Healthcare Systems and Services Practice

Where to compete in today's healthcare market

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

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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.

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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.[1,2]

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.

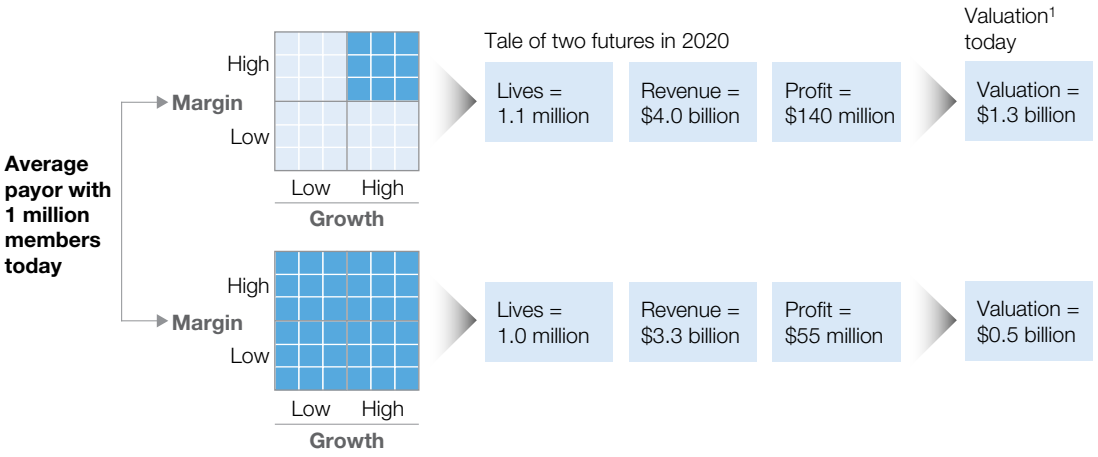
Admittedly, our models cannot predict the future with certainty, and thus actual growth (within specific states or across the country as a whole) may be higher or lower than our estimates suggest. Nevertheless, we believe that growth and margin variability will be a characteristic feature of the US health 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,

[1]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.

[2]For a look at how this general rule affects the Medicaid managed care market, see "The granularity of Medicaid MCO growth." McKinsey white paper. April 2017.

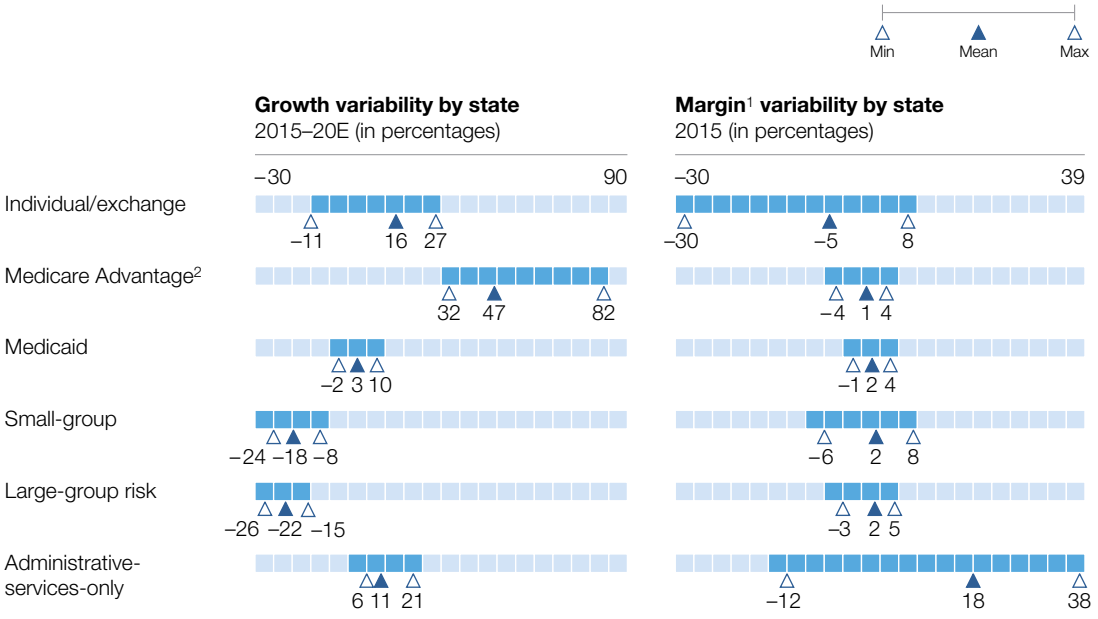
EXHIBIT 1 **Where-to-compete decisions can be powerful**



[1]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)

