



MEDICARE ADVANTAGE IS BOOMING. WHY ARE SO FEW PAYERS WINNING?

By Sanjay B. Saxena, MD, Ashish Kaura, Daniel Gorlin, and Jon Kaplan

IT'S A VAST MARKET—PROJECTED to reach more than \$360 billion a year by 2023—with attractive growth baked in. Below the surface, though, lie difficult dynamics and increasingly tough competition. Medicare Advantage—the insurance programs that private companies offer through Medicare—has established itself as a hot market segment that shows no signs of cooling, and lots of health care payers are eyeing it. But they should look carefully before they leap. Large incumbents such as United Health, Humana, CVS Aetna, and Anthem, along with powerful regional players such as WellCare, have built strong defenses. New entrants must develop a compelling value case if they are to gain a foothold, much less seize significant share. Here's what companies need to know to get into the market or increase their current share.

Size and Growth—and Fierce Competition

According to our analysis, Medicare Advantage enrollment will increase at an annual rate of 4% to 6% from 2017 to 2023, and

revenue will grow at a rate of 7% to 9% annually. By 2023, available annual profit pools will range from \$11 billion to \$13 billion, making Medicare Advantage the single biggest driver of profit growth for health care payers.

Significant tailwinds are propelling this growth, including an aging population, rising penetration in comparison with fee-for-service plans (Medicare Advantage is expected to reach 40% penetration by 2025), and a continued favorable regulatory climate. Current government policies—including support for strong rates, considerable latitude for private payers to add benefits (such as food assistance, transportation assistance, and social support) beyond core health services, changes in Medicare Part D plans, and initiatives from Centers for Medicare & Medicaid Services (CMS) for increased transparency—will add fuel to the engine.

Behind the growth, however, lies a fiercely competitive market. The number of plans available per eligible member has in-

creased over the past four years at a rate of 8% per year, from 19 in 2016 to 24 in 2019. According to Deft Research, switching rates have dropped from more than 20% for 2015 (and for each of the three years before) to 11% for 2018 and 14% for the 2019 plan year. And in many instances, consumers are simply moving from one plan to another while keeping the same carrier, making the effective switching rate even lower than the reported level. This combination of factors has made it difficult for individual companies to accurately report consistent year-on-year growth.

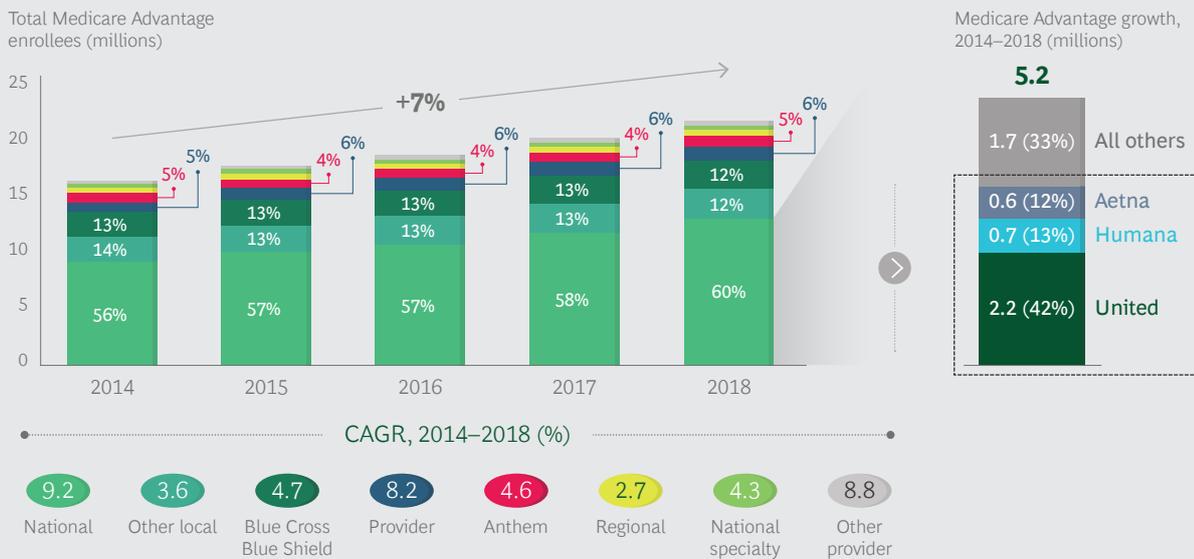
The big national players (including Anthem, CVS Aetna, Humana, and United Health) have seized the largest share of the market. (See Exhibit 1.) Despite the industry’s attractive macro conditions, new entrants—be they venture-backed plans, provider-sponsored plans, or tech-based provider transformations—have found Medicare Advantage a tough market to crack, even with strong backing and deep pockets. We analyzed some 3,000 cases of new market entrants, which we defined as new company offerings in new Medicare service areas, over the past five years—and we found only about 100 instances (3.3%) in which the payer achieved growth of 10,000 members or more. Even more daunting, in

