McKinsey & Company Case Study

Innovating employee health: Time to break the mold?

With Wellview Insights & Commentary

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Wellview Highlights

- Making employer-sponsored healthcare work better for America's workers is a **moral and economic imperative at the societal level.**
- The same consumers who are not using employer-sponsored offerings, seek solutions to enhance their health and well-being and **spend an estimated $400 billion outside the formal medical system**. **Preventive** health, **behavioral** health, **workplace** environment, **well-being**, and **social determinants** require greater focus to drive employees' overall health.
- **Employers should view health as another investment** — connect better health for employees as a way to enhance overall productivity and business results, and not as a cost on the expense line to minimize. (Every year ill employee health creates a 16% drag on the economy—a productivity-depressing cost for businesses.)
- Today's **system is organized by the stakeholders who deliver and finance, rather than utilize**, that system...The result is a system from which the **consumer is largely disengaged.**
- Employers need to **understand their employee populations' needs and preferences** (not just demographics, geography, most relevant care journeys, but also their **employees' definition of health and wellness** and their preferred modalities of engagement.)
- The goal is to **build an ecosystem of well-curated and purpose-built health and well-being offerings** (wellness programs, consumer-initiated diagnostics, med management, access to OTC meds, digital therapeutics, SDoH services).
- Consumers should be able to **intuitively access these offerings** through their engagement platform, depending on their health needs and desired modality of interaction (for example, digitally enabled self-care or person-supported guided programs).
- Effective **integration and management of clinical and non-clinical data** (helping to provide a higher degree of consumer-desired privacy) will be an important underpinning.

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Employers have rapidly adapted during the COVID-19 pandemic: Can they now apply that level of speed to innovating employer-sponsored insurance?

Poor health costs the US economy about $3.2 trillion annually from premature deaths and the lost productive potential associated with diseases. Compared with high-income peer countries, the United States has a 46 to 50 percent higher disease burden rate for 20- to 40-year-old workers, and a 17 to 33 percent higher disease burden rate for those over 40 years old. Through known interventions alone (requiring no new innovations), we could add 10 years of productive life to American workers.[1]

Making employer-sponsored healthcare work better for America's workers, then, is a moral and economic imperative at the societal level. High inflation in the cost of employer-sponsored health benefits and a decade-plus of cost shifting to employees have also contributed to leaving the average working-age household financially insecure. In 2019, the average employee contribution for family coverage was 32 percent of the average effective premium for large employers (500-plus employees), and 53 percent for small employers (10 to 499 employees). A majority of employees face potential out-of-pocket exposure greater than their household savings.[2]

We argue that it is time to break the mold of employee health. Breakthrough innovation is needed to create health and financial security for 160 million American workers and their families.

One program that could serve as inspiration is Medicare Advantage (MA)—a government program managed and delivered privately—that has delivered meaningful improvements.[3]

- *Affordability.* MA plan bids have improved from being 104 percent of Medicare fee for service (FFS) in 2010 to 88 percent in 2020.[4] The per person cost in MA (with no plan changes) was 8 percent higher in 2020 than it was in 2016, while the comparable number for employer-sponsored insurance was 26 percent. Over the same period, employers shifted 11 percentage points of the cost increase to employees to mitigate cost trend. Meanwhile, in MA, the beneficiary paid premium was reduced by 32 percent, with 93 percent of members gaining access to a zero-premium plan. MA programs also have increased supplemental benefits (for example, transportation, meals, and fitness programs) for the chronically ill.

- *Quality.* Stars scores for MA plans improved from an average of 3.96 in 2015 to 4.17 in 2020, despite performance standards to achieve four Stars tightening over time. MA plans generally outperform employer plans on many quality dimensions (for example, comprehensive diabetes care based on HbA1c control, adult BMI assessment, antidepressant medication management, smoking cessation).[5]

- *Access.* A little more than half of members on employer plans report always getting access to needed care. In MA, that percentage rises to above 60. An even bigger gap exists between employer-sponsored and Medicare members in terms of getting access to care quickly.[6]

- *Experience.* Between 37 and 42 percent of employer plan participants rated their plan a 9 or 10 on a 10-point scale, whereas more than 60 percent of those on an MA plan did so.

