Perspective

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The Future of Health Insurance

Demise of Employer-Sponsored Coverage Greatly Exaggerated

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EXECUTIVE SUMMARY

In the United States, the new healthcare reform law emphasizes expanded coverage through health insurance exchanges, leading many analysts to project a rapid decline in the traditional employer-sponsored insurance market. But a time of more ambiguous change is approaching, with new opportunities as well as many challenges. Booz & Company research suggests that traditional employer-based insurance will remain a significant market that will erode more slowly and less steeply than commonly thought. Our analyses indicate that employers, though concerned about rising premiums, are unlikely to abandon employer-based health plans and force workers to find coverage on exchanges. Some small employers may do so, but the majority will continue to offer coverage for a variety of reasons ranging from a sense of moral responsibility to the need to attract and retain talent.

As health insurers respond to the evolving healthcare environment, they must tend their core employer-based business to secure the margins and cash flow needed to develop and enhance new capabilities that will help them adapt. They must also take a proactive role in working with employers and brokers to innovate and provide value that will sustain the group market.

Historically, health plans have maintained a broad presence across customer segments. Going forward we anticipate a shift from a wholesale (employer group) market to a more retail-like market and the emergence of relatively focused health plans with specialized capabilities that target customer segments more coherently. In the future, companies will evolve toward one of four primary business models, including low-cost standard plans and highly diversified companies. Depending on the customer, insurers may adopt any one of a range of approaches and capabilities. Ultimately, employer-sponsored plans will serve as the foundation for insurers' future growth no matter how healthcare reform shakes out.

MASSIVE UNCERTAINTY AHEAD FOR HEALTH INSURERS

The healthcare industry is entering a period of even greater uncertainty, driven by regulatory, political, and economic unknowns (*see Exhibit 1*). The results of the 2010 midterm elections have made it much more difficult to discern the pace and extent of future healthcare reform. The legislation is not likely to be undone, given Democrats' veto-proof hold on the Senate and the public popularity of most reform elements. However, there is recognition that Republicans in Congress and, perhaps more important, in governors' offices around the nation could seriously undermine, slow, or whittle away at the law.

Nonetheless, no matter what happens next, some permanent disruptive changes will take place in the U.S. healthcare system as a result of the passage of the Patient Protection and Affordable Care Act (PPACA). While the new law puts a strong emphasis on making healthcare more accessible, many provisions—such as small-business tax credits, employer "pay-or-play" penalties, and health insurance exchanges—are spurring significant debate over the viability of the private health insurance industry, particularly the employer-sponsored (or group) insurance market segment.

In late 2010 and early 2011, Booz & Company conducted extensive research to understand the evolving needs of employers and how they are likely to respond to the new law. We interviewed more than 150 executives and managers at employers across sizes, industries, and regions; association members; and policy experts. We also conducted employer focus groups and surveys to gather additional input from nearly 300 small and large employers. In particular, we conducted in-depth studies of employers in Massachusetts and Utah, two states where reform efforts, most notably around health insurance exchanges, resemble the system called for by the federal health reform legislation. Finally, we integrated these inputs into a proprietary model incorporating health plan premium data and estimates of likely consumer and employer decision-making behavior, to evaluate the economic impact of various scenarios.

