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Healthcare Practice

The gathering storm: The threat to employee healthcare benefits

US inflationary pressures could significantly raise annual employer healthcare costs and impact vulnerable household finances.

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October 2022

The once-in-a-century pandemic thrust the healthcare industry into the teeth of the storm. The combination of accelerating affordability challenges, access issues exacerbated by clinical staff shortages and COVID-19, and limited population-wide progress on outcomes is ominous. This gathering storm has the potential to reorder the healthcare industry and put nearly half of the profit pools at risk.

Those who thrive will tap into the $1 trillion of known improvement opportunities by redesigning their organizations for speed-accelerating productivity improvements, reshaping their portfolio, innovating new business models to refashion care, and reallocating constrained resources. The healthcare industry has lagged behind other industries in applying these practices; players who are able to do so in this crisis could set themselves up for success in the coming years.

Inflation is putting substantial pressure on US healthcare costs—they could be $370 billion higher in 2027 relative to pre-COVID-19 projections.[1] And costs associated with endemic COVID-19 could add to this estimate, which only takes account of inflation. Providers are already experiencing the effects of inflation, but its impact on most employers and consumers is likely to be felt more significantly in the 2024 to 2026 insurance-contract renewal cycle. Employers across industries face profitability headwinds due to elevated healthcare costs. In addition, if cost pressures are unmanaged, the most vulnerable employees could end up spending 70 to 75 percent of their discretionary income on medical expenses.

This article, the final in our five-article series on the gathering storm in US health, shares our perspective on the magnitude of healthcare cost increases confronting both employers and employees. It also outlines a range of actions that employers could take to contain costs and promote long-term affordability, while maintaining access and quality of care.

How payers might respond to rising costs

Healthcare payers are likely to face inflation-induced increases in medical costs and selling expenses as well as general and administrative costs. We estimate that providers could pass on more than 6 percent incremental medical cost increases to payers in the upcoming contractual cycles (Exhibit 1).[2] These cost increases would flow through to employers as underlying provider network contracts are renegotiated. Some of this is already happening, but the full impact may not be felt until 2025, given provider contracting cycles. If these costs are passed on to customers in entirety, employers could see a 9 to 10 percent healthcare cost rise.[3] That would be greater than twice the 4 to 5 percent increase that the average employer experienced in 2022.[4] The healthcare cost increase could be even higher (about 1.4 to 1.8 times) for employers who offer high-deductible health plans (HDHP) as a result of deductible leveraging.[5] These plans represent about one-third of total commercial group enrollment.[6]

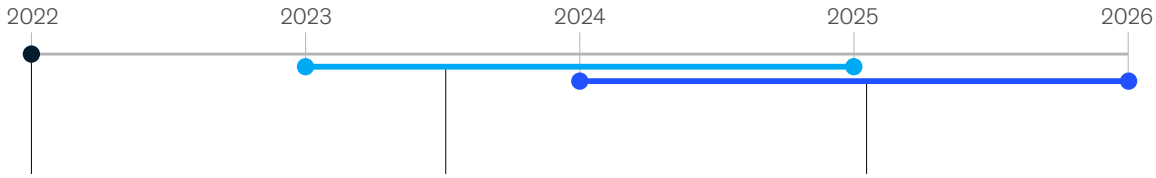
The ability of payers to pass on rate increases from providers to employers is linked to bid cycles. The first round of impact would likely occur in the 2023 provider contracting cycle for self-insured employers, and the 2024 pricing cycle for fully-insured employers. Employers, in turn, would then face the choice of bearing these increased costs or, as is more likely, buying down coverage or passing more costs onto employees.