While the employed population is different from the retiree population, the comparison shows the possibility of delivering better outcomes within the context of the US healthcare system. MA plans are managed by the same payers who administer employer plans. With clear direction and incentives, employers ought to be able to lead the breakthrough innovation in healthcare for their employees and their families.

Six elements to drive breakthrough innovation

Reframe the mindset around employee health.

Two related mindset shifts are important. First, employers need to think about health broadly, not just the care they seek as a response to illness or injury. Approximately 80 percent of employees use few if any medical services in a year,[7] yet American workers are substantially less healthy than their counterparts in other countries. Preventive health, behavioral health, workplace environment, well-being, and social determinants require greater focus to drive employees' overall health.

Second, employers should view health as another investment. The goal is to connect better health for employees as a way to enhance overall productivity and business results, and not as a cost on the expense line to minimize. The COVID-19 pandemic showed poignantly how employee health impacts the business, yet every year ill employee health creates a 16 percent drag on the economy—a productivity-depressing cost for businesses.[8] A return-on-investment (ROI) mindset would lead employers to optimize where they spend resources related to the mix of the employee base. For example, effectively treating depression and anxiety could lead to a 4:1 return (that is, $4 back for every $1 spent) in improved employee health and productivity at work.[9] Similarly, addressing health inequities between employees of different races and ethnicities could result in cost savings of around $80 billion for US employers through the reduction of days of work currently missed by minority employees.[10]

Start with employee engagement as the central focus.

A focus on health may begin by meeting employees and their families (consumers) where they are. Today's healthcare system is primarily organized around the stakeholders who deliver and finance, rather than utilize, that system. Payers spend a large portion of their time negotiating with providers, and both payers and providers spend time negotiating with pharmaceutical manufacturers or other stakeholders. The result is a system from which the consumer is largely disengaged.

Yet while we regret the lack of engagement from consumers in their health, the same consumers seek solutions to enhance their health and well-being and spend an estimated $400 billion outside the formal medical system.[11] Our research finds that consumers define wellness around the following areas: better health, better fitness, better nutrition, better appearance, better sleep, and better mindfulness.[12] These elements often tie into an ability to be present and effective at work. Poor sleep, for example, correlates to less attendance and decreased productivity at work.[13] Effective engagement requires creating a personalized experience for consumers centered around the ways they define health and wellness.

