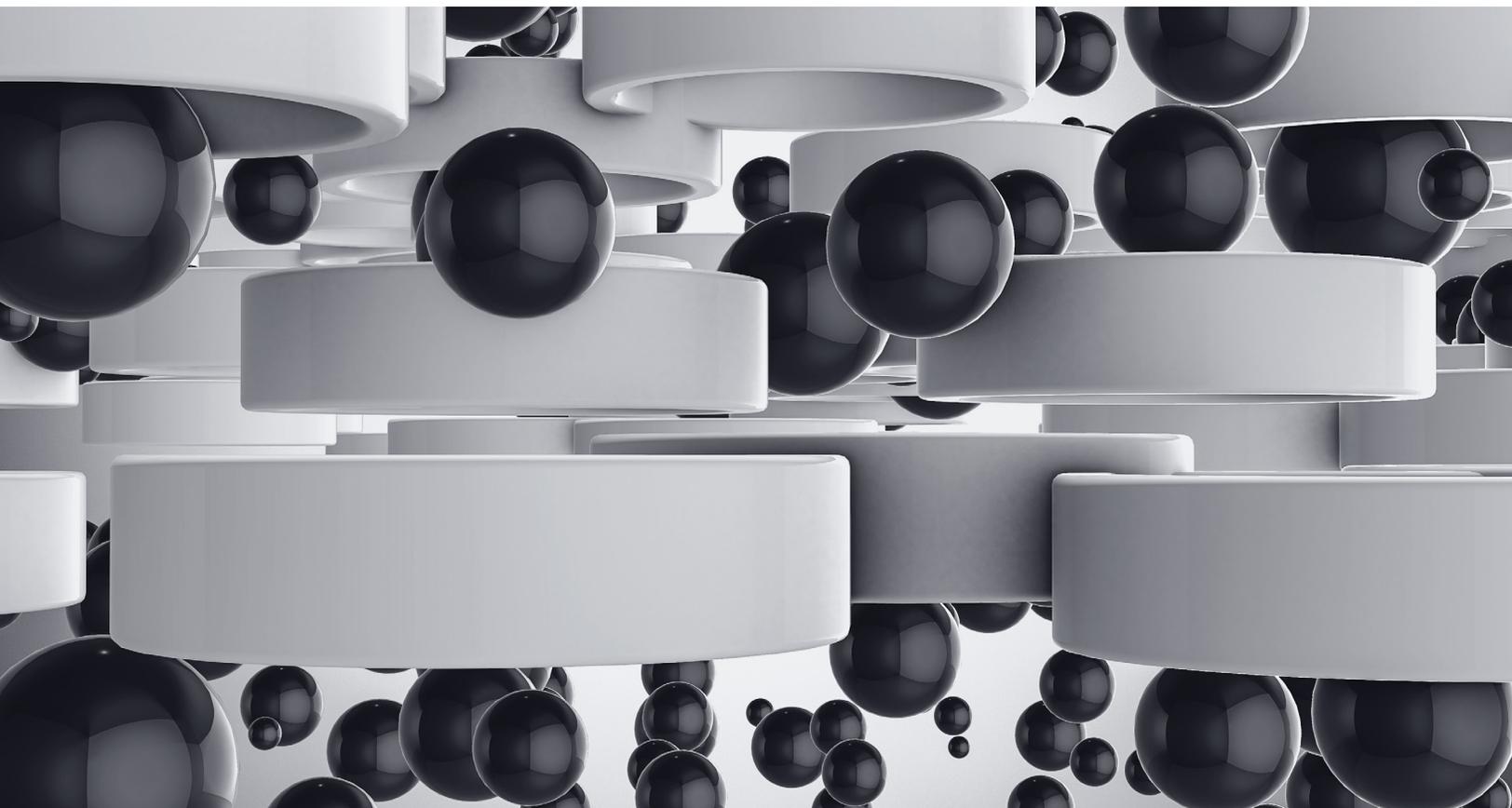


Healthcare Systems & Services Practice

How should provider-led health plans evolve?

Although they are often pursued as an approach for vertical integration, their value is not always clearly demonstrated.

by Zahy Abou-Atme, Michael L. Morley, and Gunjan Khanna



In the early 2000s, enrollment in provider-led health plans (PLHPs) began to take off, and many people saw it as the dawn of a new era. As healthcare provisions and payments were integrated, incentives would become aligned, costs would fall, outcomes would improve, and the rest of the industry would learn from the PLHP approach. Several providers, and payers, sought this type of vertical integration to drive value to their communities.

