Healthcare Systems and Services Practice

The market evolution of provider-led health plans

Gunjan Khanna, PhD; Deepali Narula; and Neil Rao

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Offering a health plan can give health systems an opportunity for growth, but it is not without financial risk. To benefit from this move, health systems should use a different lens to understand both consumers and risk, know where the best growth opportunities are, rethink their payor-provider interactions, and take advantage of integrated claims and clinical data.

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As U.S. providers adapt their business models in response to the transition from fee-for-service reimbursement to different forms of value-based payment, they are increasingly exploring the benefits of vertical integration. In some cases, they have chosen to offer their own health plans.

Many of the health systems that first took this step focused on the Medicaid market. More recently, health systems have been offering a growing number of Medicare Advantage and public exchange plans. Interest in the exchange market seems to be especially keen. Furthermore, shutdown of 12 of the 23 CO-OPs (Consumer Operated and Oriented Plans) has created a set of exchange enrollees looking for another health plan, and recent losses may cause some large payors to put less emphasis on the exchange market.

Nevertheless, available (although early) financial data suggests that the performance of provider-led health plans (PLHPs) remains mixed in all markets. More than 40 of the 89 PLHPs we analyzed have had negative margins in some or all of the past three years. Empirical data suggests, however, that scale (in terms of the number of lives) can help.

Health systems that are already offering a health plan or are considering adopting this approach must therefore carefully think through how they can take advantage of having an integrated delivery system. Success will require them to have—or develop—a range of skills. For example, they should be able to use product design to develop products that meet consumers' needs, undertake sophisticated actuarial analyses to price appropriately, and take advantage of integrated claims and clinical data to spot opportunities for better medical management. In addition, they must have a deep knowledge of competitive dynamics to identify regions with strong growth potential and be willing to adopt new administrative approaches to reduce costs.

In this paper, we will review both the growth trajectory and financial performance of PLHPs. In addition, we will discuss the four questions health systems should ask themselves if they are considering offering a PLHP or want to re-evaluate their plan's market differentiation.

Market growth[1]

Provider ownership of health plans has been increasing steadily. Between 2010 and 2014 (the most recent year for which most data is available), the number of providers offering one or more health plans grew to 106, from 94 (Exhibit 1). Furthermore, many providers expanded into additional lines of business (Exhibit 2). In 2010, only 47 (50%) of the providers owning health plans operated in more than one line of business; four years later, 65 (61%) did. As a result, PLHPs were available in 43 states in 2014

[1] Detailed explanations for how all market growth and financial performance calculations were done can be found in the Appendix.

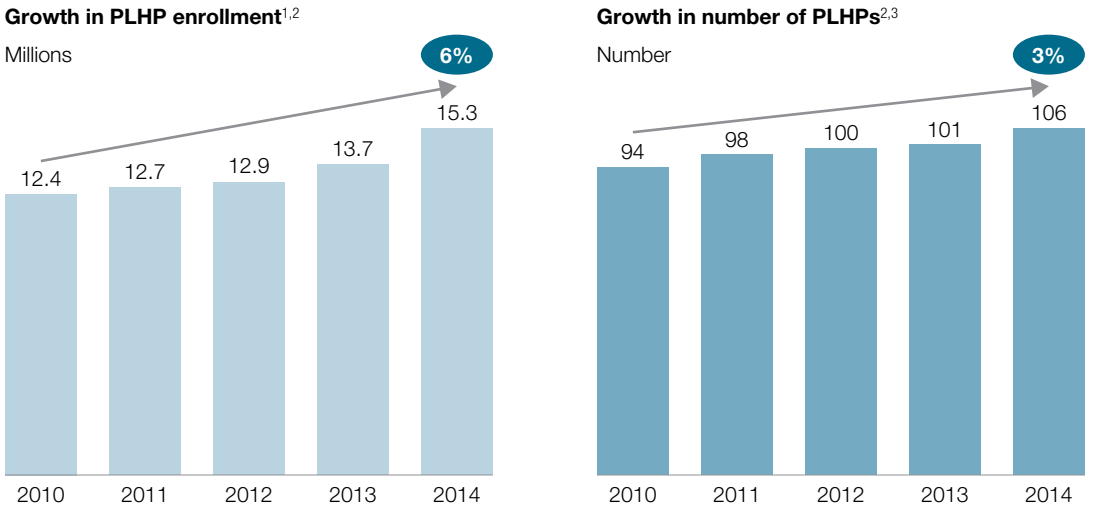
(Exhibit 3), and enrollment in the plans had surged to 15.3 million, from 12.4 million in 2010.

