Understanding and engaging a new era of Medicaid consumers

A new McKinsey survey offers payors, providers, and state governments a way to understand key differences among Medicaid consumers—differences that have important implications for how to engage current and potential enrollees effectively.

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Over the next 12 to 18 months, the Medicaid program will undergo the most fundamental change since its inception in 1965. In those states that have chosen to expand Medicaid under the Affordable Care Act (ACA), the increase of eligibility to 138 percent of the federal poverty level[1] could enable approximately 18 million new people to enter the program by 2021.[2] Even in states without Medicaid expansion, enrollment is expected to increase by 15 to 20 percent over the next eight years as people who were previously eligible but not enrolled come forward because of simplified enrollment processes and publicity about coverage expansion.[2] By 2021, Medicaid spending could total almost $800 billion.[2]

The nature of the Medicaid program is also changing in important ways. Many states are moving away from fee-for-service (FFS) models and shifting their highest-acuity Medicaid members into full-risk managed care programs that cover a comprehensive set of services. For example, a number of states are undertaking demonstration projects to better integrate care for the dual-eligible population (people covered by both Medicare and Medicaid).[3]

These changes are creating unprecedented heterogeneity and complexity in Medicaid, but they also give payors, providers, and state governments a significant opportunity for growth and mission impact. To take advantage of this opportunity, these stakeholders need a better understanding of Medicaid members, especially dual eligibles and people entering the program next year. For both of these groups, stakeholders should understand a range of variables, including current health behaviors, attitudes about health insurance and care delivery, and preferences about where to seek information and advice.

To develop quantitative consumer insights about the Medicaid population, we surveyed more than 1,100 consumers across the United States, focusing on the following groups: current Medicaid members (both dual eligibles and those covered by Medicaid alone), people who are currently eligible for Medicaid but not enrolled (EBNEs), and people who will be eligible for Medicaid beginning in 2014 (new eligibles).[4] We also included some commercially insured individuals to permit direct comparisons with them. To attract a representative sample of respondents from each group, we conducted the survey both online and at shopping malls, and administered it in both English and Spanish.

The results revealed two key insights:

- In many ways, people entitled to enter the Medicaid program next year (a group that we refer to as "potential entrants," which includes both EBNEs and the new eligibles) are

[1] About $15,400 per year for an individual and $31,800 for a family of four.
[2] DHHS. *Report to Congress. 2012 Actuarial Report on the Financial Outlook for Medicaid.* (This report acknowledges that the increase in the number of covered lives would be significantly higher if every state were to expand Medicaid.)
[3] Website of the Medicare Medicaid Coordination Office.
[4] Additional details about the survey can be found in the appendix, which begins on p. 147.

more similar to commercially insured individuals than to current Medicaid members. Nevertheless, there are several important differences between the potential entrants and commercially insured individuals. These differences have significant implications for plan design.

- Many dual eligibles are not being reached effectively, in part because of misconceptions about them. Managed care programs geared to these members will be more effective if grounded in a more accurate understanding of their needs, behaviors, and attitudes.

The results also allowed us to develop recommendations for how payors, providers, and state governments can engage effectively with the Medicaid population and to define the capabilities these stakeholders will need.

Individuals entering Medicaid

Potential Medicaid entrants appear to be similar to commercially insured individuals in many of their behaviors and attitudes. However, differences in a few key areas suggest that they may be more receptive to value-based approaches.

Behaviors

In our survey, 56 percent of the new eligibles and 40 percent of EBNEs were employed, compared with only 26 percent of non-dual Medicaid enrollees (Exhibit 1).[5] Over half of the employed potential entrants were working full-time.

About 30 percent of the new eligibles reported having three or more health conditions, a rate similar to that reported by commercially insured individuals. In comparison, 39 percent of EBNEs and 60 percent of non-dual enrollees said that they had three or more health conditions.[6] Approximately 60 percent of the new eligibles and commercially insured individuals, and 55 percent of the EBNEs, reported that they had never been smokers, but only 38 percent of non-dual enrollees made this claim.

