

Healthcare Systems and Services Practice

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

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# 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 appendix.)

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.

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<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. For more information about these segments, see “2016 OEP: Consumer survey findings,” May 2016 ([healthcare.mckinsey.com/2016-oep-consumer-survey-findings](http://healthcare.mckinsey.com/2016-oep-consumer-survey-findings)).

## 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.

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.

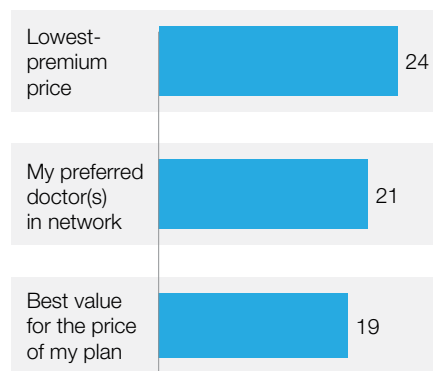
### Importance of preferred provider in network

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

## 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>4</sup>For more details about the earlier surveys, see the appendix.

<sup>5</sup>Office of The Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services, "Health plan choice and premiums in the 2016 health insurance marketplace," October 30, 2015 ([aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace](http://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace)). 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>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.

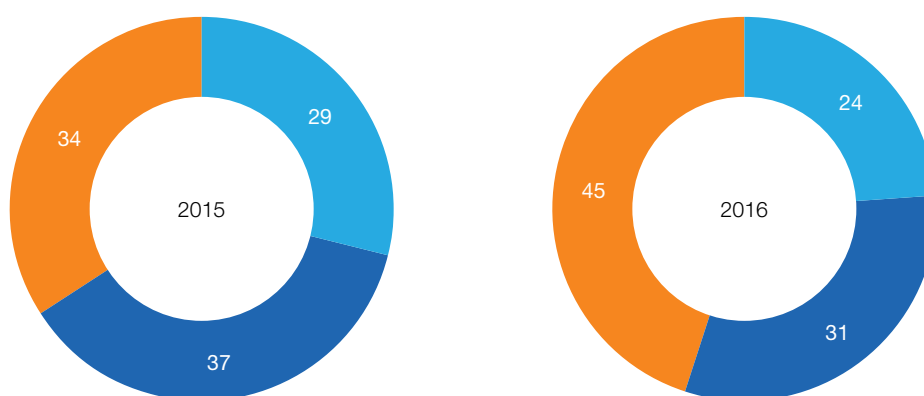
Source: McKinsey Individual Market Open Enrollment Period Consumer Survey, March 2016

**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

■ Narrowed network<sup>2</sup> ■ Unaware ■ Broad network



<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

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 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

<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.

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%

## 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 reenrolled in the same ACA plan.

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.

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,

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.

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.

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.

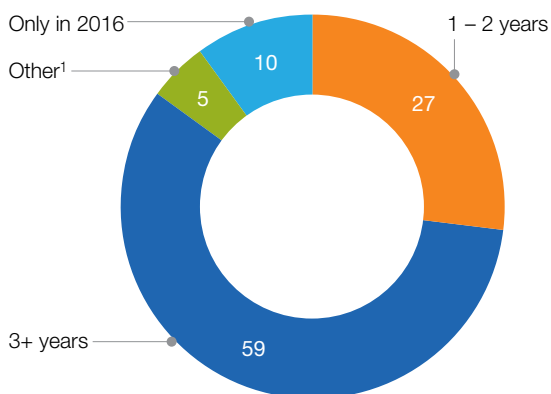
## The uninsured

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

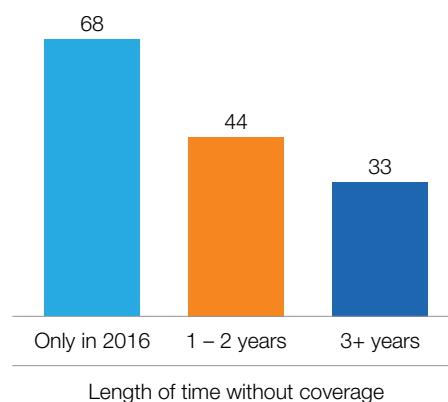


### EXHIBIT 3 Likelihood of shopping for coverage decreases as time without coverage lengthens

**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

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

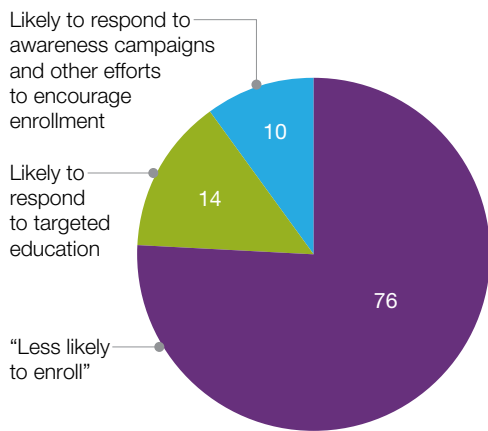
<sup>7</sup>This finding was based only on respondents who reported a change in premium price between 2015 and 2016; it excludes those whose premium prices may have stayed the same.

<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 ([www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates](http://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates)).

**EXHIBIT 4 Segmentation can identify opportunities to increase enrollment**

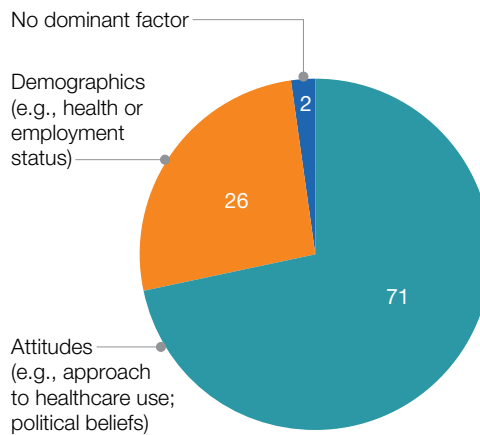
**Predictive analysis identified three subgroups among the uninsured ...**

% 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

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, 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 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 pur-

chase coverage. Certain characteristics are more common in this group than in the other 24% of the uninsured (Exhibit 4, 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 consumers 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.

<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.



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 also the sidebar “Key insights from the 2016 OEP Consumer Survey”).

### 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

## 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.

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 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 (espe-

cially 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. ○

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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.

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## Appendix: Overview of McKinsey tools and analysis

### 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.