Most of the enrollment growth in PLHPs occurred in the Medicaid, Medicare Advantage, and individual markets (Exhibit 4). However, the small-group market also increased slightly from 2010 to 2014 (2.6% CAGR). In contrast, enrollment decreased in the large-group and administrative-services-only (ASO) markets (CAGRs were –4.7% and –2.4%, respectively). The large-group and ASO markets are difficult for most PLHPs to serve, and the opportunities for growth in the other markets are more favorable.

Between 2010 and 2014, the largest enrollment growth in percentage terms occurred in the individual market, primarily because many providers introduced public exchange plans as a way to drive volume. During that time, enrollment increased at a CAGR of approximately 25%, from about 270,000 to 670,000 lives. The number of providers offering health plans in the individual market rose to 55, from 36. For PLHPs, further growth in this market is likely not only because of the CO-OP shutdowns and losses incurred by large insurers, but also because the penalty for being uninsured reaches its full amount in the 2016 tax year.

The largest enrollment growth in absolute terms occurred in the managed Medicaid market, from about 6.1 million lives in 2010 to 8.8 million lives in 2014 (a CAGR of more than 9%). The number of providers offering Medicaid plans rose to 51, from 43. Although PLHPs already have high penetration in managed Medicaid (they currently cover

EXHIBIT 1 **Overall PLHP enrollment has grown faster than the number of plans**



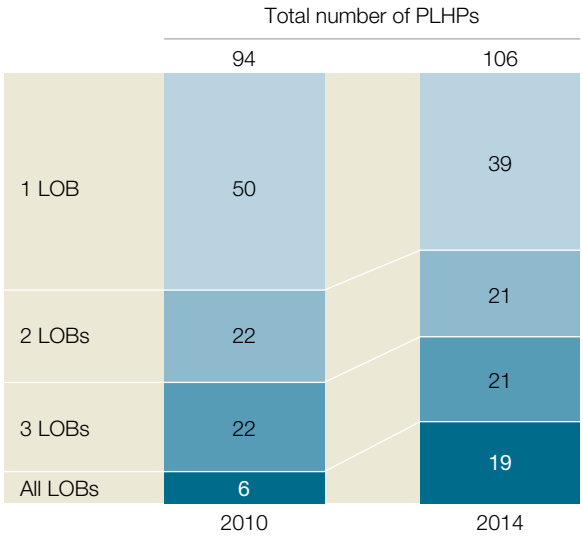
PLHP, provider-led health plan.
[1] Count of Medicare lives does not include cost products.
[2] Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.
[3] Health plans with fewer than 25 lives are excluded.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premium, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

EXHIBIT 2 **PLHPs are diversifying across lines of business**

PLHPs by line of business (LOB)[1,2,3,4]

% of total PLHPs



PLHP, provider-led health plan.
[1] Count of Medicare lives does not include cost products.
[2] Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.
[3] Health plans with fewer than 25 lives are excluded.
[4] LOBs counted are individual, Medicare, Medicaid, and other commercial (large-group, small-group, and administrative-services-only).

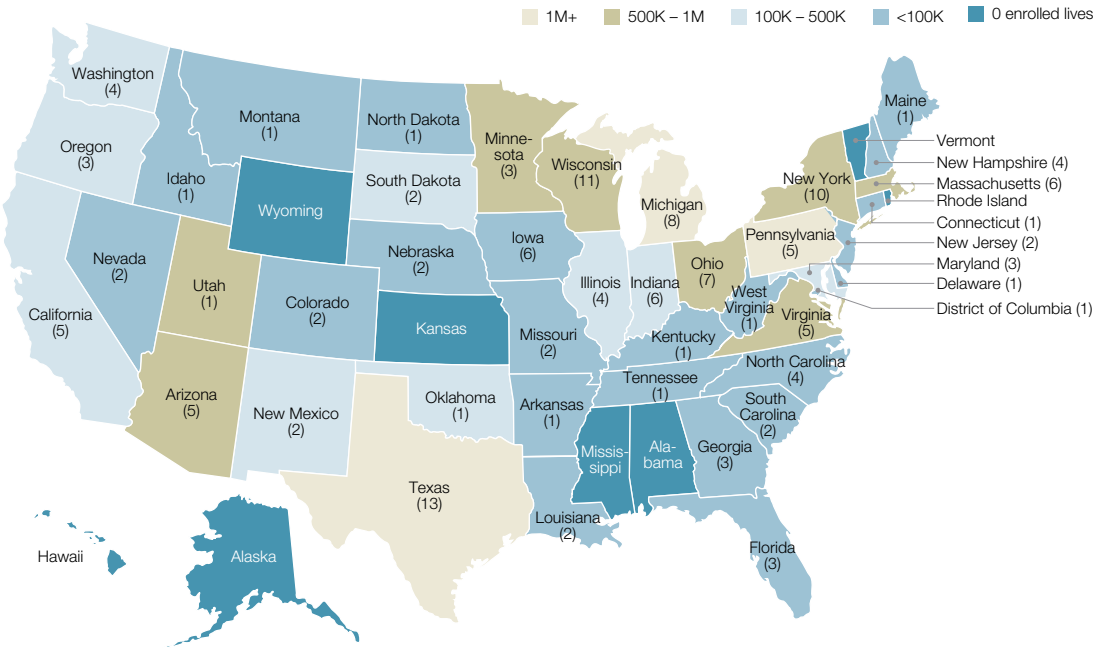
Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premium, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