Just over 50 percent of the potential entrants said that they already had health insurance, usually through a job, union, or school. However, 8 percent of the new eligibles and 13 percent of EBNEs reported having purchased coverage directly.

The lack of health insurance reported by almost half of the potential entrants appears to have influenced that group's healthcare utilization levels. On average, the potential entrants were much less likely than current enrollees or commercially insured individuals to have visited a primary care provider (PCP) during the previous year. Even among the

Fast facts about the 2013 Medicaid program

57 million	Covered population
$432 billion	Annual spending
9 million	People eligible for both Medicare and Medicaid
$320 billion	Estimated total cost for dual eligibiles[1]

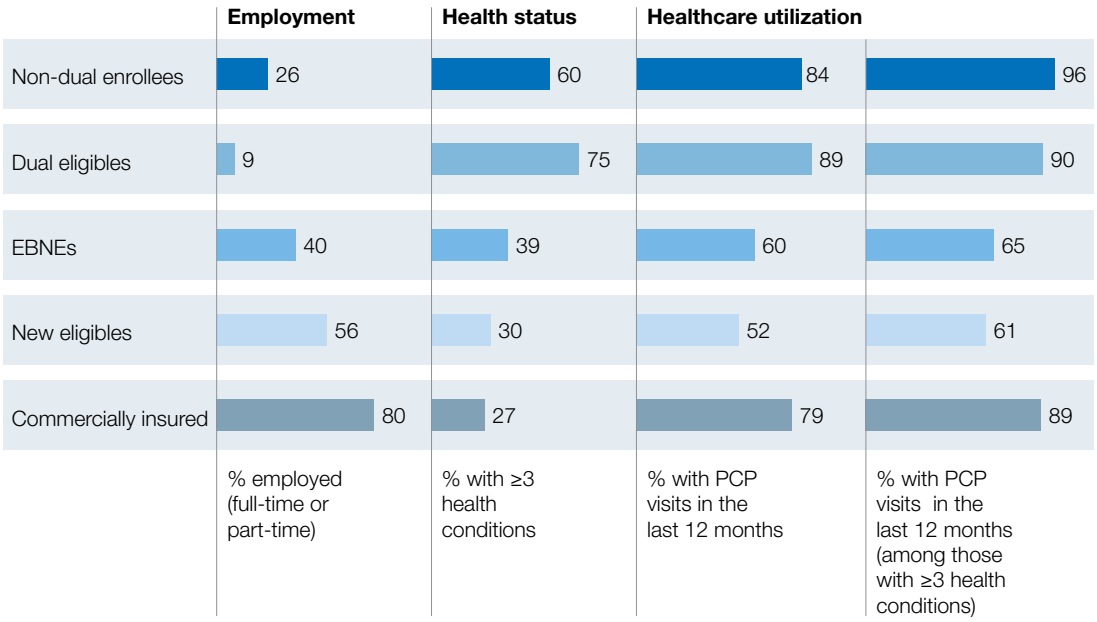
[1]Includes both Medicaid and Medicare spending.

Source: DHHS, *Report to Congress: 2012 Actuarial Report on the Financial Outlook for Medicaid*, March 1, 2013; RWJ Foundation/Urban Institute, *Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead*, October 2011

[5]In this section, all comparisons are with current Medicaid enrollees who are not also eligible for Medicare coverage. Given that, by definition, Medicare eligibility requires individuals to be elderly or disabled, comparisons between potential entrants and dual eligibles are often less relevant.

[6]The similarities and differences in health status and healthcare utilization among the various groups persisted even after age adjustment.

