POINT OF VIEW

UNDERSTANDING THE UNINSURED

OLIVER WYMAN'S NEW SURVEY OF AMERICANS WITHOUT HEALTH INSURANCE FINDS THEM READY TO PARTICIPATE IN HEALTHCARE REFORM, OPEN TO INNOVATION, AND EXTREMELY SENSITIVE TO PRICE.

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"Jennifer" is a graduate student and self-employed choreographer. She is 37, married, and, lucky for her, she's usually healthy. Her husband is also self-employed, and together they have a household income of less than $30,000 a year—and no health insurance. In the last 15 years, her experience with the healthcare system has consisted of a couple late-night visits to the ER and some weekend mornings at her neighborhood urgent care clinic to deal with flu and sinus infections. By most definitions, she has limited access to healthcare: She and her husband have sometimes chosen not to see a doctor because they couldn't afford it. But she has grown used to the idea that when she does obtain medical services, they are available 24 hours a day, seven days a week. Under the 2010 Affordable Care Act (ACA), Jennifer will be able to obtain health insurance. Her out-of-pocket costs will be much lower, but her experience of the healthcare system will change. Some things she will undoubtedly like, but others she may not—making appointments, fitting care into normal business hours, dealing with her insurance company. The fact is policy makers and healthcare organizations don't really know Jennifer—or the other tens of millions of consumers who will obtain their health coverage under ACA—or fully appreciate what they want and need. In a reform effort that hopes to use the currently uninsured as a way of focusing market forces in the service of change, that is short-sighted.

The Affordable Care Act is complicated and uses incentives and regulations to try to drive down the number of the uninsured and ultimately increase the affordability of healthcare. For it to succeed, all the pieces must work together. For example, if the penalties for not buying insurance are set too low, younger, healthier consumers like Jennifer may bail out, resulting in a less healthy risk pool and higher premiums for all. If the subsidies are set too low, some of the uninsured will be priced out of the market or will have less incentive to buy. The key to making the system work is to understand how consumers (most of them federally subsidized) will behave as they shop for health insurance for the first time in the new regulated market.

76 percent of the uninsured in our sample would purchase coverage.

- How will consumers respond to the insurance products they are offered and what will they buy?
- Will the programs and financial incentives make sense?
- What features will consumers value most?
- Will consumers understand the value of the offering when real costs are masked by subsidies and community-rated pricing?
- More broadly, will this new regulated marketplace work? And what happens if it doesn't?

To find out, Oliver Wyman conducted what we believe to be the first major market survey of the consumers most likely to participate in this new insurance market. Part of the project consisted of detailed surveys of more than 700 currently uninsured individuals. We asked about their health status, their income, and their attitudes toward the health system. To discover how they would make buying decisions we presented them with a series of discrete choice scenarios, featuring realistic descriptions of the sort of insurance products we expect to see in the under-65 (U65) healthcare exchanges when the exchanges open in 2014. The offerings carried actuarially appropriate pricing, including subsidies that reflected respondents' actual income levels, and the penalties they would actually pay if they chose not to buy. They also included a variety of coverage options, including some innovative ones, such as options for patient-centered medical homes, 24/7 access, Web-based doctor visits, discounts for losing weight, and so forth. In order to truly understand how consumers will purchase, we made every effort to simulate the actual exchange purchasing experience where consumers will chose between competing offerings.

THE LARGE RETAIL HEALTHCARE MARKET WILL TRANSFORM THE INDUSTRY.

What we found was promising. Faced with the choice of buying insurance or paying a penalty, 76 percent of the uninsured in our sample found the products and related costs compelling enough to purchase coverage.

To put that in context, we estimate that there are 51 million uninsured Americans. About 18 million have incomes below 133 percent of the Federal Poverty Level; they would be eligible for Medicaid coverage under ACA and would not be purchasing insurance for themselves. If, as our survey suggests, 76 percent of the remaining 33 million uninsured

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purchase coverage, either through the exchanges or in the individual market, that would represent 25 million newly insured Americans, reducing the number of the uninsured by about half. In addition, about 11 million currently uninsured people will enroll in Medicaid (according to the Urban Institute). Overall, the number of the uninsured will be reduced from 51 million to about 15 million, or from 16.6 percent of the population to about 5 percent.

The 25 million "newly insured" wield approximately $100 billion of purchasing power but they will likely demand new products and services unavailable in today's market.