about 22% of the people in that market), several factors suggest that significant room for market share growth remains. For example, Medicaid expansion is continuing across the states. (The 27 states that had expanded Medicaid by November of 2015 included about 60% of all enrollees in that program.) In addition, the shift to value-based payments is amplifying the need for population health management skills, and state regulations for managed Medicaid programs are favorable for PLHPs.

In the Medicare Advantage market, enrollment in PLHPs grew at a CAGR of about 17% between 2010 and 2014, to 1.1 million lives, from approximately 600,000. The number of providers offering Medicare Advantage plans increased to 69, from 47. Enrollment in provider-sponsored Medicare Advantage plans is expected to continue to grow given the favorable conditions (e.g., the adoption of risk-bearing and other innovative payment models and the heightened focus on reducing inpatient utilization rates). Nevertheless, many providers appear to view the Medicare Advantage market as having less opportunity for growth than either the individual or Medicaid markets. The number of Medicare Advantage enrollees is low (in comparison with the size of the individual and Medicaid markets), and these consumers are typically well served by payors, leaving limited opportunity for PLHPs.

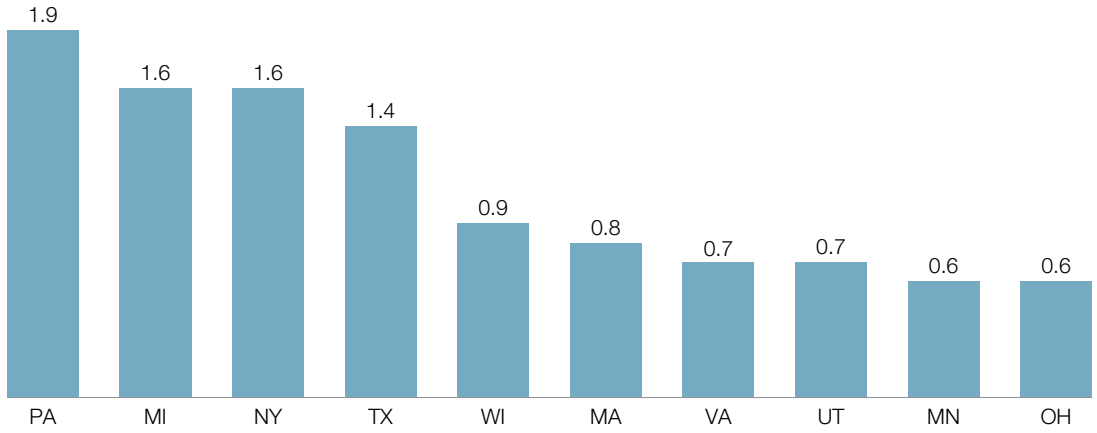
EXHIBIT 3 About 15 million people are covered by 106 PLHPs in 43 states

Number of PLHPs by state (2014)[1,2,3]



States with the highest PLHP enrollment

Total members (millions)



PLHP, provider-led health plan.

[1] Count of Medicare lives does not include cost products.

[2] Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

[3] Health plans with fewer than 25 lives are excluded.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premium, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

Despite the significant increase in overall enrollment, most PLHPs remain comparatively small. In 2014, only five providers had plans that cover more than 500,000 lives. In the aggregate, however, these plans had a fairly large market share (from about 16% in the total Medicare Advantage market to 31% in the total Managed Medicaid market). Enrollment is also concentrated at the state level. More than 40% of all people covered by PLHPs live in Pennsylvania, Michigan, New York, or Texas (see Exhibit 3).