EXHIBIT 1 **How potential Medicaid entrants compare with other consumer groups**



EBNE, eligible but not enrolled; PCP, primary care physician.
Source: McKinsey Medicaid Consumer Insights Survey

respondents with three or more health conditions, the rate of PCP visits was markedly lower among the potential entrants than among those with Medicaid or commercial coverage. Approximately 60 percent of the potential entrants said that they planned to visit PCPs more frequently once insured, and 48 percent of them were willing to be seen by non-physician providers.[7]

The rate of frequent emergency room (ER) utilization—three or more visits in the previous year—was far higher among the new eligibles (9 percent) and EBNEs (7 percent) than among commercially insured individuals (1 percent). However, the potential entrants' rate was far below that of non-dual Medicaid enrollees (16 percent).[8]

We did not find any significant behavioral differences among the various ethnic groups we surveyed. For example, Hispanic new eligibles were very similar to their non-Hispanic counterparts in terms of employment (60 percent employed), insurance status (47 percent insured), and utilization (45 percent saw a PCP in the past year). Hispanic new eligibles differed only in that they reported slightly better health status (just 19 percent said that they had three or more health conditions).[9]

Attitudes

All of the groups we surveyed said that the feature they valued most in health insurance was coverage for PCP visits, followed by coverage for prescription drugs (Exhibit 2). The potential entrants, like commercially in-

[7]Again, these differences persisted even after age adjustment.
[8]The high rate of frequent ER utilization among current non-dual eligibles is likely to reflect the problems with access to care and higher clinical acuity that Medicaid members frequently report.
[9]The health status and utilization trends for Hispanic and non-Hispanic consumers persisted even after age adjustment.

sured individuals, expressed little interest in specialty benefits, such as mental health or transportation coverage.

The potential entrants did differ from commercially insured individuals in their willingness to consider narrow provider networks. Only 38 percent of the potential entrants, but more than two-thirds of commercially insured individuals, cited provider network size as an important determinant of plan choice. However, both the potential entrants and commercially insured individuals ranked cost-sharing (premiums and deductibles), doctor visit co-pays, and prescription drug co-pays as the most important drivers of plan choice.

Age influenced some of the potential entrants' attitudes. Among the new eligibles, for example, those over the age of 50 were much more likely than young adults to list prescription drug benefits as one of the three most impor-

EXHIBIT 2 **Coverage for PCP visits and prescription drugs ranks highest among all consumer segments**

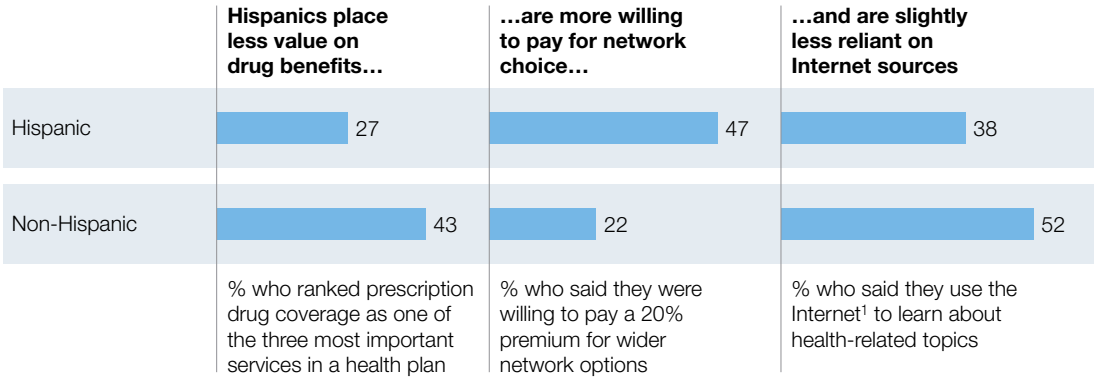
Which services are most important in a health plan?

