Navigating the coming changes in the commercial group market

While recent attention has focused on public exchanges, the commercial group market—the largest segment in the US health insurance industry—will be a hotbed of change over the next five years. Unmanaged, the segment faces profitability pressure, but payors who take proactive measures to redesign their health benefits product portfolio and optimize their pricing approaches will find revenue and earnings growth.

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Employers face an unsustainable healthcare cost burden. And, while the traditionally high annual rate of increase has moderated somewhat in the last few years, it continues to outpace inflation. This cost burden has led to discussions of whether the nature of employer-sponsored health benefits should fundamentally change.[1] Healthcare reform has intensified these discussions.

But how ready are employers to make major changes to their healthcare benefits? To better understand this issue, we conducted numerous interviews with, and two surveys of, executives at mid- and large-sized companies over the past two years. Our results, similar to reports from other leading organizations,[2] confirm that many executives are considering this issue. Many of them expressed their belief that new insurance options, such as defined-contribution models and private exchanges, hold promise for ameliorating rising healthcare costs, as would the elimination of coverage for some beneficiaries (e.g., part-time employees, Medicare-eligible employees, and spouses). Several employers, including Walgreens, Sears, and Darden, have already moved, or have announced that they will be moving, their active employees to defined-contribution private exchanges. An even greater number of companies (e.g., Caterpillar, IBM, and Time Warner) have transferred, or have announced that they will be transferring, retirees to private exchanges. Based on our analysis of the relative likelihood of a move to defined-contribution private exchanges by industry, we estimate that roughly 20 million to 30 million people will likely shift from traditional group coverage to private exchanges by 2019.[3]

However, our research also suggests that most employers are not yet ready to make major changes to their benefit models. Even if up to 30 million people are shifted to private exchanges, approximately 110 million to 120 million people will remain covered by traditional employer-sponsored health benefits.

The majority of the executives we interviewed or surveyed agreed that their company's near-term goal is to be "slightly above the industry average in benefit offerings." Many of them also expressed concerns about implementing major changes unless their competitors for talent take similar action, fearing that such a move could harm talent acquisition and retention. For the next one or two years at least, most of the executives said, they plan to continue offering health insurance benefits similar to those they provide today, while working to optimize employee satisfaction and reduce costs within the boundaries of their existing benefit models. In addition,

[1] Kaiser Family Foundation and Health Research Educational Trust, *Employer Health Benefits 2013 Annual Survey*; Christopher S. Girod, Lorraine W. Mayne, and Scott A. Weltz, *Milliman Medical Index*, May 22, 2013; "Aon Hewitt analysis shows lowest U.S. health care cost increases in more than a decade" (news release), October 17, 2013.

[2] Examples of these reports include the 2013 Towers Watson/National Business Group on Health Survey, *Reshaping Health Care: Best Performers Are Leading the Way*; the 2013 Accenture Research Report, *Are You Ready? Private Health Insurance Exchanges Are Looming*.

[3] McKinsey analysis based on MPACT and Bureau of Labor Statistics, 2013. A forthcoming white paper on private exchanges will provide more details about this shift.

they will monitor what their competitors for talent do before making any big moves themselves (Exhibit 1).

For at least the next several years, then, commercial group insurance will most likely continue to be the largest segment in the health insurance market (Exhibit 2). Today, group insurance accounts for about 58 percent of all insured lives in that market. Although group plans will not significantly benefit from the accelerated growth expected to be fueled by healthcare reform, our analyses suggest that the number of people covered under group plans (including those on private exchanges) is not apt to change significantly between now and 2019.

In this article, we will discuss how the economics and trends of the commercial group market are likely to change between now and 2019—and what the implications and opportunities are for payors.