It didn't always pan out.

Our new research shows that simply governing both payment and provision may not be enough to control the total cost of care or boost care quality and performance.¹ Indeed, we have found the “magic” that many observers attribute to integrated models, such as PLHPs, lies in their distinctive capabilities.

In this article, we compare the performance of PLHPs with the rest of the US healthcare industry. We outline the principal challenges facing the current PLHP model and detail the strategic questions that payers and providers should ask before assessing or entering into a payer-provider integration hoping that it will produce value for their plan members and patients.

Drivers of provider-led health plan growth

Payer-provider integration is now commonplace. PLHPs and other risk-bearing providers, such as independent physician associations, are experimenting across the country and the healthcare value chain. Several multistate payers and regional health systems also participate in some form of vertical integration.

Since 2011, overall enrollment in 111 PLHPs has grown an average of about 6 percent annually and, as of 2017, now covers nearly 17.5 million people across 42 states. PLHPs seem to have grown faster than the overall payer market average of 2.7 percent a year, albeit from a much lower base (Exhibit 1).

However, much of this PLHP enrollment growth has largely been driven by favorable segment mix rather than market share growth. For example, although PLHP Medicaid enrollment grew more slowly than the market average since 2011 (8.6 percent per annum compared with the market average of 9.8 percent per annum), Medicaid enrollment constitutes 57 percent of PLHP enrollment, but only 21 percent of total enrollment nationally. In addition to segment mix effects, PLHPs also significantly outpaced the market in the individual segment, growing at 22.9 percent per annum versus the market average of 4.3 percent.

Evaluating recent provider-led health plan performance

We explored why PLHPs are not delivering superior performance, including cost of care and quality, and the special circumstances that might help explain some of these shortfalls.

Looking across carriers and markets, we studied performance (including enrollment penetration by payer segment), operating margins, the total cost of care (including premium leadership and affordability), medical loss ratio (MLR) administrative costs, and quality as reflected in the five-Star quality rating system of the Centers for Medicare & Medicaid Services.

¹ Industry review of PLHP performance as assessed by Centers for Medicare & Medicaid Services five-Star Ratings, price leadership from the Patient Protection and Affordable Care Act premium rate ladders, and comparison of medical loss ratios by segment. Due to the unique model and its scale, Kaiser Permanente has been excluded from the analyses in this article.

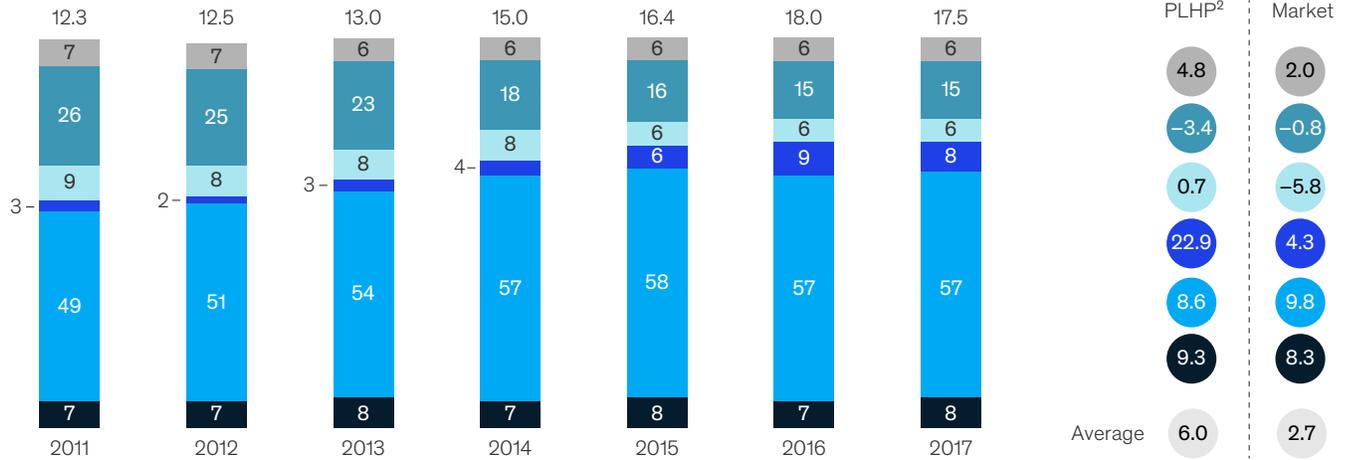
Exhibit 1

PLHP enrollment is growing faster than other carrier types driven by segment mix.