	Non-dual enrollees	Dual eligibles	EBNEs	New eligibles	Commercially insured
Visits to a PCP's office	88	90	84	87	94
Visits to a specialist	47	56	40	48	65
Visits to the hospital	17	13	24	28	41
Visits to the ER	49	42	52	55	65
Visits to a mental health professional	23	17	11	10	9
Visits to a dentist	54	36	57	52	51
Visits to an eye care professional	28	41	33	24	28
Prescription drug coverage	69	83	65	55	67

EBNE, eligible but not enrolled; ER, emergency room; PCP, primary care provider.

Source: McKinsey Medicaid Consumer Insights Survey

EXHIBIT 3 **Hispanic new eligibles resemble their non-Hispanic counterparts—but with some important differences**



[1]Internet includes websites and search engines.
Source: McKinsey Medicaid Consumer Insights Survey

tant services to include in a health plan (51 percent versus 35 percent, respectively). Conversely, 34 percent of respondents between the ages of 18 and 29 cited dental care as a top-three service, compared with only 13 percent of those over age 50. However, more than 75 percent of the potential entrants in all age groups listed PCP visits as a top-three service.

In general, there were few attitudinal differences among the ethnic groups surveyed, but some of the differences we did find were striking. For example, Hispanic new eligibles were much less likely to list prescription benefits as a top-three service than were other new eligibles; they were also much more willing to pay extra for a broad network (Exhibit 3).

The enrollment journey

Because different states have different policies about Medicaid enrollment (e.g., passive with opt-out versus voluntary) and different populations have different needs, there is no single path that people entering the Medicaid program for the first time follow. Nevertheless, their enrollment journeys share certain similarities, such as the need to learn about available options.

Our survey found that 44 percent of the new eligibles and 43 percent of EBNEs said that they did not know where to begin to select and enroll in health insurance. Thus, both groups would likely benefit from advice and assistance, but somewhat different strategies may be needed to reach them. In our survey, the new eligibles were similar to commercially insured individuals—and quite different from non-dual Medicaid members—in terms of both where they sought health-related information (Exhibit 4) and whom they relied on for advice about health insurance (Exhibit 5). The EBNEs' responses were more heterogenous. For example, the EBNEs were more likely than any other group to rely on television as a source of health-related information.

Nevertheless, both potential-entrant subgroups and commercially insured individuals demonstrated a reasonably high level of technology use. For example, 24 percent of the potential entrants and 39 percent of the commercially insured reported browsing the Internet through their smartphones for health-related topics. Nearly half of the potential entrants and two-thirds of the commercially insured said that they would like to be contacted by providers via email, and one-third of both groups welcomed text messages from providers. However, only about 15 percent of the potential entrants and 6 percent of commercially insured individuals expressed willingness to be contacted by providers through social media.

Finally, awareness of insurance company brands was relatively high among the potential entrants. For example, about 78 percent of the potential entrants were aware of the Blue Cross Blue Shield plans operating in their state, and roughly 90 percent were aware of at least one non-BCBS plan (Exhibit 6).[10] However, among the potential entrants who were aware of the various plan types, considerably more said that they were likely to make a BCBS plan their top choice than to select another brand.

Dual-eligible members

To help payors and providers understand and find better ways to engage this important group, our survey included more than 100 dual eligibles. The results revealed several shortcomings in care management and outreach that, if addressed, could markedly enhance engagement with this population.

Multimorbidity is common among dual eligibles—75 percent of them reported having

EXHIBIT 4 **Medicaid segments show distinct preferences about their sources of health-related information**

Sources used to learn about health-related topics, %

	Non-dual enrollees	Dual eligibles	EBNEs	New eligibles	Commercially insured
Websites	38	28	44	54	71
Television	41	43	47	32	26
Magazines	36	26	23	28	35
Search engines	33	22	50	42	60

EBNE, eligible but not enrolled.

Source: McKinsey Medicaid Consumer Insights Survey

[10] In our survey, we were able to test consumers' awareness of specific local (rather than national) company brand names, but we could not test for awareness of the specific products offered by those companies.

three or more health conditions (most often, hypertension, depression, and hypercholesterolemia). Healthcare utilization is also high in this population: 90 percent said that they had visited a PCP in the previous year, and 8 percent reported having made three or more ER visits during that period.