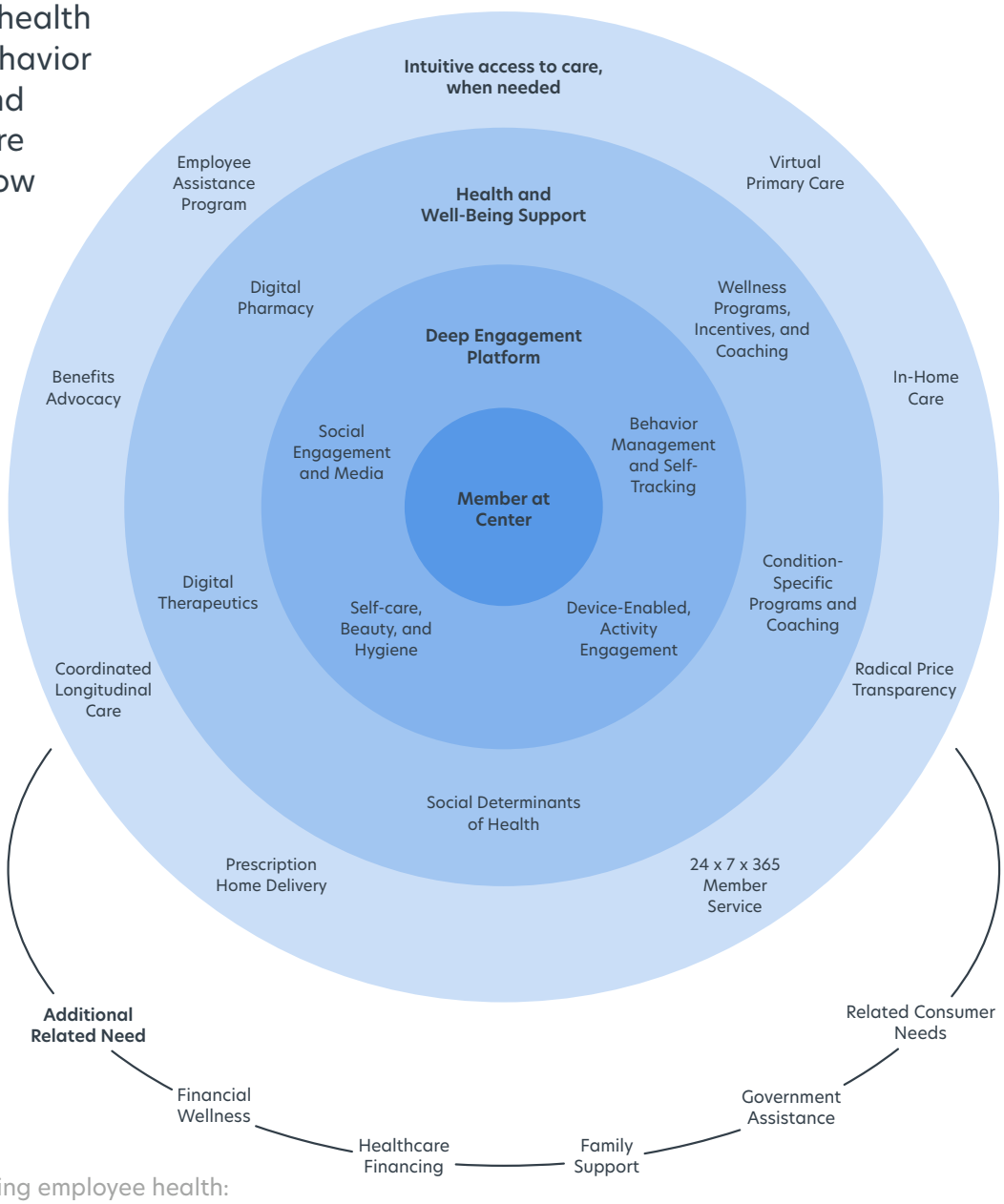
Today's employer-focused health engagement offerings (for example, digital wellness platforms like Virgin Pulse, Limeade, Vitality) are typically able to drive engagement of roughly 50 percent of an employer's workforce, largely based on the incentives the employer is willing to provide. While these incentives are a good start, there is an opportunity to have more impact. To be effective, we need to motivate the consumer to engage with their health multiple times a week.

Direct-to-consumer offerings, including Noom, Fitbit, or Apple, reflect how consumers define health and wellness. Their goal is to inspire members not only to engage in health-related behavior change without a reward, but even to pay out of pocket for these services in healthcare and related spaces. Ultimately many consumers achieve high daily engagement rates with no cash reward. The engagement achieved by non-healthcare groups, such as through social media apps, is often even higher (Exhibit 1).

Increased consumer engagement around health and wellness has the opportunity to increase overall employee well-being, physically and mentally. For 80 percent of employees, these services would represent almost all of the health services they will access in any given year.[14] Numerous studies have shown that a higher level of well-being among employees translates into improved productivity, reduced employee turnover, reduced absenteeism and presenteeism (the practice of coming to work while ill or injured, resulting in less productivity), and higher rates of return from disability leave.[15] Employers' investment in health engagement for employees, done right, has the opportunity to create positive financial returns.

Exhibit 1

Drive deep ongoing engagement to improve member health through ongoing behavior and care support and enable access to care when, where, and how members want it.



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Build an ecosystem of health and well-being offerings.

The next layer beyond core engagement should be a well-curated series of purpose-built health and well-being offerings. These could range from wellness programs and incentives (for example, smoking cessation, substance use treatment), consumer-initiated diagnostics (for example, a sexually transmitted disease test prescribed by a physician and taken at home), routine medication management and adherence, easy access to over-the-counter medications and supplements, and digital therapeutics, as well as social determinants of health services (for example, transportation, nutritional assistance).