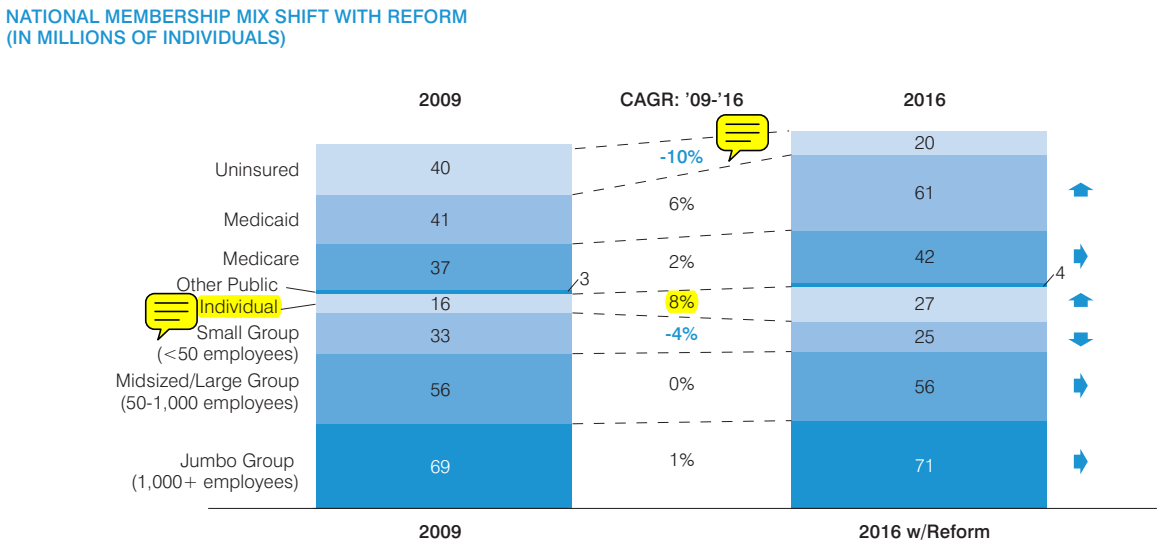
Exhibit 1
Drivers of Post-Reform Uncertainty

Source: Booz & Company

A SIZABLE EMPLOYER GROUP MARKET POST-REFORM

Unlike many prognostications forecasting rapid decline in the employer-sponsored insurance market, our research suggests that employer groups will remain a significant customer segment for health insurance plans. Today, employer-sponsored insurance makes up 62 percent of the insured market, with 158 million employees and dependents enrolled through company health benefit programs. By 2016, when most of the major reform provisions are scheduled to be implemented, employer-sponsored insurance will still constitute more than 50 percent of the market, with 152 million members enrolled in group plans (*see Exhibit 2*). Indeed, even in Massachusetts, where health-

Exhibit 2
Projected Membership Shifts, 2009-2016



Notes: Does not include illegal immigrants. Uninsured estimates from CBO, and employer estimates from Booz & Company intellectual capital. Aggregation may not sum to total U.S. population.
Source: Kaiser Employer Health Benefits 2009; Census 2007; Congressional Budget Office; Booz & Company analysis

care reform was enacted in 2006, employer group coverage programs continue to make up 64 percent of the health insurance market, down only three percentage points since reform went into effect.

More generally, healthcare reform will unquestionably lead to a larger overall market for health insurance. Based on our scenario modeling, nearly 25 million uninsured people will obtain coverage after 2016. The majority, nearly 60 percent, will enter a vastly expanded Medicaid program, about 28 percent will get individual insurance primarily through new health insurance exchanges, and the remainder will enroll in existing employer group plans.

The eventual size and long-term viability of the employer group market will be determined chiefly by the success of new state and regional health exchanges. These will inevitably attract not only the uninsured, but also some people currently covered by employer-sponsored insurance. There are open questions, such as whether smaller employers (those with fewer than 50 workers initially, 100 eventually) that are eligible to participate in the exchange will switch from the group market. Some observers expect that the introduction of exchanges and significant federal subsidies for individuals (earning as much as 400 percent of the federal poverty level) will lead a significant number of businesses to "dump" employees by dropping coverage or to "switch" them into employer-paid exchange plans.

Our research findings and simulation analysis reveal that only a small portion of employers will do so. As a result, we project that 5 million to 7 million individuals will exit

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the employer-sponsored insurance market by 2016. An estimated 3 million to 4 million will be dumped because firms decide to stop offering coverage, and 2 million to 3 million small-group employees will be switched. The overall propensity for employers to change coverage will be low, and the velocity of change will be rather slow. For the most part, employers' response to reform will be guided by cost and other factors such as the potential risk to their reputation and their ability to attract and retain talent.