Nevertheless, dual eligibles' engagement with providers and payors appears to be very limited. About 22 percent of them said that they were never contacted by their provider outside of care delivery, and 46 percent of them reported that they had never been contacted by their insurance company or program.

Like the other groups we surveyed, dual eligibles placed high value on coverage for PCP visits and prescription drugs (see Exhibit 2). Compared with other groups, however, they put greater weight on specialist visits and specialty services, such as mental health and transportation. Although one-third of dual eligibles rated provider network as an important driver of plan choice, two-thirds were willing to consider the use of non-physician providers for routine care.

Technology use was fairly high among dual eligibles. Websites were second only to television as a source of health-related information (28 percent versus 43 percent, respectively). One-third of dual eligibles said that they were interested in being reached via email for care management.

Engaging Medicaid consumers

Taken together, our results reveal significant differences among existing and potential Medicaid consumers. These differences have important implications for how payors, providers, and state governments should approach the various consumer segments.

EXHIBIT 5 **Employers are key influencers among the new eligibles**

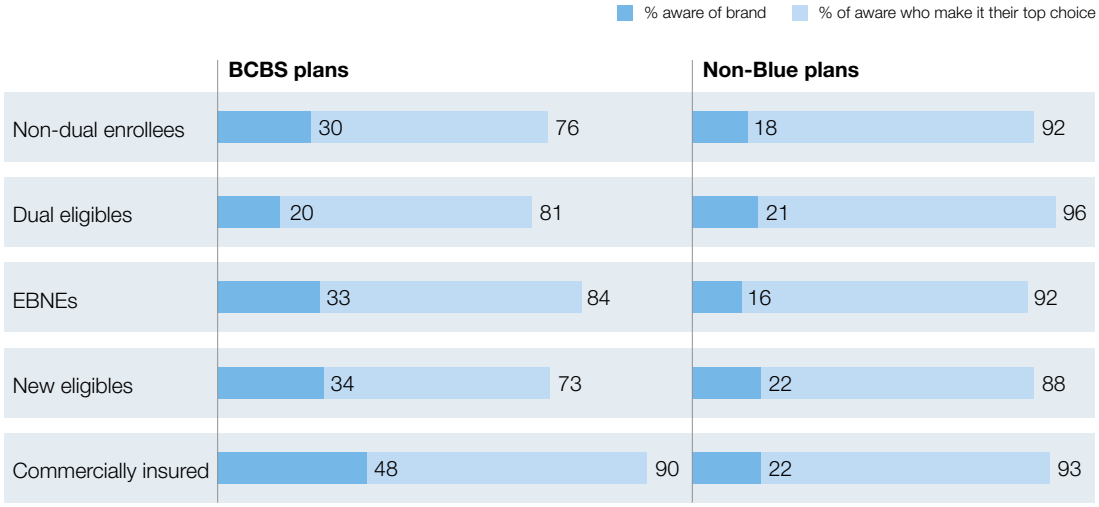
Most important party relied on for decisions about health insurance enrollment, %

Non-dual enrollees	Dual eligibles	EBNEs	New eligibles	Commercially insured
Healthcare provider 27	Healthcare provider 25	Spouse 18	Employer 23	Employer 66
Government agency 21	Government agency 23	Healthcare provider 16	Healthcare provider 13	Spouse 32
Parents 12	Parents 8	Employer 12	Spouse 13	Friends 22

EBNE, eligible but not enrolled.

Source: McKinsey Medicaid Consumer Insights Survey

EXHIBIT 6 **Potential entrants aware of various plan types are more likely to choose a BCBS plan than a non-Blue plan**



BCBS, Blue Cross Blue Shield; EBNE, eligible but not enrolled.
Source: McKinsey Medicaid Consumer Insights Survey

However, certain capabilities will help all stakeholders engage effectively with the various segments (Exhibit 7).

