The $5 PMPM health plan

Coming soon to your neighborhood
This report was originally published by Booz & Company in 2012.

The authors would like to thank Joyce Qian and Jason Sukumaran, who contributed to this report.

**Contacts**

**Chicago**

Mike Connolly  
*Senior Partner*  
+1-312-578-4580  
mike.connolly  
@strategyand.pwc.com

Anil Kaul  
*Partner*  
+1-312-578-4738  
anil.kaul  
@strategyand.pwc.com

Pier Noventa  
*Principal*  
+1-312-578-4877  
pier.noventa  
@strategyand.pwc.com

**New York**

Gil Irwin  
*Senior Partner*  
+1-212-551-6548  
gil.irwin  
@strategyand.pwc.com

Sundar Subramanian  
*Partner*  
+1-212-551-6651  
sundar.subramanian  
@strategyand.pwc.com

**San Francisco**

Thom Bales  
*Partner*  
+1-415-653-3476  
thom.bales  
@strategyand.pwc.com

**About the authors**

Gil Irwin is a senior partner with Strategy& based in New York. He specializes in business model and operating model transformations in the healthcare industry, with a focus on technology and operations strategy.

Thom Bales is a partner with Strategy& based in San Francisco. He specializes in operations, technology, and transformation strategy in the healthcare industry.

Anil Kaul is a partner with Strategy& based in Chicago. His areas of expertise are organizational design, performance measurement, process design, cost analysis, implementation of business process outsourcing/offshoring, and shared services.

Sundar Subramanian is a partner with Strategy& based in New York. He specializes in business and operating model transformations in health, and also co-leads the firm’s Medicaid/Medicare Center of Excellence.
Health plans are already working hard to lower their administrative costs in a necessary response to healthcare reform and other fundamental shifts in the market. But how low is low? Strategy& analysis reveals that payors may soon face new competitors whose administrative costs could be as much as 80 percent lower than those of today’s typical plan. Matching such a cost structure may seem like an unattainable target to legacy plans, particularly in their current business model. But if they are to defend their market share from these new competitors — especially large, integrated provider organizations — plan leaders should carefully consider whether and how they can fundamentally rethink their business models. The very existence of their companies may depend on it.
How low can you go?

Most health plans are already working hard to lower administrative costs. Their leaders are well aware that they cannot survive, much less prosper, in the post-reform era unless their operations are highly efficient and cost-effective.

The need for lower costs is clear and compelling. The Affordable Care Act, and its subsequent upholding by the U.S. Supreme Court, changed the playing field for health insurers. The law’s provisions, including medical benefit ratio minimums, rate reviews by states, guaranteed coverage, and the banning of some coverage limits, are already creating margin pressure. This pressure is exacerbated by other fundamental trends: the shift to a more consumer-centric market; budgetary constraints and transparency demands in Medicare and Medicaid; the urgent need to stem unsustainable cost increases; and the emergence of new competitors in the market.

In such an environment, the conventional operating model for health plans and its associated cost structure could easily become an anchor that will drag a plan down. But if the conventional model is no longer viable, what kind of model should a plan adopt? The manner in which a plan’s leadership team answers this question today will be a key factor in determining that plan’s future success.

Strategy& analysis suggests that a health plan will have to rethink its business model from the ground up if it is to significantly reduce administrative costs. Simply put, most health plans will not be able to drive their costs low enough to weather the changes in their markets without radically rethinking how they do business. They will need to choose what they want to be good at and ruthlessly pursue it, while enlisting other players in the value chain to perform everything else. The days of health plans maintaining full-fledged, in-house front, middle, and back offices are fast coming to an end.
What’s your baseline?

Before plans can rethink their operating models, they need to recognize the baseline costs for the services they provide today. These costs vary among plans, of course, but our research suggests that a starting point of $29 per member per month (PMPM) is a fair approximation of the operating costs of an average-performing plan with 2 million members (see Exhibit 1, next page).

The conventional health plan utilizes a variety of member acquisition channels in the front office, including consultants, brokers, employers, and other groups, along with internal sale agents and the Internet, with all of the accompanying middlemen and multichannel management. Marketing is usually brand-focused and disseminated via multiple media channels, and its ROI is rarely known.