■ Medicare Advantage ■ Medicaid ■ Individual ■ Fully insured, small group ■ Fully insured, large group ■ ASO¹

PLHP² enrollment by segment, %; 100% = million lives

CAGR (2011–17), %



Note: Figures may not sum to 100%, because of rounding.

¹ Administrative services only.
² Excluding Kaiser Permanente.

Segment penetration

Across payer segments, PLHPs appear to have higher penetration in the Medicaid and individual segments, where there is a concentrated local population of members (Exhibit 2). Conversely, PLHPs have made little headway on administrative services only or large-group fully insured accounts, wherein employers look for access to a national provider network for their employees.

Most PLHPs face challenges in negotiating positions outside their owned systems in commercial segments. Multistate employers also tend to be more demanding in terms of reporting capabilities and cross-state discounts, which are generally sweet spots for the nationals and Blues,

given their scale and ability to spread investments across members.

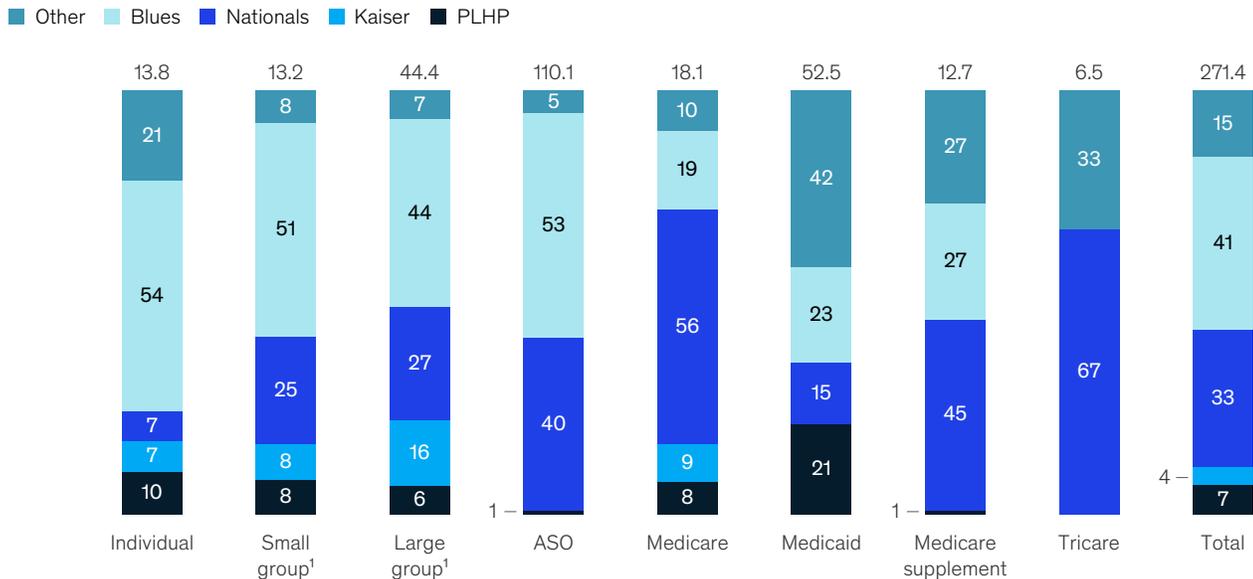
Price leadership

Reviewing PLHP premium leadership is easiest in the individual market because of the price transparency enabled by the Patient Protection and Affordable Care Act (ACA). Today, PLHPs participate in approximately 30 percent of markets, or 148 of the 499 rating areas; however they have the market's lowest-priced premiums, or price leadership, in only 39 percent of the rating areas they participate in—down from more than 53 percent in 2018. A closer examination shows that, since 2014, PLHPs improved their price leadership primarily by exiting markets where lower prices could not be sustained.

Exhibit 2

PLHPs have more penetration in local Medicaid and individual plans, but almost none in commercial administrative services only (ASO) plans.

Enrollment by carrier type, %; 100% = \$, millions



Note: Figures may not sum to 100%, because of rounding.
¹ Small group and large group are fully insured.

From 2016 to 2018, they reduced their geographic footprint by about 28.4 percent (Exhibit 3). In 2019, however, PLHPs saw a sharp drop in price leadership while remaining in approximately the same number of markets. This drop is owed to increased competition from Blues and regional players.

