 34 expansion states have rainy day funds <5% of the general fund expenditures[2] and may experience significant budget shortfalls
55%	+[3] of payer revenues are attributed to government businesses (Medicaid and Medicare)	Increased presence in Medicaid and Medicare will help diversified payers mitigate downside impact in other segments; managed care organizations (MCOs) may have an opportunity to grow in Medicaid, but may face pricing pressure as states experience budgetary shortfalls
2/3	+ Enrollees in the Individual market receive financial assistance	Increased adverse selection in recession may lead to market instability and pricing risk, particularly in regions with high pre-recession employer-sponsored insurance concentration
~800	deals[4] have been announced since 2008, involving ~1800 hospitals	Scale advantages are likely to be even more important as payer and provider market dynamics have shifted; from 2012–17, 1/3 of counties (2/5 of US population) experienced greater provider consolidation relative to payer consolidation, and 1/4 of counties (1/6 of US population) experienced the opposite[5]
1/3	of people with employer coverage have high-deductible health plans (HDHPs), compared to fewer than 1/10 in 2008	Higher cost sharing for those in HDHPs may dampen potential utilization increase pre-downturn; employers may turn to “non-traditional” levers such as narrow networks to reduce cost, providing an opportunity for payers to increase differentiation through innovative product offerings
32%	year-over-year growth in venture funding for digital health since 2011	Organizations that invested early in digital and advanced analytics capabilities may have competitive advantages in being able to respond during a downturn by better understanding coverage/utilization shifts and consumer behavior

1 As of February 2019, includes DC but excludes ID, NE, and UT, which are set to expand later in 2019. | 2 Based on National Association of State Budget Officers (NASBO) report for fiscal year 2019. | 3 As of 2018, based on McKinsey payor financial database. | 4 Gee E, Gurwitz E, “Provider Consolidation Drives Up Health Care Costs, Center for American Progress,” December 5, 2018, americanprogress.org. | 5 Measured by the shift in provider-to-payer Herfindahl–Hirschman Index (HHI) ratio from 2012–17, based on American Hospital Association (AHA) and Interstudy data. Greater provider consolidation defined as an increase in the ratio by at least 0.2, and greater payer consolidation defined as a decrease in the ratio by at least 0.2.

SOURCE: AHA database; CMS, 2017 Actuarial report on the financial outlook for Medicaid; Interstudy database; Kaiser Family Foundation; NASBO Fiscal Survey of States; McKinsey Enrollment Database

Potential impact* of an economic recession on current healthcare market

Likely coverage shifts (lives)

~4–10M
Out of Commercial

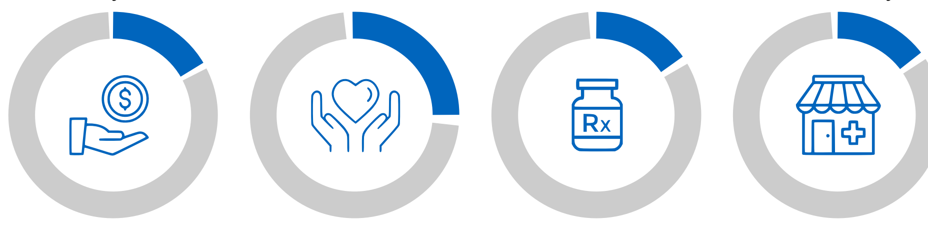
~3–7M
Into Medicaid

~1–3M
Into uninsured pool

State budgetary pressure

Medicaid cost as a percentage of states’ general revenue could increase by ~3–10 percentage points,[1] relative to 2018 levels

Stakeholder bottom line (EBITDA)