The 25 million "newly insured" Americans purchasing insurance on the exchanges and in the individual market represent 8 percent of the population, a segment more than half the size of the Generation X segment (with 45 million). They will wield something on the order of $100 billion of purchasing power in the healthcare arena. They are likely to drive healthcare transformation, demanding new products and services unavailable in today's market, where employers make most health insurance decisions. Health plans around the country will have to ask themselves, "What will it take to earn the confidence of the newly insured, and how can we create value that exceeds their expectations?"

WHAT ARE UNINSURED AMERICANS LOOKING FOR?

Who are the uninsured, and what do they value? When we analyzed the data in our survey, they fell into three categories, each fairly distinct from those who are already insured today:

- The first group, which we call "Struggling and Unengaged," consists of 17 million people, or about 44 percent of the non-Medicaid-eligible uninsured. The greatest concentration of people in this category are in their 30s and 40s. They are not economically well off; many need two jobs to cover basic living expenses. They are healthy and not looking for help or advice from health insurers. Healthcare is not a priority for the struggling and unengaged. Most have no regular doctor, little experience with the healthcare system, and little or no trust in it. They view health insurance as a commodity and just want basic protection against disaster. They are willing to get their care through low-cost urgent-care or retail clinics and interact with their insurance company through Web-based self-service and other inexpensive routes. They are interested in loyalty rebates or referral incentives. Most will buy insurance because of government subsidies or to avoid penalties. Given the size of this group, health plans will have to start thinking about how to engage this group and shift their mindset from "Healthcare is a commodity" to "I love my health plan because . . ."
- The second group, 10 million people or 26 percent of the non-Medicaid-eligible uninsured, is "Want to Be Healthier." They are largely middle-class, predominantly in their 30s and 40s, a mix of single people and small families. These are people who already have a chronic disease or are at risk of developing one, and they are interested in taking steps to improve their health. This segment wants expert advice in navigating the healthcare system and making decisions. They already have some experience with the healthcare system (not surprising given their health status) and are more trusting of their doctor (if they have one). They value concierge-like services, convenience, and access to healthcare: 24/7 coverage, same-day appointments, disease management programs. They are fairly neutral on brands—they are aware of the leading insurance brands but do not consider that a strong criterion when making buying decisions.

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- We call the third segment "Engaged to Save." The people in this segment represent 11 percent of the non-Medicaid-eligible uninsured, and they are perhaps the least like the population in the employer-driven market. They are lower middle-class, and a bit younger than the previous two segments. They are healthy today, and are far more price sensitive than any other segment we have identified. They are willing to do anything to save money: submit a detailed health assessment, wait up to two weeks for a doctor's appointment, use retail clinics for routine care, do follow-ups by phone or e-mail. People in this group want to minimize out-of-pocket costs and are willing to make tradeoffs to reduce their costs. For example, they are willing to maintain a healthy body weight or quit smoking if it will save them on premiums[1].

Healthcare is not the first industry to move from a wholesale to a retail model, and if the pattern holds true, consumers will break through the B2B paradigm and change the healthcare game.

We were fascinated to learn just how much the needs of uninsured consumers differed from the way traditional employer-driven insurance plans handle health benefits and access. Many of today's uninsured care less about access to the traditional healthcare system and more about access to healthy lifestyles. The budget-minded consumer described above is likely to value health-related lifestyle benefits: deals on healthy groceries, the fitness center, or even running shoes. Tomorrow's product designs and value propositions must be quite different from today's to attract the uninsured.

In addition, many consumers are interested in bringing down the cost of coverage by committing to healthy lifestyles or receiving care in new, more economical ways. This, too, has real implications for health plans as they design new products and services to better meet the needs of the uninsured. In our survey, we offered consumers scenarios in which they would receive a $50-a-month discount for agreeing to change how they accessed the healthcare system or for embracing healthy lifestyle choices. Many found the deals attractive:

- 41 percent were willing to receive a majority of their medical care at a retail clinic located in a pharmacy or retail store
- 52 percent were willing to reach a healthy body weight
- 38 percent of those who smoked were willing to quit
- 48 percent were willing to interact with their doctor primarily online.

While many consumers were looking for ways to make healthcare coverage more affordable, others were looking for premium service and willing to pay for it. For example, we learned consumers were willing to pay as much as $50 per month extra for more inclusive coverage and service upgrades (See Exhibit 1, next page):

- 36 percent were willing to pay extra for 24-hour-a-day, seven-day-a-week access to doctors
- 26 percent would pay for coverage and access to alternative medicine.