[1] Addie Fleron, Aneesh Krishna, and Shubham Singhal, "The gathering storm: The transformative impact of inflation on the healthcare sector," McKinsey, September 19, 2022.
[2] About $100 billion total incremental inflationary costs for providers due to clinical wage inflation and non-labor inflation, of which about $70 billion could be passed through to non-government payers based on historical provider revenue mix. This is equivalent to a 6 percent ($70 billion divided by $1.2 trillion) incremental increase in provider costs paid by non-government payers.
[3] Assuming a 6 percent incremental medical cost increase driven by inflation on top of a 3 to 4 percent base trend, based on McKinsey analysis.
[4] "National survey of employer-sponsored health plans, 2022," Mercer, 2022.
[5] In deductible leveraging cases, the medical trend does not affect the deductible as it is a fixed dollar value. Thus, it only affects the portion of the bill that crosses the deductible limit, so the employer ends up bearing a greater financial burden each year, either in the form of increased premiums (for fully insured plans) or increased employer share of allowed cost (for self-insured plans).
[6] "Employer health benefits survey 2021," KFF, November 10, 2021. Enrollment in HDHPs is reported to be 28 to 31 percent during the period 2019 to 2021.

Exhibit 1

Employers could face health cost increases of 9–10 percent through 2026 because of inflationary pressure passed through from providers.

Inflationary cost pass-through from providers to employers



~$100 billion

Potential incremental annual provider costs from 2022 inflation[1]

~$80 billion in incremental clinical wage costs, and ~$20 billion in incremental non-labor spending driven by heightened inflationary environment in 2022

~6%

Incremental unit cost increase passed to non-government payers over 3-year contract renewal cycle

~$70 billion of the $100 billion incremental provider cost passed to non-government payers,[2] equivalent to a 6% increase of non-government payer total medical costs

9–10%

Total rate increase passed on to employers at the next renewal during 2024–26 benefit years

Total annual rate increase to employers is equivalent to the ~6% inflationary unit cost increase on top of 3–4% annual baseline trend

[1]Based on macroeconomic forecasts from McKinsey Global Institute applied to historical provider cost pools.
[2]Based on historical provider revenue base from non-government payers and historical payer cost pools across payer lines of business.

The latest Consumer Price Index (CPI) report shows that the medical care index rose 0.7 percent in August after rising 0.4 percent in July, as major medical care component indexes continued to increase across hospital services, prescription drugs, and physician services.[7] Continued inflation in the sector could further increase the healthcare cost pressure.

Employers face reduced profitability

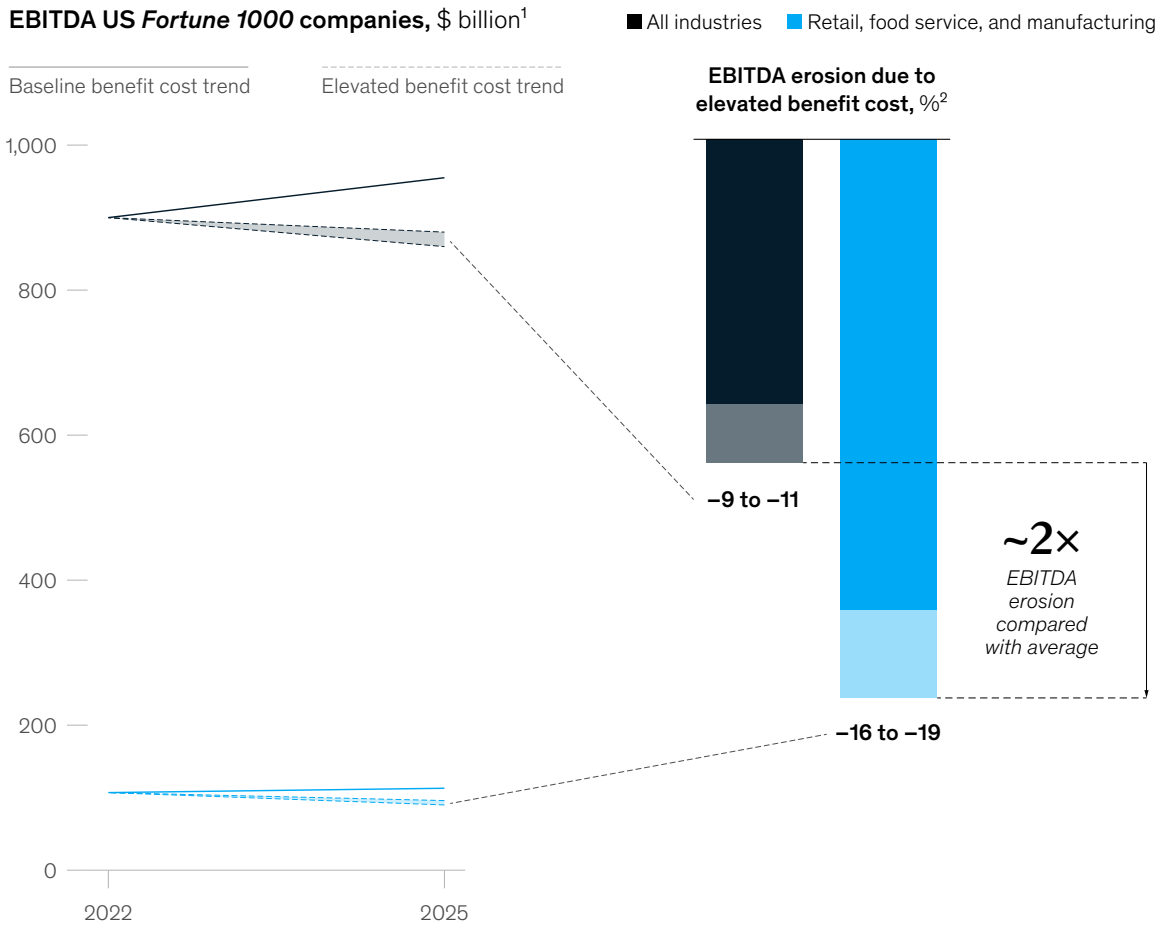
Higher benefits' expenses could add to employer labor-related costs on top of wage inflation. As a result, Fortune 1000 companies could face profitability headwinds due to elevated healthcare costs (9 to 11 percent of overall industry earnings by 2025).[8] Employers in labor-intensive industries such as retail, manufacturing, and food services could be disproportionally affected and experience 16 to 19 percent EBITDA erosion by 2025 (Exhibit 2).

