

Medicare Advantage: Dispelling market misconceptions

Five misconceptions are limiting payors' ability to take advantage of the opportunities in the MA market—but those opportunities are considerable. To succeed in this market, payors must balance tailored investments in local-market planning and care-delivery effectiveness with greater administrative efficiency.

Over the past several years, Medicare Advantage (MA) has proved to be a growing and profitable market, especially for payors that have invested in and focused on it. However, recent MA rate cuts and the tightening of both risk-adjustment rules and stars revenue potential have led some to doubt whether MA remains a viable business.

We disagree. We believe that MA will remain one of the most exciting growth opportunities for payors over the next several years, as well as a venue for innovations in care delivery and reimbursement. Our analyses suggest that by 2018, membership could grow by 4 to 6 million, revenue potential could reach \$180 billion to \$200 billion, and profit pools could range between \$5 billion and \$10 billion.¹

In this article, we discuss five common misconceptions about MA and describe the strategies and capabilities payors will need to sustain a profitable MA business.

Misconception #1

CMS rate cuts are likely to make MA an unattractive business over the next few years.

We believe that most MA plans can weather the changes ahead through a combination of efficiency improvements and better care

management. If the Centers for Medicare and Medicaid Services (CMS) maintain a stable and predictable rate environment, MA will continue to be an attractive business, especially for plans able to achieve 4+ star ratings.

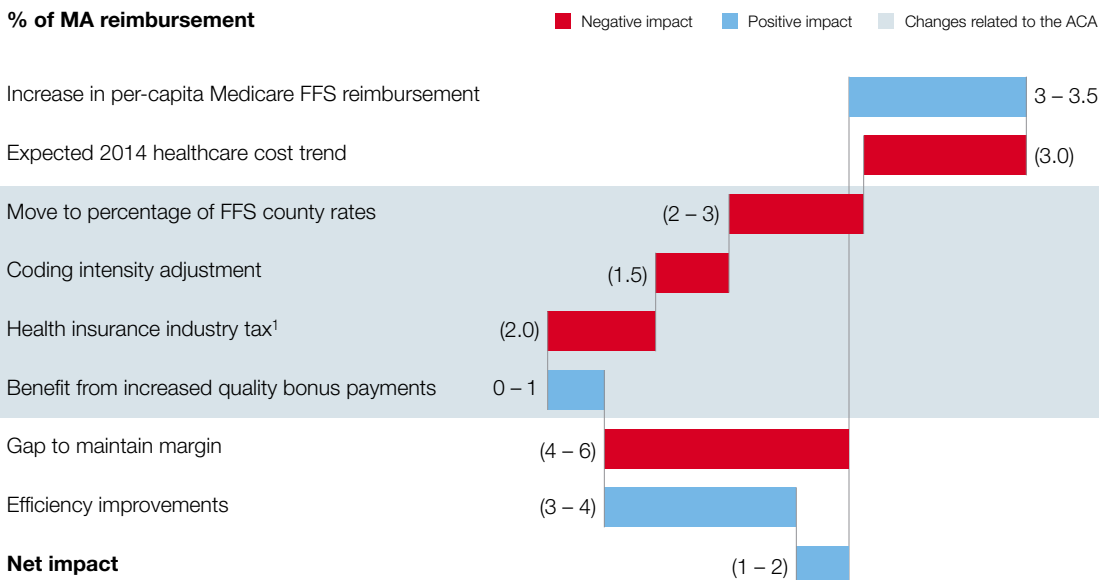
Almost half of the ACA's impact on MA plans is expected to take effect in 2014. In the absence of efficiency gains, plan margins could be reduced by 4 to 6 percent because of the move to a percentage of fee-for-service (FFS) county rates, the introduction of a health insurance industry tax, and multiyear coding intensity adjustments (Exhibit 1). In contrast, the cumulative margin decrease between 2015 and 2018 is likely to be only about 6 percent as MA reimbursement (excluding quality bonuses) is reduced to FFS levels (Exhibit 2). Consequently, 2014 will be the most challenging year. Rate-cut pressures are likely to lessen thereafter.

Most of the margin pressures can be mitigated if MA plans relentlessly seek to improve the efficiency of their administrative operations and the effectiveness of their care-management programs. Administrative efficiency will be especially important for profitability because of the mounting cost/margin pressures payors are facing, including an 85-percent medical-loss-ratio floor starting in 2014.

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¹McKinsey Medicare Growth Model, based on May 2013 data from the Congressional Budget Office.