Fifteen percent of employees will have more substantial health needs in a given year. Exhibit 2 shows the care journeys with the highest spend for those covered by employer-sponsored health benefits. Coaching and assistance programs around these specific care journeys are important to ensure timely and appropriate management of the condition and required care.[16] Likewise, easy access to early care through telehealth and on-site or near-site care will encourage employees on these care journeys to access care quickly when needed, avoiding exacerbations and potential healthcare emergencies.

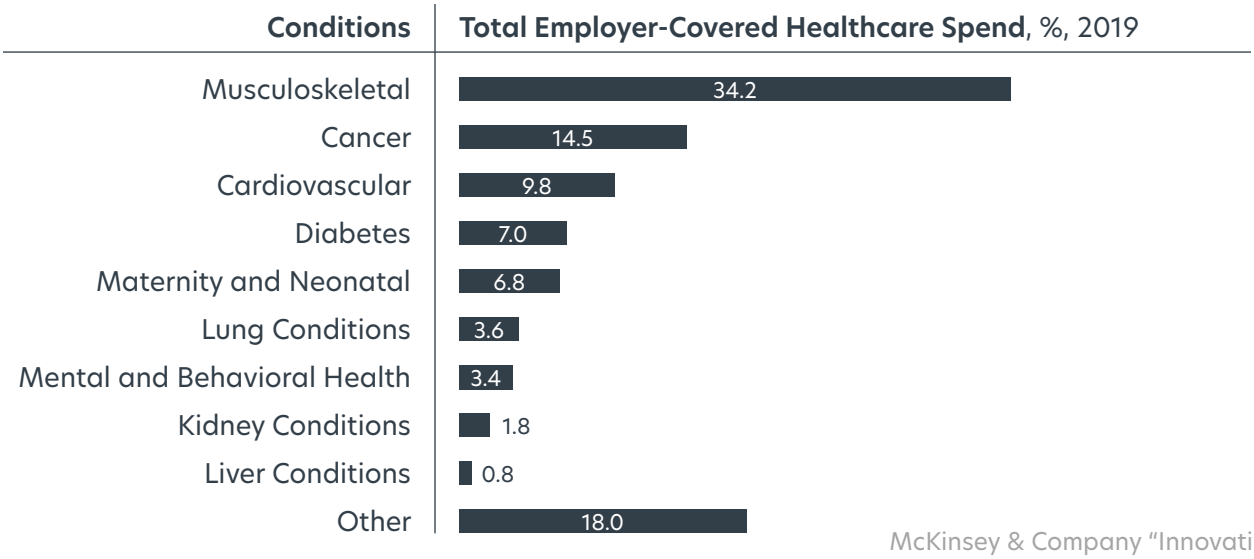
Importantly, consumers should be able to intuitively access these offerings through their engagement platform, depending on their health needs and desired modality of interaction (for example, digitally enabled self-care or person-supported guided programs). Moreover, the personalization engine should help ensure that each offering they access does not feel disjointed or duplicative. Effective integration and management of clinical and non-clinical data (helping to provide a higher degree of consumer-desired privacy) will be an important underpinning.

Refashion medical care and payment.

The medical care system must feel integrated to its members around their end-to-end care journey and with the rest of their health needs. As we noted above, engaging members and supporting them through health and well-being offerings is essential. A minority of members will encounter the need for formal medical care in any given year. Access to medical care must be an intuitive extension for these members. Doing so requires the medical care journey to be integrated with their health and wellness programs, personalized based on the information they've provided, and accessed and coordinated through the engagement platform.

Exhibit 2

Top care journeys driving employer-sponsored healthcare spend.



Source: Truven 2019

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As described above, this 15 percent of members encountering a select set of care journeys accounts for a large percentage of total employer healthcare costs. An end-to-end redesign around these care journeys should rest on an accountable provider bearing meaningful risk for quality, access, experience, and total cost outcomes. This redesign would require a clean break from the current mindset of finding the lowest unit cost for each procedure or service. Employers and payers might begin by selecting high-performing providers to create Centers of Excellence (CoEs) to support each care journey.