As reported in the "2022 McKinsey Healthcare Stakeholder survey," over 70 percent of employers stated that premium increases above 4 percent would be unsustainable. As a result, the respondents said they would consider actions to control costs, including increasing employee contributions (Exhibit 3). However, such moves could exacerbate current talent attraction and retention pressures.

[7] "Consumer price index – August 2022," Bureau of Labor Statistics, US Department of Labor, September 13, 2022.
[8] Assumes 2 percent annual EBITDA growth with baseline benefit cost trend, 4 percent baseline benefit cost trend, and 5.5 percent/9.5 percent/9.5 percent elevated benefit cost trend over 2023 to 2025, based on McKinsey analysis.

Exhibit 2

Industries with a high employee base and low margin may experience approximately 2x higher EBITDA erosion from elevated benefit costs by 2025.



[1]Assumes 2% annual EBITDA growth with baseline benefit cost trend, 3–4% baseline benefit cost trend and 5.5%/9.5%/9.5% elevated benefit cost increase over 2023–25.
[2]Erosion numbers represent 2025 baseline vs elevated cost range.
Source: McKinsey analysis of *Fortune 1000* companies, Truven data

Vulnerable populations are confronted by rising medical expenses

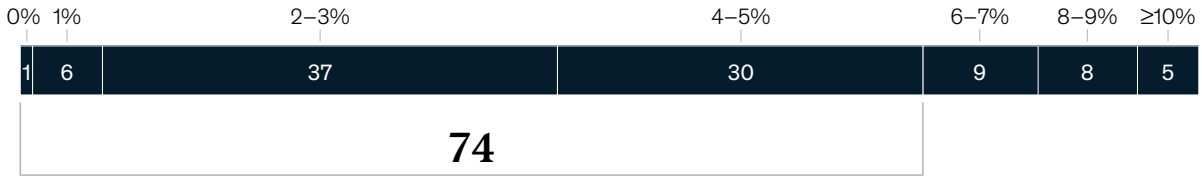
As noted above, employers indicate a willingness to continue shifting healthcare costs to employees. They would do so by increasing the employee share of premium costs, moving to HDHPs, and raising the employee share of out-of-pocket costs as top actions, among others (Exhibit 3).