Total cost of care

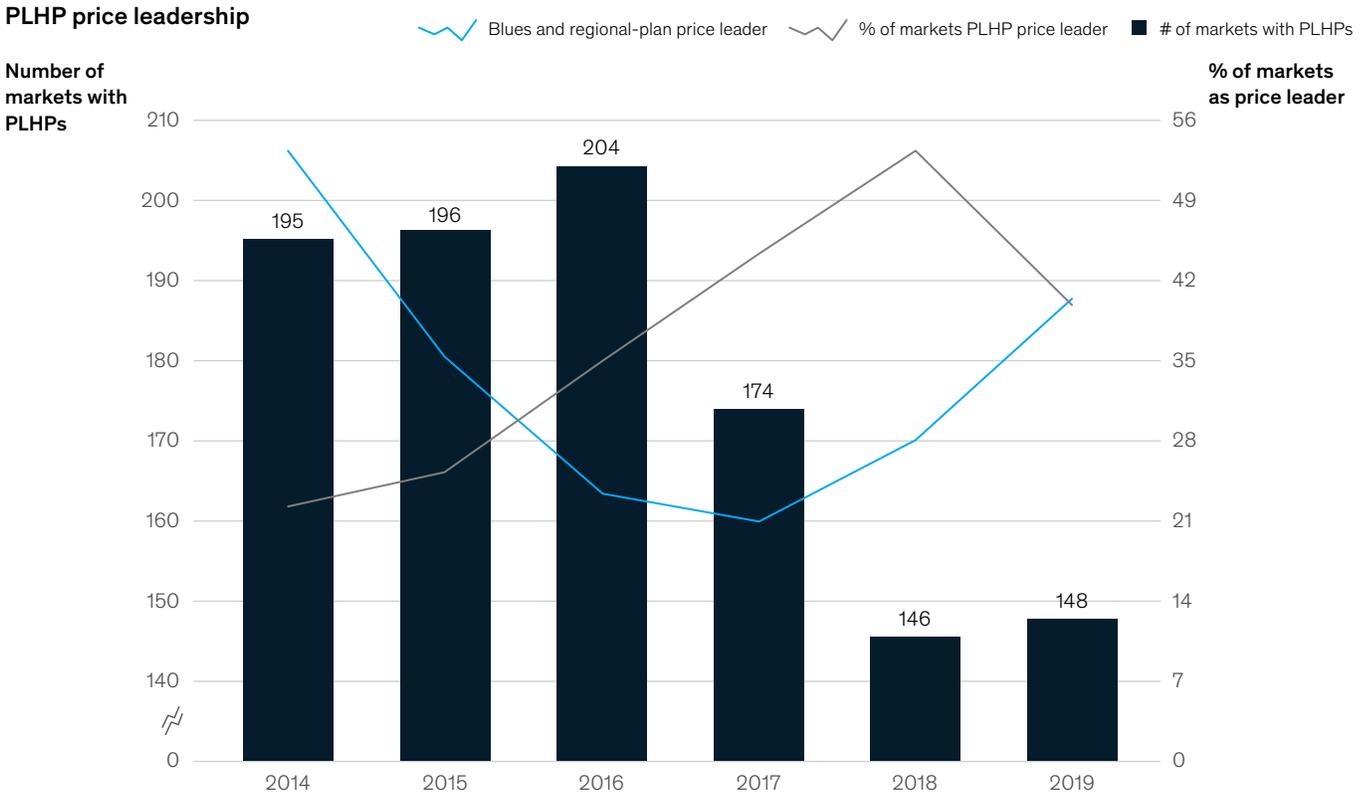
Across nearly every segment, the median MLR of PLHPs is higher than that of Blues and nationals; additionally, PLHPs exhibit a greater range in their MLR. From our experience, this range in the MLR performance of PLHPs is due to a few different factors, based on the size and sophistication of the health plan.

First, smaller plans tend to lack the scale necessary to accurately control claims variance, requiring them to include a larger buffer when pricing their products. Second, product pricing is not a core competency of health systems, and relatively new PLHPs tend to lack the sophistication needed to achieve a top-quartile performance. Finally, PLHPs may not prioritize managing costs and utilization as much as stand-alone payers because PLHPs also capture the economics on the health system side of the business.