Large and Jumbo Employers Unlikely to Drop Current Coverage

Recent press coverage has highlighted concerns about healthcare insurance raised by certain major employers, including AT&T, Verizon, Caterpillar, and McDonald's: namely, that new regulations and added costs would lead them to drop employee coverage. Yet our feedback from extensive interviews with benefit managers, chief human resource officers (CHROs), and chief financial officers (CFOs) indicates that larger employers will adopt a long-term "wait and see" approach that is unlikely to result in significant dumping or switching. Similarly, the vast majority of large employers in our Massachusetts employer survey plan to continue providing health insurance. Moreover, our economic modeling suggests that employers that consider dropping coverage and paying the associated penalty will need a significant cost–value differential to offset the risks to employee morale and retention. Although some employers might save money by dropping coverage and paying penalties, many report that the savings may not be worth the potential downside. Many large employers, particularly those with more than 500 workers, and jumbo-sized companies also report a moral obligation to retain employee health insurance coverage.

Midsized Employers May Shift to Self-Insurance

Midsized companies are also unlikely to drop their current employee healthcare coverage, for many of the same reasons as their larger counterparts. There is significant interest among these employers in moving from fully insured to self-funded products (where the employer assumes direct risk for paying healthcare claims), as most large and jumbo employers have progressively done over the past decade. The anticipated shift is primarily driven by the desire to avoid costly reform provisions that introduce health insurer premium taxes and medical loss ratio constraints on fully insured products, both of which insurers are likely to pass on to employers in the

form of higher rates. In addition, some midsized employer focus group participants say self-insuring offers greater flexibility and creativity in areas such as benefit design, health and wellness incentives, and care management programs. Again, while most midsized employers seem inclined to continue offering health insurance, some companies, such as a local 250-worker factory, a private equity–owned firm, and a financially distressed business, are considering dropping coverage altogether.

Smaller Firms Most Likely to Drop Coverage

Microbusinesses—those with fewer than 10 employees, which represent only a tiny portion of the group market—are the most likely to drop coverage altogether, leaving their employees to obtain insurance through exchanges. Focus groups suggest that—if exchanges offer a viable alternative—those microbusinesses with relatively low average wages and a high proportion of employees eligible for individual subsidies will be the most tempted to drop coverage and direct employees to purchase through exchanges. Indeed, membership in existing private small-business exchanges indicates that a large majority come from groups of fewer than 10 employees. Larger and well-established firms have less incentive to dump employees, because of the variance in wages, the number of subsidy-eligible employees, and employee expectations of healthcare benefits as a condition of employment. In principle, they may explore exchange products in hopes of reducing costs, but most of them feel obliged to continue providing coverage for their employees after 2014. Even among companies this size, massive exchange switching will not happen overnight. Focus groups reveal that microgroups will closely evaluate the option to switch, and even for today's private small-business exchanges, adoption has been slow.