The impact would fall disproportionately on vulnerable populations, specifically families under 200 percent of the federal poverty line. These families currently spend 62 percent of discretionary income on medical expenses, including premium contributions and out-of-pocket expenses. A 9 to 10 percent healthcare cost increase for employees would raise their healthcare expenses to 68 percent

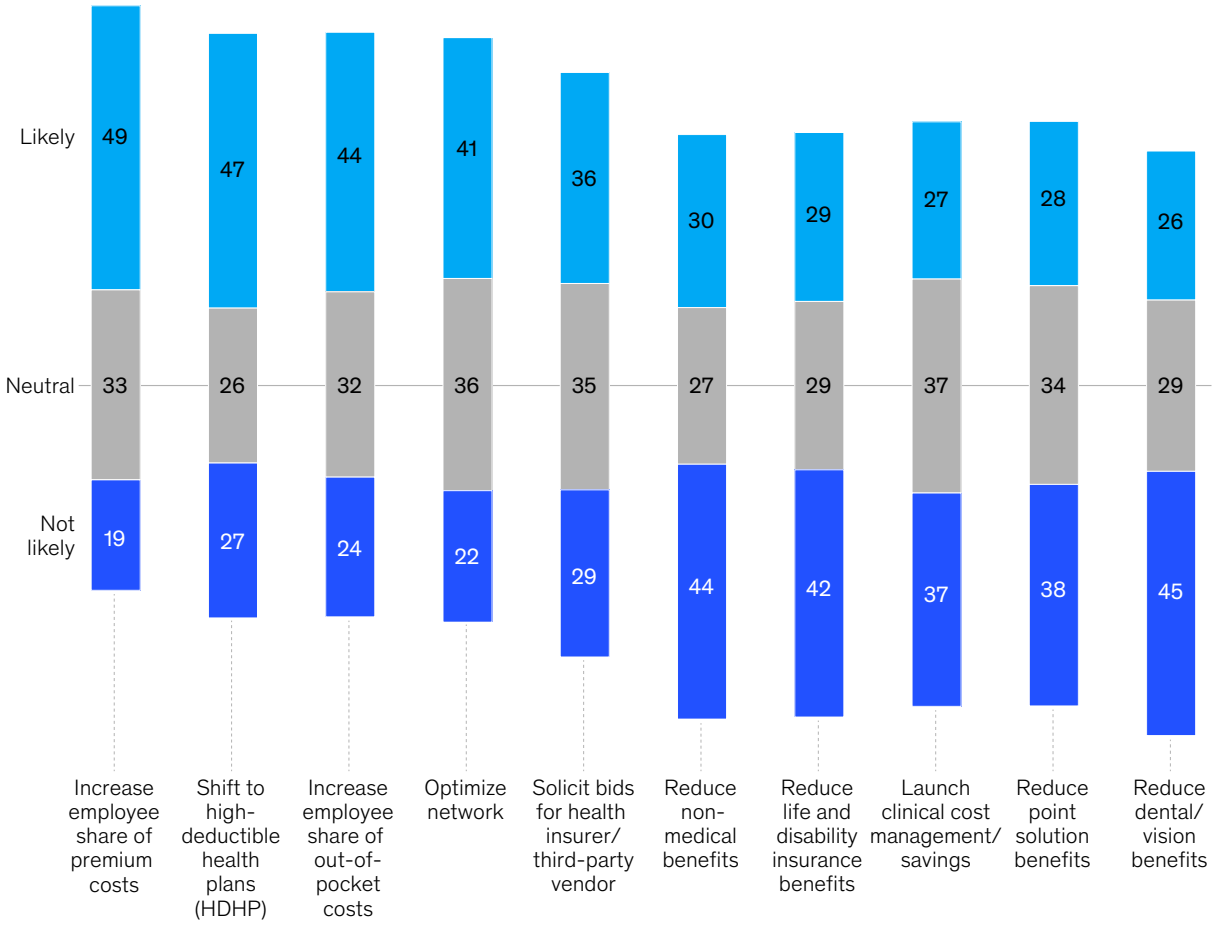
Exhibit 3

Over 70 percent of employers stated that premium increases above 4 percent would be unsustainable; many would consider increasing employees share of costs.