EXHIBIT 1 Impact of expected changes on 2014 MA margins



¹Equivalent to a decrease in reimbursement.

ACA, Affordable Care Act; FFS, fee for service; MA, Medicare Advantage.

Source: CMS Final Announcement of MA CY 2014 capitation rates and payment policies; McKinsey analysis

To optimize their administrative costs, MA plans should leverage scale efficiencies with other parts of the organization (and, in some cases, with vendors), outsource non-core administrative processes, and enhance overall productivity. However, efforts to increase administrative efficiency should not preclude MA plans from investing strategically to achieve differentiated capabilities and improve quality of care. Humana, for example, was able to increase its star ratings in Florida to 4.5 by investing the equivalent of more than \$125 per member per year (PMPY) in physician quality incentives focused on preventive and chronic-condition management initiatives.²

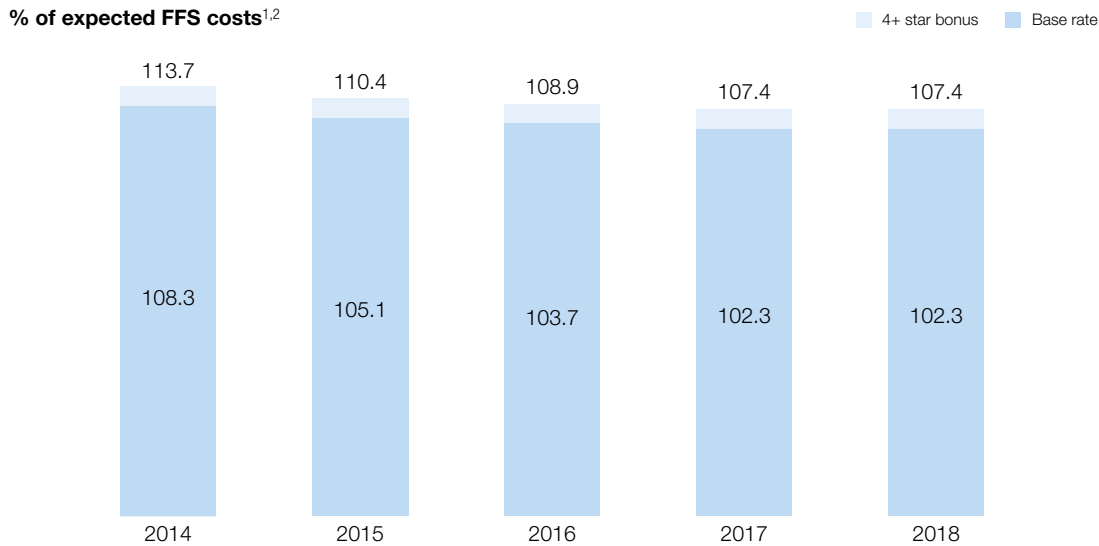
to more members, investing in predictive algorithms to proactively identify gaps in care, and enhancing risk coding to ensure appropriate compensation. To support these efforts, the plans should also consider engaging in expanded provider partnerships that incentivize higher quality and improved outcomes, and reshaping their networks to manage utilization and drive volume to high-quality, cost-effective providers.

Admittedly, the future attractiveness of the MA market will vary by geography based on relative reimbursement levels, competitive intensity, and other factors. Market attractiveness is also likely to vary over time. Thus, payors will need to carefully choose where to compete and focus their effectiveness improvement efforts in those areas.

In addition, MA plans should consider extending comprehensive care coordination

²Carol Gentry, "Humana Gold Plus leads in Medicare star ratings," *Health News Florida*, November 1, 2012.

EXHIBIT 2 MA reimbursement relative to expected FFS costs



¹MA enrollment estimated per county based on McKinsey Medicare Growth Model projections.
²Based on continued CMS assumption at the time of rate setting that Congress will override SGR-mandated physician-fee reductions.
 FFS, fee for service; MA, Medicare Advantage; SGR, sustainable growth rate.
 Source: CMS Final Announcement of MA CY2014 Capitation Rates and Payment Policies; McKinsey Medicare Growth Model; McKinsey analysis

However, the overall outlook remains positive. Consumers continue to view MA as an attractive alternative to conventional Medicare, since it gives them greater choice of plan and benefit design, as well as access to familiar insurers and provider networks. Between 2010 and 2013, over 70 percent of new Medicare enrollees chose an MA plan, and MA enrollment grew by 9.1 percent annually.³ We believe that the MA market could increase by 5 to 7 percent per annum between 2014 and 2018 as long as the reimbursement environment remains stable.