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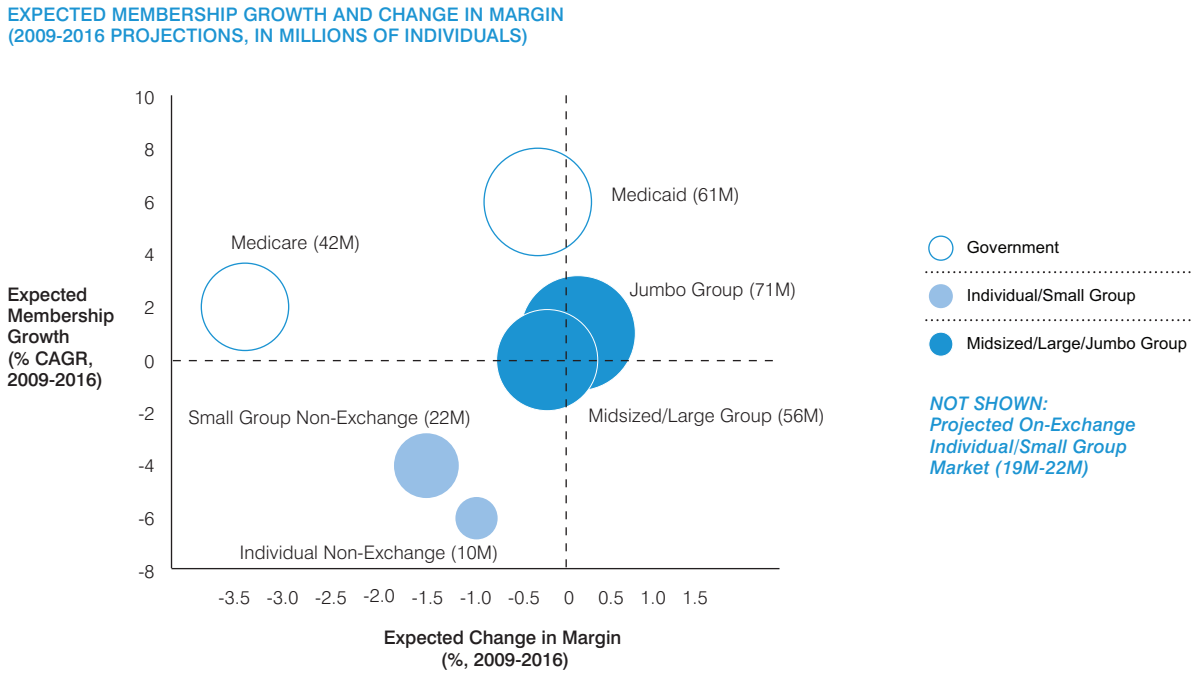
CHALLENGES TO PROFITABILITY

Although the employer-sponsored group business is unlikely to erode as rapidly as widely predicted, health reform will unequivocally diminish the financial viability of the health insurance industry. Indeed, every segment will experience declining profitability between now and 2016, though the magnitude of the impact will depend on a given insurer's book of business (*see Exhibit 3*). For instance, insurers with more business in the jumbo and government segments will see more stability. Conversely, those catering primarily to the individual and small-group markets will face significant uncertainty as exchanges are introduced.

While reform provisions will result in sizable membership growth in the Medicaid and individual markets, margins will be considerably lower than in the employer group business. Our analysis also indicates that Congressional Budget Office (CBO) estimates of the future size of the post-reform insured market are overly optimistic, potentially overstating the 2016 insured market by as many as 7 million individuals. A weak individual mandate (or no individual mandate, if the Virginia court ruling is upheld by the U.S. Supreme Court) will yield even lower enrollment levels. Finally, federal reform legislation has introduced significant constraints, such as minimum actuarial value thresholds, underwriting restrictions, and medical loss ratio requirements, limiting how insurers can operate and profit from their core health insurance business.

Exhibit 3
Healthcare's Bleak Outlook



Source: Membership projections based on Booz & Company analysis; margin projections based on Goldman Sachs' 10-Year Industry Model for Managed Care and Booz & Company analysis

STRATEGIC IMPLICATIONS FOR HEALTH INSURERS

The movement to direct-to-consumer healthcare benefits may be slow, but it will also be persistent. Every insurer will need to establish a new strategy and capabilities system to accommodate this shift. This will mean getting used to a more retail environment, in which exchanges increasingly allow consumers to "shop" for healthcare plans in the same way that they currently shop for life insurance or other financial services.

Managing the Core Employer Group Business

Overall, our research suggests that health insurers have a longer runway to derive benefits from their traditional employer group business than some analysts have projected. Nonetheless, as health insurance exchanges eventually shift employer group membership into a more retail-like environment, health plans will experience a steady erosion of their fully insured group business. Uptake in the exchanges will likely be gradual and vary by state, beginning with microgroup segments. As such, it is imperative for health plans to carefully manage their group business to ensure that it generates sufficient margins and free cash flow to enable reinvestment in the new capabilities that will be necessary to compete in the post-reform era.

As part of this transition from a wholesale (employer group) to retail market, health plans need to pursue a number of strategies. First, they should take a more proactive role

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in working with employers to help sustain the viability of the group market. Our research shows that most employers are aggressively looking for alternative ways to manage costs, but have not seen health plans as partners in these efforts. It is up to the insurers to give them reason to do so.