Sustainable annual increase for health benefits over the next 6–18 months,[1,2] % of respondents



Likelihood managers will consider each type of benefit optimization strategy to minimize costs,[3] %



Note: Figures may not sum to 100%, because of rounding; n = 301.
[1]Question: *What is a sustainable annual increase for health benefits over the next 6–18 months?*
[2]4% repondents selected 'Don't know' reponse for this question.
[3]Question: *Which of the following benefits optimization strategy are you likely to consider to tackle inflation and recession challenges over the next 6–18 months?*
Source: 2022 McKinsey Healthcare Stakeholder survey, July 1, 2022

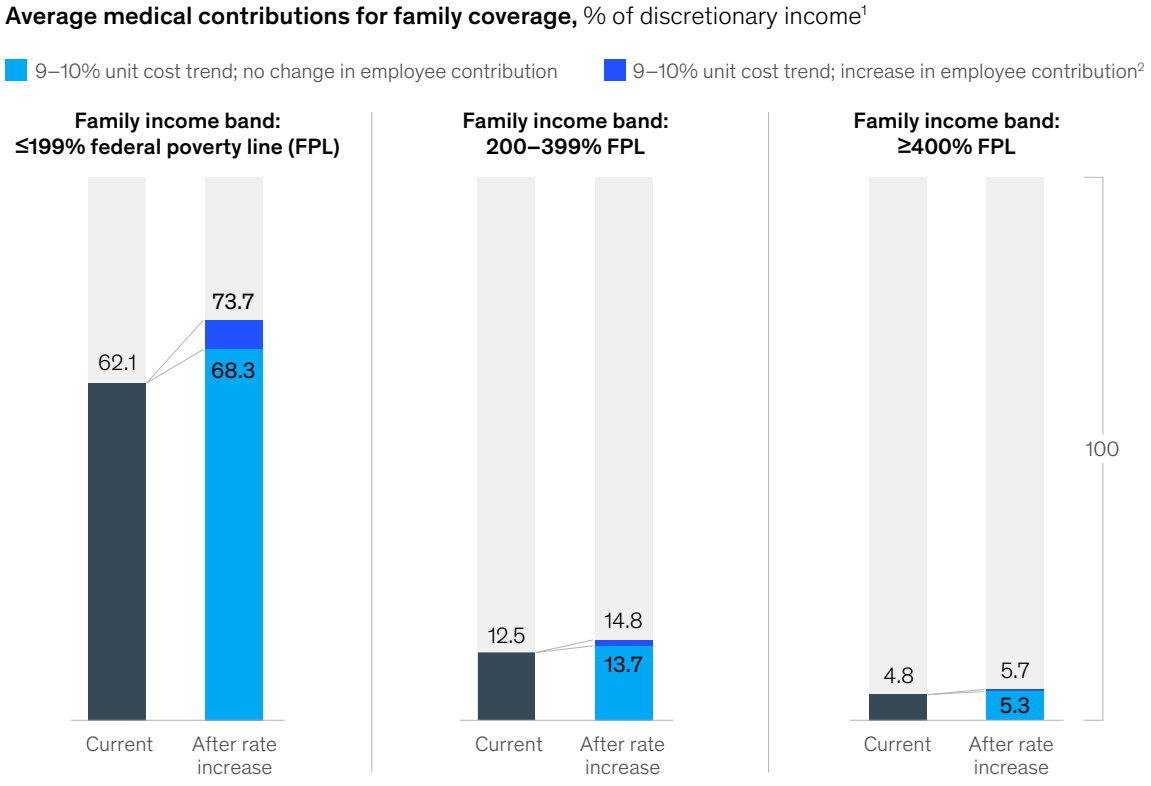
of discretionary income. If employers shift some of their increased cost burden to employees by further raising the employee share of premium contribution, say from 18 percent to 20 percent, this population could see nearly 75 percent of discretionary income consumed by healthcare expenses (Exhibit 4).[9]

