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Healthcare Systems and Services Practice

The great acceleration in healthcare: Six trends to heed

Next generation care management, health for all, consolidated care delivery, and reform efforts are among the trends that may shape healthcare in the years ahead.

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"The fault lines between industries and business models that we understood intellectually before the COVID-19 crisis have now become giant fissures, separating the old reality from the new one." Our colleagues in the Strategy practice wrote this in their article, "The Great Acceleration." We see seeds being sown of a similar acceleration in healthcare during the COVID-19 era. As US healthcare leaders set the direction for their organizations, six trends stand out.

Reform

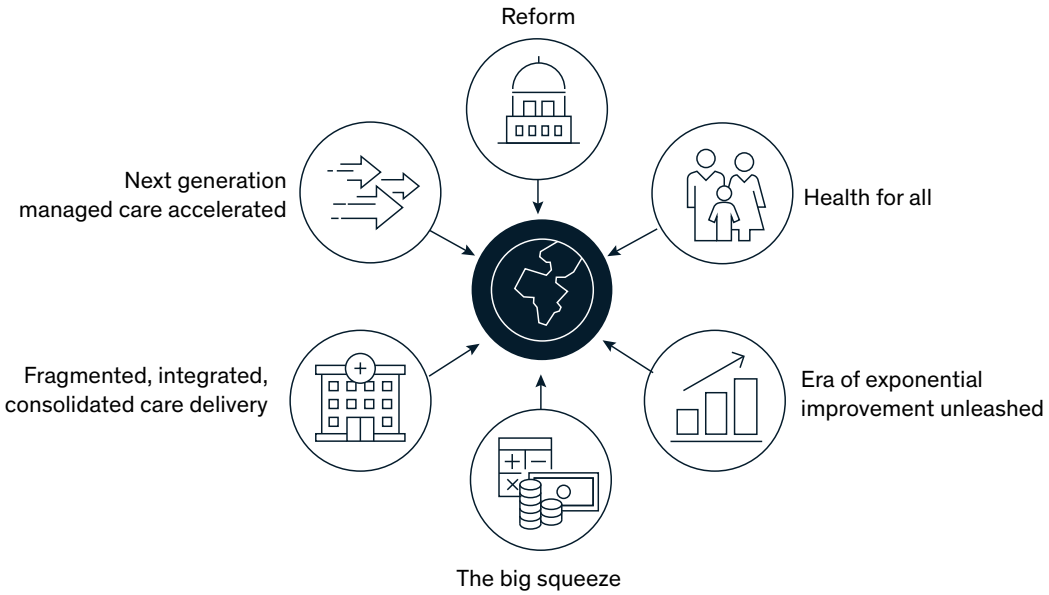
COVID-19 has potentially set the stage for healthcare reform along three dimensions: COVID-19-era waivers that could become permanent; actions that may be taken to strengthen the healthcare system to deal with pandemics; and reforms to address the COVID-19-induced crisis.

To enable the healthcare system to respond to the pandemic, the Centers for Medicare & Medicaid Services has introduced more than 190 waivers and modifications since the beginning of March 2020.[1] These actions impact the clinical practice of medicine and the financing and reimbursement for services. Many of these measures are only relevant during the crisis (for example, the waiver of intensive care unit death reporting). A retrospective assessment of others (for example, expansion of telehealth access) could reveal beneficial innovation worth preserving.

The frontline workers and leaders in healthcare took heroic action to save lives. At the same time the crisis has revealed areas that could improve the resilience of the system. Some of these opportunities include ramping up measures to control the spread of such a fast-moving virus, greater resilience in the healthcare system to avoid being overwhelmed (for example, addressing weak links within the medical supply chain and developing the ability to flex up critical care capacity and clinical workforce), as well as ways to improve the baseline health of the population (for example, offering services to mitigate the prevalence of chronic conditions and obesity rates).

The economic impact of COVID-19 is unprecedented in the last 75 years, creating historic economic pressure across federal and state governments, corporations, and Ameri-

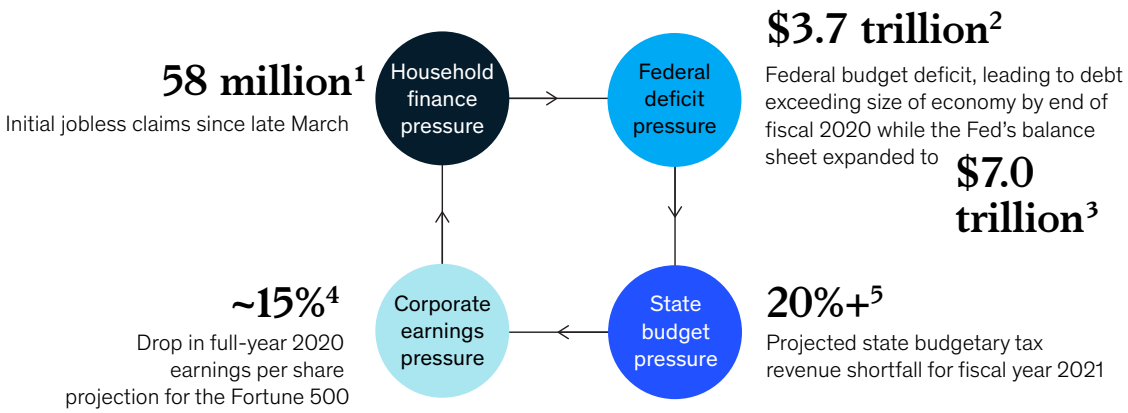
These six trends are likely to shape post-COVID-19 healthcare.



[1] As of August 18, 2020, based on research from the McKinsey Center for US Health System Reform.

Exhibit 1

Severe COVID-19-era economic pressure may be likely to heighten calls to contain rising healthcare costs.



[1]Department of Labor as of August 27, 2020.
[2]Congressional Budget Office.
[3]Federal Reserve Report as of August 17, 2020.
[4]Tully S, "Here's how far corporate profits could plummet in 2020," Fortune, May 17, 2020, fortune.com.
[5]Center on Budget and Policy Priorities.

can households (Exhibit 1). Furthermore, in some cases the impact of COVID-19 may cause up to roughly 10 million Americans to lose employer-sponsored healthcare coverage by the end of 2021.[2] In the United States, such economic dislocation has often been followed by major healthcare reform (Exhibit 2). If the United States embarks on new reform, the contours are unclear at this time. However, given the substantial shifts in relative market positioning among industry players that prior reforms have created, leaders would do well to plan ahead now, as we discussed in the article "Getting ahead of the next stage of the coronavirus crisis."

Health for all

COVID-19 has amplified existing inequitable health outcomes. These five intersecting health and social conditions are correlated with poorer health outcomes.