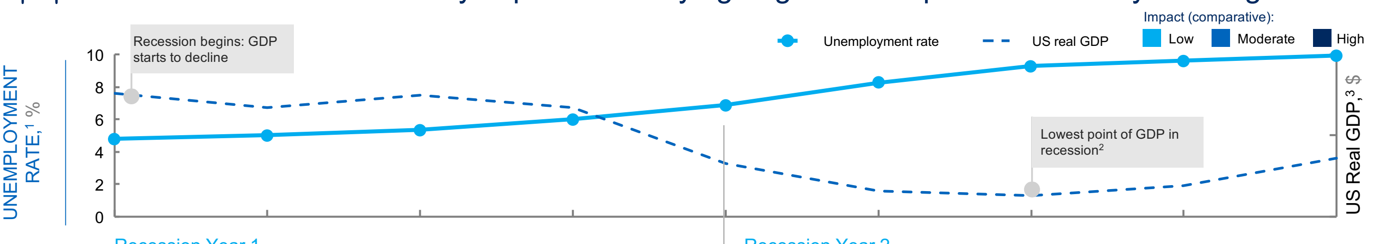


Payer	Provider	PBM	Pharmacy
5–20% drop	5–30% drop	5–20% drop	5–15% drop

* For illustrative purposes only; impact estimate ranges were modeled based on the severity of the 2001 “dot com” recession (low range) and the 2008 “Great Recession” (high range). Given the uncertainty on the severity of the next downturn, we have used economic indicators (e.g., unemployment rates, GDP decline) from the last two and applied those to the current legislative and regulatory environment to highlight the potential impact. The analysis does not factor in any specific actions payers, providers, pharmacy benefit managers (PBMs), or pharmacies might take in response to the recession.

1 Includes state portion of Medicaid cost only; increase in Medicaid cost also accounts for non-recession factors such as reduction in Federal Medical Assistance Percentage (FMAP) for expansion population and reductions in Disproportionate Share Hospital (DSH) payments.

Healthcare stakeholders may experience varying degrees of impact due to likely coverage shifts



LIKELY STAKEHOLDER AGGREGATE MARGIN IMPACT, RELATIVE TO BASELINE[4]

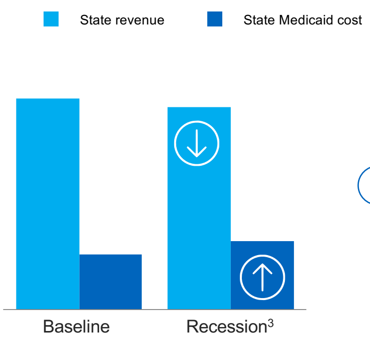
	Recession Year 1 Coverage shifts begin as unemployment rises and some employers reduce coverage and benefits	Recession Year 2 Coverage shifts increase (driven by growth in Medicaid coverage and uninsured rates) as unemployment rate peaks
Payer	▪ Increase in uninsured lives ▪ Shift of fully insured commercial lives to Medicaid ▪ Increasing medical loss ratios (adverse selection)	▪ Low or no growth in Medicaid MCO capitation rates, and employers strengthen cost controls
Provider	▪ Shift to Medicaid decreases reimbursements ▪ Rising uninsured rate increases bad debt ▪ Utilization upticks in elective care and ancillary services as individuals anticipate coverage loss	▪ Utilization drops, especially for elective and ancillary services; states could further cut provider reimbursements
PBM	▪ Shifts to Medicaid/uninsured, along with drug utilization decreases (as consumers tighten budgets), reduce revenue and rebates retained	▪ Coverage shifts and utilization decreases continue; employers and payers strengthen utilization management
Pharmacy	▪ Shifts to Medicaid/uninsured, along with drug utilization decreases, reduce revenue, but there may be an increase in 340B-eligible[5] pharmacies	▪ Coverage shifts and utilization decreases continue; PBMs and payers reduce dispensing fees and drug reimbursement

1 Based on unemployment rates observed in the 2008–09 recession for illustrative purposes. | 2 Defined as quarter with the lowest GDP in recession period. | 3 Real GDP for illustrative purposes only, not modeled. | 4 Assumes consistent market position and share. | 5 Allows hospitals and contracted pharmacies to purchase medications at a lower price; eligibility partially based on volume of Medicaid patients served.

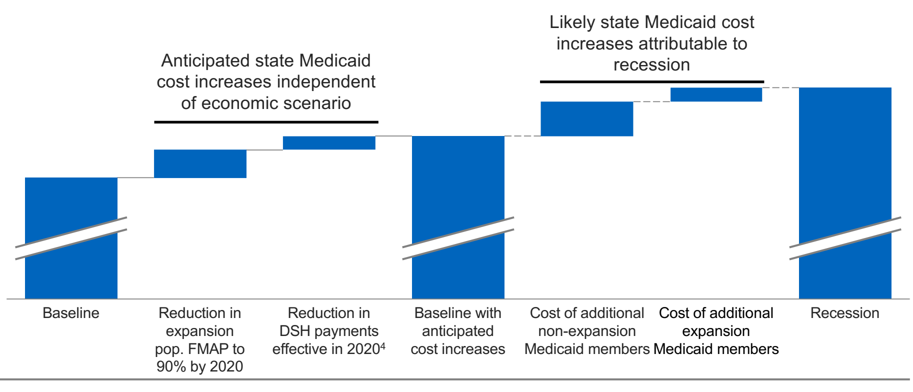
SOURCE: Expert interviews; literature review; Multpl.com; McKinsey Healthcare Recession Model

States will likely experience significant budgetary pressures as Medicaid costs rise and general revenue declines