Market regulation is likely to limit the choices health plans can offer. But it is clear that consumers want to tailor the benefits, access, and service they receive from their health plan. They will reward companies that find innovative ways to make healthcare more affordable while personalizing products and services. Healthcare is not the first industry to move from a wholesale to a retail model, and if the pattern set in other industries holds true here, consumers will break through the existing B2B paradigm and change the healthcare game.

1 You may have noticed these percentages don't add up to 100. The rest of the exchange-likely population fits into two other consumer segments that are already insured by either Individual or Small Group plans.

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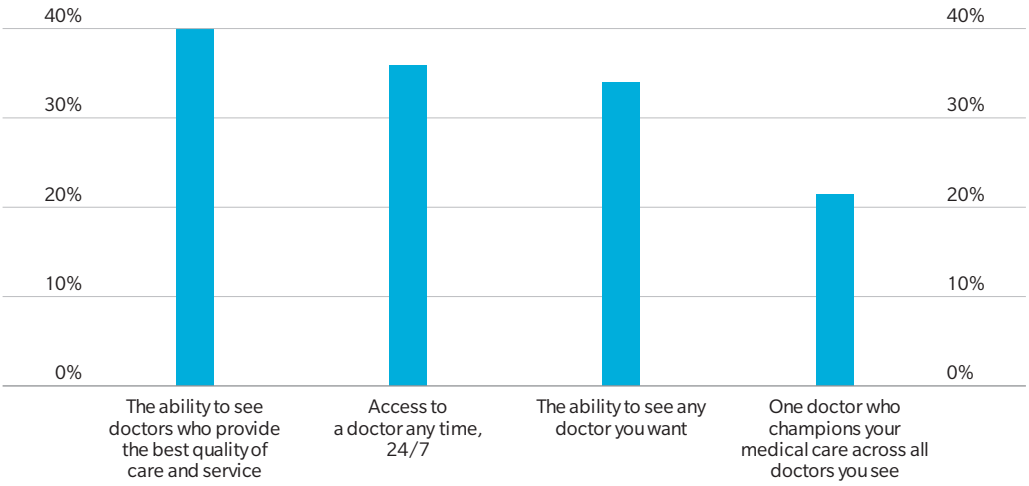
EXHIBIT 1: PERCENT OF CONSUMERS WILLING TO PAY $50 PER MONTH FOR EACH ADD-ON



Source: Oliver Wyman Consumer Survey and Analysis

CONSUMER EDUCATION IS KEY FOR HIGH EXCHANGE PARTICIPATION RATES.

No one should expect that 76 percent of the uninsured will flood the market and buy coverage the day the exchanges open for business. Our research shows that while uninsured Americans overwhelmingly see value in coverage, few really understand their options or even what a regulated product exchange is. If the system is to succeed, consumers need to be prepared to participate. The government and private sector will have to work together to inform and educate uninsured Americans about coverage options, subsidies, the value of health insurance, and how the exchanges will work. Without well-orchestrated communications, initial participation rates are likely to be low and consumers may make uninformed product choices in the first round.

The government and the private sector both have vital roles to play in setting healthcare policy and creating the infrastructure for the new market—creating the subsidy and penalty structure, building the exchanges, and motivating health plans to make use of them. The burden rests with the government to inform its citizens, and with health plans to invent the right products and stimulate demand in much the same way retailers and consumer companies do today.

RISING HEALTHCARE COSTS POSE A REAL THREAT TO THE SUCCESS OF THIS NEW MARKET.

We've learned through our research that the uninsured are acutely price sensitive. The net cost of premiums after subsidies had a major impact on whether consumers bought

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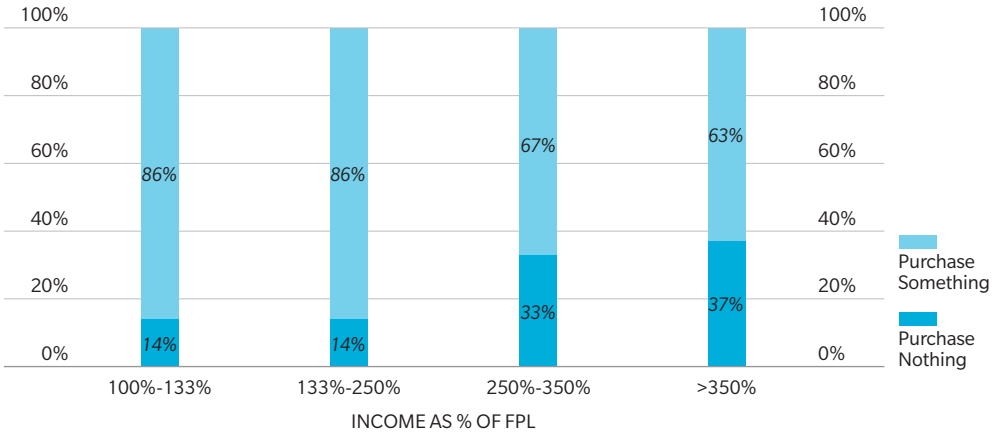
If the net cost to the consumer rises too sharply, or if government subsidies fail to keep pace with the rising cost of healthcare, consumer participation rates will fall – threatening America's first real shot at universal coverage.