- **Physical health status.** People with chronic conditions, the immunocompromised, and the elderly make up most COVID-19 deaths in the United States. For example, obese patients, defined as those with a Body Mass Index above 35, are 2 times more likely to be hospitalized and 3.5 times as likely to be admitted to the intensive care unit due to COVID-19.[3]
- **Behavioral health challenges.** Individuals at an increased risk of developing severe COVID-19 symptoms are nearly twice as likely to have a behavioral health condition, including mental health and substance abuse disorders.[4]
- **Unmet social needs.** Americans living in areas with significant unmet social needs (for example, food insecurity, housing insecurity) account for 15 percent of the population but 28 percent of COVID-19 deaths.[5] In areas

2 McKinsey payer economics model v7.0, as of Aug 14 2020.
3 Lighter J et al., "Obesity in patients younger than 60 years is a risk factor for COVID-19 hospital admission," *Clinical Infectious Diseases*, July 2020, Volume 71, Number 15, pp. 896–7.
4 Based on a representative claims data sample of over 15 million individuals in the United States with Medicaid, Medicare, or Commercial insurance. Only includes diagnosed behavioral health conditions.
5 Areas with significant unmet social needs defined as the top quintile of counties on the basis of neighborhood stress score. Areas with high unemployment defined as the top quintile of counties on the basis of percent unemployment. Neighborhood stress score is calculated based on a composite of Census values including income, employment, use of public assistance, transportation, single parent households, and education. See the McKinsey Vulnerable Populations Dashboard for additional detail and related data.

with high unemployment levels, COVID-19 deaths per 100,000 are 2.4 times higher than in areas with low unemployment.

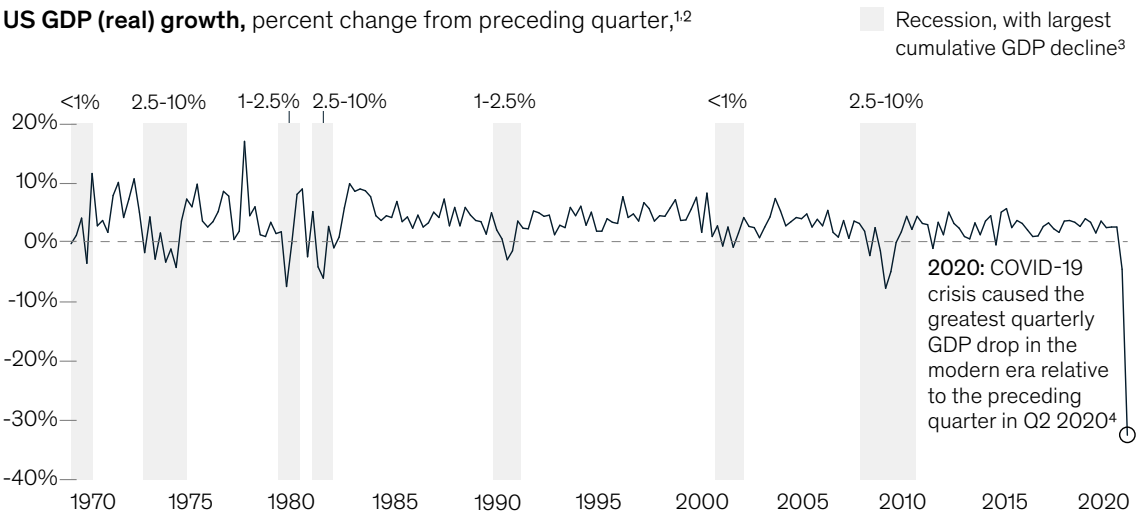
— **Racial inequity.** Compared with white Americans, the estimated age-adjusted COVID-19 mortality rate for Black Americans is 3.8 times, for American Indians 3.2 times, and for Hispanic/Latinx Americans 2.5 times.[6]

— **Access to care.** Challenges in access to care continue across the United States, with around 60 million Americans living in counties with low physical access to care.[7] Furthermore, around 63 percent of all counties in the United States have a shortage of psychiatrists.[8] Telehealth offers a great opportunity to expand access: inadequate physical access to care could be redressed for up to an additional 50 million Americans. However, 10 million Americans still do not have broadband access and live in areas with low physical access to care (Exhibit 3).[9]

6 As of July 8, 2020.
7 Low physical access to care defined as less than the average of counties in primary care physicians per 100,000 population and mental health providers per 100,000 population.
8 Bradford J, Coe E, Enomoto K, and Moss C, "The implications of COVID-19 for vulnerable populations," May 20, 2020, McKinsey.com.
9 McKinsey analysis based on 2019 FTC Deployment Report, American Community Survey (ACS) data, and Census Bureau.

Exhibit 2

Economic recessions have been fertile ground for healthcare reform.



1972: Social Security amendments expand Medicare coverage to cover those with long-term disabilities

1973: HMO Act leads to formation of health maintenance organizations

1974: ERISA establishes standards for employer-sponsored health plans

1990: Medicaid expansion under OBRA 90 requires coverage for lowest-income children

1993: Health Security Act fails to gain widespread support but inspires future legislation

1997: Balanced Budget Act reduces Medicare reimbursements to providers, creates Medicare+Choice program, and establishes CHIP for low-income children's coverage

2003: Medicare Modernization Act introduces drug benefit, tax-exempt HSAs, new Medicaid MCOs

2010: Affordable Care Act established, expanding Medicaid coverage, creating an individual exchange, and limiting coverage and benefit restrictions

CHIP, Children's Health Insurance Program; ERISA, Employee Retirement Income Security Act; HMO, health maintenance organization; HSA, health savings account; MCO, Managed Care Organization; OBRA, Omnibus Budget Reconciliation Act.
[1]Expansionary period is defined as duration from through to peak.
[2]Economic cycle defined as duration length of "peak to peak" timeline.
[3]Largest cumulative GDP decline in 2-year period after NBER peak.
[4]Q2 2020 change is projected based on scenario A1 based on McKinsey Global Institute analysis.
Source: Bureau of Economic Analysis; Bureau of Labor Statistics; National Bureau of Economic Research; McKinsey Global Institute

Era of exponential improvement unleashed

As we previously highlighted in "The era of exponential improvement in healthcare?," technology-driven innovation may improve our understanding of patients, enable the delivery of more convenient, individualized care, and create from $350 billion to $410 billion in annual value by 2025. While the pace of change in healthcare has lagged other industries in the past, potential for rapid improvement may accelerate due to COVID-19. An example is the exponential uptake of digitally enabled, virtual care. Our analysis presented in "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" showed that health systems, primary care, and behavioral health practices are reporting increases of more than 50–175 times in telehealth visits, and the potential market size for virtual care could reach around $250 billion (Exhibit 4).

Proliferation of digitally enabled, virtual care could further contribute to the rise of personalized and intuitive healthcare ecosystems. As we shared in "The next wave of healthcare innovation: The evolution of ecosystems," ecosystems in healthcare have the potential to deliver an integrated experience to consumers, enhance productivity of providers, engage both formal and informal caregivers, and improve outcomes while lowering cost.

