Healthcare Systems and Services Practice

Provider-led health plans: The next frontier—or the 1990s all over again?

Gunjan Khanna, PhD; Ebben Smith, MD; and Saum Sutaria, MD

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By offering its own health plan, a hospital system may be able to gain a variety of strategic and economic advantages. The move is not without risk, however—and often the risk is greater than the potential benefits. Three sets of questions can help hospital systems determine if offering a health plan is right for them.

Gunjan Khanna, PhD; Ebben Smith, MD; and Saum Sutaria, MD

Over the past few years, forces have been aligning to make offering a health plan look increasingly attractive to health systems. Many providers we speak with believe they deliver efficient, outstanding care and superior customer service, and thus they assume that if they were to offer a health plan, they would succeed. Our experience suggests, however, that many of these providers will fail to meet their expectations. Without a deep understanding of the strategic, operational, and organizational factors needed for success, health systems may end up repeating mistakes of the past.

History has shown that it is quite difficult to reach the level of payor-provider integration needed to succeed as a provider-led health plan. In fact, the health systems that have successfully sponsored health plans (e.g., Intermountain, Geisinger, University of Pittsburgh Medical Center) have special circumstances or unique market structures that are not easily replicated. If new entrants are not deeply familiar with the challenges they are likely to face and the factors required to win—and if they do not know how to position the owned health plan in their specific market—success will likely be elusive.

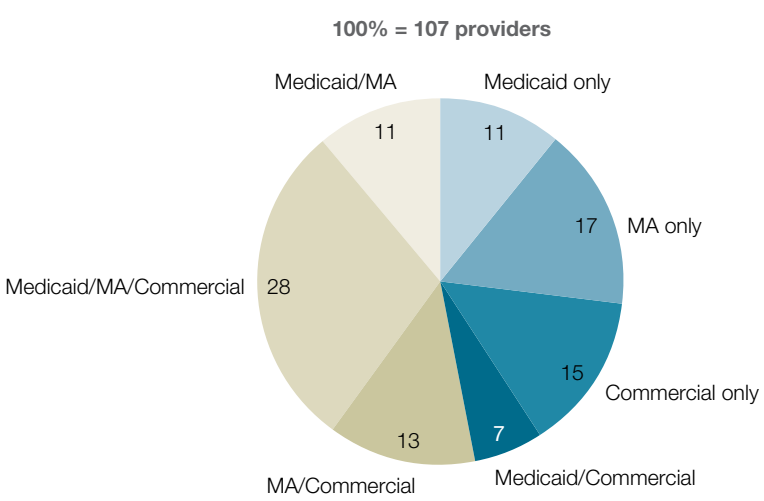
Many of us witnessed this phenomenon in the 1990s, when there was a similar wave of entrants to the provider-led plan space. Furthermore, some of the challenges to success have become even more acute since then. Thus, it's hard not to wonder: Is this current phenomenon a repeat of what we saw during that decade? There are at least four core reasons to believe that might not be the case:

- Explicit linkages between care quality/outcomes and reimbursement. Increasingly today, reimbursement is being tied to quality and outcomes, causing more providers to be "at risk" for the care that they are delivering. Payors at all levels (e.g., federal, state, private) are recognizing the limitations of trying to manage care from a distance and are increasingly willing to fund provider efforts to take on longitudinal management of care beyond their office walls.

- Improved access to data, driven by technology. The healthcare delivery infrastructure is much more connected now, and significant improvements have been made in how to use data to design better clinical care programs.

- Increasing consumer acceptance of restricted-access networks. Consumers today, unlike those in the 1990s, are increasingly willing to accept restrictions on access to providers. Although consumers rebelled against the strict gatekeeper model used

EXHIBIT 1 **Provider systems are offering a range of health plans**



MA, Medicaid Advantage.
The percentages shown do not sum to 100 because of rounding.
Source: 2013 AIS database; 2014 InterStudy database; CMS MA enrollment data; McKinsey analysis

in earlier health maintenance organizations (HMOs), they now appear to be much more open to narrow networks (in part because of their concerns about rising healthcare spending).