HDHPs would likely see average premium increases as high as 18 percent at the next contract renewal. As small businesses typically have a higher percentage of employees in HDHPs, they would bear the brunt of these cost increases, and a large proportion would see healthcare costs rise substantially. In fact, the proposed rate increase requested in 2023 for small-group Affordable Care Act (ACA) plans across the country was as high as 46 percent.[10]

Apart from these potential healthcare cost increases, our 2022 McKinsey & Company US Consumer Pulse Survey suggests that two-thirds of consumers are already concerned about inflation

Exhibit 4

Lower income populations could spend ~68–75 percent of discretionary income on medical costs due to unmanaged cost increases.



[1]Total medical contributions incl. out-of-pocket and premium costs. Assumes: 9–10% allowed cost trend; ~$20,000 average cost of care PEPY; 85% average MLR; OOP spend based on KFF survey data.
[2]Assumes employee contribution to increase by 2%.
Source: Enrollment projection tool, KFF 2021 Employer Health Benefits Survey, Peterson-KFF Health System Tracker, 2020 US Census data

[9] For a family of four under 199 percent of the federal poverty line, with an average annual discretionary income of $8,400. The 9 to 10 percent premium increase and 2 percent increase in the employee share of cost would translate to $1,200 more in healthcare spending for a total of about $6,200 per year, equivalent to 74 percent of discretionary income.
[10] "Rate review," HealthCare.gov.

in general, while three-fourths indicate that they are purchasing less or delaying purchases across categories. In such an environment, employees facing unaffordable premiums and out-of-pocket burdens may decide to self-select out of group coverage in favor of individual policies, Medicaid (if eligible), or no coverage (uninsured).

Now is the time to transform employer benefits

Cost pressure from inflation is uncertain—it may be fleeting or persist over the next five years. Either way, there is over a trillion dollars of value available in the healthcare system.[11] The current economic situation could spur the industry to pursue this opportunity and take effective cost-management action. Employers could partner with payers, pharmacy benefits managers, or providers to push for system-level change to address cost pressures, as well as improve care, enhance employee experience, and increase productivity.

While there is no "silver bullet," a combination of five measures could help employers defray cost increases in the near term as well as put the system on a more sustainable long-term trajectory.

Reimagine medical networks

Levers to improve network performance have long been available but not widely deployed. As stated in industry research, high-performance, narrow provider networks can reduce costs while maintaining efficiency and quality of care.[12] Other levers, including tiered networks, centers of excellence, referral management, and site-of-care strategies, can generate savings of 5 to 15 percent. These measures can be applied across the care continuum—hospitals, primary care, specialty groups, post-acute providers, and ancillary care—while maintaining access and quality of care.

Consumer-centric solutions, like reference-based pricing, can enable patient-level financial transparency and lead to savings of up to 30 percent.[13] Financial transparency should increase as payer price-transparency mandates enhance visibility into cost variation. Consumer-friendly cost comparison tools could empower employees to make tradeoffs based on cost and other metrics, such as quality, access, and experience.

Manage specialty drug expense

Specialty drug spending is expected to continue to grow at an 8 percent CAGR through 2025.[14,15] Although fewer than two percent of insured members use specialty drugs, specialty prescriptions account for close to 50 percent of total pharmacy spending.[16] These individuals have serious health conditions (such as cancer, cystic fibrosis, multiple sclerosis, HIV/AIDS, and rheumatoid arthritis) that require complex therapies and higher-touch care models.

Employers could re-focus their attention on the broader healthcare needs and conditions of these patients, given their complex needs and costly care. Managing these costs requires a comprehensive approach, employing both traditional and innovative levers.