Jonathan Blum, director of CMS’s Center of Medicare, underscored the agency’s commitment to MA’s stability when the 2014 rates were announced.⁴ Thus, it seems reasonable to conclude that although CMS will continue

to pressure payors to improve efficiency and effectiveness, approved rates will continue to allow low- to mid-single-digit margins for the best MA plans.

Misconception #2

Given their low incomes, complex health conditions, and psychosocial needs, dual eligibles are an unattractive segment.

The 9 million people who qualify under both Medicare and Medicaid account for annual spending of about \$320 billion—roughly one-third of the total combined spending in the two programs and approximately 10 times the revenue pool likely to be available in the new 2014 ACA marketplaces.⁵ How-

³CBO Medicare projections, May 2013; Kaiser Family Foundation, “Medicare Advantage 2013 spotlight: Enrollment market update,” June 2013.
⁴CMS press release, “CMS ensures greater value for people in Medicare drug and health plans,” April 1, 2013.
⁵Estimates for the number of dual eligibles, the spending on them, and the total Medicare and Medicaid spending come from 2011 National Health Expenditure projections and the RWJ Foundation/Urban Institute report, “Refocusing responsibility for dual eligibles: Why Medicare should take the lead,” October 2011. The estimate for the likely 2014 marketplace revenue pool was based on Congressional Budget Office estimates of 7 million insured lives and revenues of approximately \$4,000 per member per year.

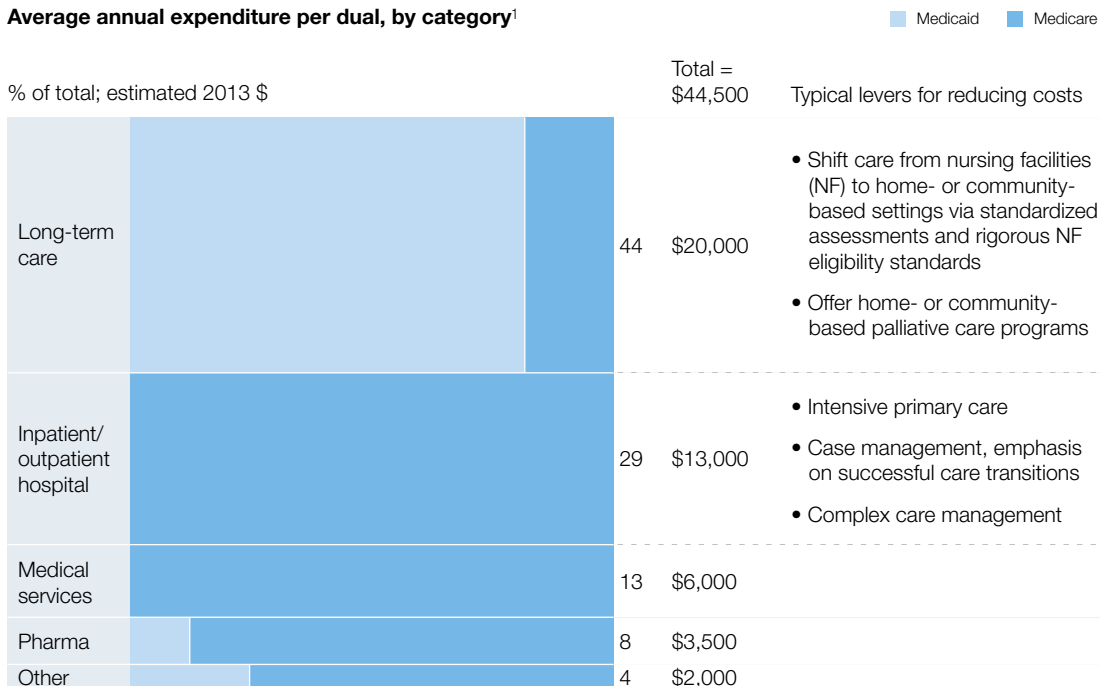
ever, the Congressional Budget Office estimates that only 5 to 6 percent of dual eligibles are enrolled in a comprehensive managed care program, and only 21 percent are in either Medicare or Medicaid managed care.⁶ Thus, a significant opportunity for care management exists (Exhibit 3).