Group-market profitability will remain pressured

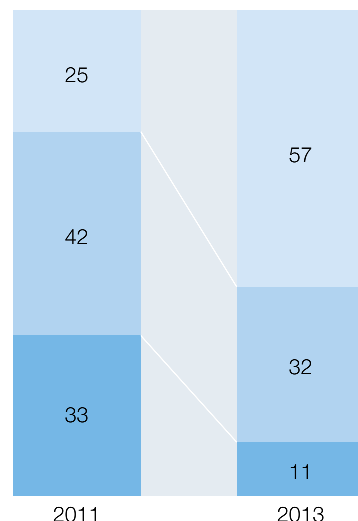
Our estimates suggest that revenues in the commercial group market could potentially increase from today's $300 billion to $425 billion by 2019, but profits are likely to stagnate as a result of several pressures (discussed below). The result could be a decline in profit margin of up to 30 percent. We believe that five trends

EXHIBIT 1 **Many employees are waiting for others to make the first move on major benefit changes**

How employers surveyed rated the impact of competitors' actions on their own plans to modify health benefits

Major impact | Minor impact | No impact

%, n = 1,329 (2011), n = 37 (2013)



We've done the cost-benefit analysis [and think dropping would be beneficial], but don't feel we can take action unless someone else does.

—Marketing industry CFO

We want to be on the cutting edge, not the bleeding edge.

—Benefits executive

Our goal is to be slightly above the industry average in our benefits offerings.

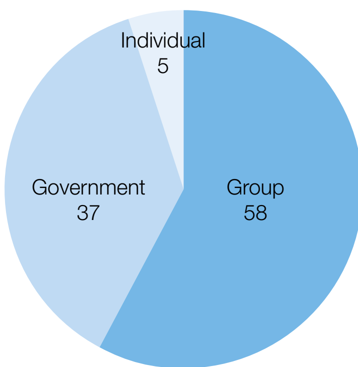
—Benefits executive

Source: McKinsey employer interviews and surveys, 2011 and 2013

EXHIBIT 2 The commercial group market will continue to be important in the future

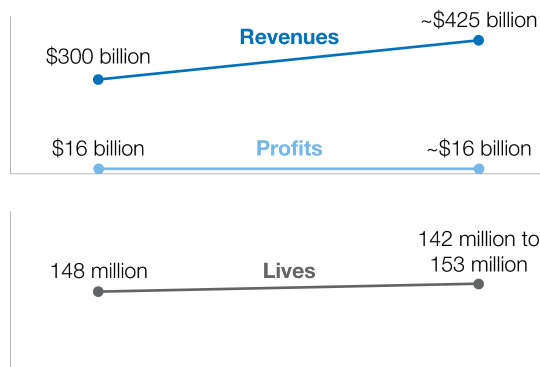
Member lives by market

% of total



Changes in the group market

2011 – 2019



[1]The group market includes fully-insured plans, administrative-services-only plans, and plans offered through private exchanges.
Source: MPACT 6.0; SNL filings; MAHA Payor Performance Index

will contribute to the potential decline in profitability:

MLR regulations. Regulations governing medical loss ratios (MLRs) dampened the profitability expectations of both small- and large-group plans. The requirement that 80 percent of premiums for small groups, and 85 percent of premiums for large groups, be spent on medical costs will squeeze payor profits. Although MLR regulations are in effect already, we have not yet seen the full impact of them on payor profitability. Healthcare utilization has dampened in recent years, and so payors have been able to keep both medical costs and associated administrative costs below expected levels. This has enabled them to manage MLRs close to the regulatory limits and retain a larger percentage of the remainder of premiums as profits. It is unlikely, though, that this situation will continue. As utilization rises, profits are apt to suffer.

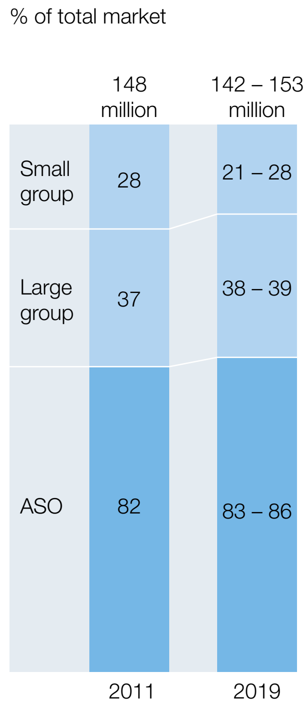
Risk adjustment. Risk adjustment is likely to change the profitability of many insured small groups. Groups with healthier-than-average employees (historically, an attractive target segment for payors) are apt to become less profitable and perhaps even unprofitable, because of the net payments payors insuring these groups will have to make into the risk-adjustment pool.