- New markets in which to offer products. Providers today have more options for marketing themselves to consumers (e.g., through public and private exchanges). This flexibility disrupts the status quo in a way that offers providers an entry point into rapidly growing consumer segments.

These factors increase the likelihood that providers will consider offering health plans and that the health plans will succeed. It is not clear, however, that offering a health plan can ensure a viable economic future for every health system, or that providers can maximize the value they could potentially derive from having a health plan. Although this move can deliver several potential advantages, it also entails considerable risk, the degree of which varies from one health system to another. This paper presents a comparison of the pros and cons—including financial, option value, channel conflict, and operational implications—of establishing a provider-led health plan. It also outlines a series of questions health systems considering this step should ask themselves before moving forward.

Note: A large number of health systems are considering various accountable care organization (ACO) relationships, including Medicare Shared Savings Programs and Pioneer ACOs. In this paper, however, we focus not on ACOs but on health systems that are already offering insurance products or may be considering offering them in the future.

The current landscape

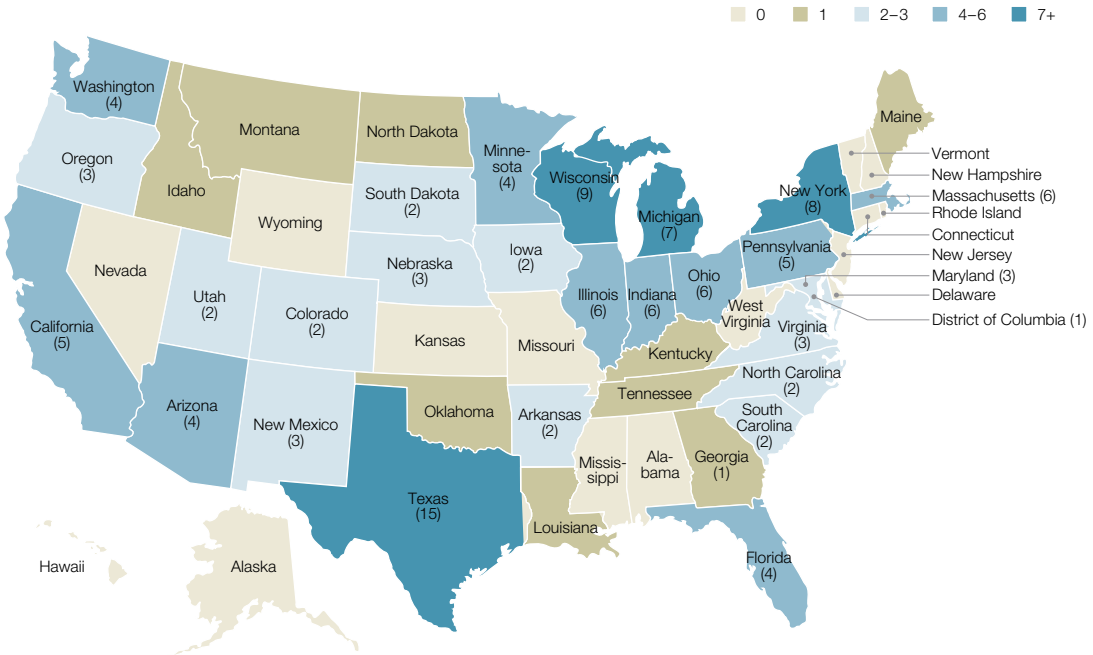
Today, 13 percent of all US health systems offer health plans in one or more markets—commercial, Medicare Advantage (MA), or managed Medicaid (Exhibit 1).[1] Together, these 107 systems operate health plans covering about 18 million members, about 8 percent of all insured lives. Ten more provider-led plans will be offered on the public exchanges in 2015. Approximately half of all those covered by provider-led plans—8.9 million people—are enrolled in Medicaid products and represent 23.5 percent of all insured lives in that market. The 7 million people covered by provider-led commercial plans constitute 4.3 percent of that market. Another 1.6 million people (9.7 percent of the market) are enrolled in provider-led MA plans.