The big squeeze

While the aftermath of the 2008–09 financial crisis led to a net outflow due to the transition of commercially insured employees to uninsured, the Affordable Care Act brought an injection of $130 billion-plus of funding into healthcare (for example, Medicaid expansion, funding for the marketplace). However, a similar injection of funding to mitigate the **$70 billion and $100 billion outflow** (for example, coverage shifts, state budgetary pressures) due to COVID-19 **may not take place by 2022**. This outflow is expected to be primarily driven by coverage shifts out of employer-sponsored insurance and possible cover-

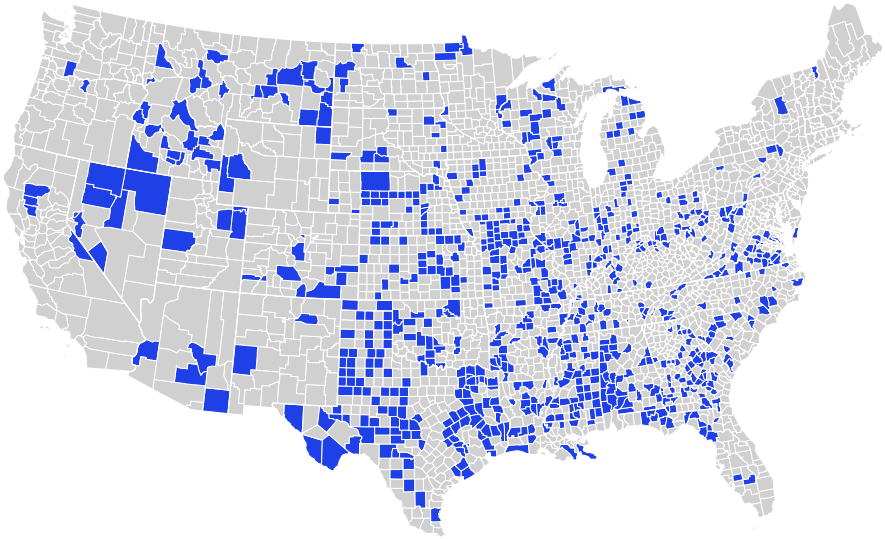
Exhibit 3

Virtual care will expand access to many, but not all, areas of the country with limited physical access.

US counties with low physical access to care and no access to broadband in lower 48 states[1]

~10 million people

live in counties with low physical access to care and do not have access to broadband



[1]n = 3,075 counties with sufficient data for comparison.
Source: Census Bureau, American Community Survey and FCC 2019 Broadband Deployment Report

age reductions by employers as well as Medicaid rate pressures from states.

We estimate that COVID-19 could depress healthcare industry earnings by between $35 billion and $75 billion compared with baseline expectations. Select high-growth segments will remain attractive (for example, virtual care, home health, software and platforms, specialty pharmacy) and will disproportionally drive growth. These high-growth areas are expected to increase more than 10 percent over the next five years, while other segments may stagnate or decline altogether.[10]

Despite the pressure in earnings, organizations with businesses that operate in the lower-growth segments may still outperform and deliver higher-growth returns by improving productivity. We estimate between $280 billion and $550 billion in opportunity within healthcare delivery by 2028 achievable through productivity gains. More details can be found in our publication "The productivity imperative for healthcare delivery in the United States."

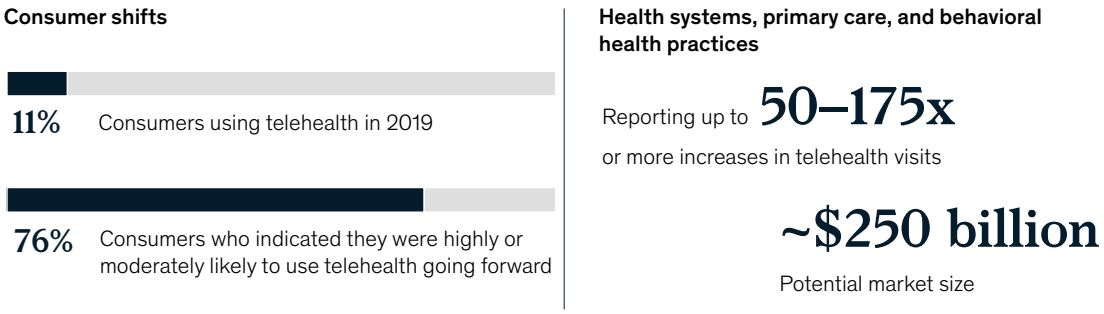
Fragmented, integrated, consolidated care delivery

The shift of care out of hospitals is not new but has been accelerated by COVID-19. Care in the next normal could be increasingly delivered in distributed sites of care (Exhibit 5), integrated around the patient through digital and analytics across patient-centered ecosystems, and driven by at-scale players pursuing proven models to outperform. Larger, geographically diversified providers are weathering the financial impacts of COVID-19 better.[11] These systems also own an outsized share of the distributed, outpatient assets that could drive earnings growth in the next normal. For example, the largest 25 percent of health systems generate 60 percent of revenue from outpatient assets compared with around 40 percent for smaller systems.[12] Furthermore, large payers have rapidly become major owners of non-hospital care delivery assets, with nine out of ten top payers already owning distributed, outpatient assets.[13]

[10] McKinsey Profit Pools model.
[11] McKinsey CFO/Finance VP Financial Resilience Survey of Health Systems >1B annual revenue, May 21–29 2020, n = 44.
[12] Ibid.
[13] Company annual reports, press search; Top payers by 2019 premium revenue. Ownership of select care delivery assets includes joint ventures.

Exhibit 4

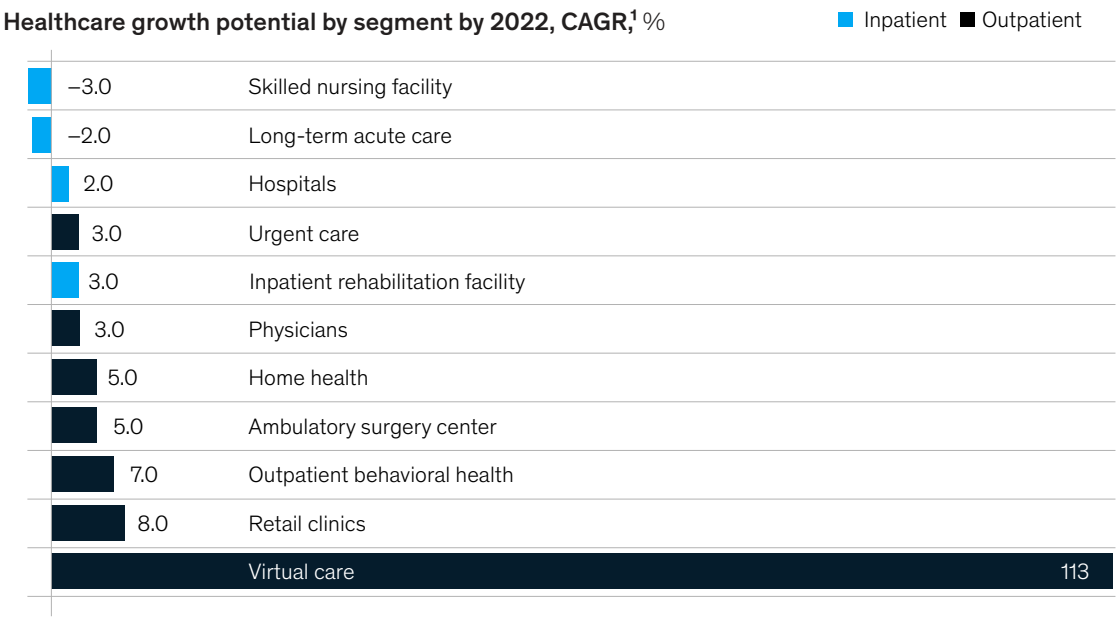
COVID-19 and the potential of digitally enabled, virtual care.