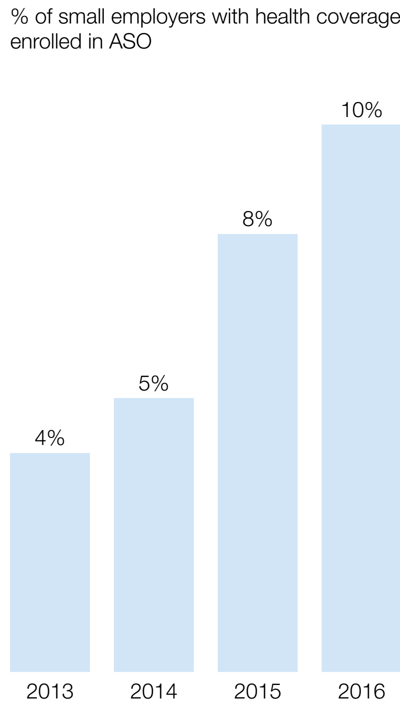
Shift from fully insured small-group plans to ASO plans. Up to one-quarter of people currently covered by fully insured small-group plans may see their employers shift to administrative-services-only (ASO) plans over the next several years (Exhibit 3). Our research suggests that small employers are considering moving to self-insurance for two reasons. First, starting in 2014, community rating will make it more attractive for small businesses with healthy employees to self-insure. Second, many of the regula-

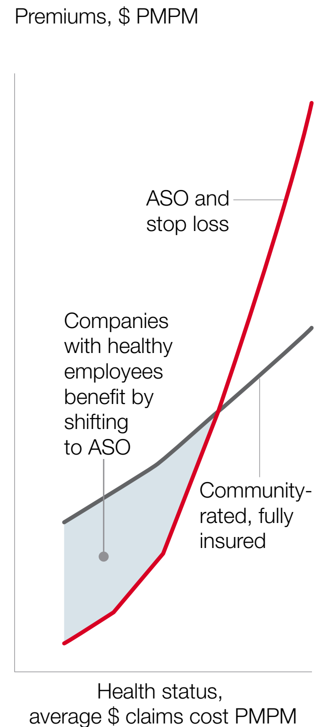
tions in the Affordable Care Act that apply to small groups (e.g., the ten categories of essential health benefits and minimum deductibles) do not apply to self-insured companies.[4]

Increased competition. Payors will probably see competition intensify on three fronts. First, many employers are expressing interest in direct partnerships with providers—the employer and provider agree on pricing for a specific (typically narrow) range of bundled services without involving a payor (e.g., the Lowe's–Cleveland Clinic partnership for certain types of transplant surgery). Some employers are also making direct arrangements with pharmacies (e.g., the Caterpillar–Walmart partnership). Many providers, concerned about the shrinking size of the commercial market, find these direct partnerships attractive because they guarantee volume in select specialty areas or geographies. Second, new models for offering health coverage to employees,

EXHIBIT 3 **ASO will be a more attractive option for some employers post-reform**







[1]Given a constant level of benefits, deductibles, and copays.
ASO, administrative services only.
Source: KFF Employee Health Benefits Survey, MPACT 6.0; McKinsey analysis

[4]§2707(a) of the Public Health Service Act (as added by the ACA) stipulates that health insurance coverage in the individual and small-group markets must include essential health benefits. This provision applies only to health insurance issuers; it does not apply to employers with self-insured ASO plans.

such as the public and private exchanges, will, in essence, "compete" with payors trying to retain groups in traditional employer-sponsored coverage.[5] Third, the private exchanges could potentially increase the level of competition among payors, because they could make it easier for national carriers to enter local markets for smaller groups and for regional carriers to go after national accounts' employees in their service areas.