Financial performance

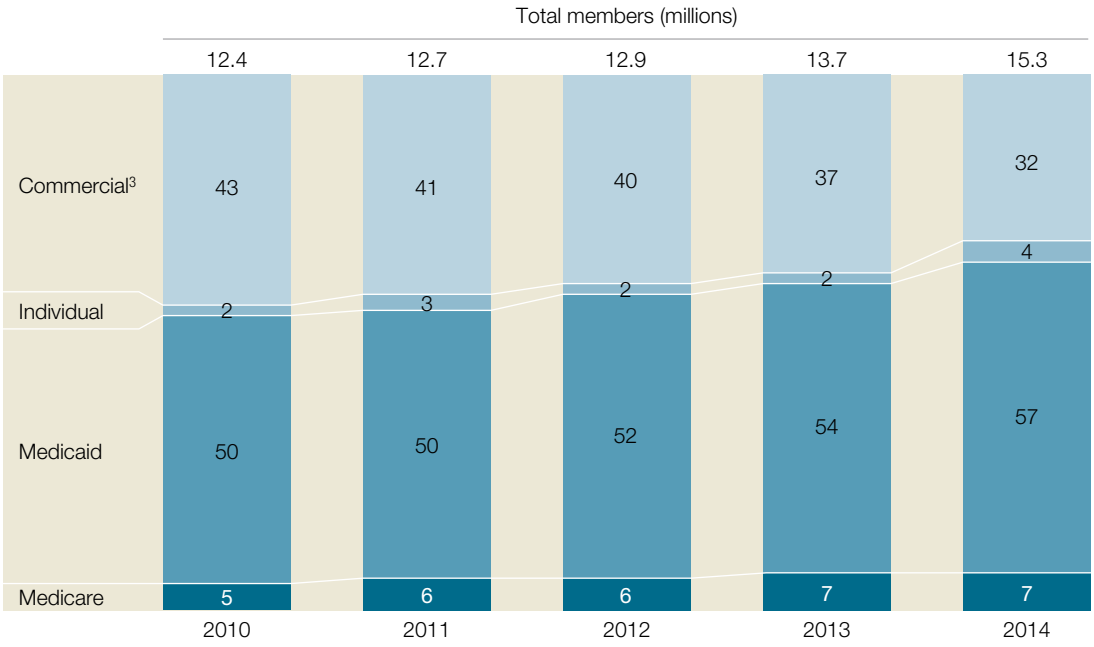
Between 2010 and 2014, average medical loss ratios (MLRs) for PLHPs increased steadily in most lines of business (Exhibit 5). In the Medicaid market, for example, the average MLR rose to 89%, from 86%. The exception was the large-group market; the average MLR there decreased to 87%, from 89%.

During those years, average administrative loss ratios (ALRs) in most lines of business

EXHIBIT 4 **PLHP enrollment has increased in all markets except large-group commercial**

PLHP enrollment by line of business[1,2]

% of total PLHP members



PLHP, provider-led health plan.

[1] Medicare lives do not include cost products.

[2] Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

[3] Commercial including non-individual commercial plans: large-group, small-group, and administrative-services-only plans.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premium, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

were often slightly higher (usually, by no more than 1% of premiums) among PLHPs than in the rest of the market. Exceptions did occur, though. In 2014, for example, both Medicaid and Medicare PLHPs had ALRs slightly below the industry average.

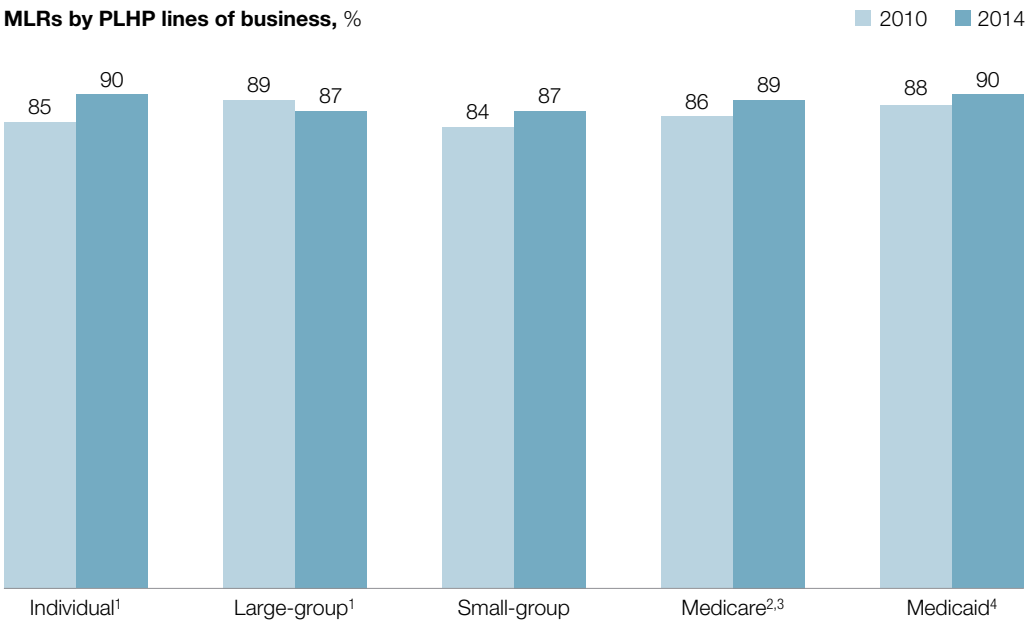
The comparatively high MLRs and ALRs narrowed the operating margins on the health plans but, in some cases, may have had a more favorable effect on the health systems as a whole. Only by considering the economic impact across the entire integrated system can providers understand the full impact of owning a health plan.