These CoEs would likely be based around capitated, episode-based payments to the provider with the most influence over the care journey—likely the relevant specialist, such as an oncologist for cancer or an OB/GYN for pregnancy and delivery. Employers could begin by modeling after select provider groups that are currently taking risk on select episodes or populations (for example, Axia Women's Health for OB/GYN, Catalyst Health Network for primary care, Landmark for complex chronic members). This capitated rate could initially be set at the average of total FFS payments for the given episode, which would allow high-quality providers a meaningful opportunity upside and encourage them to participate in a cost-effective way. A Stars-like measure (similar to Medicare) could be created and tied to a meaningful (say 5 percent) holdback from the capitation payment based on quality metrics and experience scores. In order to create a path from our current FFS employer system to this new one, and to encourage providers to invest in the back-end technology required to support a value-based payment model, payers and employers should be willing to pay a higher capitated rate upfront. This initial upfront payment strategy would also require a lower trend of annual increases compared with the current FFS model.

In addition, less than 5 percent of members have multiple, persistent chronic conditions and require a PCP-anchored, multispecialty, integrated care solution.[17] The needed model is similar in many ways to the integrated care and care management models successful in MA and can be designed to mimic similar risk-based arrangements with a focus on total cost (including full capitation) and payment for quality and experience. An important difference between this population and a Medicare population is that many of these members may still be working while managing their conditions, so existing models will need to be adapted to take these differing needs into account.

Some care will continue to be required outside these CoEs or integrated models, for example, potentially commoditized tests like colonoscopies. For these, payment reform could be driven by new entrants, for example, technology players who might create a comprehensive repository of provider pricing. They could then use their heft and influence to publicly encourage other providers to converge pricing to the mean.

With the convergence of these trends—CoEs, integrated models, commoditized services—we may over time see some evolution of the traditional network of providers in the large, commercial market. Without the network as a competitive advantage and barrier to entry, the outcome could be similar to the emergence of ride-sharing services, where pricing and availability are often based on consumer demand. Outpatient and elective care services (and potentially even emergent inpatient services) could be priced by the technology platform, with predetermined prices serving as a ceiling. An opportunity exists to dynamically price down in real time, based on a provider's marginal capacity. The platform could more efficiently route consumers to available local capacity (for example, by predicting out-of-pocket cost and provider availability upfront, prior to appointment scheduling), similar to what we have already seen in transportation and mobility. The platform also could more efficiently connect patients using AI with more cost-efficient supply-side options, such as through "one-click" integration with virtual care. The 38 times rise in telehealth services from pre-2019 levels may offer employees faster access to a provider.

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Share economics back with employees.

Participation in such a redesigned health ecosystem is likely to yield substantial healthcare cost savings (similar to MA delivering Part A and B benefits at 87 percent of Medicare FFS) in addition to improvement in employee health and well-being. Employers must redesign their benefits programs to share back the value creation with employees through reduced premiums, out-of-pocket exposure, and provision of supplemental benefits. This savings share back will be important to drive higher opt in to such a model (thereby creating an incentive for providers to participate), higher rates of engagement, and greater financial security.

Current evidence suggests that plans with lower out-of-pocket and premium share for employees are attractive. For example, newer employer health options (for example, Bind, Centivo) have been offered alongside more traditional offerings, and have generally seen uptake of around 20 to 30 percent with a more attractive employee price. Another option could be to use the cost savings to significantly incentivize employees to choose CoE or other preferred providers, as Bind's and Garner Health's models do.

Demand productivity from suppliers.

In an upcoming analysis, we have found the total administrative cost spend across the US healthcare system is $950 billion, or about 25 percent of total healthcare expenditure. Our analysis estimates that productivity-enhancing measures could reduce these administrative costs by 22 percent through known actions (for example, adopting digital and analytics tools) that are used in other industries such as financial services.