Benefit buy-down. As employees are moved to new coverage models—in particular, the private exchanges—they will gain greater control over their health insurance and other benefits choices. Our research suggests that in these more "retail" environments, many consumers are likely to choose less-expensive, lower-actuarial-value health plans and then "buy up" by purchasing supplemental or ancillary benefits, such as dental, vision, disability, or life coverage.[6] In our Private Exchange Simulation, for example, consumer spending varied widely (from those who spent less than the employer contribution to those who contributed a significant amount out of pocket); however, all segments purchased supplemental and ancillary products (Exhibit 4). Our Private Exchange Simulation findings also suggest that some consumers may choose less-expensive coverage overall and allow some of their employer's defined contribution to remain unspent.[7] This interest in less-expensive plans mirrors what we have seen in our Consumer Exchange Simulation, which focuses on the individual market. Across multiple runs of that simulation, 54 percent of consumers chose from the least-expensive plans available to them, usually bronze or silver plans with narrow provider networks.[8]

As a result, a significant portion of the group market could potentially shift to less-expensive plans, resulting in lower revenues and profits for group payors overall. It is also possible that when *employees*—not employers—are selecting the coverage they want, they may select plans that better match their specific health needs. In this case, the benefits offered in the plans may be more extensively utilized, which could further lower payor profits.

Implications for payors

Despite the likely decrease in profitability, the commercial group market offers payors attractive opportunities to grow profitably in the near term. Over the next few years, employers will continue to look for innovative benefit solutions that help them keep costs under control and meet their employees' needs. Clearly, payors capable of delivering a differentiated, cost-effective value proposition that helps employers achieve these goals will have the greatest possibility of success. With that backdrop of base requirements to win, we outline four actions that can enable payors to achieve profitable growth in the commercial group market.

Develop granular retention strategies

Payors need to understand—on a very granular level—how market shifts will affect each segment of their existing books and then develop customer acquisition and retention approaches accordingly. For example, which industries, and which employers within those industries, are likely to shift to private exchanges? Which employers could be retained on traditional employer-sponsored insurance? What products should

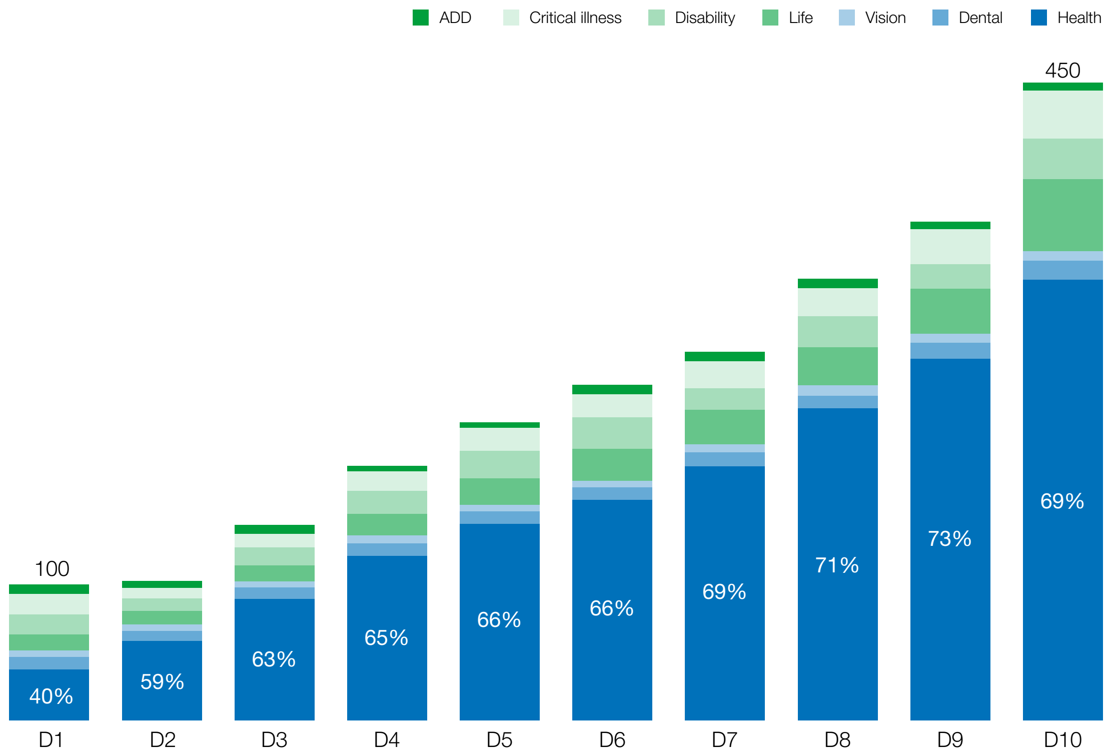
[5] Although we do not believe that a high volume of people with group insurance will be moved to these exchanges in the next few years, even a shift of only 10 percent of covered lives could decrease payor profitability.
[6] For more information about how payors can adapt to a more retail-like environment, see the article by Jenny Cordina, Ali Keshavarz, Rohit Kumar, and Shubham Singhal, "Winning with consumers: What payors can learn from 'consumer' companies," on p. 51.
[7] McKinsey 2013 Private Exchange Simulation.
[8] 2011–2013 McKinsey Consumer Exchange Simulations.