Moving forward, the most successful insurers will be those that help employers manage costs to increase affordability and enhance employee productivity. For instance, through more innovative payor–provider collaboration and care management programs, leading plans are already engaging with employers to jointly address costs. Others are designing benefits for employers based on a limited network of providers tied to local accountable care organizations (ACOs) with bonuses aligned to encourage member engagement. Plans will also need to work with employers to co-design low-cost alternative products that still adhere to standards laid out in the reform regulations.

Second, health plans should partner more closely with their key brokers to jointly manage and support the group business. While brokers can expect volatility in the microbusiness segment, larger companies are likely to maintain their long-standing relationships with brokers, whom they perceive as trusted advisors. Our research also suggests that, given the complexity and importance of the health insurance purchasing decision, health insurance brokers will continue to provide a service to companies by helping them sort through the complexity to find value. In this role, they will be more akin to real estate agents, who have retained a place in their industry, than to travel agents, who have been largely disintermediated by online solutions. Health insurers should redefine their broker engagement strategy from today's transaction-based model to a strategic partnership model. For example, top-performing brokers, armed with the proper incentives, tools, and other support mechanisms, could more directly advise companies, a role traditionally held by benefit consulting firms.

Third, given the likely shift to self-funded arrangements, particularly among midsized employers, health plans should introduce more administrative-services-only (ASO) packages to serve this segment. Today's ASO products are characterized by a high degree of complexity and customization for large and jumbo employers. In the future, as ASO moves downmarket, greater standardization will be required to profitably serve the new groups. Finally, while the shift from risk-based revenues (in fully insured products) to fee-based revenues (in ASO products) will have significant financial implications, insurers should develop complementary add-on offerings (e.g., specialty products, health and wellness, work-life services) to enhance their share of wallet.

Rethinking the Traditional Health Insurance Business Model

Post-reform, health plans will need to consider a number of important questions with respect to their key capabilities and future business models, including the following:

- What is the future role of the health plan? Will it continue to focus on administering health benefits, or will it play a larger role in enhancing medical value?
- What business models and capabilities will be required to serve different target segments coherently in the future?
- Given the need for critical new capabilities, what steps can health plans take to streamline costs in less critical functions and secure funding for new investments?

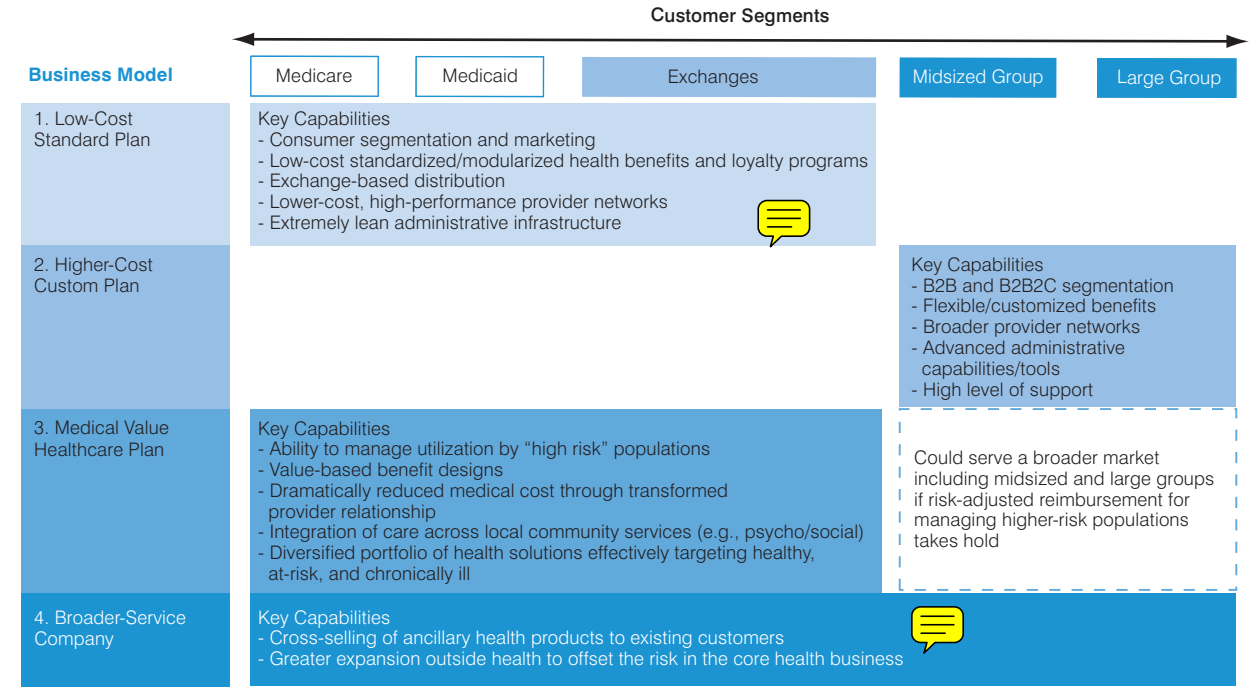
Looking ahead, we see the emergence of health plans with specialized capabilities to target segments coherently—in other words, with a high degree of alignment between a company's market strategy, the capabilities required to deliver services to that market, and the full lineup of products and services. This will represent a change for many companies. Historically, health plans and other insurance companies have maintained a presence across as many customer segments as possible, marshaling separate products and capabilities for each if necessary. Going forward, they may feel compelled to serve fewer segments in a more coherent way, by focusing on just one primary business model—or "way to play"—that applies to all of their chosen customers. This will allow them to gain efficiencies and invest more effectively by applying the same system of capabilities to all their products and services.