Many large employers routinely ask their suppliers for productivity improvements and healthcare stakeholders can apply similar thinking in this area. Employers could consider innovative arrangements with payers where they reduce the payers' incentive to overstaff administrative functions by paying rates based on utilization (such as the number of calls into call centers, number of prior authorizations) rather than flat administrative fees.

By streamlining and clarifying the administrative aspects of employee health, employees can reclaim precious daytime hours often snagged by wrangling over medical bills, investigating what medical services might be covered, or finding an available provider.

Our analysis indicates a more novel opportunity exists to dramatically shrink the $160 billion spent on financial transaction processing within healthcare. In the aforementioned example, consumer engagement or pricing reform tools could be extended, as many fintech players have done, to enable efficient transactions between consumers, providers, and employers or payers. The current expensive model of provider billing, claims processing, and reconciliation could be made obsolete. Financial transactions would be completed through the core engagement platform. The essential data that today's claims capture (for example, diagnosis code, procedure codes) would be readily available on the engagement platform and also be enhanced as clinical data follows the patient and is integrated into the platform.

Actions to break the mold

Employers need to go beyond incremental changes in a system that is no longer delivering adequate health or financial security for their employees. To adopt a mindset of "health as an investment," employers should begin with understanding their employee populations' needs and preferences. These investigations would not only include demographics, geography, most relevant care journeys, and more, but also their employees' definition of health and wellness and their preferred modalities of engagement. Armed with these facts, employers can consider leading in articulating the broad health, well-being, and care ecosystem they would like to have for their employees and their families. Employers could consider appointing a chief health officer, potentially with oversight over benefits, wellness and behavioral health programs, and occupational health—in recognition that employee health is about more than benefits.

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Many employers have learned how to adapt and move at speed during the pandemic; they should demand the same level of speed of innovation in addressing this critical area both from their own organizations and the healthcare players they work with.

Healthcare players need to take an innovation mindset to bring forth the solutions that enable this future. While the specific solutions each player, whether incumbent or new entrant, creates will depend on their specific endowments (for example, scale, depth in local markets, strength of relationships in various parts of healthcare), we believe a high-speed business-building mindset and approach will be critical. Healthcare players that embrace speed are more likely to deliver the first minimum viable solutions to employers and members within 6-to-12 months. These minimum viable solutions should not be point solutions, but should instead deliver the core engagement platform and the initial version of the ecosystem. A team free from historic baggage and day-to-day responsibility of the current business will be important to drive the creation of this new model.[18]

SOURCES:

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[8] Jaana Remes, Katherine Linzer, Shubham Singhal, Martin Dewhurst, Penelope Dash, Jonathan Woetzel, Sven Smit, Matthias Evers, Matt Wilson, Dr. Kristin-Anne Rutter, and Aditi Ramdorai, "Prioritizing health: A prescription for prosperity," July 8, 2020, McKinsey.com.

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[11] [12] Shaun Callaghan, Martin Lösch, Anna Pione, and Warren Teichner, "Feeling good: The future of the $1.5 trillion wellness market," April 8, 2021, McKinsey.com.

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[15] For example, employers with a higher number of mental health supports offered to employees report a 50 percent greater return-to-work rate after mental health-related disability leave than employers offering fewer supports, see Erica Coe, Jenny Cordina, Kana Enomoto, Alex Mandel, and Jeris Stueland, "National surveys reveal disconnect between employees and employers around mental health need," April 21, 2021, McKinsey.com.

[16] For example, a pilot program by a payer to provide coaching and administrative support to families of children with special needs resulted in medical cost savings of $1,500 per child per year, plus administrative savings through reduced claims appeals, see "Special needs initiative: An integrated strategy to help simplify a complex journey," United HealthCare Services, August 28, 2020, uhc.com.

[17] Peter Graven, et al., "Preventable acute care spending for high-cost patients across payer types," Journal of Health Care Finance, 2016, Volume 42, Number 3, healthfinancejournal.com.

[18] We outline this approach further in Shubham Singhal and Ari Libarikian, "Leap to the future of healthcare: Reinvent through business building," April 9, 2021, McKinsey.com.