Higher MLRs and lower premiums also help explain why PLHPs have lower margins than nationals and Blues. While many observers attribute this to

Exhibit 3

PLHPs are losing price leadership to Blues in the individual segment.



Source: McKinsey Center for Health Systems Reform

a margin shift toward the provider side of the house, such a shift has not always been evident in our experience with integrated delivery networks (IDNs). In our analysis, we found far greater variance in MLR performance among PLHPs—ranging from 54 to 140 percent—than among Blues or nationals, suggesting that PLHPs may benefit more than Blues and nationals from pursuing administrative and care-management best practices (Exhibit 4).

While average sales, general, and administrative costs for PLHPs are in line with those of nationals and Blues, at about 11 percent of premium, they

are far more variable—from 4 to 28 percent of the premium.

Quality

In terms of Star metrics, when Kaiser Permanente is excluded, we see that PLHP ratings fall below those of Blues and nationals in 2019 (Exhibit 5). A more detailed analysis reveals that PLHP scores have declined across all Star metric groups—such as Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS)/Health Outcomes Survey (HOS), operational metrics, and Part D—

Exhibit 4

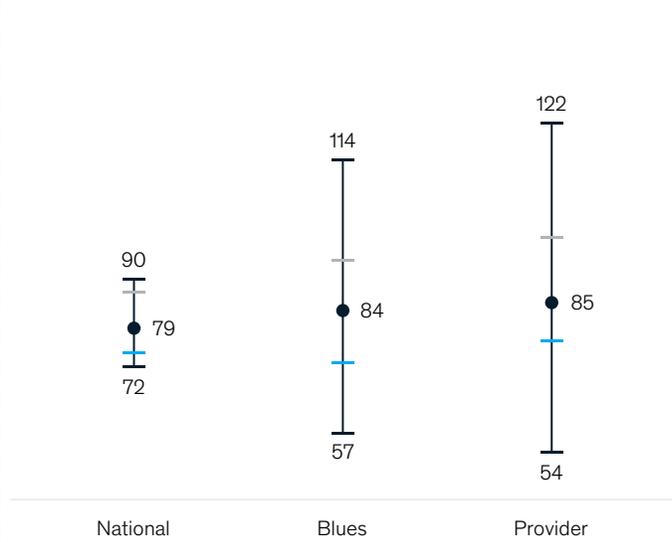
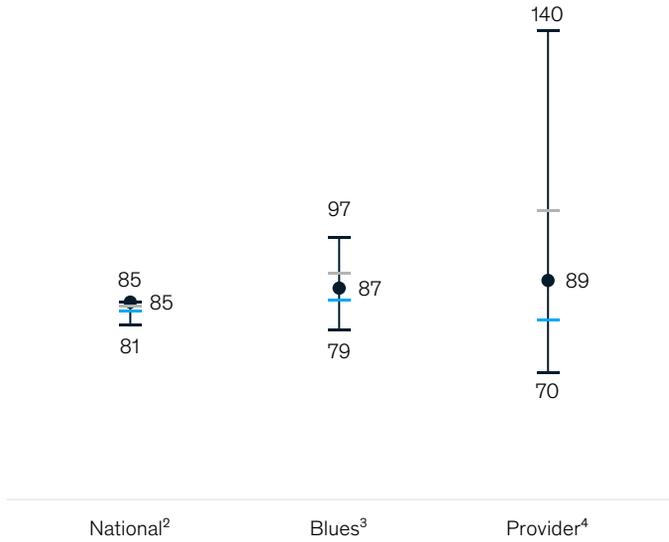
PLHPs' high medical loss ratios lead to underperformance.

2017 medical loss ratio (MLR), %

— Minimum¹ — Maximum¹ — Quartile 1 ● Median — Quartile 3

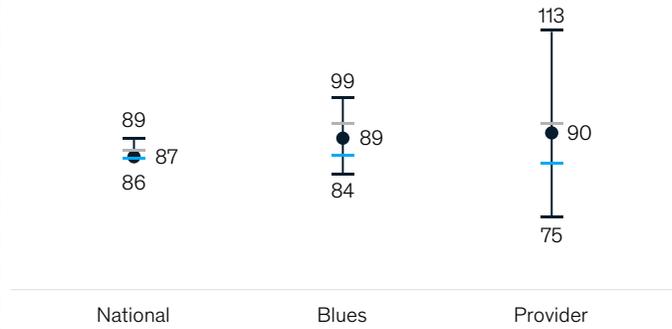
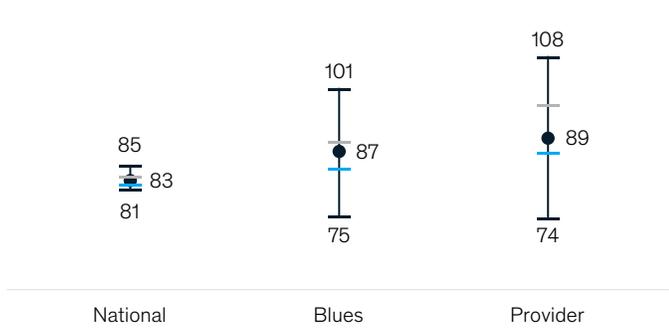
Large group