Admittedly, a number of factors have made care delivery and cost management difficult in this population:

- Insufficient coordination between Medicare and Medicaid benefits and conflicting incentives (e.g., Medicaid pays for most long-term care, whereas Medicare pays for acute care)
- Rich benefits that restrict the use of traditional steerage mechanisms (e.g., co-payments)
- Limited effectiveness of stand-alone disease management programs (over 60 percent of duals have more than one chronic condition⁷)
- High prevalence (above 50 percent) of mental and cognitive problems,⁸ which constrains the success of preventive care, post-acute care, and treatment adherence
- Socioeconomic conditions beyond health status (e.g., homelessness) that further complicate care delivery and cost management

EXHIBIT 3 Annual spending on dual eligibles is high

Average annual expenditure per dual, by category¹



⁶Congressional Budget Office, "Dual-eligible beneficiaries of Medicare and Medicaid: Characteristics, health care spending, and evolving policies," June 2013.

⁷Kaiser Family Foundation, "Chronic disease and comorbidity among dual eligibles: Implications for patterns of Medicare and Medicaid service use and spending," July 2010.

⁸Kaiser Family Foundation, "Dual eligibles: Medicaid's role for low-income Medicare beneficiaries," May 2011.

¹2013 per capita costs are based on 2009/2010 per capita costs extrapolated at a 6% per annum growth rate. Source: Kaiser Family Foundation, *Medicare Chartbook*, 2010

Nevertheless, we believe that when appropriate, financially sustainable models are in place, dual eligibles can be an attractive source of growth for payors that can successfully manage this population. Furthermore, healthcare reform is likely to support the rapid growth of managed care for these patients. Because the intervention intensity required is likely to be significantly greater for duals than for other populations, MA plans that want to succeed in this area should consider using a combination of:

Setting-of-care management. For dual eligibles, costs can often be lowered significantly when long-term care (LTC) is delivered in home- and community-based settings (HCBSs) rather than in nursing facilities. One of the most successful examples of such shifting, Arizona's Managed Medicaid program, increased the share of LTC patients receiving HCBS care to over 70 percent by using a combination of standardized assessments, strict nursing-facility eligibility standards, and rigorous care management.⁹

Intensive primary care. Intensive programs designed to improve prevention and treatment adherence can lower the rate of hospitalizations, emergency room (ER) visits, and readmissions. ChenMed, for example, delivers intensive primary care by setting up a minimum of one primary care appointment a month for patients and often provides transportation for the visit. Using this approach, ChenMed has reduced the number of days its patients in the Miami region are hospitalized to 38 percent below the national average.¹⁰

Case management to avoid readmissions. The use of extensive transition assistance

and post-acute care can markedly lower the rate of hospital readmission. Kaiser Permanente's Heart Failure Transitional Care Program, for example, supplements traditional case management with community-based support, including an outpatient clinical pharmacist and a team of home health nurses, to ensure that patients receive proactive follow-up care. The program has enabled Kaiser to reduce its readmission rate among heart failure patients by 30 percent.¹¹

Complex case management. HCBS patients with multiple chronic conditions are at a high risk of hospitalization, but careful case management can reduce their admission rate significantly. Successful programs use high-touch, multidisciplinary teams that integrate healthcare professionals, social workers, and community-based agencies. Such programs are often augmented with frailty management and fall-prevention initiatives to further reduce the risk of acute episodes. Fidelis SecureCare's comprehensive multidisciplinary approach, for example, has lowered both the risk of unnecessary hospitalizations and the death rate among its elderly members.¹²

As part of ACA implementation, CMS is working with states to undertake demonstration projects that integrate care and align Medicare and Medicaid financing for dual eligibles. Capitated models managed by health plans have proved popular; the majority of states that have submitted proposals have put forward such models. These projects will help increase the penetration of comprehensive managed care plans and better enable payors to balance the conflicting incentives in Medicare and Medicaid spending.¹³

⁹Arizona Long Term Care System (ALTCS) overview. Report to the annual meeting of the National Association of Medicaid Directors, October 28-30, 2012.

¹⁰Craig Tanio and Christopher Chen, "Innovations at Miami practice show promise for treating high-risk Medicare patients," *Health Affairs*, 2013;32:1078-1082.

¹¹Kaiser Permanente Institute for Health Policy, "Reducing hospital readmissions," March 16, 2012.

¹²Fidelis SecureCare website; Bob Mobley interview with Sam Willcoxon, Fidelis's CEO, 2013.

¹³For more insights into the dual-eligible population, see the article by David Knott, Meera Mani, and Tim Ward, "Understanding and engaging a new era of Medicaid consumers," on p. 100.

Misconception #3

Medicare Advantage is a national game, making primarily national market strategies the most effective.