Provider-led plans are currently present in 39 states (Exhibit 2). However, considerable variation exists in both the number of plans in each state and the size of each plan. The 10 largest plans[2] cover about 43 percent of the 17.9 million lives in the provider-led market. The next 10 largest plans cover another 20 percent of lives. In contrast, the 10 smallest provider-led plans include only 1 percent of covered lives.

It is not yet clear how many more health systems will decide to offer health plans—

EXHIBIT 2 **Provider-led health plans are operating in most states**

Distribution of provider-led health plans in each state, number of plans offered



Total exceeds 107 because some provider-led health plans offer coverage in multiple states and/or in more than one line of business.
Source: Plan websites

[1]The statistics in this section were provided by McKinsey's Center for U.S. Healthcare Reform and its Objective Health group.

[2]AmeriHealth Caritas, Fidelis Care, HealthPartners, University of Pittsburgh Medical Center, HealthFirst, Intermountain Healthcare, Spectrum Health, Henry Ford Health System, Geisinger Health System, and MetroPlus Health. Enrollment in these plans ranges from about 465,000 to more than 1.3 million people. Many of these plans have a particularly strong presence in the Medicaid market.

or how many of the current provider-led plans will succeed. As we discuss below, success with this approach requires a range of capabilities that not all systems have or can acquire.

Advantages of provider-led plans

Acquiring or launching a health plan potentially offers health systems five benefits. First, it can enable them to preserve or increase *volume* in settings where payors are attempting to steer lives. Provider-led plans with low premiums or a compelling value proposition can attract members and increase the flow of patients to a system's hospitals—a particularly important advantage in areas where narrow-network products have become common. (When consumers buy such products, they essentially choose providers at the point of purchase, not when care is needed.) If health systems design their products and networks well, they should also be able to increase patient inflow by improving their alignment with community physicians; better alignment should also help them better manage the total cost of care. The approaches used to increase alignment can be similar to those providers have been using with clinical integrated organizations that include independent and/or employed physicians.

Second, having a health plan can permit the systems to leverage local or geographical *economies of scale and skill*. Among other things, it can give them access to the full set of resources needed to manage care—and the total cost of care—effectively (e.g., clinical and claims data, including information from other providers). In addition, it can enable them to consolidate and customize care management resources and infrastructure, and to share best practices in care delivery. In some cases, vertical integration can help reduce the administrative friction between payors and providers, but the size of that reduction often depends on the health system's relationships with third-party payors. As a result, having a health plan can help health systems prepare for population health management (PHM) and mitigate some of the risks it entails.

Third, offering a health plan can enable the systems to create *strategic option value for the future*. For example, it can enable a health system to redesign utilization management efforts (e.g., prior authorization, medical necessity reviews, and retrospective audits) to better suit the needs of the system and its potential new network(s). It can also help them design internal incentive strategies to better align the performance of executives and employed clinicians with the system strategy—a skill that will become increasingly important if the healthcare industry continues to move away from fee-for-service reimbursement. These actions create new strategic options for the future, such as the ability to offer services directly to local employers and/or consumers.

Fourth, having a health plan can *lower barriers to entry* in many areas. A health system with a provider-led health plan can offer narrow network options effectively on the public and private exchanges. Such a system could also deal directly with regional or national companies willing to carve out local network arrangements for employees.

Fifth, in some cases having a health plan may give health systems *economic advan-*

tages. Not only can it allow them to capture all of the premiums paid by employers and individuals, but it can also help them preserve market competition. In areas dominated by a few payors (or where payor consolidation is expected), providers' pricing power typically erodes. By gaining a foothold in the payor space, health systems can bring the market to better equilibrium.

As Exhibit 3 shows, per-patient economics could improve when a health system offers its own health plan, especially if it is able to increase physician alignment—the additional operating profit from the payor arm is not the only incremental contributor to the improved system economics. It cannot be assumed, however, that offering a health plan automatically creates economic benefits—the risks could result in a negative return on investment.

Risks and challenges with provider-led plans

Perhaps the biggest risk health systems offering health plans face results from the inherent *tension between payor and provider value creation*. Payors have traditionally created value by negotiating reduced reimbursement rates with providers, lowering utilization rates, or both. Providers have created value through pricing and by increasing asset utilization; some have also sought to improve their economic mix of patients or have focused on higher-margin procedures. Health systems that want to benefit from having a health plan must be proactive in reconciling these differences in value creation.