Middle-office capabilities are determined by the structure of the provider network — typically, a PPO, POS plan, or an HMO with a primary-care physician acting a gatekeeper. These are often broad networks operating under fee-for-service (FFS) contracts that require significant oversight in terms of utilization and case/disease program management.

Back-office operations are characterized by laborious claims processing with a significant volume of manual claims from providers. Often, back-office operations involve complex processes for claims resolution, which require the use of multiple, non-integrated data platforms.

Corporate functions and IT tend to reflect the operating philosophy of the plan and so are often bloated too.
Exhibit 1
The cost of the conventional operating model is approximately $29 PMPM

Note: All costs are per member per month, in US$. Source: Strategy&
As health plans consider their strategies for the future, they could choose one of four ways to play: lean operator, direct marketer, direct marketer–medical cost innovator, or risk and network aggregator. Each approach is different and requires its own operating model (see Exhibit 2, next page). Yet each of these fit-for-purpose operating models enables a plan to tailor its operations to its strategy and to differentiate itself in the marketplace. Each also comes with its own set of cost benefits.

**Lean operator model**

Many health plans are already pursuing lean operations to reduce their administrative costs. Such a plan retains much of the operating model used by conventional plans, but it streamlines the way in which it serves the individual, small group, and Medicare/Medicaid markets. It also drives down costs and improves service levels by eliminating redundant processing, increasing automation, leveraging labor arbitrage, and capturing the benefits of a mature vendor base.

A lean operator makes very careful make-versus-buy decisions about which tasks to perform in-house and which to procure from external vendors. The best-in-class lean operator is an aggregator of low-cost capabilities needed to deliver on the current broad spectrum of services that plans provide to their various stakeholders, including members, employers, providers, and regulators.

The lean plan enhances the efficiency of front-office operations by improving the productivity of the product development and rating/underwriting functions. It lowers marketing spend by measuring ROI at the event and program levels and eliminating low-return activities. It shifts its sales channel mix from brokers toward more cost-effective direct channels.

This plan also reduces middle-office costs by focusing care and disease management on a few high-value programs. Provider networks are
Exhibit 2

Fit-for-purpose operating models can dramatically reduce administrative costs

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Lean operator</th>
<th>Direct marketer</th>
<th>Direct marketer—medical cost innovator</th>
<th>Risk &amp; network aggregator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broker-based sales</td>
<td>Broker &amp; direct sales, ROI-based marketing</td>
<td>Product/underwriting simplification &amp; direct sales</td>
<td>Product/underwriting simplification &amp; direct sales</td>
<td>Product/underwriting simplification &amp; direct sales</td>
</tr>
<tr>
<td>Care management</td>
<td>ROI-based care management</td>
<td>ROI-based care management</td>
<td>Care management done by provider</td>
<td>Care management done by provider</td>
</tr>
<tr>
<td>Broad provider networks</td>
<td>Broad provider networks</td>
<td>Broad provider networks</td>
<td>Integrated provider networks</td>
<td>Integrated provider networks</td>
</tr>
<tr>
<td>Fee-for-service (FFS) reimbursement</td>
<td>FFS reimbursement</td>
<td>FFS reimbursement</td>
<td>Outcome-based reimbursement</td>
<td>Outcome-based reimbursement</td>
</tr>
<tr>
<td>Customer service &amp; claims processing</td>
<td>Automation &amp; lean customer service &amp; claims processing</td>
<td>More automation &amp; lean customer service &amp; claims processing</td>
<td>Simpler customer service &amp; claims processing</td>
<td>Simpler customer service, no claims processing</td>
</tr>
<tr>
<td>IT support</td>
<td>Lean IT support</td>
<td>Reduced IT support requirements due to simplified products</td>
<td>Increased IT support to integrate with providers</td>
<td>Reduced IT support because of no claims processing</td>
</tr>
<tr>
<td>$29 PMPM</td>
<td>$18 PMPM</td>
<td>$11 PMPM</td>
<td>$8 PMPM</td>
<td>$5 PMPM</td>
</tr>
</tbody>
</table>

Note: PMPM costs are based on an average-performing plan with 2 million members. Source: Strategy&
narrowed and rationalized; services are streamlined — and, when they lie outside the plan’s expertise, outsourced.