be offered to each set? Which large employers will be looking exclusively to reduce healthcare costs, and which ones will want value-added member services from payors?

We believe that the assessment should begin with small employers. Significant near-term opportunities exist in this market, given that many companies renewed their coverage early in 2013 and must now shift to ACA-compliant plans. Often, payors will be able to identify mutually beneficial opportunities for these companies and themselves. For example, companies whose employees appear to be less healthy than average may be eligible for a premium reduction in a community-rated environment. And, if such groups include fewer than 50 people, payors could experience a potential increase in profits due to risk-adjustment payments. Conversely, small employers with healthier-than-average employees might be better off self-insuring.

EXHIBIT 4 **All consumer segments by spending level elect to purchase supplemental products on a private exchange**

Percentage of average premium paid in each category,[1] USD



[1]Premium amounts shown indexed to Decile 1. Health insurance premium was significantly higher for family coverage as compared to non-health premiums.

Source: McKinsey 2013 Consumer Healthcare Survey Private Exchange Simulation

To capture the opportunities in the small-group market, payors may need to develop ASO products that meet the unique needs of small employers. Many payors are already investing to pursue this market aggressively; they have been developing new ASO and stop-loss offerings designed for companies with as few as 10 to 25 employees. These products have low attachment points for their stop-loss provisions and other features customized for smaller groups, such as distribution through brokers or even directly through the web. The new products must be carefully designed, however, because stop-loss underwriting risks are much higher for smaller groups.

Align ASO value propositions with employers' price preferences

Most employers, large and small, that currently have ASO plans have been hard pressed by healthcare cost trends, and many of them would like to see their costs lowered. To retain these employers, payors should look for ways to lower their ASO fees, even if it requires them to reduce the service benefits they currently offer to members. (For example, they could use pricing or other methods to encourage employees to manage claims online rather than by calling member services. Or payors could include only limited or no wellness offerings in their "basic" ASO plans.) Also vital is the need to offer these employers innovative ways (e.g., transparency tools) to manage their employees' medical spending, given that medical spending far exceeds the ASO fees these employers are charged.