A key challenge is ensuring that the provider-led plan offers *a differentiated value proposition and strong branding*, especially if it

EXHIBIT 3 **Provider-led health plans can improve a provider system's economics**

Patients utilizing the provider-led system Patients utilizing other systems

Scenario	Health plan premium revenue	Health plan operating profit	System utilization	Net provider revenue	Provider contribution margin	Total system impact
Patients insured by third-party payor	—	—		$$$$$ $$$$	$$$$$	$$$$ $
Patients insured by provider-led health plan	$$$$$$$$ $$$$$$$$ $$$$	$		$$$$$ $$$$$ $$$	$$$$$ $	$$$$ $$$

The dollar signs shown here illustrate in general terms how a provider's economics can change by launching a health plan. They do not represent actual sums of money.

Source: McKinsey Healthcare Systems and Services Practice

includes a narrow network. As a growing number of consumers contemplate the trade-off between network breadth and premium size, the importance of strong branding, superior customer experience, and competitive pricing should not be underestimated. To state the obvious, providers will derive increasing economic benefits from offering a health plan as volume grows—but growth will materialize only when consumers recognize and understand the value offered by the plan. Only if there is real synergy between the payor and provider arms will an integrated value proposition beat its competitors.

Questions a health system should ask itself if it is considering offering a health plan

1. Strategy

What strategy are we trying to pursue, and where will the incremental value created by the health plan come from?

- Which consumer segments and which markets offer incremental value creation if we create an integrated delivery network?
- What type of health plan will we offer?
- How can we best capture value from integration?
- How do the benefits we can gain from offering our own health plan compare with those that could be obtained through a closer partnership with one or two local payors?
- What risks are we most likely to face if we offer a health plan?

2. Structure

How should the health plan be structured to manage the tension between the different businesses?

- How will we manage value creation conflicts between the payor and provider businesses?
- How should we address channel conflicts between our health plan and third-party plans?
- What is the optimal way to organize the combined entity (e.g., by geography, customer segment, or something else)?
- Which part of the organization should own specific business processes?

3. Operational, financial, and regulatory readiness

How should the health system get ready, and what investment is required?

- In what key areas do we need additional skills or capabilities (e.g., member acquisition, regulatory and compliance, utilization management)?
- How do we manage the heightened balance sheet risk of a combined payor-provider entity?
- How much capital will we need not only to build infrastructure but also to maintain the appropriate risk-based capital levels?

Having a health plan also exposes the systems to *balance sheet risks*. At present, medical cost inflation is relatively low, which makes the payor business look less risky than it has been at other times. Interest rates are also low and liquidity is high, and thus funding the capital needed is easier. As a result, the joint economics of a provider-led health plan can look quite attractive. However, if both medical cost inflation and interest rates rise significantly, health systems that own health plans (and, to a lesser extent, those that have joint ventures with payors) could face strong financial pressures. In our experience, only a few systems fully grasp these balance sheet risks today.

Scale also presents risk. Unless a health system acquires a health plan with a substantial membership, it will have to invest considerable capital in such things as claims management and service operations infrastructure. Smaller systems could find it difficult to fund these investments while waiting for membership to grow to the point that economies of scale kick in.

Regulatory compliance is another concern. Maintaining compliance with federal and state insurance regulations, and the regulations governing certain programs (e.g., MA and Medicaid) is both complex and expensive. Health systems should not underestimate what it takes to establish and maintain a robust regulatory function—even national payors with long-standing expertise in regulatory compliance have sometimes been penalized (both financially and through market restrictions) for not meeting requirements.

Having a health plan also increases a health system's *list of competitors*. The system must consider the strategic moves made not only by other health systems in its market, but also by national, regional, and local payors. Furthermore, negotiations with these payors will be complicated by the fact that the health system now competes against them. These negotiations could be especially tricky given the current trend toward narrow networks.