Employing traditional levers to optimize the use of cost-effective drugs in optimal care settings (for example, home or ambulatory infusion sites) will be paramount. These levers include formulary and utilization management, and network and benefit design. To minimize waste and optimize health outcomes in the highest value settings, employers should work with pharmacy benefits managers and payers to redefine formularies across brands, generics, and biosimilars. This can realize savings from cost-management measures and help adopt targeted care-management programs to facilitate a more streamlined patient experience and improve patient outcomes. In addition to these levers, employers can explore value-based care programs with manufacturers or participation in financing solutions (such as risk-pooling and pay-per-

[11] "The gathering storm: The transformative impact of inflation on the healthcare sector," September 19, 2022.
[12] Jonathan Gruber and Robin McKnight, "Controlling health care costs through limited network insurance plans: Evidence from Massachusetts state employees," National Bureau of Economic Research, September 2014.
[13] Reference-based pricing refers to the pricing approach where the employer (supported by a third-party administrator or other vendor) pays a set price for each healthcare service instead of negotiating prices with providers. When a provider bills for the service, the payer remits the set amount. If the provider is dissatisfied with the payment, it can bill the patient for the unpaid portion of the claim.
[14] Specialty drugs are often classified as high-complexity (for example, requiring complex logistics), high-touch (patient monitoring and case management), and higher-cost (compared with traditional drugs).
[15] Shubham Singal and Neha Patel, "The future of US healthcare: What's next for the industry post-COVID-19?" McKinsey, July 19, 2022.
[16] Adam J. Fein, *2022 Economic report on U.S. pharmacies and pharmacy benefit managers*, Drug Channels Institute, March 2022.

performance programs) that may require adopting a longer-term lens to capture savings.

Increase the use of value-based care or risk-sharing models

Value-based care (VBC) models can better align incentives across employers and providers by incorporating quality of care and outcomes in provider reimbursement arrangements. Successful risk-sharing models involve an efficient network and a new approach to benefits management that requires greater use of analytics, patient engagement, and targeted care-management interventions.

VBC models that show promise in the employer context include high-performance provider networks with cost- and quality-based metrics, episode-based payments for standardized patient-care journeys (for example, cancer), and risk-based contracts for end-to-end management of high-cost conditions (Exhibit 5). Employers have an opportunity to scale proven VBC models, especially by applying extensive learning from Medicare.

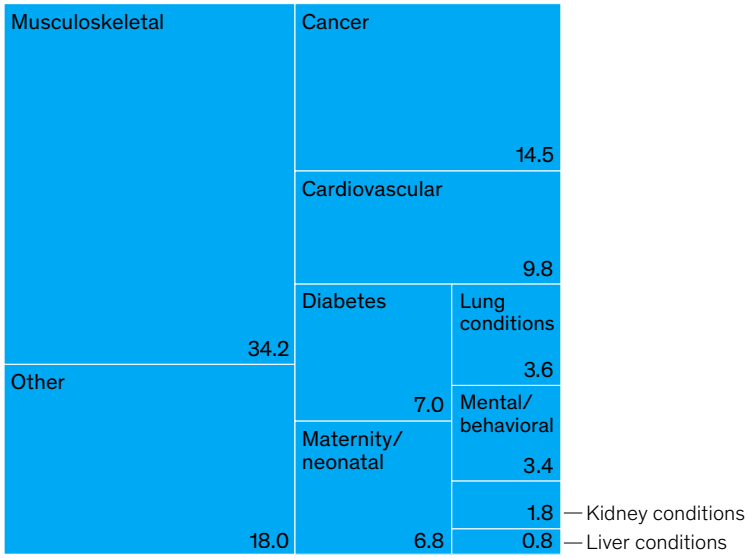
Adopt high ROI care-management programs

Continued rising costs and the COVID-19 pandemic have generated substantial demand for care-management programs focused on the most prevalent conditions and episodes, such as diabetes, musculoskeletal, maternity, and cardiovascular, as well as behavioral health (Exhibit 6). Employers could work together with their healthcare partners to make greater use of the vast amount of healthcare data at their disposal to understand their employees' healthcare needs and

Exhibit 5

Employers could prioritize innovative value-based care or risk-sharing models around the top spend conditions.

Total employer-covered healthcare spending by condition, 2019, %



Note: Figures do not sum to 100%, because of rounding.
Source: Truven 2019

Exhibit 6

There is opportunity to better address employee sub-segments of healthcare risk through improved care management.