Individual



Medicaid Advantage

Medicaid



¹ Minimum and maximum have been calculated using the industry-wide financials of carriers in the category.

² Includes Aetna, Cigna, Humana, and United.

³ All Blues, including Anthem.

⁴ Does not include Kaiser Permanente.

Source: McKinsey Payor Financial Database

PLHP enrollment growth has largely been driven by favorable segment mix rather than market share growth.

since 2015. Over the same period the Blues' Star scores improved relative to PLHPs on HEDIS and CAHPS or HOS metrics, while the nationals' Star scores improved on both operational and Part D metrics. While PLHPs started out with higher aggregate Star scores than Blues or nationals, the initial advantage PLHPs may have had in HEDIS scores—by being tightly linked with providers—appears to have eroded as Blues and nationals adapted and invested in their own capabilities.

Improving HEDIS, CAHPS/HOS, and operational metrics requires significant investment, particularly because of digital transformations or provider incentives needed to effect meaningful change. Therefore—with respect to improving HEDIS and CAHPS/HOS metrics—both nationals and Blues can take advantage of their scale to spread fixed investments over more members. This suggests that PLHPs cannot rely solely on their unique payer-provider integration to maintain their Star Rating while larger payers continue to accelerate clinical and operational improvements. Furthermore, high

ratings become increasingly difficult to maintain as cut points continue to rise with increasing performance across the market.

The unique challenges facing provider-led health plans

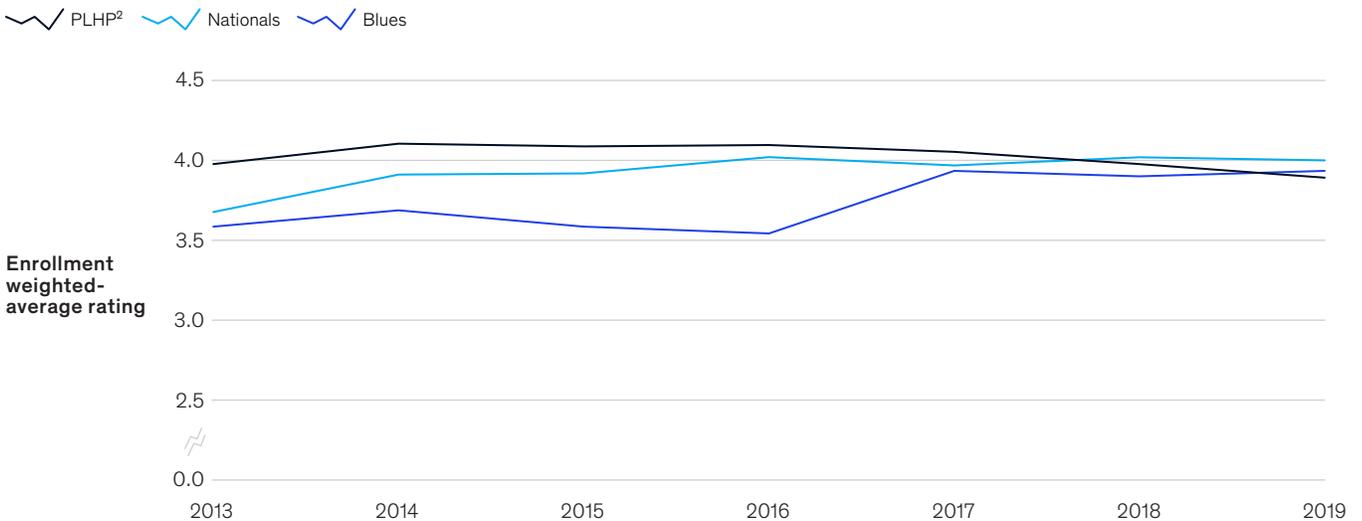
Serving payers-providers across the country, we have found that PLHPs face the following common challenges that may limit their ability to create sizable value:

- *Lacking strategic clarity on the role of the health plan as a vehicle for exclusive networks or a broader play in the healthcare value chain to capture insurance economies.* Payers-providers can struggle without a clear definition of a payer's role in the IDN. In our experience, inside most PLHPs, the answer to this question varies: should the payer act as the mechanism for steering patients into the hospital system, or should it be just one of several ways providers can capture margin from taking on risk?