Questions to consider

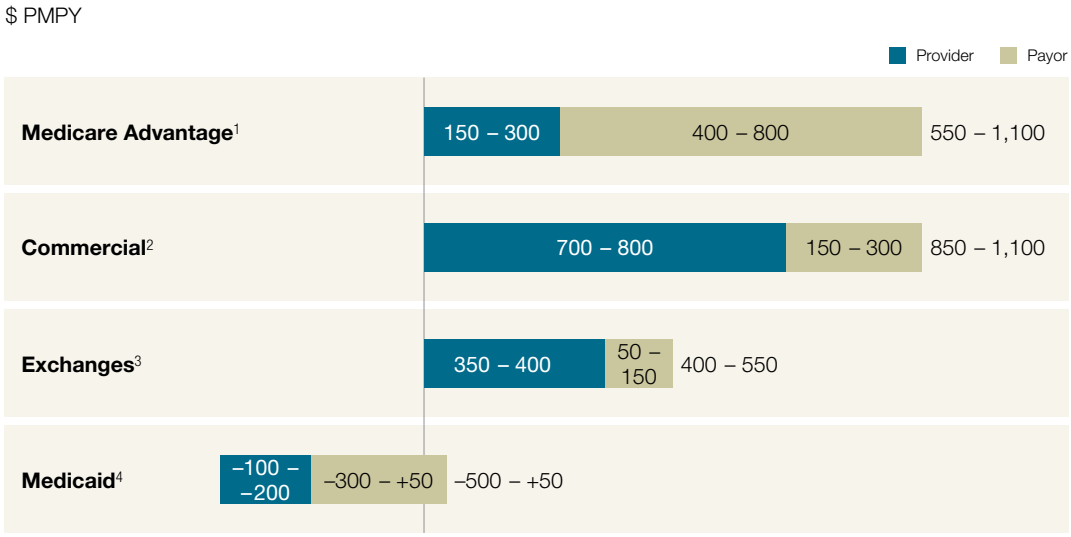
Health systems considering offering health plans should ask themselves questions in three key areas: strategy, structure, and operational/financial/regulatory readiness. These questions are outlined in the sidebar on p. 6.

Strategy

Market segmentation: The overall value of the payor's members to the health system is largely determined by the percentage of medical spending that stays within the provider-led plan. If the percentage is low, more cost-efficient care delivery will not enable the system to retain a greater share of revenue as profit or to reduce the plan's premiums enough to stimulate enrollment growth.

Value differs by market, though (Exhibit 4). For a typical provider-led plan, the potential per-patient profit is likely to be lower on individual products than commercial products—but the individual market is growing much more rapidly. The MA market is also growing rapidly, a result not only of population aging but also of increased consumer interest. For health systems, the economics of an integrated MA plan can be especially appealing given the high profit potential on the payor side (particularly for systems that can use care management effectively to lower utilization). The value health systems can derive from Medicaid plans depends primarily on the state and the Medicaid

EXHIBIT 4 **Net profit per incremental new member for a hypothetical regional provider-led health plan**



PMPY, per member per year.
[1]Assumes average net profit margin of ~2–4% for providers and ~4–8% for payors.
[2]Assumes average net profit margin of ~25% for providers and 4–8% for payors.
[3]Assumes average net profit margin of ~25% for providers and 2–4% for payors.
[4]Assumes average net profit margin of about minus 5–10% for providers and between 2% and minus 10% for payors.

Source: McKinsey Healthcare Systems and Services Practice

rate it is paid. If the Medicaid rate is sufficient to help cover the variable costs for PHM, then having an integrated system can improve the provider's economics. Otherwise, the integrated system will likely have negative margins.

Segmenting health plan members can also help health systems in other ways. For example, when a system is negotiating with employers that have private exchanges or administrative-services-only accounts, it may make sense to lower the health plan's premium—and profit margin—to attract more members.

Plan type: Provider-led plans can be completely closed (the health system and health plan work only with each other) or partially or wholly open (the system can accept patients covered by other health plans, the payor business can reimburse for care delivered elsewhere, or both). Value creation in the two plan types differs.