only 12 cases (0.4%) did new entrants in a Medicare service area grow from a starting point of zero members to 10,000 or more. (See Exhibit 2.)

Cracking the Medicare Advantage market has proved equally challenging for existing health plans, such as regional Blue Cross Blue Shield plans, which have often found it difficult to translate their historical strength in employer-sponsored commercial insurance into success in Medicare Advantage. Similarly, Medicaid plans, which have largely focused on the “duals” population (typically, seniors who are also eligible for Medicaid), have found it difficult to capture traditional Medicare-eligible seniors.

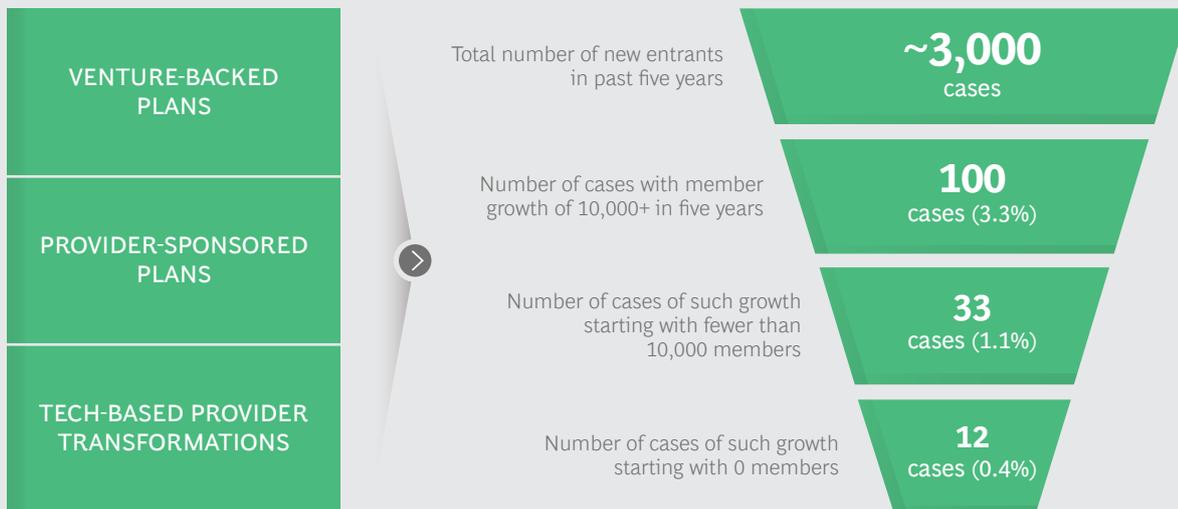
Even the national players face challenges in their efforts to deliver consistent growth over time, and they are leveraging their scale for price advantage, investing in plan value (making their benefits richer for members), and offering more \$0 premiums and Part B givebacks (through which insurers actually put money back into members’ social security accounts). For example, the newly merged CVS Aetna has devised a strategy to leverage its retail footprint to reach more than 75% of all Medicare Advantage-eligible members in the near term, and it has already instituted

EXHIBIT 1 | Large National Players Have Captured Most of the Growth to Date



Sources: Centers for Medicaid and Medicare Services enrollment data; BCG analysis.

EXHIBIT 2 | New Entrants Have Found Growth Challenging



Sources: Company press releases; CMS enrollment data for July 2014–2018 and January 2019.

Note: “Cases” are calculated as Number of players × Number of Medicare service areas.

a product strategy that uses a \$0-premium local preferred provider organization to achieve share gains. National players are also exploring avenues that may enable them to differentiate themselves on attributes other than price, by innovating their plan designs, investing in brand campaigns, expanding their networks of care providers, and integrating clinical assets to maintain and grow share. For example, United Health, which already has one of the largest provider networks, is building local market depth by acquiring clinical assets, and it is using advanced analytics to better understand its members and costs.