Although there is value in the scale and scope that comes from a national presence in MA, wide variations exist at the county level in MA penetration, likely future growth, and reimbursement rates (Exhibit 4). Similarly, there are local variations in competitor activity, consumer demographics, physicians'

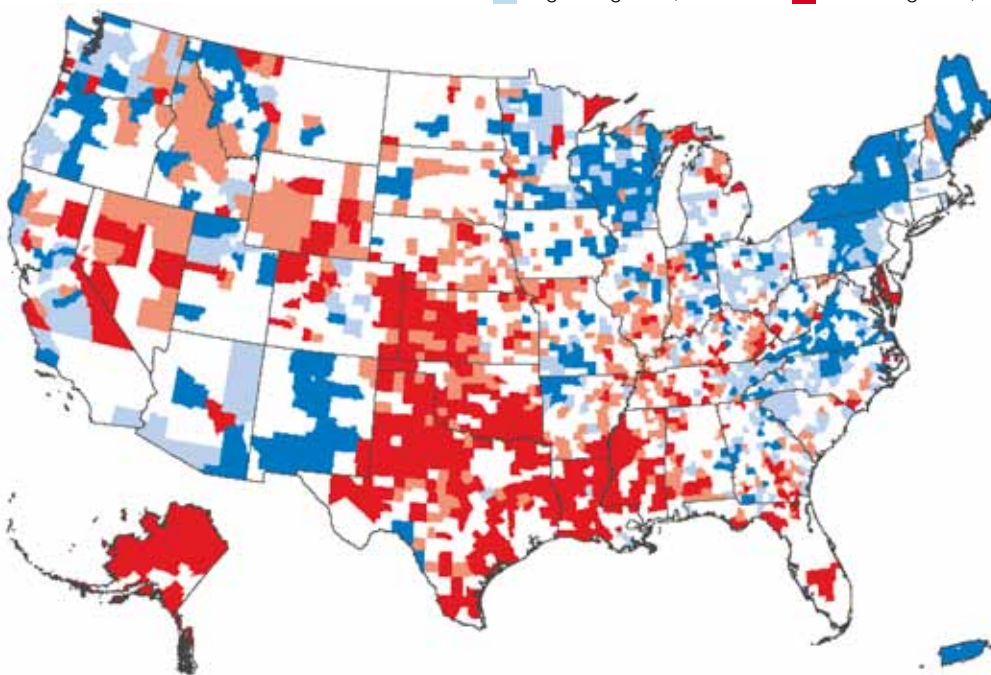
willingness to assume risk, and a payor's ability to scale rapidly. As a result, it is more important to use a local lens when developing an MA strategy than to employ a broad regional or national lens.

In California, for example, MA penetration is above 40 percent in Stanislaus County but only 14 percent in Santa Barbara County.¹⁴ (In general, MA penetration is higher in California than in many other states.) In 2014, per-capita reimbursement for a 4-star plan with an average risk score of 1.0 is expected

EXHIBIT 4 **Market attractiveness varies by county, based on growth and reimbursement levels**

**Net growth in MA lives, 2013–2021;
Reimbursement, % of FFS**

■ High net growth;¹ 115% ■ Low net growth; 100%
■ High net growth;¹ 107.5% ■ Low net growth; 95%



¹High net growth: estimated 1,000+ additional MA lives between 2013 and 2021; low net growth: fewer than 500 additional lives during that period.

FFS, fee for service; MA, Medicare Advantage.

Source: CMS final announcement of MA CY 2014 capitation rates and payment policies; McKinsey Medicare Growth Model, McKinsey analysis

¹⁴Data about MA plans in California was obtained from CMS.

to be \$11,521 PMPY in Stanislaus and \$10,147 in Santa Barbara, a 14-percent difference. This difference will likely increase as ACA reimbursement changes are fully phased in.

Competitive intensity varies substantially as well. One payor has a 70-percent MA market share in Santa Barbara but covers less than half the market in Stanislaus because it faces greater competition there. In four of California's smaller counties (Lassen, Mariposa, Mono, and Yuba), only one MA plan is available.

Because MA is primarily a local game, developing a sustainable MA strategy entails two key steps: identifying the most attractive micro-markets and then developing appropriate member-acquisition and care-management strategies by micro-market. However, payors must ensure that the benefits of having differentiated local strategies outweigh the cost of managing the additional complexity.

Identify the most attractive micro-markets.