Value capture: Health systems must also determine whether building or buying a health plan would better enable them to capture value. Our experience in both healthcare and other industries shows that seven factors can help guide this decision (see the sidebar on p. 9). For many systems, the most critical factors are the cost of building the payor component (especially given that the payor will likely have few members initially) and their ability to access the market (e.g., their regulatory and marketing expertise).

Seven questions that help guide build vs. buy decisions

1. **Focus**

   Which approach will enable us to deploy limited resources (e.g., capital, people) more effectively?

   Example: A buy decision is favored if we plan to expand our range of insurance products.

2. **Uncertainty**

   How do we want to manage input cost variability and use pooling to respond to unpredictable demand?

   Example: A buy decision is favored if we anticipate significant near-term variability in patient volumes, since it would enable us to stabilize inpatient demand sooner.

3. **Cost**

   Which approach will best enable us to achieve lower costs from economies of scale (fixed-cost absorption) and more efficient processes?

   Example: A build decision is favored if we are confident we can increase the productivity of our existing clinical staff to meet the needs of the payor function.

4. **Speed**

   Which approach will deliver faster time to market?

   Example: A buy decision is favored if we need to become a payor quickly so that we can control part of the market and maintain inpatient volume.

5. **Innovation**

   Which approach will provide access to better product and process innovations?

   Example: A buy decision is favored if the payor environment is competitive and we plan to serve multiple market segments that require frequent product innovations.

6. **Market access**

   Which approach will best enable us to comply with external restrictions (e.g., government regulations, taxes) and give us access to markets, customers, and suppliers?

   Example: A buy decision is favored if significant barriers to entry exist and we need to gain regulatory expertise rapidly.

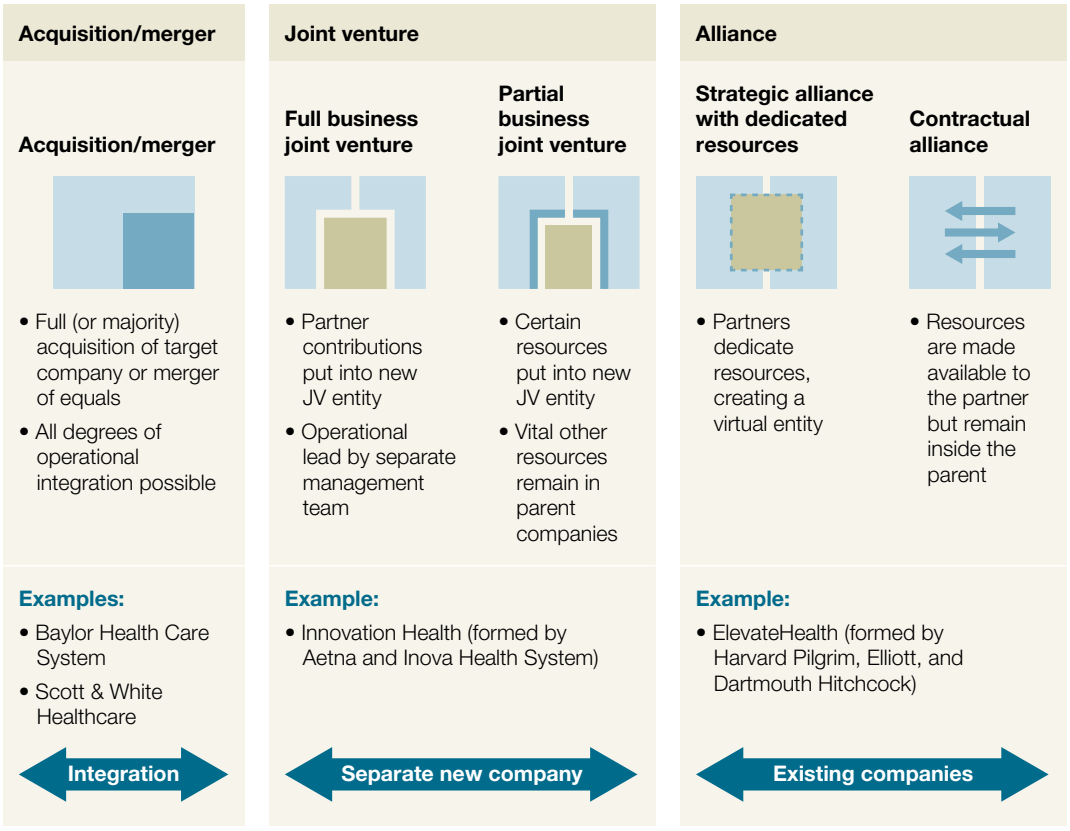
7. **Control**

   Which approach will best enable us to maintain control of intellectual property, critical pipeline information, and quality standards?