Source: McKinsey analysis published in Bestsennyy O, Gilbert G, Harris A, and Rost J, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality," May 2020, McKinsey.com.

Exhibit 5

Virtual care and outpatient options show more potential revenue growth through 2022.



[1]Compound annual growth rate.
Source: McKinsey analysis

Exhibit 6

Payers pursuing the next generation managed care model demonstrate better financial performance (2017–18).

[1]Does not include administrative services only, Individual, and Medicare stand-alone prescription drug plan.
[2]Weighted average on premium for excess gain across all lines of business.
[3]Does not include Kaiser.
Source: McKinsey Payer Financial database

Next generation managed care accelerated

Payers pursuing the next generation managed care model (through deep integration with care delivery) demonstrate better financial performance, capturing an additional 50 basis points of earnings before interest, taxes, depreciation, and amortization above expectation (Exhibit 6). This next generation managed care model has been driven in large part through Medicare Advantage, where positive outcomes have been delivered to beneficiaries.

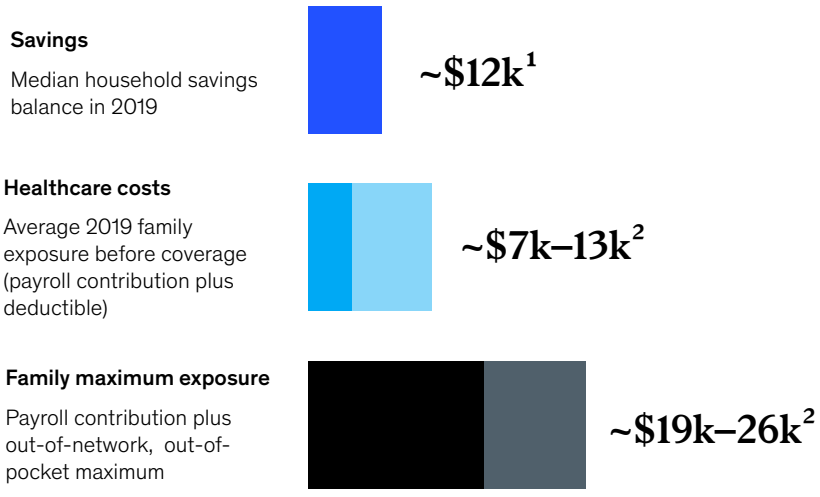
As discussed earlier, the current crisis is placing substantial pressure on employers' economics. However, the primary lever of shifting costs to employees to promote value conscious consumption has run out of steam. In 2019, average employee contribution for family coverage was 32 percent at employers with more than 500 employees and 53 percent for smaller employers with less than 500 employees. The intense pressure on household financials makes the overall healthcare exposure larger than many consumers' ability to absorb (Exhibit 7). Employers and payers could consider fundamentally rethinking how employer-sponsored health coverage is structured. Learnings from Medicare Advantage could provide inspiration for such a reimagination.

What actions could you take?

- Launch a **plan-ahead team** to collect forward-looking intelligence, develop scenarios, and identify decision points for action to navigate uncertainty in the path to the next normal. As we outlined in "Getting ahead of the next stage of the coronavirus crisis," planning ahead for crises requires a dedicated effort, with a full-time senior executive leading and accountable for a team of high performers located "next door" to the CEO.
- **Question everything** about your role in healthcare and future business model as your organization transitions from "wartime" to "peacetime." More details on the transition can be found in our article "From 'wartime' to 'peacetime': Five stages for healthcare institutions in the battle against COVID-19"

Exhibit 7

Households may no longer be able to absorb further healthcare cost shifting.



[1]Based on MagnifyMoney report derived from Federal Reserve and Federal Deposit Insurance Corporation data.
[2]Range based on the following: Low-end based on a family enrolled in a preferred provider organization plan with an employer of 10–20k employees (low end) and a family, high-end based on a family in high-deductible health plan with an employer with <500 employees.
Source: Census Bureau American Community Survey Data; Mercer 2019 Health and Benefits Survey; Survey of Consumer Finances (SCF)

— Ramp up capabilities to **transform your business, including acquisitions and alliances**. Our two decades of research outlined in the article "The power of through-cycle M&A" show that a through-cycle mind-set to M&A can enable and accelerate the strategic shifts necessary to emerge from the COVID-19 crisis healthy and profitable.

— **Reimagine your organization to lock in the speed** of decision making and execution achieved during the crisis. In "Ready, set, go: Reinventing the organization for speed in the post-COVID-19 era," we share nine discrete ways companies can get faster.

— Lean forward on actions to **drive health equity**. We expressed the criticality of tracking the damage of COVID-19 and the recovery from the pandemic along racial lines in "COVID-19: Investing in black lives and livelihoods." It is incumbent on all stakeholders to take proactive action to mitigate disparities and push toward health for all.

While the challenges are numerous, leaders who seize the mind-set that "disruptive change provides an opportunity to separate yourself from the pack" will build organizations meaningfully stronger than the ones they ran going into the crisis.

