The payor industry in an era of discontinuous change

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Three of the five largest health insurers in the United States in 1980 had ceased to exist by 2000, and today's two largest US health insurers were barely on the map in 1980. The advent of managed care (sparked by the HMO Act) and the shift to employer self-insurance (prompted by ERISA provisions) led to radical changes in what it meant to be a payor, how value could be created, and how competitive advantage could be gained in the health insurance market.[1] Powerful concepts, such as provider networks and care management, emerged. Pre-existing structural advantage did not matter—those payors that innovated ended up winning, and several previously strong incumbents that did not exited.

We believe the payor industry has entered another period of discontinuous change. Innovations in new business models, experimentation with new roles across the value chain, the emergence of new competitors, and a variety of acquisitions and partnerships will be the order of the day. Eventually (as with any evolutionary cycle), many of the new approaches and players will fail, exit, or be bought. The culling process will deliver only the strongest survivors. As evolutionary cycle plays out, the risks of stasis will be very high.

In this environment, existing structural advantage is unlikely to be sufficient to ensure future success. Conduct—that is, the actions taken by players—will determine who wins and who loses. Superior insight and foresight, bold strategies developed with an attacker mind-set, flexible planning processes, operating models capable of rapid reorientation, and effective execution will be clear differentiators. To ensure that they can acquire these differentiators, payor organizations, which have traditionally been steeped in slow cycles of annual group sales and multiyear product development, must significantly transform themselves.

Drivers of disruption

Industries are disrupted or reshaped when a major change occurs in the external environment. The trigger is typically one of three elements: new regulations, a shift in customer preferences (or who the customer is), or technological advances. The payor industry is experiencing substantial changes in all of these elements. The disruptive forces unleashed by these changes have, together, engendered five major trends that are reshaping the context within which payors operate.

Accelerated growth with margin compression is straining existing business and operating models and hampering payors' ability to achieve scale, add new capabilities, and simultaneously cut costs. During the current decade, the payor industry is likely to see increases in membership (by more than 30 million lives), revenues (by over $400 billion), and profits (by about $5 billion).[2] This growth will predominantly occur in two areas: partially or fully government-funded plans (Medi-

[1] The HMO Act is the Health Maintenance Organization Act of 1973. ERISA is the Employee Retirement Income Security Act of 1974.

[2] For more information about changes in the payor industry, see parts 1 and 2 of the video, "Strategy Matters: Insights in Healthcare" (available on mckinsey.com).

care Advantage and managed Medicaid) and consumer-purchased or -selected products (subsidized individual plans). As the numbers suggest, the growth will be accompanied by significant margin compression.

Inversion of insurance economics will completely upend the profit-generation model. Because of the Affordable Care Act, risk-adjustment mechanisms now exist in the Medicare, Medicaid, individual, and small-group markets. These mechanisms serve to flatten and, in many cases, invert profitability—healthy consumers who were previously very profitable are now much less so, and those with health conditions who were previously unprofitable are often now profitable. As a result, business models built over decades on health-status underwriting are now obsolete.

The centrality of the healthcare consumer is a trend that has been growing substantially over the past decade and will continue to grow. The payor industry is, unmistakably, heading toward a predominantly B2C model. New channels, such as the public and private exchanges, are beginning to put a price on choice/access trade-offs, given that lower-priced narrow networks are being sold side-by-side with more expensive broader networks. In our Consumer Exchange Simulation, more than 50 percent of participants chose bronze- or silver-tier products with restricted networks because those products had comparatively low premiums.[3] This finding has dramatic implications—when purchasing health insurance, consumers are making a choice about the providers they do (and do not) want to pay for.

Consumerism is also coming to the fore in government-sponsored business. Medicare Advantage continues to grow. A shift away from fee-for-service reimbursement in Medicare is prompting providers to view Medicare Advantage as the most attractive alternative for them. Furthermore, managed Medicaid plans are becoming more common; about 30 percent of the swelling ranks of Medicaid enrollees can choose among multiple managed Medicaid plans.