To look more closely at the economics of a PLHP, we conducted deep dives on the two areas with the strongest current growth: managed Medicaid and the individual market.

Managed Medicaid

Among the 51 providers offering managed Medicaid plans, operating margins varied significantly in 2014 (Exhibit 6). The average was about 1.3%. Among the PLHPs with less than 100,000 lives, operating margins averaged 1.58%, compared with 0.53% for plans covering 100,000 to 500,000 lives and 2.95% for plans with more than 500,000 lives. However, within each of these three subsets,

EXHIBIT 5 **PLHPs have higher MLRs in most lines of business**



PLHP, provider-led health plan.
[1] Medical loss ratios (MLRs) reflect payments and receivables from ACA risk programs.
[2] Financials include claims and premiums from cost products.
[3] Because NAIC Supplementary Healthcare Exhibits were not always submitted, MLRs are known only for about 80% of the Medicare line of business.
[4] Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits and its 2010–14 end-of-year Premium, Enrollment, and Utilization Exhibits; CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

there was significant variation in operating margins, indicating an opportunity for many provider-led managed Medicaid plans to better manage profitability. That aggregate profits as a percentage of premiums were highest among carriers with more than 500,000 lives suggests that scale is important.

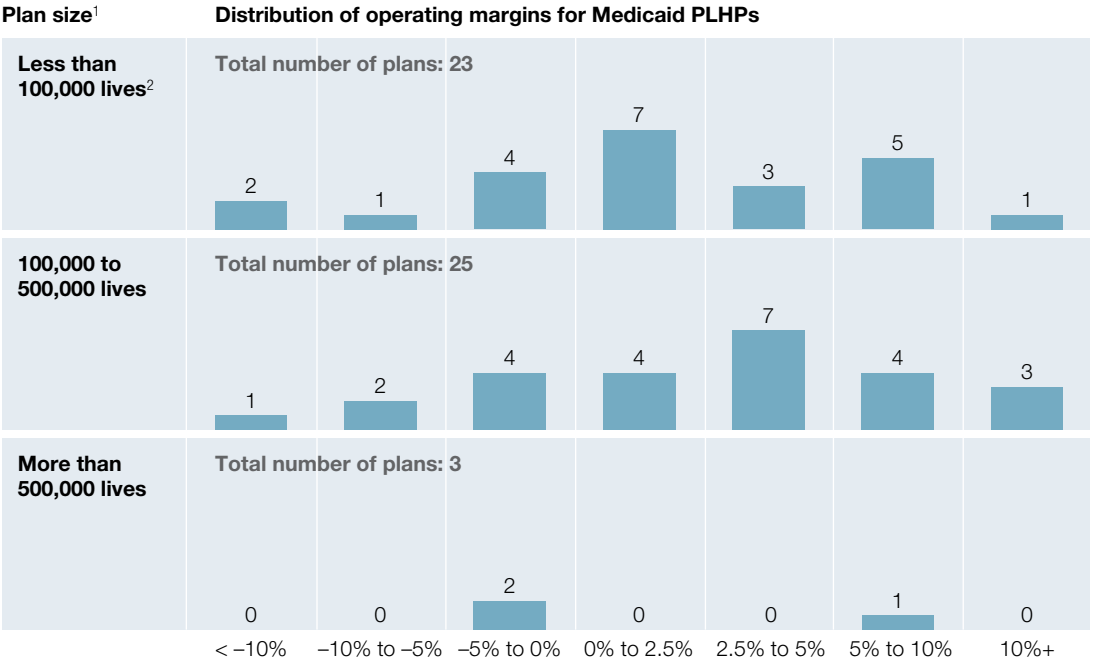
At least four providers focusing on children's health are currently offering Medicaid PLHPs. Together, these PLHPs covered 9% of total Medicaid enrollees in 2014. Before 2013, these plans tended to have lower MLRs than other PLHPs did. Since then, their MLRs have risen and now exceed those of other PLHPs.