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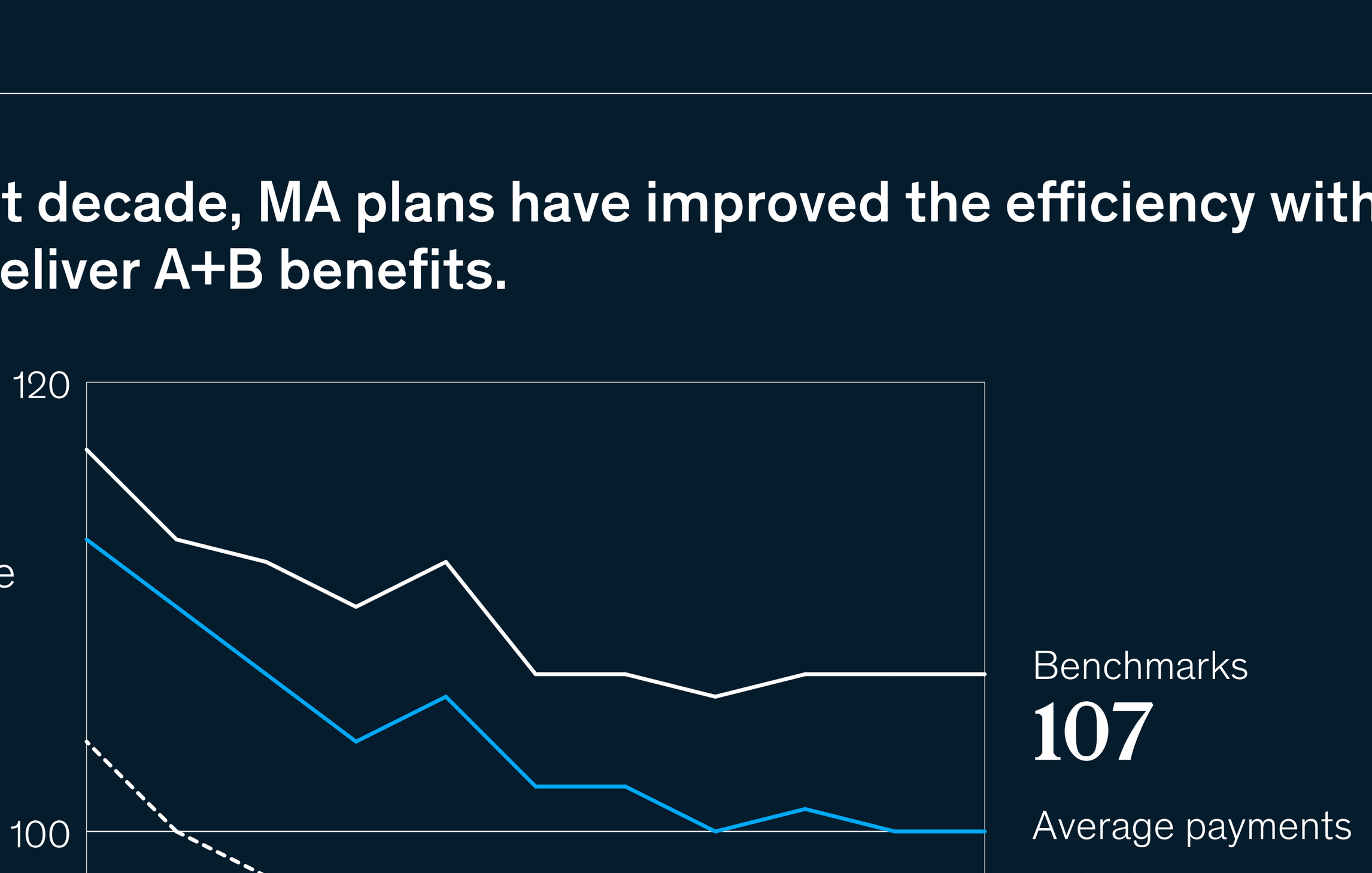
What employers could take away from Medicare Advantage

Medicare Advantage (MA) seems to have managed cost, quality, and experience positively over the last few years. In addition to consistently delivering greater cost efficiency over traditional Medicare, the cost trend has been better than for employer-sponsored insurance. Some of the efficiency has been reinvested in providing new benefits (for example, transportation, meals) and lower premiums paid by beneficiaries. How might employers adapt the approaches used in MA to improve the plans they sponsor as cost shifting to employees runs out of steam?

1 Over the past decade, MA plans have improved the efficiency with which they deliver A+B benefits.

Average MA bids, benchmarks, and payments, % of fee-for-service spending[1,2,3]



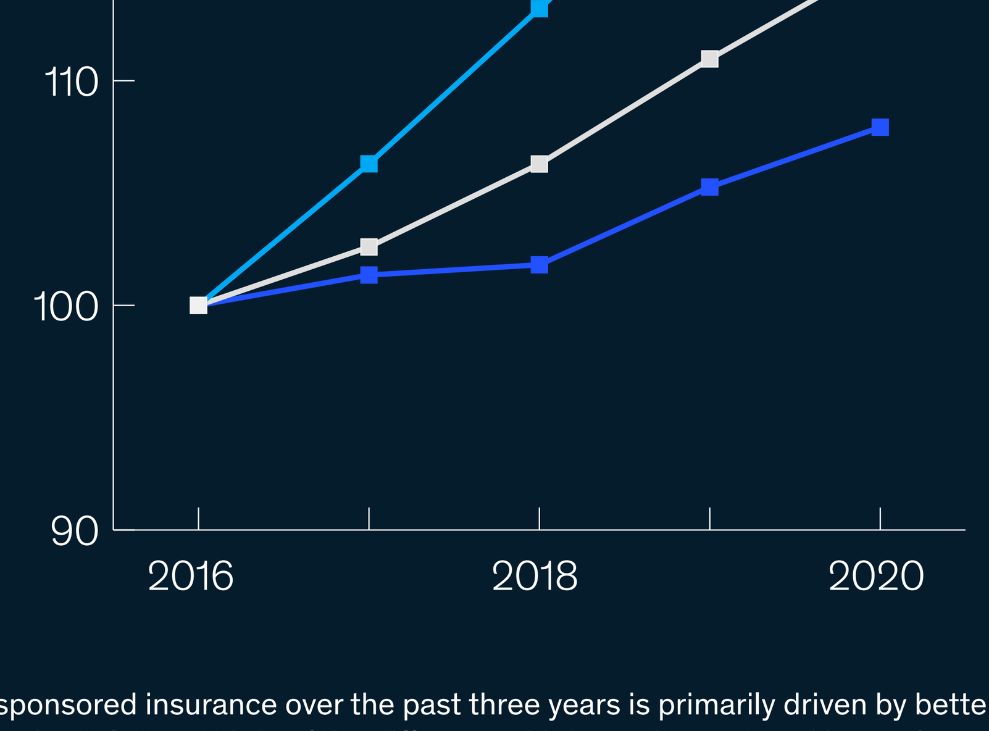
Benchmarks
107

Average payments
100

Plan bids of A+B
88

2 Cost trend for employer-sponsored insurance has been higher than MA.

Change in per-person cost trend in employer-sponsored insurance[4] compared to MA, 2016–20, indexed to 100[5]