Payors

Payors that want to develop a Medicaid outreach program with a high return on investment should combine insights about each consumer segment with information about the relevant state regulatory landscape (e.g., passive versus opt-in enrollment, lock-in periods, and switching guidelines). For instance, worksite outreach may be an overlooked but important channel for reaching potential entrants, given their high employment rate and reliance on employers for insurance information. Similarly, websites may be an overlooked but important way to reach dual eligibles, given that a significant portion of this population uses the web as a source of health-related information.

Where payors have the flexibility to do so, they should develop benefit designs that align with consumer preferences. The fact that 48 percent of potential entrants are willing to see non-physician providers, 60 percent would consider narrow provider networks, and more than 80 percent rank PCP coverage as the most important insurance benefit strongly suggests that these consumers will be attracted to value-based designs (e.g., primary care networks staffed by both physician and non-physician providers). The strong interest potential entrants also show in prescription drug coverage indicates that they may be receptive to add-on benefits such as over-the-counter (OTC) drug coverage (similar to the prepaid pharmacy debit cards that can be used for OTC products and other drugs not included in the standard benefit design).

Payors should also consider closer collaboration with Medicaid providers, some of whom

EXHIBIT 7 **What the Medicaid consumer journey reveals for stakeholder capability building**

Multichannel outreach	• **Define new models of outreach** targeted to specific steps in the enrollment journey (e.g., worksite programs) • Create differentiated capabilities for each segment
Network and benefit design	• **Explore opportunities for high-value network creation** (e.g., narrow network, non-physician providers) for each segment
Payor-provider collaboration	• **Create innovative models for outreach collaboration**, particularly for groups that rely on providers for guidance • **Focus on jointly building capabilities**, including care delivery transformations and data analytics infrastructure
Care management	• **Define care management programs tailored by segment** and based on current understanding of consumer behavior (e.g., online self-management)
Technology enhancement	• **Upgrade** to support new member influx, revised eligibility verification, and member tracking • **Develop analytics** to better link clinical and financial metrics and assess risk

they may not have worked with extensively before. Two areas are particularly important: enrollment and care delivery transformation. For example, payors can work with safety-net providers to support enrollment in a variety of ways. They can help educate the clinical and office staff about the eligibility criteria for Medicaid and its care management programs. They can also create data systems that the clinical and office staff can use to identify eligible patients (based on the states' new presumptive eligibility statutes[11]) and work with the staff to co-develop targeted outreach programs to inform patients about eligibility. Care delivery transformation is also ripe for collaboration, particularly for multistate payors with sophisticated capabilities. Such payors can help safety-net providers improve their clinical operations, data and analytics infrastructure, and care coordination programs.

Given that income fluctuations will alter the eligibility status of many Medicaid consumers (up to 80 percent of new enrollees over the next four years, by some estimates[12]), important adjacencies will arise between the Medicaid market and the low-income exchange market. These adjacencies will give payors that offer both Medicaid and individual plans the opportunity to create synergies. For example, they can extend their Medicaid value provider networks to support the exchange population and use their expanded scale as a way to find cost efficiencies.

[11] Beginning January 1, 2014, the ACA allows hospitals to make presumptive eligibility determinations beyond the current "moms and kids" populations.

[12] Benjamin D. Sommers and Sara Rosenbaum, "Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges," *Health Affairs*. 2011;30:228-236.

Providers

The implications of Medicaid expansion for providers depend primarily on two considerations: first, how much of their current patient mix involves uncompensated care or Medicaid coverage and, second, how Medicaid's growth and margin profile compares with other opportunities (e.g., Medicare Advantage) in their local market. For example, for health systems with a high volume of uncompensated care (e.g., through their ERs), Medicaid expansion represents an important chance to improve margins and/or reduce deficits, not only because of new member entry but also because of the direct payments they will receive for some previously uncompensated care. In this situation, the health systems most likely to benefit from Medicaid expansion are those that can concurrently invest in primary care, be clear about which patient segments they want to attract and serve, and ensure that those patients get timely access to care in the right setting.