Individual market

Although the performance of the PLHPs present on the public exchanges has varied, most have struggled to achieve profitability in the individual market (as have many other carriers). In the aggregate, these plans had an operating margin loss of 10.5% post-tax in 2014 after the 3Rs (reinsurance, risk corridors, and risk adjustment) were factored in.[2] Nevertheless, 29% of the PLHPs in the individual market had positive margins that year.

In general, the PLHPs received better results than most other carrier types did if the 3R payments are calculated as a percentage of

EXHIBIT 6 **Scale appears to benefit PLHPs in the Medicaid market**



PLHP, provider-led health plan.

[1] Plans with fewer than 25 lives were not included.

[2] Count of Medicaid lives and plans does not include the Visiting Nurse Service of New York or the Universal Care Medical Group because of differences in financial reporting.

Source: NAIC 2010–14 end-of-year Supplementary Health Care Exhibits (SHCE) and its 2010–14 end-of-year Premium, Enrollment, and Utilization Exhibits; 990 forms (when SHCE is missing); CMS August 2010–14 enrollment by county; McKinsey Provider Plan Database

[2] Kaiser Permanente was excluded from this and all other analyses of market growth and financial performance. Given its origins as an insurer and atypical structure, we have not included it in the set of PLHPs.

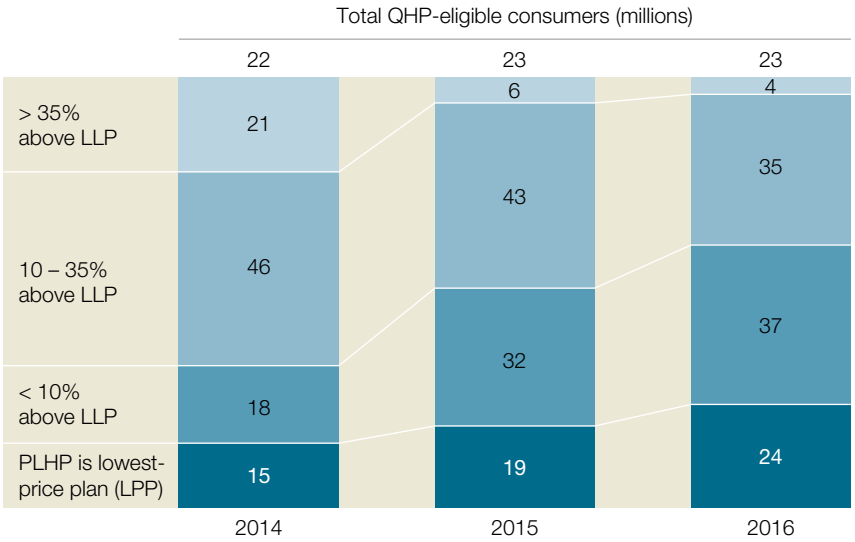
premiums (the exception was the CO-OPs, which usually received significant amounts in reinsurance). As a group, the PLHPs received the equivalent of about 17% of premiums as 3R payments for 2014, but individual payments varied, especially among the smaller plans: some providers had to pay more than 70%, but others were given more than 150%. Almost all of the 3R money came from reinsurance funds because risk corridor and risk adjustment payments to the PLHPs did not amount to more than 1% of premiums.[3] The reinsurance program will terminate in 2016, which could apply further pressure on margins unless plan pricing is done carefully.

Since 2014, PLHPs have become more price competitive on the public exchanges (Exhibit 7). In the first open enrollment period (OEP), they were the price leader—the carrier offering the lowest-priced silver plan—in 15% of the counties where one or more PLHPs were available. That percentage rose to 19% in the 2015 OEP and then to 26% in 2016. PLHPs were especially likely to become price leaders in areas where CO-OPs exited the 2016 exchanges. It is not yet clear, however, whether the competitive pricing is a sustainable strategy for many exchange PLHPs, given their large losses to date and the upcoming termination of some of the transitional programs (especially reinsurance).

EXHIBIT 7 PLHPs are becoming more price competitive on the public exchanges

Cost of lowest-price PLHPs relative to the lowest-price silver plans[1]

% of QHP-eligible consumers (in areas where PLHPs are available)



PLHP, provider-led health plan.

[1] In counties where PLHPs are available, the premium for the lowest-price PLHP was compared with the cost of the lowest-price silver plan. The lowest-price PLHPs were then grouped into categories based on the size of the pricing differential. This information was combined with the number of QHP-eligible consumers in each county to determine how many of those consumers could be placed into each category.