+26%
trend in employer-sponsored plans before plan changes*

+15%
trend in employer-sponsored plans after plan changes

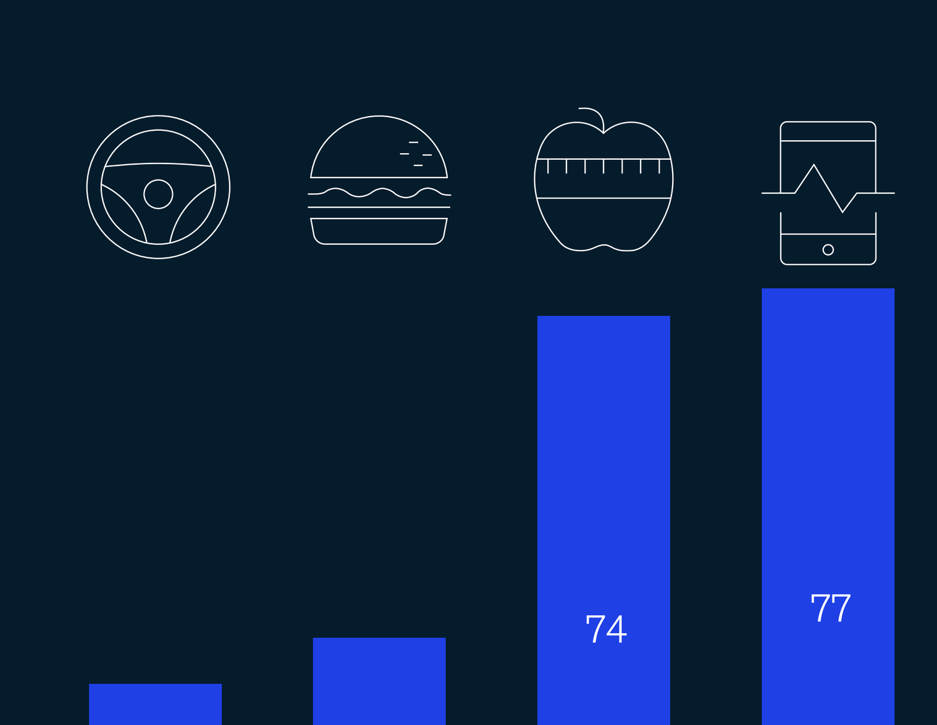
+8%
change in MA benchmark (no plan changes)[6]

* Higher trend in employer-sponsored insurance over the past three years is primarily driven by better care efficiency achieved in MA, accounting for approximately two-thirds of the difference; higher unit cost trend in employer-sponsored insurance accounts for approximately one-fourth of the difference. Remainder is attributed to differences in demographic mix changes.

3 MA plans have added benefits and lowered beneficiary premiums.

Share of MA enrollees in plans with supplemental benefits, by type in 2020, %

Employer-sponsored insurance plans have shifted 11% of cost onto members in the last five years through benefit design changes and payroll contribution increases to control costs, while MA plans have increased supplemental benefits and reduced premiums.



32%
Reduction in average monthly MA premiums from 2016 to 2020

93%
Of beneficiaries have access to a zero-premium MA plan in 2020

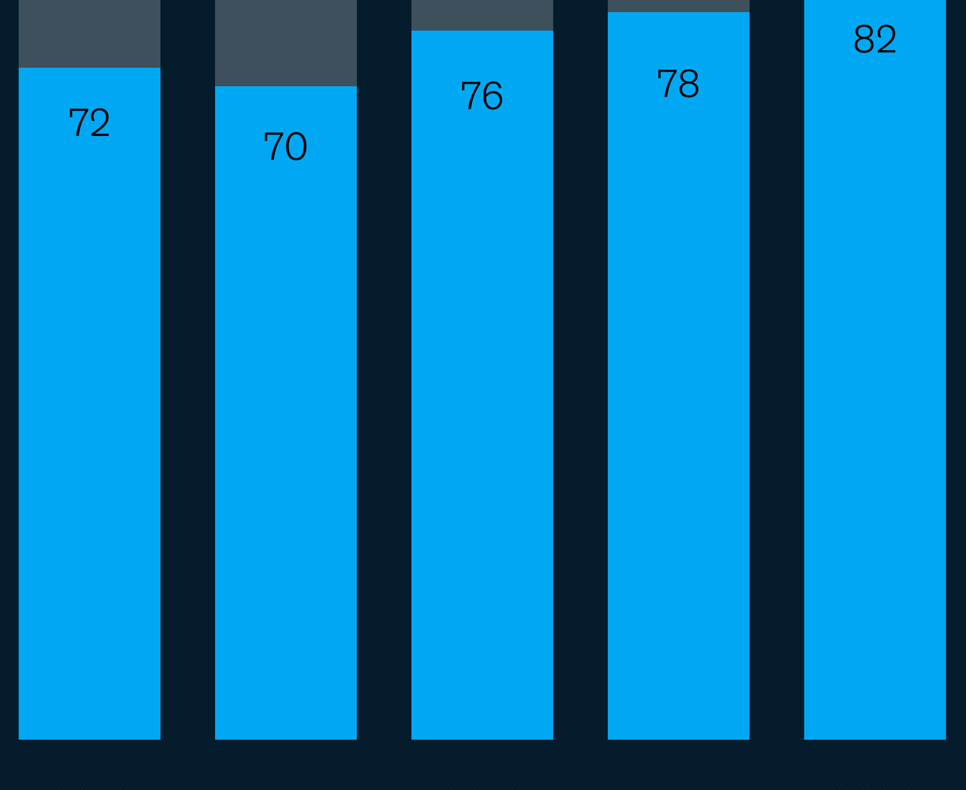
4 MA has achieved overall health quality improvements over time.

Enrollment-weighted average Star rating for MA-PD[8] plans, score out of 5

2015 ★★★★ 3.96   2020 ★★★★ 4.17

This improvement has been achieved despite tightening performance standards to achieve 4 Stars over time[7]