Exhibit 5

PLHP Star Ratings have slipped below those of Blues and national payers.

Medicare Star Ratings¹ by plan category



¹ Centers for Medicare & Medicaid Services five-Star Ratings.

² Excludes Kaiser.

Source: McKinsey analysis of CMS Medicare Five-Star Quality Ratings data (2013–19); CMS December enrollment files (2012–17); CPSC September 2018 enrollment files

- ***Determining the right level of owned-provider discount.*** Several payer-providers must decide whether or not to provide themselves a bigger discount. But we have found that without the appropriate mechanisms to manage utilization, a payer might funnel savings from its provider, in the form of higher reimbursement, to other participating providers. The issue then becomes calculating a discount that will hit the “sweet spot,” a reimbursement figure that is the right balance between provider margins and payer premium competitiveness. PLHPs still require the participation of other providers at reasonable prices, and local health systems and health plans will catch on to owned-provider discounts, resulting in challenges during contracting. Successful IDNs create an independent unit to define the integrated economics of all their decisions—including contracting and new product development—and assist in making them fact-based.
- ***Underestimating segment complexity.*** While most PLHPs prefer to manage multiple segments, we have found that few manage all segments equally well. The complexity of and differences between managing individual ACA and Medicare businesses—for example, strategies to manage utilization patterns for the Medicare cohort—are significantly different from those of managing the ACA population. Often because of a lack of scale, most PLHPs do not have a clear profit-and-loss structure by payer segment. Without P&L leadership, accountability tends to be limited, and plans tend to lack a performance culture and approaches tailored to each segment.
- ***Balancing facility utilization with integrated economics.*** Most health systems are accustomed to improving performance by maximizing utilization, resulting in higher premiums—a result at odds with a PLHP’s goal to manage members’ utilization. If the PLHP manages utilization well, the health system risks reducing physician productivity, which hurts economics. Striking this balance is critical. Another common problem is a lack of payer and provider alignment, such as when the payer

enters into a state Medicaid contract without clear buy-in on the provider side, which has material financial implications for the health system. To clarify the strategic direction and reduce internal organizational challenges, senior leaders of PLHPs need to agree on their approaches to each challenge.

The unique opportunities available to provider-led health plans

We have seen organizations already in a PLHP improve their competitive market positions by using the following tools unique to PLHPs:

- ***Differentiated care pathways that dramatically reduce the total cost of care and improve quality of care for plan members, patients, and the micromarkets they serve.*** In some markets, this means an expanded footprint for primary care that is accountable for the total cost of individual patient care. In others, it may mean better collaboration with post-acute assets used to reduce elderly members’ readmission rates. Making moves like these requires clear build-versus-buy strategies with care-management vendors, which constitute a new and rapidly growing industry. Whereas launching a PLHP is a strategic imperative for some health systems, some might choose to outsource payer care-management operations to these emerging vendors to mitigate risk and improve performance.
- ***Integrated economics that capture price leadership.*** To make advances, players must not confuse prices with true costs for the system or patient. To be the most affordable, PLHPs need a deep understanding of how integrated economics can yield more competitive health-plan premiums. Most will need to gain operational efficiencies that are unique to integration, such as streamlining revenue cycle management and claims review for the health system; this may involve moving to shared services for support functions and consolidating case managers and care management across hospitals and payers.

Most PLHPs will need to decide in which segments to play—for example, by evaluating whether they can achieve the necessary scale within a segment across both the provider and payer sides of their business. For instance, one IDN found there was 250 percent greater value for a Medicare Advantage member than for a Medicare fee-for-service member—this vast difference was due to the network’s ability to learn from member experiences, generate margins, and support patient-care pathways in the provider system (Exhibit 6).