Back-office costs are reduced by developing self-service channels and steering members toward them, automating operations, and maximizing the use of labor arbitrage. The use of outsourcing vendors and package solutions decreases corporate overhead and IT support.

Our analysis suggests that these actions can enable a lean operator to drive down administrative costs to as low as $18 PMPM — roughly 38 percent less than the conventional operating model (see Exhibit 3, next page). But is 38 percent enough? If the health insurance market was operating in a business-as-usual situation and competition existed within normal bounds, a lean model might produce a healthy competitive advantage for a plan. But in today’s environment, a 38 percent reduction in costs seems more like table stakes in a game that could end at any moment.

**Direct marketer model**

The direct marketer model offers health plans an opportunity to drive down costs by eliminating complex offerings from the product portfolio and marketing relatively simple products through direct channels.

This model is characterized by a streamlined front office, in which customer-facing activities are significantly limited. The rationalization of the product portfolio and the adoption of simplified benefit structures combine to reduce complexity in rating and underwriting. The dedicated use of private or public exchanges and other direct marketing channels disintermediates brokers and eliminates their commissions — generating the largest share of potential cost reduction for this model.

Middle-office costs for the direct marketer are no different than for the lean operator. In the back office, simpler benefit structures reduce customer service complexity for members and providers. As in other operating models, corporate overhead and IT support needs decrease in proportion to the simplification of the operating model.

Our analysis finds that the adoption of the direct marketer model could enable a health plan to lower its administrative costs to approximately $11 PMPM — a cost reduction of nearly 60 percent compared to the conventional plan (see Exhibit 4, page 11).
Direct marketer–medical cost innovator model

The savings potential of the direct marketer model can be further bolstered by a shift to even more integrated provider network structures, such as the patient-centered medical home (PCMH) and the accountable care organization (ACO). A direct marketer–medical cost innovator restructures its provider network around a small number of providers, which are virtually organized into outcome-based, capitated-payment settings.

In front-office operations, a closer relationship with providers creates an additional indirect sales channel, enabling a plan to reduce its sales costs. The targeting of advertising and promotional efforts is improved by the holistic understanding of members derived from closer integration with providers.

In the middle office, a plan can move away from FFS payments and leverage its close interaction with providers. Because the provider network is responsible for care coordination, preventive care, and wellness, this approach eliminates the need for plans to maintain care and disease management programs. The migration to ACOs and PCMHs also reduces the need for many FFS-related activities in managing provider contracts.
In the back office, customer service needs are reduced through simpler and more efficient claims processing. This also facilitates the easy adoption of self-service capabilities that significantly simplify the workload by reducing the member and provider services functions. However, these savings are tempered by the additional IT capabilities needed to integrate providers into the plan’s information systems.

The direct marketer–medical cost innovator model can reduce administrative costs to $8 PMPM. This represents a cost reduction of approximately 70 percent compared to the conventional operating model (see Exhibit 5, page 13).

**Risk and network aggregator model**

The risk and network aggregator model is the most radical rethinking of the conventional operating model available to today’s health plans. It reduces the number of providers in the network to just a few large, integrated organizations that cover the full continuum of care.

Front-office costs remain in line with the direct marketer–medical cost innovator model discussed above. But middle-office costs are reduced because the risk inherent to health outcomes is transferred to providers.
via capitated payments. This approach also eliminates the complexities of provider contract administration and minimizes network management costs, although it does require additional network management activity in order to build and maintain integrated networks.

In the back office, limited billing and greater collaboration and integration with provider systems reduce provider call volume. Claims processing is largely eliminated via capitated payments and full integration with the provider’s office systems. Capitated payments also eliminate multiple claim payments, minimizing billing complexity. Direct connections to provider systems are used to track the encounters with patients. Corporate overhead is reduced in proportion to total operating spend, and IT support costs decline with the elimination of claims.