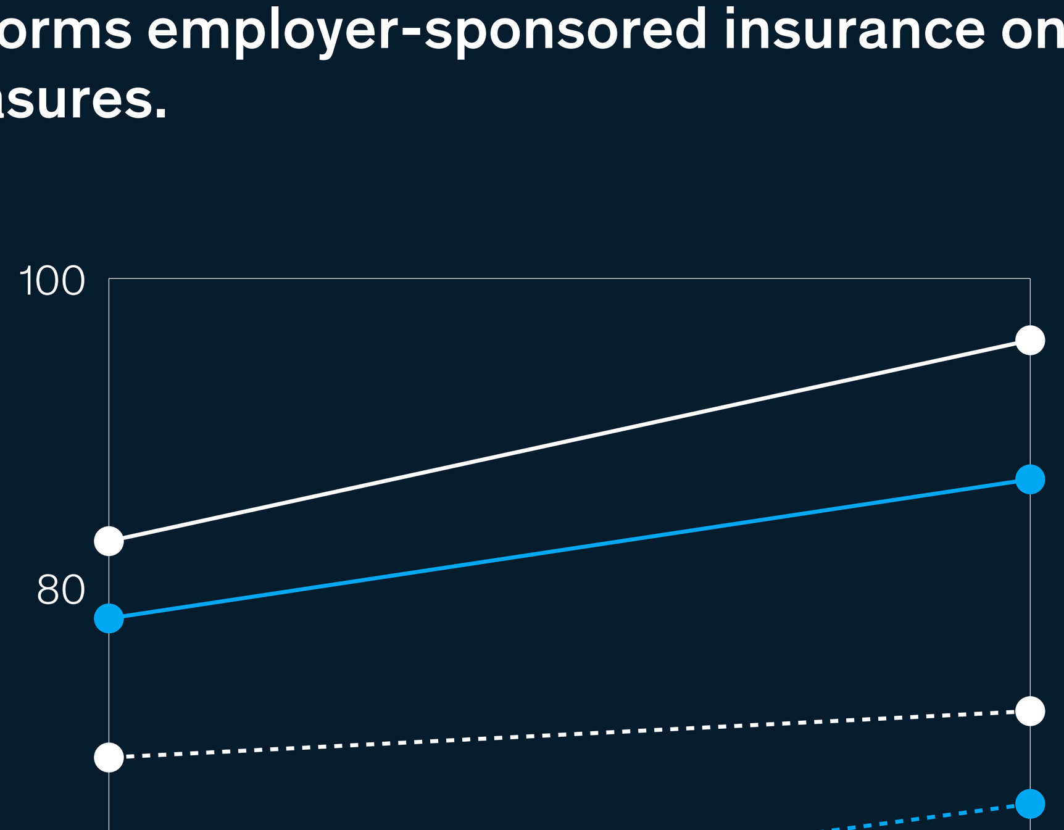
Enrollees in 4+ Star plans, %



+10
percentage-point increase 2016–20

5 MA outperforms employer-sponsored insurance on comparable quality measures.

2018 Healthcare Effectiveness Data and Information Set (HEDIS),[8] score

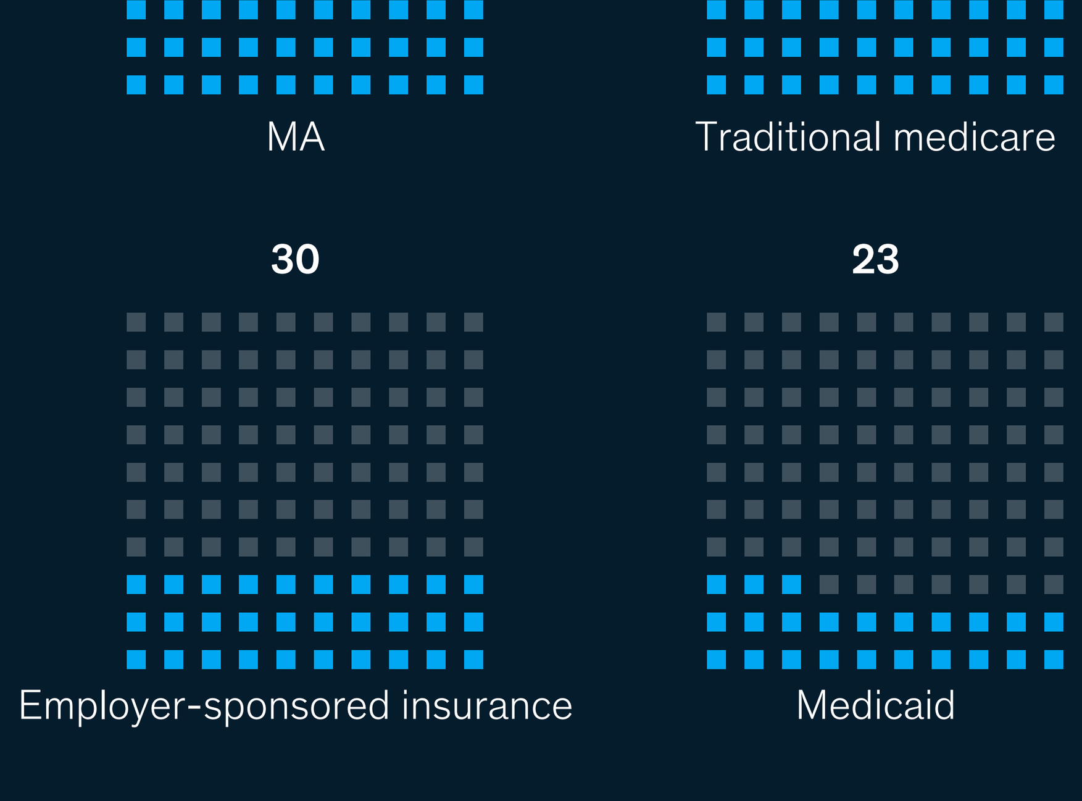


Prevention measures
Adult BMI[9] assessment rate
Advising smokers and tobacco users to quit

Treatment measures
Antidepressant medication management
Comprehensive diabetes care: HBA1C control

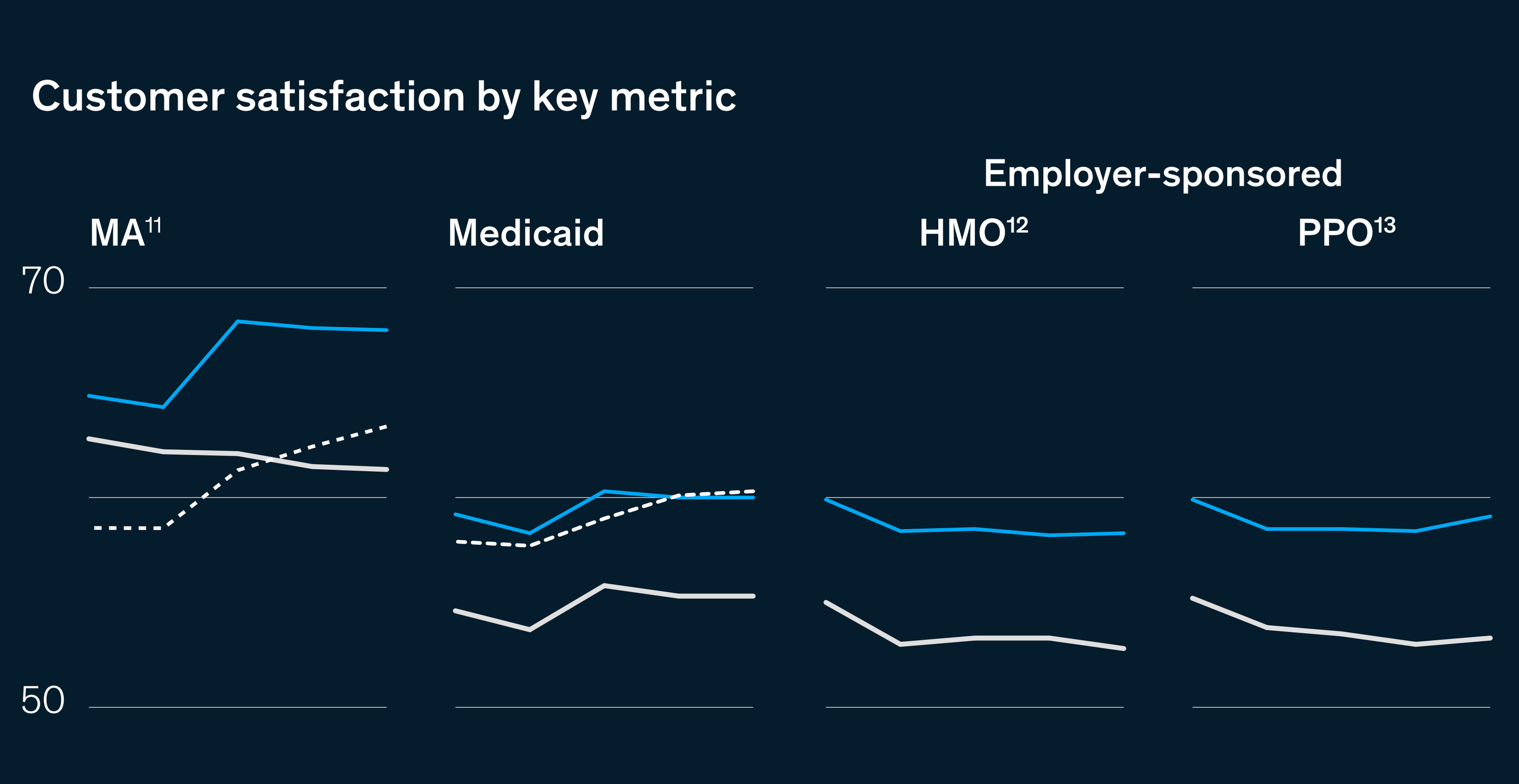
6 MA plans lead in the transition away from fee-for-service reimbursment.