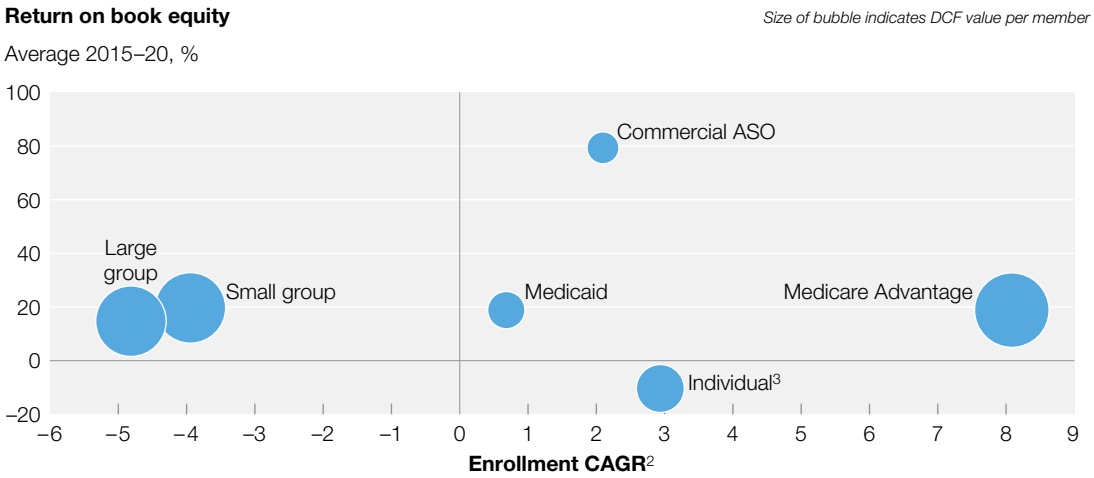
EXHIBIT 2 **Growth and margins vary across industry segments and states**



[1]Margin is defined here as post-tax operating gain.
[2]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**[1]



ASO, administrative services only; CAGR, compound annual growth rate; DCF, discounted cash flow.
[1]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).
[2]Enrollment CAGR projected based on 2015–20.
[3]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.[3] 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

[3]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.

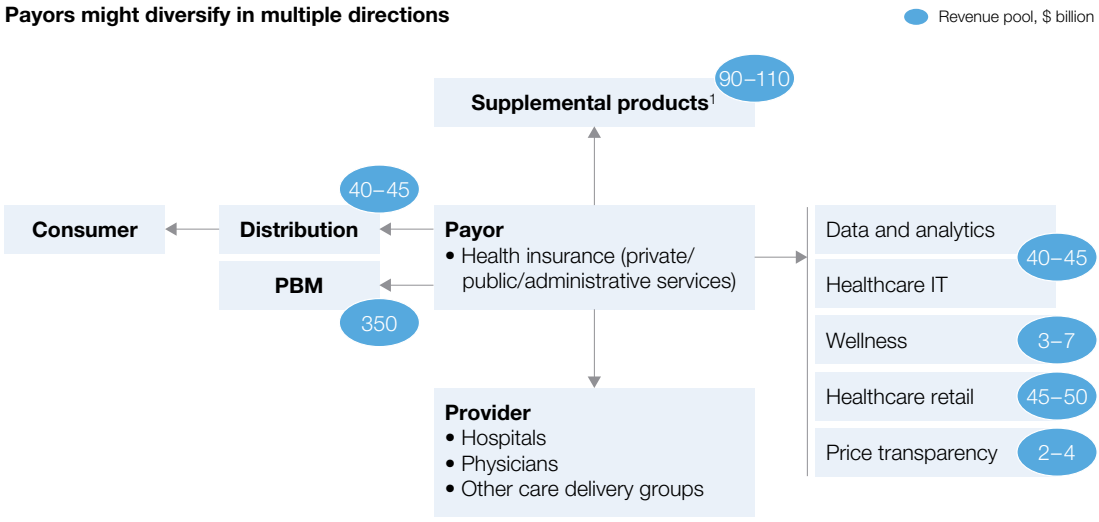
Acting on where-to-compete decisions

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).[4] 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**

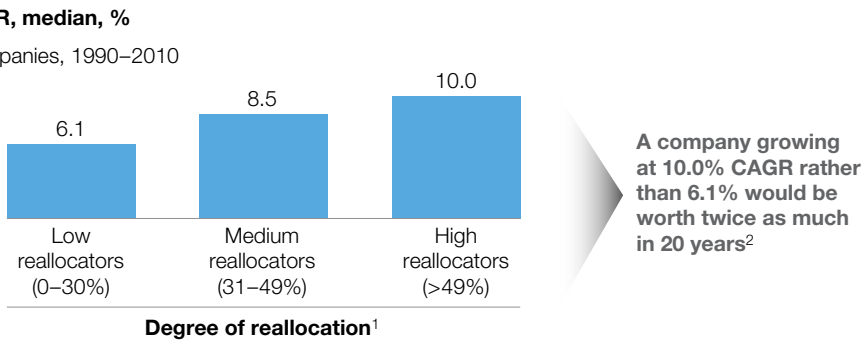
Payors might diversify in multiple directions



PBM, pharmacy benefits manager.
[1]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

[4]McKinsey Corporate Strategy Research Program.

EXHIBIT 5 **Companies that can reallocate resources nimbly win**



CAGR, compound annual growth rate; TRS, total return to shareholders.
[1]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.
[2]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.[5]

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 about this database, see the appendix.

[5]Hall S, Lovallo D, Musters R. How to put your money where your strategy is. McKinsey Quarterly. March 2012.

Appendix

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.

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