There will be several viable business models to choose from (*see Exhibit 4*). Some of them will be relatively "pure tone" strategies: being a low-cost standard plan, a higher-cost custom plan, a medical value healthcare plan, or a broader-service company, expanding beyond health insurance in some coherent way. In each case, the company would serve only the customers that would benefit from that model. A company could also institute a hybrid of these various approaches, as long as the same system of a few key capabilities were used to serve all of its customers. If insurers take a more diversified path, they will need to reconcile the cost and culture issues that may arise in attempting to pursue a hybrid model. For example, can the new low-cost products needed to succeed in exchanges be supported on the same higher-cost, flexible operating chassis plans used for large or jumbo accounts?

Low-cost standard plans will differentiate themselves based on retail marketing, network management, and price. Their capabilities will be retail excellence, low total cost, and regulatory relationship management required in the predominantly government-sponsored (Medicare and Medicaid) and exchange-based segments. In contrast, higher-cost custom plans, aimed at midsized and large group segments, will differentiate themselves on product design, analytics, and complex administrative capabilities. The third pure-tone approach, aimed at providing better

medical value, will innovate on product, member behavior, and provider levers to achieve superior outcomes, lower costs, and improved employee productivity. Finally, the broader-service company will follow a retail-like approach to offering a range of products and services—possibly including some that have traditionally been outside the health insurance domain, such as other insurance products or even the delivery of care—to capture a greater share of spending from its core health plan customer base. It may also explore business-to-business opportunities to monetize its capabilities by marketing them to other companies, including its health plan competitors.

Exhibit 4
Future Health Plan Business Models



Source: Booz & Company

CONCLUSION

Ultimately, the employer group business of the past will serve as the foundation for growth in the future, as insurers devise strategies to compete in new markets. Insurers will need to renew efforts to capture as much value as possible from the current core business. They should focus on managing employer costs and healthcare affordability, and differentiating on medical value, as they search for diversification and opportunities to expand market share. Savings from these efforts will provide capital for investment in new capabilities supporting new business models.

Employers will maintain a huge stake in healthcare and will be valuable partners with health insurers in addressing the critical issue of medical costs. From what we see in the early exchanges, costs and premiums remain difficult to manage. To initiate change, insurers need to work with employers—along with providers, government, and consumers—to develop new structures and capabilities that will create medical value. Without new and innovative approaches to this central problem, the promise of reform will remain only a promise.

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