Source: McKinsey Exchange Offerings Database; McKinsey Provider Plan Database

[3] In 2014, PLHPs, like other carrier types, were affected by the change in risk corridor rules to make the program revenue-neutral. Of the risk corridor receivables all carriers booked, only 12.6% was actually paid out to them.

The proportion of preferred provider organization (PPO) plans offered by providers on the public exchanges decreased from 22% in the 2014 OEP to 20% in 2016. (Most other carriers have been making a similar move). The change may reflect an attempt to manage utilization more tightly given the financial pressures all payors are facing. In contrast, there was a small increase in the number of broad-network plans offered by providers.

Design choices for a PLHP

There are four essential questions a health system should ask itself if it is considering offering a PLHP. These questions are also helpful for providers already offering plans that want to re-evaluate their differentiation in the market.

How can consumerism benefit a PLHP? As healthcare consumerism rises, what many people want from providers and health insurers is changing—in ways that could put PLHPs at an advantage. If providers want to use health plans to increase volume, however, they must understand consumers' price sensitivity and benefit preferences.

Data from the public exchanges demonstrates that people who buy health insurance for themselves tend to prefer low-cost plans—but not necessarily the lowest-cost product. For example, in a survey of exchange participants we conducted after the close of the 2015 OEP, 49% of the respondents who had purchased exchange plans and remembered the plans' pricing said that they had selected products with premiums that were average or above average relative to other plans within the comparable metal tier.[4]

Furthermore, consumers appear to be willing to pay for convenience. In a broader consumer survey we conducted in 2015, we explained to the more than 2,200 participants what an integrated delivery network (IDN) was and then asked them to tell us which features they would be willing to pay up to $20 per month for if they joined this kind of network.[5] The features selected most often were guaranteed appointments, after-hours appointments, and weekend appointments.

We also asked the participants to tell us how much they would want some of the features that typically characterize an IDN if those features were offered to them. Two of the features chosen most often indicate that consumers are willing to let their health information be shared between insurers and providers. Specifically, 76% said they would want their providers and health insurer to have a single, up-to-date view of their care history and future care needs. And, 75% said that they would want technology that allows all their providers to access their health and treatment information, and to coordinate care.

Thus, there is an opportunity for PLHPs to consider pricing and product benefits in a new way. The product benefits should be tailored to the strengths of the care management offered by the underlying health system.

When is growth through a PLHP most likely? If a health system is looking for growth through a PLHP, it should consider carefully which regions are suitable and which are not. The most suitable place for a PLHP is a region where the health system has a large share of a consolidated provider market and the level of payor consolidation is low. Even in this situation, however, the health system should make certain that its physician alignment skills are as strong as possible if it is to maximize the benefit of owning a health plan. In addition, it should be

[4] McKinsey's 2015 Post-Open Enrollment Survey.
[5] McKinsey's 2015 Consumer Health Insights Survey.

sure to have solid capabilities in both population health management (to contain medical costs) and the necessary actuarial analyses (to price products accurately). PLHPs also need to account for existing third-party payor relationships.

Is an alternative type of administrative infrastructure possible? Often, the administrative infrastructure used to set up a PLHP is similar to that of a stand-alone health plan (granular claims requirements, extensive prior authorization lists, utilization management and care management prerequisites, etc.). If most health plans led by providers are going to cover fewer than 100,000 or 150,000 lives, however, then achieving benefits of scale through this type of infrastructure will be next to impossible. Health systems have an opportunity to depart from this approach by establishing a radically different administrative infrastructure—for example, one that aligns clinical policies between the health system and the health plan's business units to minimize the need for utilization management, strives for an auto-adjudication rate of 90% or higher, establishes a common care management infrastructure, and makes claim submissions an exception rather than a necessity. We recognize that the administrative infrastructure must take into consideration the health system's relationship with third-party providers and other payors in the market. Nevertheless, we believe that all PLHPs have—and should take advantage of—the chance to rethink the traditional payor administrative infrastructure.

What can be gained through granular analytics? Health systems with their own health plans have an important advantage: integrated claims and clinical data that can allow them to undertake sophisticated analytics. As a result, they should be able to make the most of opportunities for better medical management by identifying at-risk patients, offering them appropriate preventive care, and, when necessary, intervening early. For example, the health systems can use the claims and clinical data to accurately determine the end-to-end cost of managing their high-risk patients and then change their approach to managing these patients (e.g., by directing them to the right care settings and offering timely interventions). Integrated data can also give health systems unique insights into the health plan's performance in the different channels they are using to attract members to gain an end-to-end view of the lifetime value of a member within an IDN. The traditional payor or provider approach to calculating lifetime value will lead to conflicting results for an IDN; hence, a unique, comprehensive approach informed by deep analytics is critical.