2018 alternative payment models by line of business,[10] %



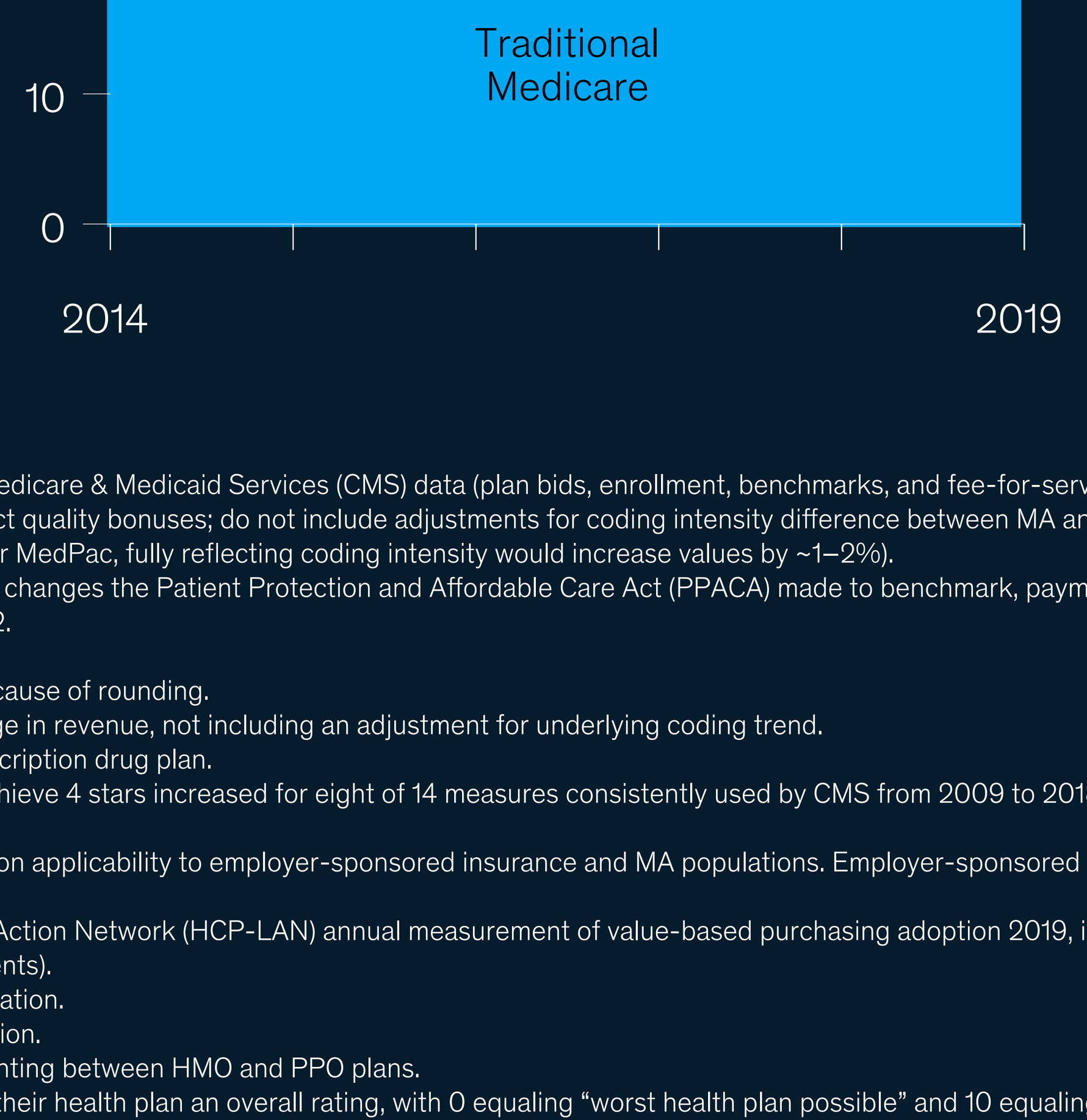
7 Consumers' satisfaction with their overall experience and access to care is higher in MA plans.

Customer satisfaction by key metric



8 Medicare beneficiaries seem to find value in MA plans driving its superior growth.

Total Medicare enrollment,[15] millions



CAGR,[16] 2014–19, %
3.2 Overall
7.3
3.5
0.1

[1]MedPAC analysis of Centers for Medicare & Medicaid Services (CMS) data (plan bids, enrollment, benchmarks, and fee-for-service expenditures).
[2]Values are risk-adjusted and reflect quality bonuses; do not include adjustments for coding intensity difference between MA and fee for serviceexceeding statutory minimum adjustment (per MedPac, fully reflecting coding intensity would increase values by ~1–2%).
[3]Note that data may be affected by changes the Patient Protection and Affordable Care Act (PPACA) made to benchmark, payment, and rebate methodology, first taking effect in plan year 2012.
[4]Before and after plan changes.
[5]Figures may not sum to 100%, because of rounding.
[6]Based on expected average change in revenue, not including an adjustment for underlying coding trend.
[7]MA-PD, Medicare Advantage prescription drug plan.
[8]Quality performance needed to achieve 4 stars increased for eight of 14 measures consistently used by CMS from 2009 to 2018.
[9]BMI, body mass index.
[10]Specific measures chosen based on applicability to employer-sponsored insurance and MA populations. Employer-sponsored insurance and MA scores shown reflect HMO plans.
[11]Health Care Payment Learning & Action Network (HCP-LAN) annual measurement of value-based purchasing adoption 2019, includes categories 3 (risk-based payments) and 4 (capitated payments).
[12]HMO, health maintenance organization.
[13]PPO, preferred provider organization.
[14]Reflects enrollment average weighting between HMO and PPO plans.
[15]Respondents were asked to give their health plan an overall rating, with 0 equaling "worst health plan possible" and 10 equaling "best health plan possible."
[16]CAGR, compound annual growth rate.
Source: CMS Star ratings data (2011–20) and June enrollment data (2011–19)—note that enrollment weighted Stars ratings may differ slightly from CMS reports due to enrollment used in analysis; HCP-LAN 2019 annual report; Kaiser Family Foundation; MedPAC Reports to Congress and CMS rates announcements; Mercer 2019 Health and Benefits Survey; Mercer's National Survey of Employer-Sponsored Health Plans; NCQA 2019 State of Health Care Quality Report

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