MA micro-markets are typically defined at a county level because of meaningful variations in growth rates, market dynamics, and reimbursement levels (relative to FFS costs). Five major factors drive local-market attractiveness:

- Current and prospective market growth, as determined by historical market size and growth rates, prospective growth rates, and market penetration
- Existing providers, including the level of provider concentration, physician affiliations, and level of alignment between primary care physicians, specialists, and hospitals

- Potential to better manage care (as reflected in quality indicators, such as readmission rates) and utilization indicators (e.g., risk-adjusted admissions per thousand members)
- Member profitability of various customer segments, their associated lifetime value, and the size, growth, and density of their profit pools
- A payor's current and prospective competitive position, as influenced by the number of competitors and their market share, the relative strength of the payor's networks (provider, distribution, etc.), and its current or impending affinity partnerships

Develop appropriate strategies for each market.

For each micro-market, a payor will need to determine its target penetration levels, which can help it balance scale efficiencies against market-specific price and benefit requirements. The payor will also need market-specific distribution and customer-acquisition strategies, as well as network and care-management strategies. To develop these strategies, most payors will require a much deeper understanding of the local market than they have today. A payor's distribution plan, for example, should include information about how competitors in each market use external brokers and agents rather than internal sales forces, as well as detailed data about competitors' compensation and bonus structures.

To attract and enroll members, the payor will need to understand the consumers in each market, including their dynamics, ethnicities, language preferences, and buying patterns. One regional payor, for example,



was able to double its acquisition of Hispanic members by tailoring its marketing language and messaging to that community. Also crucial are detailed insights into consumers' needs and desires, as well as how well those needs and desires are being met by competitors. These insights will allow the payor to design an optimized benefits package that makes the appropriate trade-offs between price and benefits. The failure to develop these insights can be costly. Another regional payor with a very low market share in one part of its state was eventually able to trace its problem to its lack of a zero-deductible product, even though its plans were competitive on a total-cost basis.

Provider alignment is critical for ensuring that the enrolled population receives adequate care management. A thorough grasp of provider nuances in each market (including physicians' ability and willingness to bear population-health risk, their influence on consumers, and their level of integration with local health systems) can help the payor determine who its care-management partners might be and identify markets in which the likelihood of success is higher with vertical integration than with value-based partnerships.

Misconception #4

Commercial care-management programs are sufficient to manage the needs of the MA population.

Our view is that the MA population requires not only more intense care management than commercially insured members do, but also a novel approach toward program design and member engagement. This belief is driven by two observations:

- For MA members, expenses in the last 12 months of life account for 25 to 30 percent of total medical spending¹⁵
- Among commercially insured members, medical spending is driven primarily by the subset of people with a single costly condition (e.g., hemophilia). In MA, however, the costliest members have multiple comorbidities that complicate one another and require expensive treatment (Exhibit 5)

The following types of programs have been shown to deliver significant value and can be tailored to address the unique needs of MA members:

Comprehensive end-of-life programs.

Effective end-of-life programs address members' physical, mental, and social needs; in particular, they focus on symptom management and a gradual transition to palliative care. These programs are based on home or hospice care, proactively engage members' caregivers in advanced planning decisions, and ensure alignment of the primary care physician with the treatment plan. (Effective programs have shown that decisions about patient transitions are best made by a joint physician-family-payor team. However, only 13 percent of surveyed seniors reported being asked by a doctor about their end-of-life wishes.¹⁶) Palliative care programs, such as the one run by Kaiser Permanente, have been shown to significantly decrease costs while improving patients' satisfaction with care.¹⁷

"Whole-person" care management.

Whole-person programs are designed to provide integrated care to patients with a high number of comorbidities. In this approach, a "personal navigator" manages

¹⁵Gerald F. Riley and James D. Lubitz, "Long-term trends in Medicare payments in the last year of life," *Health Services Research*, 2010;45:565-576.