Our analysis of the cost drivers in the risk and network aggregator model reveals that administrative costs of $5 PMPM and less are attainable. This represents a cost reduction of more than 80 percent compared to today’s conventional operating model (see Exhibit 6, page 14).
Exhibit 5
A direct marketer–medical cost innovator model could drive down operating costs by more than 70 percent, to $8 PMPM

Note: Savings are calculated relative to the $29 PMPM health plan. Source: Strategy&
Exhibit 6
The risk and network aggregator model can drive down administrative costs by more than 80 percent, to $5 PMPM

<table>
<thead>
<tr>
<th>Front office</th>
<th>Middle office</th>
<th>Back office</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating &amp; underwriting</td>
<td>Product development</td>
<td>Care mgmt.</td>
<td>Customer service</td>
</tr>
<tr>
<td></td>
<td>Sales &amp; marketing</td>
<td>Disease mgmt.</td>
<td>Claims processing</td>
</tr>
<tr>
<td>Commissions</td>
<td>Commissions</td>
<td>Pharmacy &amp; other</td>
<td>Enrollment &amp; billing</td>
</tr>
<tr>
<td>Advertising &amp; promotion</td>
<td></td>
<td>Network mgmt.</td>
<td>Corporate functions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Support IT</td>
</tr>
</tbody>
</table>

|                      |                       |                      | Note: Savings generated |
|                      |                       |                      | are calculated relative to |
|                      |                       |                      | the $29 PMPM health plan. |
|                      |                       |                      | Source: Strategy& |

|                      |                       |                      | $0.25 |
|                      |                       |                      | $0.09 |
|                      |                       |                      | $1.00 |
|                      |                       |                      | $0.30 |
|                      |                       |                      | $0.40 |
|                      |                       |                      | $0.60 |
|                      |                       |                      | $0.65 |
|                      |                       |                      | $0.50 |
|                      |                       |                      | $0.62 |
|                      |                       |                      | $0.10 |
As these models demonstrate, incumbent health plans could radically transform their operating models and capture dramatic reductions in costs. In reality, of course, change of this magnitude is always difficult to achieve. It would involve a significant — and, in some cases, fundamental — rethinking of how a health plan plays and wins in the marketplace. In addition, many plans will have to overcome corporate cultures steeped in outdated assumptions, inertia, and entrenched interests. If past results are indicative of future performance, many plans will acknowledge the need to change the way in which they do business, but only an enlightened and courageous few will actually change. These are the companies that will shape the future, instead of being shaped by it.

It is clear that the greatest reductions will come from clean-slate thinking about how a plan operates and, beyond that, about its strategy and positioning in the market. Is $5 PMPM a feasible target? Certainly, it is possible. Moreover, it is a target that new competitors, such as large, integrated provider organizations, could hit sooner and more easily than established health plans. Such a competitor could take a bottom-up approach to operations, setting up a very lean and limited set of functions that would enable it to behave as a very simple health plan and capture market share from the existing players. In fact, new players in the market are already working toward this end, with increasing interest and activity levels.

We offer $5 PMPM as a call to action. Use it to convince your organization that it must either proactively and ambitiously reshape itself or face the existential threat of disintermediation.
Strategy& is a global team of practical strategists committed to helping you seize essential advantage.

We do that by working alongside you to solve your toughest problems and helping you capture your greatest opportunities.

These are complex and high-stakes undertakings — often game-changing transformations. We bring 100 years of strategy consulting experience and the unrivaled industry and functional capabilities of the PwC network to the task. Whether you’re charting your corporate strategy, transforming a function or business unit, or building critical capabilities, we’ll help you create the value you’re looking for with speed, confidence, and impact.

We are a member of the PwC network of firms in 157 countries with more than 184,000 people committed to delivering quality in assurance, tax, and advisory services. Tell us what matters to you and find out more by visiting us at strategyand.pwc.com.

This report was originally published by Booz & Company in 2012.

www.strategyand.pwc.com

© 2012 PwC. All rights reserved. PwC refers to the PwC network and/or one or more of its member firms, each of which is a separate legal entity. Please see www.pwc.com/structure for further details. Disclaimer: This content is for general information purposes only, and should not be used as a substitute for consultation with professional advisors.