Operational Excellence Is the Price of Entry

To compete in Medicare Advantage, health plans must have operating capabilities that can deliver superior processes and service, maintain margins and price competitiveness, and fund differentiating characteristics. For all players, this level of operational excellence depends on four critical elements:

- **Robust Utilization and Care Management.** The traditional care management approach focuses on intervention at a point in time. Payers need to step back

and take a long-term view of patients’ health needs, including social determinants of health, and apply predictive analytics to anticipate care demands and, if possible, avoid adverse outcomes. For example, Humana has developed robust predictive models and invested heavily in home care assets (its investment in Kindred, which provides care for people recovering from illness or injury, is one case in point) to be on the front lines of care.

- **Efficient and Effective Network Design.** To achieve high-quality outcomes, payers must identify high-value providers and use incentives and other means to direct care appropriately. Leading payers are not only pursuing value-based contracts (including full-risk contracting with primary-care providers) but also taking a more strategic approach to shaping the primary-care network for members. Strategies range from owning or partnering with primary-care facilities and physicians to investing in insight engines designed to identify the highest-performing providers and develop helpful data for primary-care physician to use in adapting their practice or referral patterns.

- Accurate Risk Stratification.** Payers need to conduct risk assessments in concert with providers, incorporating data from external sources to achieve as full and accurate a view as possible (consistent with privacy laws and regulations) of the member’s risk and needs. Newer models incorporate self-learning technologies enabled by machine learning algorithms that increase predictive accuracy over time, and they connect the patient’s risk stratification with provider treatment plans. Having best-in-class risk stratification capabilities enables payers to address potential gaps in care for members and also to capture important patient risk factors, thereby ensuring accurate scoring of the risk adjustment factor and, where appropriate, additional payment revenue from CMS.
- Improving Performance in the Context of Medicare’s Stars Rating System.** Most payers have already invested heavily in robust analytics and a dedicated organization to manage and predict Stars scores. Health plans should align their network design and their Stars strategies to create the foundation for a high-quality provider partner base. For example, co-designing incentives with provider partners can help create alignment across the care continuum.

Payers need to recognize that Medicare Advantage requires a fundamentally different operating model and set of capabilities than those they have developed for their commercial group and individual lines of business. While many of the competencies may seem similar and scalable, they have proved not to be. Health plans that have tried to transfer existing care management, network, and risk stratification capabilities as is, or with limited tailoring, have struggled to effectively manage and profitably serve Medicare Advantage members. As a result, many predominantly commercial plans—including a number of Blues—have become trapped in a pattern of rapid growth, followed by pruning to address mounting losses. Only a few such plans have been able to escape this cycle.

Winning Requires Differentiation

Besides depending on operational excellence, achieving long-term growth through consumer differentiation requires investing in improvements in three high-impact areas: tailored products and services, innovative care delivery, and listening to members.

Tailored Products and Services. Conventional consumer segmentation has not yielded strong positive results in Medicare Advantage. Products have lost their distinctiveness, with too many me-too attributes; they often overlap in benefits and vary only in price and network. Payers need a better segmentation model—one rooted in an understanding of seniors’ emotional and functional needs.

Consumers, including seniors, have learned from the likes of Amazon, Netflix, and Apple to expect a high degree of personalization and customization in the products and services they buy. To win in Medicare Advantage, payers must develop a consumer-centric plan design with offerings tailored to meet the needs of subsegments within the patient community. BCG’s 2019 Medicare Advantage Innovation consumer survey reveals a series of emotional and functional needs that companies can use as the basis for product design that goes beyond conventional segmentation. For example, the top three areas of emotional reassurance that consumers seek when selecting a Medicare health plan are as follows:

1. Getting the care they need
2. Being prepared for the unexpected
3. Feeling free to live retirement well

With respect to a plan’s functional components, 49% of Medicare Advantage–eligible consumers prioritize having access to all of the care they may require with the best possible providers. Another 29% want to understand all of their options, maintain control of their health care, and keep their independence. These varying priorities of-

fer health plans avenues for differentiation that extend beyond benefits and network coverage alone.