STATE MEDICAID COST[1] & REVENUE COMPARISON FOR **EXPANSION** STATES, UNDER RECESSION SCENARIO[2]



PROJECTED STATE MEDICAID COSTS[1] FOR **EXPANSION** STATES IN A RECESSION SCENARIO



ACROSS EXPANSION STATES, MEDICAID COST AS A PERCENTAGE OF TOTAL STATE REVENUES MAY INCREASE DRIVEN BY:

- Reduced state tax revenue during a recession
- Anticipated FMAP reductions for the expansion population to 90% and DSH reduction of $4B by 2020[4,5]
- Increased enrollment of traditional and expansion members

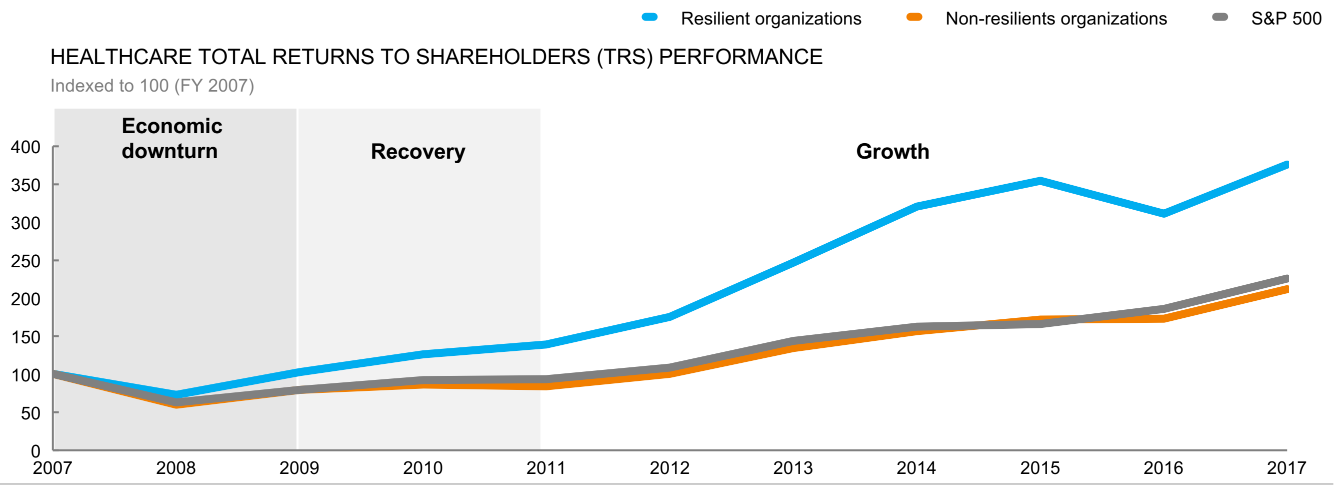
1 Accounts for state portion of the cost (i.e., total cost less federal match). | 2 Does not include DC. | 3 Assumes 3.5% state budget increase. | 4 Scheduled Medicaid DSH cuts of $4 billion in FY 2020, and $8 billion thereafter. | 5 For majority of expansion states.

SOURCE: Holahan J, The 2007–09 recession and health insurance coverage, *Health Affairs*, 2011;30(1):145–52; Jacobs PD et al, Adults are more likely to become eligible for Medicaid during future recessions if their state expanded Medicaid, *Health Affairs*, 2017;36(1):32–9; Moody’s Analytics stress testing states, 2018; National Association of State Budget Officers, Fiscal survey of the states; McKinsey Healthcare Recession Model; McKinsey Medicaid Reform Model

Analysis of the last recession shows that “resilient” organizations outperformed others throughout the downturn and widened the performance gap after

HEALTHCARE TOTAL RETURNS TO SHAREHOLDERS (TRS) PERFORMANCE

Indexed to 100 (FY 2007)



Resilient organizations are the top 20% of performers in their sectors, as measured by average total returns to shareholders from 2007–11

Note: Calculated as median of “resilient” and “non-resilient” companies within healthcare industry, including healthcare services, distributors, facilities, device manufacturers, suppliers, technology companies, and managed healthcare organizations.

SOURCE: Capital IQ; CPAnalytics; McKinsey resilience analysis

The resilient organizations that survived (and even thrived) during the last downturn did three things differently:

Secured their balance sheets ahead of the downturn

Moved faster to drive a step-change improvement in clinical and administrative operating costs

Purposefully shaped their portfolios by divesting before the downturn and acquiring afterwards, as appropriate

Is your organization prepared for the impact of a potential economic downturn?

Are you ready to do the three things listed above better than others to survive and even thrive during a potential downturn?