Type of member; average annual cost per member	Example conditions	Share of members, %	Share of costs, %	Example programs
Healthy *<$2,500*	• Preventative care • Minor acute care • Pregnancy	>80	<20	• Maternity program featuring e-consult, digital member education, care condition, remote patient monitoring for high-risk pregnancy
Rising risk *>$8,000*	• Early-stage single chronic illness (eg, type 2 diabetes)	~15	~20	• Diabetes management with remote patient monitoring, digital engagement/consultation, and medication adherence management
Persistent super utilzers[1] *~$90,000*	• Unmanaged behavioral health needs (eg, anxiety, depression) • Poorly managed chronic illnesses (musculoskeletal, diabetes, hypertension) • Cancer	2–3	~30	• Behavioral health program focusing on virtual consulting, digital-driven personalized care, prescription monitoring, peer engagement • Joint pain/joint replacement management via Rx utilization management, patient navigation, remote therapy
Catastrophic *>$100,000*	• NICU/PICU[2] cases • Heart failure • Renal disease	2–3	~30	• Cardiovascular disease management with remote patient monitoring and multi-discipline post-acute care coordination

$6k
Average spend per member

[1]More than one year in top ~5% of spending.
[2]Newborn intensive care unit/pediatric intensive care unit.
Source: Kaiser Family Foundation 2019; Population Health Management 2019

risks, determine the best way to engage them, and deploy the right combination of high-performance care-management solutions.

Employers who were early adopters of care management are likely to have already implemented such programs. To continue encouraging uptake, offerings should show true return on investment (ROI) impact. Employers could work with solution providers to transition activity-based reimbursement arrangements (typically structured as per-employee per month) to higher quality engagement (for example, fees per engaged employee), and from fee-for-service to percentage of shared savings and ROI guarantees. With these enhancements, ROI of two times or more for care-management programs is feasible.

Consider using value-based insurance plans
Innovation is a prerequisite for transforming the benefits system and creating a stronger incentive for consumers to encourage preventive care and shop for high-efficiency providers. In particular, value-based insurance design (VBID) plans carefully structure benefit coverage and cost-sharing policy based on the degree of consumer discretion and influence, the ability of consumers to absorb cost risk, and the value at stake. This approach attempts to align patient and payer financial incentives around utilization of care (Exhibit 7). Employers can work directly with payers or third-party vendors to tailor such designs based on their employee population and provider networks.

Exhibit 7

Next-generation benefit design accounts for healthcare risk, consumer discretion and ability to absorb risk, and value.

Comparison by risk category

Type of risk	Example	Consumer discretion	Consumer ability to absorb risk (cost)	Value
Routine	Minor acute low-cost conditions; usually require outpatient medical care	High	High	Medium
Preventive	Evidence-based preventative care	High	Medium	High
Chronic care	Evidence-based chronic disease management	High	Medium	High
Catastrophic, chronic	High-cost chronic disease management	High	Low	High
Catastrophic, not chronic	High-cost acute care	Low	Low	Low
End of life	Specialized care at the end of life	Low	Medium	High
Discretionary	Shoppable non-emergent services	High	Medium	Medium
Purely elective	Procedures often not covered by medical benefits	High	Medium	Low

Employers have tried some of the approaches discussed above but only sporadically and not at scale. Achieving impact in benefits reform requires employers to adopt a transformational approach, including pursuing multiple levers in a coordinated way and at scale within a local market. Employers could move to enhance member engagement with intuitive consumer navigation using contemporary technology, real-time localized market and employee data, and advanced analytics. This transformational approach could offer tailored solutions for employee sub-segments based on their underlying conditions, healthcare and socioeconomic needs, and local market context.

The economic imperative for employers to address rising healthcare costs is clear. Also, pressure on health benefits will affect employer value proposition at a time of continuous talent shortage. Employers must act now. While premiums are already set for 2023 in most cases, there is an opportunity to adopt the above actions to spur a step change in long-term affordability. Partnering with healthcare services' vendors and challenging them to comprehensively redesign employer health benefits will be necessary to ensure that healthcare coverage is affordable—for both employers and employees.

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