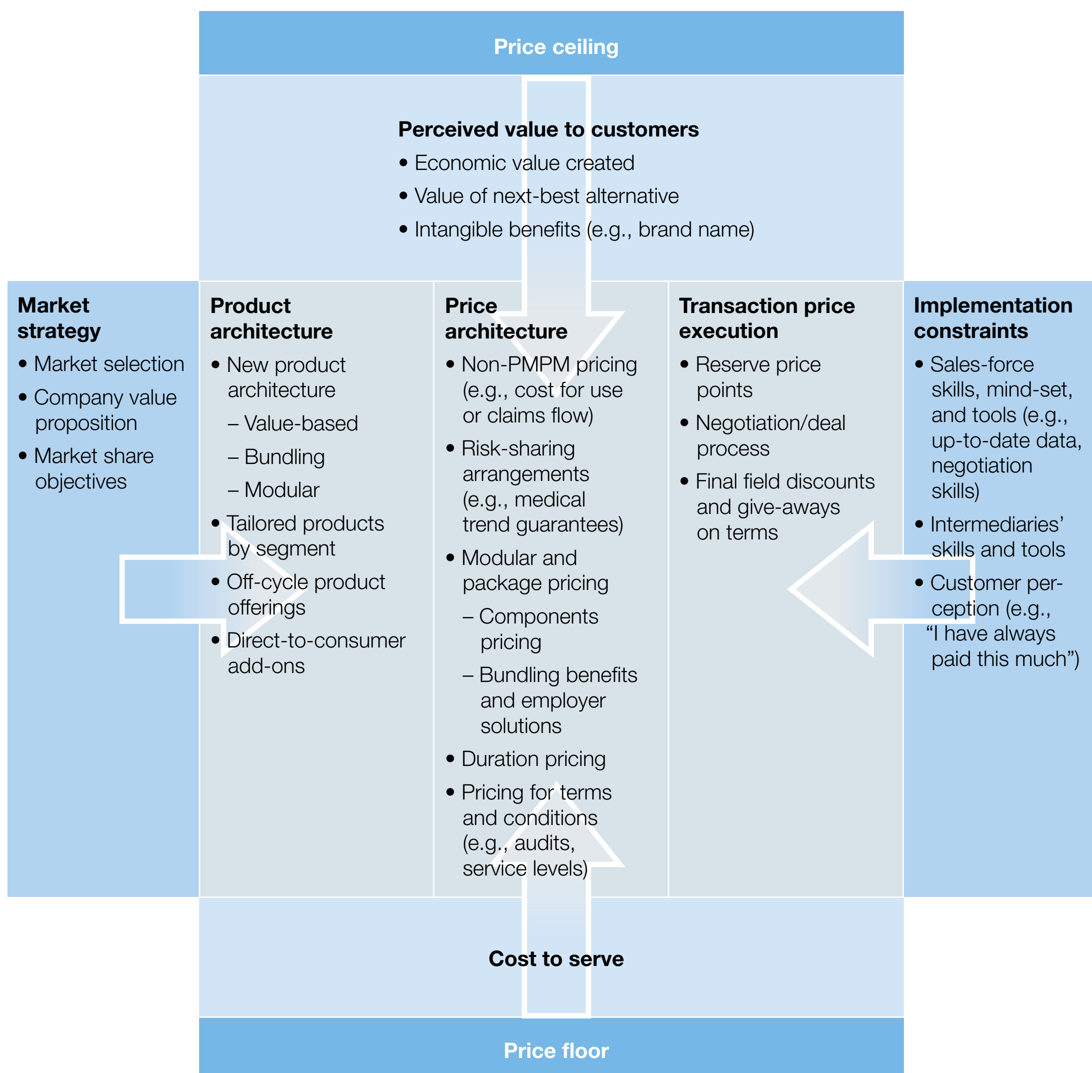
Conversely, some companies may want to offer their employees (and their HR staff) premium services and features and may be willing to pay higher ASO fees in exchange. Payors that want to serve these employers should focus on creating value in two ways. First, they should offer these companies a range of premium services and features, such as dedicated member call centers and comprehensive wellness programs that encourage talent retention. Second, they should offer the companies innovative ways to bend their cost trend, such as opportunities to participate in accountable care organizations and the application of medical home concepts to employee groups and the worksite.

As payors redesign their ASO products to better meet the needs of different employer segments, they should attempt to adjust the pricing for these products accordingly (Exhibit 5). For example, to meet the needs of employers looking for lower ASO fees, payors could partially unbundle their products and charge a base price for the lowest level of service. Additional fees would then be charged for additional services. Alternatively, payors could base their pricing on utilization (e.g., the number of minutes of call center time used) rather than a flat per-member per-month (PMPM) fee; this approach could enable payors to reduce fees for some employers but ensure that they are appropriately compensated for companies whose employees continue to use the call center heavily. For companies that want to offer their employees premium services, payors could design premium bundles priced accordingly. They could also determine the pricing for these bundles through a combination of base PMPM fees and additional charges linked to utilization.