insurance or turned it down. Because federal premium subsidies are lower for those with higher incomes, this means that middle-income consumers are less likely to purchase insurance than the lowest-income group. (See Exhibit 2 below.) Only 14 percent of those with incomes between 100 percent and 133 percent of the federal poverty level (or between $22,000 and $29,000 for a family of four, using the 2010 guidelines) said they would not buy insurance. The figure rose to 33 percent for those between 250 and 350 percent of FPL, and 37 percent for those greater than 350 percent of FPL. As disposable incomes rose past this point, consumers opted back into the market. For those earning more than 600 percent of FPL (about $130,000 for a family of four), the likelihood to opt out dropped back down to 19 percent.

EXHIBIT 2: LIKELIHOOD TO BUY INSURANCE BY INCOME LEVEL



Source: Oliver Wyman Consumer Survey and Analysis

Yet people who can access these subsidies don't fully appreciate the value they are getting relative to the total cost of care. The old and the sick in particular are getting the bargain of the century—paying just pennies on the dollar—and they are still price sensitive. This speaks in part to the opacity of medical costs in this country today, but it also shows that the public and private sectors have a long way to go in educating consumers about medical costs.

This "net cost" mindset creates real marketplace vulnerability. "Full cost" healthcare is unaffordable for most. If the net cost to the consumer rises too sharply, or if government subsidies fail to keep pace with the rising cost of healthcare, consumer participation rates will fall.

This could be a big problem. Healthcare costs are rising two and half times faster than the Consumer Price Index and the tax revenue that ultimately pays for government programs. It will be difficult for the federal government to increase subsidies at the same pace as medical trend—especially if the eligible uninsured numbers continue to grow. More likely support for subsidies will soften as policy makers face unprecedented deficits. It is a near certainty the net cost to consumers will rise considerably—driving consumers out of the market and threatening America's first real shot at universal coverage.

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HOW CAN THE NEW RETAIL HEALTHCARE MARKET REMAIN VIABLE IN THE LONG-TERM?

Long-term viability means healthcare companies must shift the cost and quality value equation and consumers must begin to understand the true cost of healthcare while managing their own health.

If the retail healthcare market is to be sustainable, consumers and health service companies (health plans, providers, health information companies, etc.) must redefine the model to dramatically improve the value of the system. Consumers will have to determine what is really important to them and health service companies will need to work together to fix the broken system—taking costs out and vastly improving quality and the consumer experience. While ACA is a big step toward universal coverage it does little to fix healthcare or change the system's gross misalignment between health service companies' profit models and consumer value.

For the market to work in the long term, healthcare service companies must shift the cost and quality value equation in healthcare—20 percent more value for 85 percent of the current costs would be a great start. And consumers must begin to understand the true cost of healthcare, stop considering it an entitlement, and start taking responsibility for managing their own health. Great healthcare policy and private sector innovation cannot be expected to offset Americans' unhealthy lifestyle choices, the growth in chronic disease, or consumers' reluctance to complete prescribed treatment plans. Part of making the retail market work includes a big consumer wake-up call.

The good news is that many consumers are willing to make informed choices about healthcare coverage, access models, and services—choices required to keep healthcare affordable. Just as they are with most other products and services they decide to buy; trading features and brand to reach a comfortable price point. Given well-constructed options, consumers are interested in making tradeoffs between cost, coverage, premium services, and increased levels of personal accountability.

Policy makers will have to carefully consider how best to balance social healthcare issues like providing access to care for Americans with chronic diseases with creating a competitive retail market where consumers make real price/choice tradeoff decisions. Protecting basic healthcare rights for everyone seems reasonable, while creating a broad-based healthcare entitlement program (independent of circumstance) undermines long term market sustainability. ACA's "protectionist" starting point must eventually give way to consumerism. The power of the consumer market will create the economic motivation for health services companies to begin fixing our broken healthcare system. It's a novel idea—but designing the system around the consumer needs and values is big step in the right direction.

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