To engage effectively with Medicaid consumers, these health systems should begin with a robust outreach approach for each segment (similar to the approach described above for payors). For example, because individual healthcare providers are the primary source of insurance advice for dual eligibles, the health systems should educate them about how to identify and better reach out to the patients in their panels who are eligible for both Medicaid and Medicare. Similarly, the health systems should scale up their worksite and online outreach efforts to reach potential entrants.

Health systems that serve a high volume of Medicaid consumers should also consider whether they need to optimize their care delivery models to serve new members, with special emphasis on timely access to outpatient care. Our survey, like the results of the Oregon Medicaid lottery and Massachusetts' health exchange, strongly suggests that Medicaid expansion will reveal an unmet need for PCP services and result in increased outpatient utilization. Given that both the potential Medicaid entrants and dual eligibles are relatively open to narrow provider networks, health systems therefore have an opportunity to recruit and train more mid-level providers to deliver primary care services and manage specialty referrals. Furthermore, the greater level of ER use (including use for "primary care treatable" and "non-emergent" conditions) by Medicaid enrollees in the Oregon lottery suggests a need to assess ER services in the broader context of unscheduled care and the implications for required efforts on primary care access.

Care coordination is another area ripe for improvement. Our findings about dual eligibles suggest that there is a need for better provider-led care management—but also an opportunity to use technology for self-directed care and to involve a broader group of influencers in patient care.

Providers that do not have a substantial Medicaid base (e.g., freestanding ambulatory surgery centers and specialty hospitals) must decide how they want to participate in Medicaid expansion in terms of both scale and type (e.g., dual eligibles versus non-duals, FFS versus managed care). This decision should be based on an evaluation of the needs of various Medicaid segments, the provider's current capabilities to meet each set of needs, reimbursement options (pure FFS versus value-based), and the provider's positioning within the community.

State governments

We believe that state governments should consider consumer preferences as they make detailed program design decisions to match their policy choices. We do not presume here to comment on the policy choices the states must make on a range of issues, including eligibility and enrollment focus, benefit design, and requirements placed on payors and providers. However, we believe that states can increase the effectiveness of those choices by taking into account the need to tailor programs to the different consumer segments that are emerging within Medicaid (this holds true both for programs offered directly in Medicaid FFS states and those administered through managed care organizations). For example, consumer preferences about a range of variables—including network breadth, access to specific specialties, co-pays, prescription drug coverage, and premium levels—suggest that states may have the opportunity to design combinations of features that increase the programs' attractiveness to different consumer groups while also balancing the need to address the program's financial viability.

We also recommend that states begin to determine how they want to handle Medicaid data availability, transparency, and reporting. The overall direction each state takes is, again, a public policy choice and beyond the scope of this article. But as they make their choices, states may benefit from contemplating the extent to which they will need direct access to data on consumer behaviors and preferences so that they can make policy and management decisions effectively during program growth in the years ahead. In addition, states should consider whether they might benefit from making some of their Medicaid data (at an appropriately aggregated level) available to a broad range of stakeholders to help advance a more robust understanding of how best to serve this population.

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Our survey results reveal important insights into how current and potential Medicaid enrollees differ—insights that stakeholders can use to better serve Medicaid members and engage them more effectively. However, as ACA implementation progresses, the various consumer segments are likely to evolve and new segments (e.g., those who shift between Medicaid and individual coverage) will emerge. We will continue to investigate the behaviors and attitudes of the various consumer segments to help Medicaid stakeholders with their strategy and portfolio allocations, marketing tactics, and capability-building plans.

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This article leverages proprietary research and analysis that McKinsey has conducted over the past 18 months, especially the Medicaid Consumer Survey. The major research sources we used in this compendium are described in the appendix, which begins on p. 147.