— *PLHP-specific product innovation that would be difficult for stand-alone health plans to replicate.* In some ways, it would be easier for a PLHP and an owned health system to agree on and pilot new healthcare-benefit innovations than for a payer to establish a risk partnership with an unrelated health system. A PLHP may

consider an integrated product-design team that considers the strengths of its services. It could increase cost-sharing to members for services that are priced competitively or accelerate payment innovation—for example, with bundled payments for skilled nursing facilities. A PLHP might also better manage social determinants of health and offer an integrated health experience through creating a member app that integrates care management, scheduling, referrals, scripts, and more across the payer-provider, which is currently something only IDNs can do.

Strategic considerations for the next era of payer-provider integration

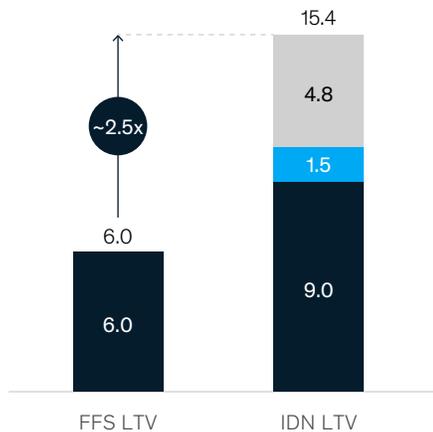
Based on our experience and research, we believe vertical integration in the form of a PLHP does not always provide a distinctive value proposition to the

Exhibit 6

Integrated delivery networks (IDNs) can generate more than twice the lifetime value (LTV) for a Medicare Advantage member than for a Medicare fee-for-service (FFS) member.

LTV of a Medicare member or patient to an IDN, Lifetime patient margin, NPV,¹ \$, thousands

■ Health system contribution margin ■ Incremental care alignment within IDN ■ Health plan margin



¹ Net present value.

² Health maintenance organization.

Source: McKinsey analysis from a disguised client example

Drivers of value

Health-plan margin

- Margin over time
- Member persistence
- Improvement in utilization and risk coding

Higher owned-provider utilization

- Increased referral alignment with the clinical enterprise
- Care coordination

Higher contribution margin

- Owner-provider contracting differences
- Shift from FFS (broad) to HMO² product
- Narrow or tiered networks

market. Leaders who are exploring or evaluating new and current vertical integration need to revisit what it means to have privileged oversight of both healthcare payment and provision. We suggest that they start this journey by addressing a few strategic questions:

- *What is the strategic imperative for vertical integration—in other words, to what end?* Payers may consider vertical integration to ensure low-cost access to their members in a competitive environment. However, in many cases, this solves the problem in one core geography but creates new issues in others. Providers are able to pursue launching a payer to help provide a more streamlined patient flow through their system with limited prior authorization requirements and less administrative burden. We encourage leaders to spend plenty of time resolving this question by understanding the value for the patient or member, the business problem they are trying to solve, and the dynamics of other competitors and markets.
- *What subsegment of the patient population, and which care services, will derive the greatest value?* Deeply understanding the needs of the patient population that vertical integration is intended to serve will affect the management of care and vertical integration selection. For example, for a payer looking to provide small-group coverage, tightly integrating with a provider in the overlapping geography and providing distinctive benefits at low premiums would be an attractive value proposition; however, the same may not be true for large employers with a statewide or multistate presence.

In addition, understanding the conditions of the target population (multiple chronic conditions, dual conditions, or diabetes, for instance) will also

enable conversations further downstream about the right type of participation across the care continuum. Leaders should start by evaluating how their participation across care pathways will help to better manage population health while improving affordability and organizational performance.

- *What is the right vertical integration model—that is, which will allow the systems to create the most value from integration?* The answers to the first two questions can help a leader determine the best way to address this, and a PLHP should be seen as one option. Compared with 20 years ago, several additional alternatives are available to health systems pursuing more focused vertical integration strategies, ranging from expanding bundled payment programs to launching hospital-based accountable care organizations and developing vertically integrated clinical models that accept capitated risk. These new models allow systems to thoroughly integrate the subset of their patient population, while avoiding some of the operational and strategic complexities of PLHPs.

Because each payer and provider is unique, the answers to these questions will vary. However, the insights a payer or provider gains from carefully considering its challenges, opportunities, and potential decisions will help to inform a clear and powerful strategy set to benefit the organization, healthcare providers, patients, and, ultimately, the nation.

PLHPs have some natural advantages, but they will need to build on their successes and take fresh approaches to help their respective organizations maintain a strategic advantage and keep pace with more sophisticated consumers and competitors in a changing healthcare landscape.

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