Even within the employer-sponsored insurance market, the impact of consumerism is being felt. Although it is only a decade since consumer-driven, high-deductible health plans were introduced, they now account for over 20 percent of employer-sponsored lives. This shift has prompted changes in both consumers' consumption behavior and physician's prescribing behavior, and has resulted in a meaningful dampening of utilization trends. Even more recently, the move to private exchanges by both smaller employers and large bellwether companies (e.g., Walgreens, Sears, and Darden) is taking the group insurance market retail. In 2013, about 1 million employer-sponsored lives were on private exchanges. Our analysis, based on announcements from employers and the exchanges themselves, suggests this may now have more than quadrupled, to approximately 4.3 million lives in 2014.[4]

Finally, the emergence of a variety of wearable sensors combined with mobile applications has increased the possibility that consumers can become the central conveners of their care. In such a world, consumers will have greater freedom to delegate their care to providers as they choose, with little switching cost.

[3] 2011 – 2013 McKinsey Consumer Exchange Simulations.
[4] McKinsey analysis based on MPACT 6.1 and press searches. For more details, see our forthcoming white paper on the private exchanges.

However, adapting to a consumer-centric world may be difficult for many payors. The business and operating models required to address consumers' needs are radically different from those used to serve business customers.[5]

The realignment of medical risk across the value chain is reshaping the roles each player in the healthcare value chain performs. For example, it is requiring payors to redefine their value-add. In 2009, our paper entitled, "Why understanding medical risk is the key to health reform," described how the fundamental nature of medical risk in the United States has changed over the past 20 to 30 years.[6] It has shifted away from random, infrequent, and catastrophic events (driven by accidents, genetic predisposition, or contagious disease) toward behavior- and lifestyle-related chronic conditions. Treating these conditions, and the serious medical events they commonly cause, now costs more than does the treatment of the more random, catastrophic events that health insurance was originally designed to cover.

We noted then that, 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; they are woefully short of the savings required to pay predictable, controllable expenses; and they are all too likely to be dealing with providers who have incentives to treat individual episodes of care rather than prevent illnesses and manage chronic conditions effectively. We argued that the underlying goal of reform should be to align risks—both risk exposures (e.g., lifestyle choices that induce chronic conditions) and expenses incurred (treatment choices that affect costs and outcomes)—with the parties best equipped to control them. Achieving this goal requires that the most appropriate financing mechanisms and provider reimbursement models be identified for each healthcare risk category.

In the past three years, we have seen rapid movement, particularly on the supply side, to realign risks through outcome-based provider reimbursement models. This movement has been driven by both government and private payors. Whether the long-term impact of this change is positive (e.g., through a reduction in the total cost of care) or potentially negative (e.g., through provider consolidation and integration, leading to an increase in unit prices) remains to be seen. But in either case, this movement of risk to providers has material implications for payors' role in the value chain.

The continued growth of high-deductible health plans is also leading to a realignment of risk toward consumers, but these plans may be a relatively blunt instrument. Intelligently designed wellness incentives and more creative cost-sharing arrangements are likely to emerge over the next few years as this realignment of risk continues. Driving this realignment through product and incentive design will require payors to become substantially more adept at understanding consumer behavior and how to modify it—not a small feat for enterprises that have been B2B-focused till now.

[5] For a closer look at the changes payors will need to make, see the article by Shubham Singhal and Tom Latkovic, "The retail revolution in health insurance: An industry transitions from wholesale to retail," April 2007 (available on mckinsey.com).

[6] Ozgur Adigozul, Thomas M. Pellathy, and Shubham Singhal, "Why understanding medical risk is the key to health reform," *McKinsey Quarterly*, June 2009 (available on mckinsey.com).