   Example: A build decision is favored if it is important that we control the payor assets in a way that an acquisition would make challenging (perhaps because of cultural differences).

EXHIBIT 5 **Value can be captured through different transaction types (the right type is not always obvious)**

Typical forms of intercompany transactions



JV, joint venture.

Source: McKinsey JV and Alliance Service Line

Ownership versus partnership: A related question is whether an alliance or joint venture could provide the benefits of an acquisition without the risks. Factors that favor these arrangements over M&A include the abilities to share risk and leverage complementary capabilities. In contrast, M&A is likely to be more beneficial for health systems if there is considerable overlap in assets between the potential partners. Exhibit 5 outlines the full range of partnership choices available.

Structure

Value creation conflicts: If health systems offering health plans are to achieve the alignment required to overcome value creation conflicts, they must be able to manage internal incentives for both physicians and operating unit leaders. A recent McKinsey survey showed that compensation remains a very important incentive for physicians—but not sufficient on its own to drive behavioral change.[3] Training, leadership capability building, and a robust commu-

[3]Pooja Kumar, MD; Anna Sherwood; and Saumya Sutaria, MD. Engaging physicians to transform operational and clinical excellence. *The Post-Reform Health System: Meeting the Challenges Ahead*. McKinsey & Company. May 2013.

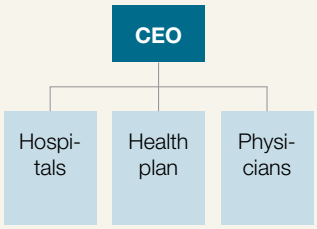
nication plan are also required. Operating unit leaders should be offered incentives tied to the integrated system's value drivers (e.g., lowering care costs, improving quality metrics).

Channel conflicts: Unless a health system obtains 100 percent of its patients through its health plan, problems may arise when it negotiates with third-party payors, especially those with considerable market power. Systems considering offering health plans should carefully evaluate when and where such challenges are likely to surface. Being aware of these potential problems, and ensuring internal alignment on how they should be addressed (e.g., through a decision framework that spells out who makes decisions, who is consulted on decisions, etc.), is an important part of organizing for success.

Organizational optimization: Health systems also need to think through where the health plan's sources of value can be maximized. If value creation is primarily derived from specific consumer segments, for example,

EXHIBIT 6 **Integrated system's structure should be driven by the sources of value**

Business line prioritized

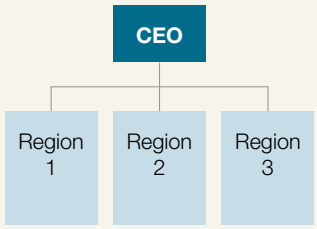


- Ideal if you believe growth/margin opportunities will vary by business
- Optimizes for:
  - Managing portfolio: investment, M&A, and growth decisions can be made separately
  - Responsiveness of businesses to individual opportunities
  - Minimizing disruption

Key question:

Are health plan assets going to be important going forward?

Geography prioritized

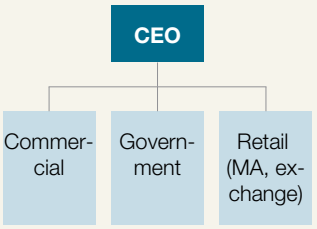


- Ideal if you believe primary growth/margin opportunities are from market penetration/integration
- Optimizes for:
  - Capturing integration value
  - Speeding decisions in markets
  - Community responsiveness

Key question:

Do you believe that regional networks are required for success?