Innovative Care Delivery. Baby Boomers have the same high expectations for their senior years as for most of the rest of their lives. In particular, they expect to continue to live on their own terms. Payers can drive growth and improve overall care, consumer convenience, and experience by integrating innovations that appeal to this generation of Medicare consumers. These include incorporating high-touch, convenient, easy-to-schedule primary-care models and providing in-home care management support for consumers who prefer to age in place and maintain their daily routines. Some payers are investing in in-home care and wellness programs designed to help people return home more quickly after hospitalization or live more easily at home when managing long-term illnesses or chronic conditions.

Listening to Members. Payers in general receive low trust scores from consumers. To improve their members' experience, they need to increase their transparency and pay closer attention to the qualities and attributes that Medicare buyers are looking for. BCG's 2019 survey identifies the following functional product attributes (contributing to a seamless end-to-end member experience) that respondents who are 60 to 70 years old frequently cite:

- Online collateral information as part of the process for choosing a Medicare Advantage plan (84%)
- Full-coverage lump-sum premium payments (64%)
- In-home (versus nursing home) care at affordable cost (62%)
- A cash-back plan if annual health care costs fall below a certain threshold (58%)
- Ability to sign up online directly with insurance company (22%, second only to "in person with an insurance broker," at 26%)

Payers can also explore deepening customer relationships through concierge-like models, whole-person approaches, lifestyle and wellness programs and incentives, consumer-friendly tools that offer members transparency about their care choices, and a customer service team supported by a technological back end that the team can leverage to help members navigate the maze of the health care system. Differentiation in service can help smart payers position themselves as part of the answer, not part of the problem.

How You Play Depends on Where You Start

How each company—or type of company—should approach the Medicare Advantage market depends in large part on its starting point. Large national incumbents can use their scale, share, and expertise to protect share and make new inroads. They can push the operational excellence and differentiation levers described above to offer further-advantaged pricing that builds on their strengths, but they should not lose sight of their other structural advantages. They can invest in care delivery and other network assets on a national scale and apply advanced analytics to reduce costs, curate networks, predict risks, and offer timely interventions. They can also partner nationally with digital companies to develop innovative user experiences.

Blue Cross Blue Shield plans can draw on their considerable strengths, including long-standing relationships with members, robust commercial books of business, established provider partnerships, and presence in other government-sponsored business segments (such as Medicare supplemental plans and Medicaid). We recommend that they consider leveraging these attributes into avenues of entry into and growth in the Medicare Advantage market. The following opportunities seem especially promising:

- Capturing a disproportionate share of age-ins by capitalizing on the strength of their brand, commercial market position, and local provider relationships

- Creating new, transitional Medicare Advantage products for employee and retiree subsegments
- Expanding insight into network performance to create networks tailored to seniors' needs and priorities
- Building more-affordable joint plans with provider partners
- Launching new drug distribution channels
- Expanding service to include Medicare Advantage-based rewards and navigation
- Converting Medicare supplemental members to Medicare Advantage plans
- Moving into Medicare special needs plans by leveraging Medicaid expertise

Regional plans, which typically have less mature government businesses than national carriers, should assess whether entering Medicare Advantage makes sense as part of their overall business strategy. If it does, they should probably focus their plans on operational excellence and partnerships to build Medicare Advantage capabilities, as opposed to trying to go it alone. Some regional players can leverage their local market positions and existing provider relation-

ships, especially with a Medicare preferred-provider organization offering.

Other, smaller plans—such as new analytics-driven entrants, provider-sponsored plans, and pure-play Medicare Advantage plans—can bring unique differentiating capabilities to the market, but they will need to focus on delivering outside value through an improved customer experience and network curation because they probably cannot compete effectively on price and scale. These entrants may also be able to take a page from disruptors in other industries and leverage digital distribution to promote new marketplace buying behaviors. In the auto retailing market, for example, one digital disruptor created a million-user marketplace for purchasing and financing vehicles online by introducing a mobile app that reduced buying time from more than five hours to just ten minutes.

THERE'S PLENTY TO attract payers to Medicare Advantage. But playing the game at a winning level requires a defined strategy that is consistent with the organization's core competencies, a substantial degree of commitment—and perhaps some patience as well. In this competitive arena, management teams must assess their opportunities with eyes wide open.

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