• • •

Offering a health plan may be an attractive growth opportunity for many health systems, but it is not without risk (as current financial data attests). Health systems, if they are to benefit from offering a health plan, will need to be able to understand how they can use consumerism to their advantage and where the best opportunities for growth exist. In addition, they must be willing to rethink the administrative infrastructure they want to use and take advantage of the integrated claims and clinical data at their disposal.

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Appendix

Data used

- Some data about the products offered on the 2015 and 2016 public exchanges has now been made public, but financial results are available only through 2014. Thus, all calculations are based on 2014 data unless otherwise stated.

- The **McKinsey Provider Plan Database** includes detailed information about the 106 health systems currently offering one or more health plans in the United States. Among other things, the database provides details about 2010-2015 plan financial data, including (by state and entity) covered lives, health premiums earned, claims, and G&A expenses. It also describes the associated provider organization, the state(s) in which the plan operates, the states where it is offered on public exchanges, and the year(s) of opening and termination (2010-2014). Thus, the database contains information valuable to payors, providers, pharmaceutical companies, and medical device manufacturers.

- The **McKinsey Exchange Offerings Database** offers a granular view of all individual exchange products across the country offered in 2014 through 2016, as well as pre-reform benchmarks. It includes details on more than 340,000 ACA-compliant on-exchange products (from all 3,143 U.S. counties), such as premiums, benefit design, and network design. In addition, it includes carrier and pricing details for all new entrants and incumbents (including 315 carriers participating on the 2016 exchanges), as well as hospital network data (including more than 2,000 unique exchange networks in 2014 and over 2,500 such networks in both 2015 and 2016, as well as network participation data for all U.S. acute care hospitals).

- The primary sources of external data used in the article were the National Association of Insurance Commissioners' (NAIC's) Supplemental Health Care Exhibits; its Premium, Enrollment and Utilization Exhibits; and its Analysis of Operations Exhibits (for G&A expenses). Additional data was obtained from the August 2015 enrollment report by county released by the Center for Medicare and Medicaid Services (CMS); Internal Revenue Service (IRS) 990 forms; and financial reports from the California Department of Health Care (DMHC).

Calculations

- ***Number of health plans.*** Calculating the number of health plans offered by providers (or other insurers) in all lines of business is difficult because the available sources differ in their method of reporting (e.g., by legal entity, company, or organizations within companies). Comparisons between sources are therefore often inexact. For that reason, we have focused in this paper on the number of providers offering health plans rather than the aggregate number of plans being offered.

- ***Enrollment.*** The enrollment calculations in this paper are based on data from the NAIC's Supplemental Health Care Exhibits

Appendix *(continued)*

and its Premium, Enrollment and Utilization Exhibits, as well as CMS's August 2015 enrollment report by county. This approach is somewhat different from the one used in our last paper on PLHPs. In that paper, we used national InterStudy lives data which, in some cases, included covered individuals in U.S. territories. Also, the InterStudy calculations employed a wider definition of fully insured commercial lives. As a result, its estimates of overall market size are significantly larger.

- ***Growth estimates.*** The estimates of growth in the Medicaid market are based on the fact that as of February 2016, 32 states (including the District of Columbia) had expanded Medicaid. The calculations of Medicare enrollment growth include only members in Medicare Advantage plans, not Medicare cost plans.

- ***Financial performance.*** Financial data was taken from the NAIC's Supplemental Health Care; Premium, Enrollment and Utilization; and Analysis of Operations Exhibits. For those carriers that did not submit this information to the NAIC, we supplemented the financial data with information from IRS 990 forms and DMHC financial reports.
  - —The Visiting Nurse Service of New York and the Universal Care Medical Group are not included in the estimates of financial performance among Medicaid PLHPs because of differences in their financial reporting.
  - —The estimates of Medicare Advantage financial performance cover about 80% of the total Medicare market and include cost products.

- ***Aggregate margin loss.*** The aggregate margin loss was calculated by taking the sum of all margins (positive or negative) reported by PLHPs and then dividing that amount by the sum of all premiums.

- ***Operating margins.*** For all lines of business, operating margins were calculated as premiums paid minus SG&A expenses, claims, taxes, licenses, and fees.
  - —For commercial lines and Medicare, this information was derived from the Supplemental Health Care Exhibit.
  - —For Medicaid, it was taken from the Premium, Enrollment and Utilization Exhibit as well as the Analysis of Operations Exhibit (for G&A expenses).

For more information, contact McKinsey_on_Healthcare@mckinsey.com