Develop a broader distribution strategy

Although brokers will remain important in the group market, they will face immense pressures in the post-reform world, including a reduction in commissions that could reach 30 percent as payors seek to reduce distribution along with other administrative costs.[9] Thus, it is likely that many low-performing brokers will exit the market. Payors should therefore segment their brokers according to those who were more profitable in the pre-reform world and who are likely to remain profitable post-reform. (One example would

EXHIBIT 5 **ASO pricing should be based on a sound framework**



Source: McKinsey analysis

[9]For more information about potential changes in broker commissions, see the article by Bradley Chen, Jenny Cordina, Josh Gottlieb, Hanneli Hudock, Prashanth Reddy, Shubham Singhal, and Jeris Stueland, "Health insurance distribution in a consumer-driven world" July 2012 (available on mckinsey.com).

be a broker who has been able to achieve strong sales of both core health and supplemental products, given the likely increased attractiveness of supplemental products in a more retail-like market.) Payors could then target these brokers using a clear return-on-investment approach.

Payors should also take the opportunity to improve their sales-force effectiveness. Our research on sales forces across a wide range of industries, including healthcare, reveals wide variability in seller performance. The top sales forces have developed a fact-based understanding of what drives performance and what differentiates the best sales people from the rest of the sales force. We have found that companies that use targeted capability-building programs to close the gap between high and average performers achieve up to a 25-percent increase in productivity.[10]

Develop a supporting supplemental/ancillary product strategy

Finally, having the right collection of supplemental and ancillary products is likely to be crucial for a successful group-market play. Because these products are not subject to MLR pressures, an increase in their sales could help payors support profit margins. And, because these products appear to have strong appeal to employees shifting to a more retail-like environment, an increase in their sales could help payors recapture some of the revenue they may lose if employees "buy down" on health benefits. Furthermore, the right mix of supplemental and ancillary products may be attractive to the brokers payors would most like to retain as they tailor their group distribution strategy.

To design the right mix of supplemental and ancillary products, payors should consider which customer segments they want to focus on and which products the employees in those segments are likely to prefer. (For example, younger employees may prefer dental or disability coverage, whereas older employees may prefer long-term care insurance.) Payors should also ensure that the selection of supplemental products they offer supports their core product design and pricing strategy. For example, dental and vision products could be offered as add-ons (for an additional price) to "de-bundled" ASO products but included in higher-priced premium bundles.

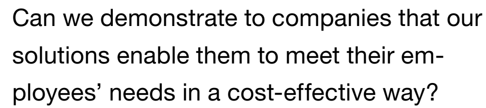
Although winning strategies will vary among players, all payors need to evaluate the impact of market trends on their existing commercial-group book and have a clear strategy for how to grow profitably as competition increases and margin pressures intensify. Payors can test their strategy by using the following questions to assess how well positioned they are to emerge as winners:

- How is our fully insured versus ASO mix likely to change post-reform? Which customers are expected to shift to self-insurance?

- Is our small-group strategy based on a granular understanding of each group's risk? Does our strategy maintain a balanced risk mix? Does our retention strategy target win-win opportunities for each customer type?

- How well do our ASO products meet different employer segments' unique needs?

[10] More information about McKinsey's research into sales-force effectiveness can be found in the book by Thomas Baumgartner, Homayoun Hatami, Jon Vander Ark, and Marc Benioff, *Sales Growth: Five Proven Strategies from the World's Sales Leaders* (John Wiley & Sons, 2011).



Can we demonstrate to companies that our solutions enable them to meet their employees' needs in a cost-effective way?

- Is our broker coverage model aligned with the best opportunities in the post-reform broker channel? Do we have the right capabilities to help our priority brokers succeed?

- What supplemental and ancillary products should we offer to support the rest of our group strategy?

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This article leverages proprietary research and analysis that McKinsey has conducted over the past 18 months, especially our employer interviews and surveys, MPACT, the Consumer Exchange Simulation, and the Private Exchange Simulation. These tools and the other major research sources we used in this compendium are described in the appendix, which begins on p. 147.