Healthcare data and information technology promises a digital revolution that could reshape much of healthcare. Payors have already automated many of their back-office functions (e.g., claims processing), but the impact of this next wave of technology applications will most likely be significantly greater. Big data and analytics will be central to competitive differentiation in all important areas of payors' business, including how they acquire members/customers, ensure better outcomes and healthcare quality for dollar spent, provide better customer service, and retain members/customers.[7] In addition, cloud computing is presenting payors with an opportunity to radically redesign their operating model (and simultaneously increase efficiency and functionality) by completely changing the scale equation.

The digital revolution in healthcare is being accelerated by providers' massive spending (encouraged by government funding) to make clinical data digital. For example, the HITECH Act authorized $19.2 billion in payments to providers for health information technology use.[8] Governments are also pushing data-transparency initiatives, such as Medicare's move to make claims data available and the efforts multiple states are making to make all payors' claims data available. These initiatives are leading to new ways to deliver, measure, and manage care delivery and conditions.

Payors will need to rapidly adapt their operating models to take advantage of these new opportunities. Otherwise, they risk falling behind competitors, attackers from other parts of the value chain, or new entrants.

Emerging responses

In response to the disruptive forces buffeting the healthcare industry, a Cambrian explosion of experimentation, transformation, and innovation is increasing the pace of evolution in the payor industry. Many payors are questioning whether the conventional wisdom about the boundaries of the payor business, and the way to most effectively create value within that business, still holds.

This compendium is designed to help them answer that question. The first article, "Thriving under disruption: How to succeed in the years ahead" provides a framework for how payors can think about disruption and describes the three strategic paths that the companies in other industries have used to come out on top. The next four articles zero in on specific strategic choices payors must make: Where should they compete? What scale is right? What scope? When does vertical integration make sense?

Once a payor has defined its horizontal and vertical scope, it can focus on how to compete within its chosen business lines. Three articles address specific business lines that require major redesign for payors: Medicare Advantage, Medicaid, and group markets. Our Center for US Healthcare Reform is monitoring closely the public exchanges and is releasing monthly Intelligence Briefs about developments in the individual market.[9] For that reason, we have not included an article on that market here.

The central issue across business lines is how to innovate along two themes: becoming more consumer-centric and improving healthcare value. "Winning with consumers:

[7] For more information about the impact big data and analytics are likely to have on the healthcare industry, see the article by Peter Groves, Basel Kayyali, David Knott, and Steve van Kuiken, "The big-data revolution in US health care: Accelerating value and innovation," January 2013 (available on mckinsey.com).

[8] The HITECH Act is the Health Information Technology for Economic and Clinical Health Act of 2009.

[9] See, for example, the recent Intelligence Brief by Erica Coe, Chiara Leprai, Jim Oatman, and Jessica Ogden, "Prevalence of narrow hospital networks in the post-reform world," November 2013 (available on mckinsey.com).

What payors can learn from 'consumer' companies" describes ideas from other industries that payors can use to become successful consumer-centric organizations. Outcomes-based payments and high-performance networks are areas of innovation that appear to hold the greatest promise to deliver a step improvement in healthcare value. "What's needed to make outcomes-based payment work" outlines five steps payors can take to ensure the effectiveness of this new payment approach. "Why the time is right for episode-based payments" dives deep into one effective and practical outcomes-based payment model that is gaining rapid adoption. "Maximizing value in high-performance networks" discusses how payors can build upon their initial forays into network innovation to drive further value.

The last two articles in our compendium focus on organizational issues. "Health-focused redesign: Creating a payor organization for the future" describes how payors can restructure themselves to achieve the radical transformation required by the industry disruption. "Riding the next wave of payor M&A" outlines six characteristics that increase the likelihood that a deal will succeed.

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At this time, when the pace of change is rapid and its direction uncertain, strategy matters more than ever. We hope you find this compendium useful as you think about important questions of strategy definition and enablement. If you would like more information about any of these topics, please contact one of the article's authors directly or one of the McKinsey partners you work with regularly. He or she will be happy to connect you to the right experts.

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