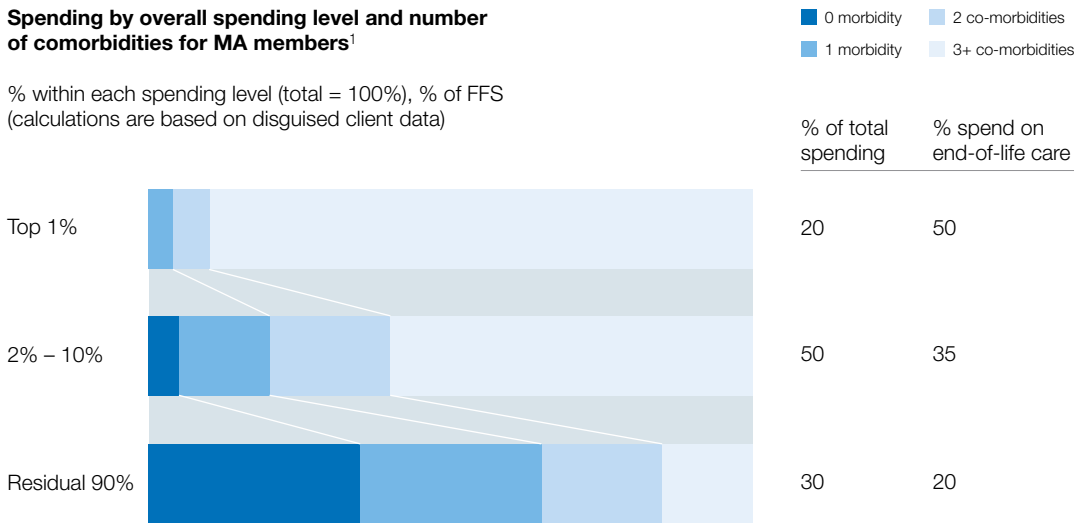
¹⁶California HealthCare Foundation, "Final chapter: Californians' attitudes and experiences with death and dying," February 2012.

¹⁷Richard D. Brumley, Susan Enguidanos, and David A. Chernin, "Effectiveness of a home-based palliative care program for end-of-life," *Journal of Palliative Medicine*, 2003;6:715-24.

EXHIBIT 5 MA medical spending correlates strongly with the number of comorbidities and reimbursement levels

Spending by overall spending level and number of comorbidities for MA members¹

% within each spending level (total = 100%), % of FFS (calculations are based on disguised client data)



¹Segment spend includes end-of-life care
Source: Disguised client data; McKinsey analysis

a patient’s care continuum. He or she coordinates the care delivered by multiple providers, arranges for home healthcare and transportation to care sites, and ensures timely care transitions. As a result, the navigator helps prevent unnecessary hospital admissions and readmissions. The whole-person approach also emphasizes behavioral health management to avoid the cost amplification that can result from treatment non-adherence and high ER use.^{18,19}

Low-acuity care management. These programs are designed for patients with a lower number of chronic or pre-chronic conditions. They use a light-touch approach (often, based on telemedicine and electronic monitoring devices) so that problems can be spotted and interventions offered early to prevent disease progression whenever

possible. In our experience, programs for patients with chronic conditions that require frequent inpatient admissions and high-cost acute treatments (e.g., diabetes, congestive heart failure, and chronic obstructive pulmonary disease) deliver a decent return on investment by lowering the number of admissions and average length of stay.

Although some assets from care-management programs designed for commercially insured members (e.g., lower-acuity care managers) can be leveraged for the MA book, payors will need to robustly segment their MA member base to develop a deep understanding of their health status and consumption of healthcare services. The MA programs will then need to be carefully tailored to address those members’ needs and manage their costs.

¹⁸Benjamin G. Druss and Elizabeth Reisinger Walker, “Mental Disorders and Medical Comorbidity,” RWJ Foundation report, February 2011.
¹⁹Moran Company, “Trends in the Provision of Emergency Department Evaluation and Management Services,” report to the American Hospital Association, January 2013.

Misconception #5

There are limited opportunities for incremental payor-provider collaboration in MA.

CMS has helped jump-start payor-provider collaborations to improve care for senior populations. However, many of the existing collaborations have focused on Medicare FFS populations. We believe that opportunities for improved patient care and shared savings are also significant with MA members. Furthermore, the time has never been as conducive as it is now for providers to partner with payors.