Customer segment prioritized



- Ideal if you want to maximize competitiveness as payor, and integration is less important
- Optimizes for:
  - Segment competitiveness (especially on national and regional level)
  - Membership growth
  - Plan acquisition
  - Product innovation

Key question:

Are the different consumer segments unique enough to require special attention?

MA, Medicare Advantage.

Source: McKinsey JV and Alliance Service Line

the plan's organizational structure should focus on those segments. In contrast, the organizational structure should be based on geography if regional differences require unique strategies (Exhibit 6).

Business process ownership: As they develop their new organizational structures, health systems should also think through which parts of the new organization should have ownership of various business processes. Four questions can help them make these decisions. First, what type of expertise is needed? (Payors and providers have historically had distinct areas of expertise.) Second, how is financial risk allocated? (Resource allocation should align with the extent of risk each business is allocated. This holds true regardless of whether a health system owns a health plan or has a JV/alliance with a payor.) Third, what is the degree of benefit from scale? (For example, the provider arm of the organization should own the business processes related to PHM if larger scale would enable it to justify investments in such things as having nurses embedded in physician offices.) Fourth, how will critical decisions, including those related to capital and growth, be reached? (In other words, how will the health plan be governed?)

Operational, financial, and regulatory readiness

Additional skills/capabilities: Offering a health plan often requires health systems to develop new skills and capabilities, particularly those needed for PHM. Although most systems have put at least some effort into building PHM capabilities, those considering offering health plans must get serious about it. Many systems face a capability gap with PHM because of their lack of experience in managing care outside of clinic or hospital walls. For example, few health systems today have experience in managing the continuum of care that extends through post-acute care, but the ability to do so is likely to be crucial to the success of integrated plans. In our experience, the capabilities health systems need to develop can be grouped into four main areas: financial risk management, care management, clinical integration, and patient engagement (Exhibit 7).

Heightened balance sheet risk: Senior leaders should consider taking steps to dampen the impact of a more volatile risk environment. For example, a countercyclical reimbursement mechanism that redistributes funds between payor and provider when utilization is very high or low can stabilize operations while meeting the regulatory requirement to maintain adequate capital reserve levels. This functions similarly to risk corridors to soften the impact on balance sheets when system utilization is volatile.

Capital requirements: Insurance regulations put in place and monitored by the National Association of Insurance Commissioners (NAIC) require payors to hold capital to guard against insolvency. The amount of risk-based capital (RBC) needed is determined by a formula that calculates the minimum amount of money an insurer should have on hand to support its overall business operations, given its size and risk profile. The NAIC RBC system operates as a tripwire—regulators have legal authority to intervene in the business affairs of an insurer if capital levels fall to one of the action levels specified in the RBC law. Awareness and active monitoring of RBC levels is yet another function that requires specific expertise and dedicated resources.

EXHIBIT 7 **Readiness for population health management requires capabilities in four key areas**

Financial risk management • Cost and utilization analytics • Financial risk accounting/reporting • Contract management • Documentation and accurate coding	**Care management** • Care coordination, including post-acute and supportive care • Case management • Utilization management • Chronic disease management • Wellness and prevention • Clinical analytics for risk segmentation and provider reporting
Clinical integration • Governance, strategy, and alignment across the network • Clinical-quality best-practice dissemination, clinical pathways • Clinical-operations improvement to optimize quality and cost • Practice transformation • IT tools that enable integration (e.g., EHR operability)	**Patient engagement** • Patient navigation tools, including transparency • Tools to manage own health/engagement • Superior patient experience and customer service

EHR, electronic health records; IT, information technology.

Source: McKinsey Healthcare Systems and Services Practice in the Americas

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For most health systems, offering a health plan is not easy. The providers most likely to succeed with this move are those that have an aligned strategy across their system, a strong balance sheet, well-developed PHM capabilities, solid brand recognition, and sufficient scale. By answering the questions we posed in this article, senior provider executives can determine how ready their organization is, and how well aligned they are, before they venture into health insurance. Some health systems (especially those with strong balance sheets) are in reasonably good shape to take the first steps. Other systems, however, should avoid this move, because they are unlikely to achieve a positive return—much as occurred when many providers established health maintenance organizations in the 1990s.

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