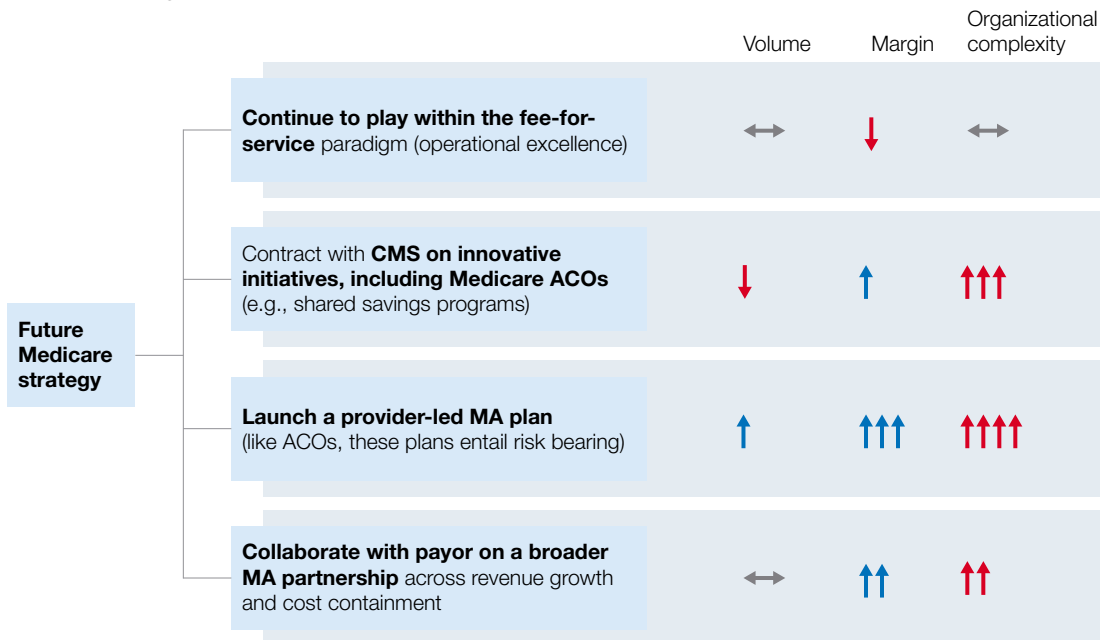
For most hospital systems today, Medicare patients account for about 42 percent of all admissions.²⁰ Our analyses indicate that the contribution margin of the Medicare population is only in the 25- to 40-percent range and is often insufficient to cover fixed costs. Furthermore, the contribution margin of Medicare patients is expected to decline over time. If hospitals are to continue to break even at Medicare reimbursement rates, they will need to reduce their costs per case by 13 to 15 percent.²¹

Providers are addressing this problem in a number of ways (Exhibit 6). Some are launching their own MA plans. Our calcu-

EXHIBIT 6 For providers, collaboration with payors on MA plans may offer the best “risk-adjusted” returns

The arrows below indicate the direction of a given change; the colors indicate whether the change has a positive or negative impact on providers

● Negative impact ● Neutral impact ● Positive impact



²⁰National Hospital Discharge Survey, 2010.

²¹McKinsey MPACT analysis; underlying data is from industry benchmarks and the Congressional Budget Office.

ACOs, accountable care organizations; CMS, Centers for Medicare and Medicaid Services; MA, Medicare Advantage.

lations suggest that this approach might enable a hospital to double its net margin on MA patients, but the associated risks are high. Other providers are establishing Medicare-specific accountable care organizations, which could help them improve their MA margin but will eventually require them to successfully bear downside risk.²²

We believe that broader payor-provider partnerships that focus on revenue growth and cost containment offer providers superior returns and less downside.²³ Closer, more innovative partnerships between payors and providers could unleash substantial value in the MA business that both parties could share. We estimate that the potential ranges between \$3 billion and \$20 billion, depending on which partnership models are adopted and how able the partnerships are to drive joint value creation.

Over the past several years, we have observed many successful payor-provider partnerships. Although these partnerships took different forms, they shared two common elements:

An appreciation of each partner’s economics. Too often, payors and providers have only a cursory understanding of the factors driving their counterparty’s profitability. In successful partnerships, high transparency levels permit both sides to understand each other’s economics and align incentives in a meaningful way.

Independent and complementary capability contribution. Oftentimes, partnerships result in either insufficient or duplicative capabilities. Successful partners delineate the contributions each party will make (e.g.,

who will handle which portions of care management and how efforts will be coordinated), recognize the capability gaps that may be present, and co-invest to close those gaps before the collaboration begins.



As we have shown, MA remains an attractive business segment for payors today. Given its high growth rates and profit pools, the question for payors is no longer *whether* to play in MA, but rather *where* and *how* to play. The payors that succeed will be those best able to balance tailored investments in MA (especially those needed to improve the effectiveness of care delivery) with cost-efficient leveraging of enterprise assets. However, implementing comprehensive MA strategies and ensuring competitive differentiation requires a higher degree of analytic skill, closer clinical and financial integration, and stronger collaboration with providers than the payor industry is conditioned to today. ○

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

²²Upside-only is possible under the Medicare Shared Savings Program Track 1 for a maximum of three years.
²³CMS’s proposed ACO regulations (CMS-1345-P and CMS-1345-F); McKinsey analysis for 4-star plans.

