

Inside the Plan Podcast Series

Featuring Don Antonucci, President and CEO of Providence Health Plan

[00:00:00] Don Antonucci: When you really look at the pressure on the financials as a health insurer and wanting to create affordable care and deliver on that mission and promise, you have to have a culture that's different than it was for sure 42 years ago, let alone five years ago. And you also have to make sure that all the things you talked about, Medicare stars, risk adjustment, actuarial pricing, technology, we use, the facets claims platform, all of that has to be really humming on all cylinders to be able to get the type of performance that we need inside of a provider owned plan.

[00:00:35] Craig Savage: Welcome to Inside the Plan. I'm Craig Savage, Managing Director and head of the Health Plans and Managed Care practice within the Health Industry group at Alvarez and Marcel. I'm joined today by my colleague and cohost, Managing Director Mike Epstein. Today we're pleased to welcome Don Antonucci, President and Chief Executive Officer of Providence Health Plan A and M, recently published a white paper examining the CFO and CEO perspective on the future of vertically integrated health systems, specifically the financial, operational and strategic implications of provider sponsored health plans. Don joins us to explore a critical question facing many health system leaders. Are provider sponsored health plans strategic bridges to integration and long term resilience or do they risk becoming capital intensive anchors that strain liquidity and dilute leadership focus?

[00:01:40] Mike Epstein: Welcome Don. We're looking forward to today's conversation and understanding how Providence Health Plan supports the providence health system's 2030 strategy.

[00:01:51] Don Antonucci: Thanks for having me, Craig and Mike really appreciate it.

[00:01:54] Craig Savage: In the paper we argue that provider sponsored health plans were originally positioned as strategic hedges intended to offset shrinking fee for service margins, capture premium revenue and accelerate the move towards value based care. The theory was fairly straightforward. If a system could finance care as well as deliver it, it could better control total cost, retain margin and strengthen enterprise resilience. But what we're seeing nationally is a growing divergence. For some systems, the plan has become a true strategic asset, a bridge to integration, scale and long term competitiveness. For others, it has become capital intensive and dilutive, an anchor that traps reserves, pressures liquidity and diverts leadership attention. From your vantage point, what was the original strategic promise behind launching your health plan and how has that thesis evolved as market realities have changed?

[00:02:54] Don Antonucci: Thanks for the question. So I would first just back up by saying Providence Health Plan is part of Providence and the health plan is about two and a half billion dollars in revenue today and providence is about 30 billion. Very provider focused and we operate heavily in one of Providence's seven states in Oregon and then we have a little bit of membership in Washington and then also California.

I would go back 42 years, which is how long the health plan has been in place. So the original intent and Providence has been around for 170 years, is truly around mission. Serving the vulnerable and poor is part of Providence's mission. And then also, and this was developed in recent years, our promise to know, care for and ease the way of members that we serve, of patients and providers. The reason I start there definitely hear what your question is. I've worked at nonprofit payers. I've worked at for profit, publicly traded. I think going back maybe even four or five years ago, it was much more about what you said. How do we not only first and foremost serve on our mission, but capture the full economics of and really have that focus on population health.

The key thing I would say that's shifted and changed not just for Providence but across the country is the financial pressure across the entire system. So Covid came, we saw the financial pressure that hit heavily on providers when that started and then as we've seen recently, that's hit payers. And why, you know, and this is just some of it, you've got Medicaid that pays something like 60 cents on the dollar for every dollar of care. You've got Medicare Advantage that pays 80 cents on the dollar for every dollar of care.

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And the commercial shift that we know about that's always been shifted to employers has only been exasperated because of the financial pressures on delivery systems, inflation, labor costs and all of that.

So I know this sets up the rest of our discussion. I think now we're very much in a place that each component of health care, of each component of the system has to absolutely be humming on all cylinders if you're going to be able to stay focused on that mission going forward because you can't afford to have just the financial losses in any part of healthcare. Absolutely.

[00:05:17] Mike Epstein: Yeah, that's a great point. You know, the market is showing polarization. There's a handful of large provider sponsored health plans that have scale and capabilities. But what we're seeing is a, a larger group of subscale plans facing structural headwinds and financial headwinds as you just articulated. How would you describe Providence health plan when you assumed the CEO role? What were the most pressing challenges you faced?

[00:05:46] Don Antonucci: Well, looking back, I've been here four and a half years and the key challenges really were related to the pressure on the broader Providence from a Financial standpoint coming out of COVID and Providence is still very much in the midst of its turnaround and lots of great momentum happening there for Providence as a delivery system.

But I look back four and a half years ago and the health plan was still newly just coming out of a structure where it was part of really Oregon in that Oregon delivery system, part of Providence and became much more a separate PNL as part of Providence. So when I look back, what we've done over the four and a half years is focused on. What I like to just say is we call ourselves focused on being a brilliant at the basics health plan. Now easier said than done. What that means inside of a provider sponsored plan when you're two and a half billion dollars of \$30 billion and the focus is very much the things that have to sustain a provider side is how do we make sure that we pay claims accurate and well. How do we make sure the technology is in the best position it can be? How do we make sure our customer service continues to have the great reputation but is wrapped in technology to help those people. But most importantly we had a lesson I think for ourselves is how are you brilliant at the basics in achieving things like Medicare stars of four stars or above. We had three and a half stars for the first time in a decade for the year 2025 revenue. And that was a huge hit for the health plan for Providence. So we did everything to get back to four stars and got that for 2026 and 2027. And right now we're working on 2028 revenue. So that's an example of a lot of hard work because as you know, getting four stars or better in Medicare Advantage as a health plan of our size, we today serve about 65,000 members is a lot of work. It only is getting harder. But I think these are all things that you've put in your, in your paper as well. We also have to be brilliant. The basics at risk adjustment. We want to make sure that we're accurately coding. We want to make sure that we're within compliance. But there's a whole lot of work, technology, people and resources and sophistication levels that had to advance over those four and a half years to get us to a place where we can feel really good about that business. Now the ultimate goal still remains. I'll tie back to the mission. You know, Medicare is a great example. Some of the most vulnerable in our population back to that promise to know, care for and ease the way of those members. But to do that being four STAR is a threshold from my perspective as a provider sponsored plan so that we can actually have the financials that allow us to invest back into benefits and the communities that we serve. So that would be one example of one second for us.

[00:08:32] Craig Savage: Don, you mentioned star's performance risk adjustment broadly as you think about building a durable payer grade organization which is fundamentally different than the provider side, which capabilities prove most mission critical to get right. So you mentioned STARS risk adjustment. What about actuarial pricing discipline, the distribution strategy, regulatory compliance? And candidly, which of those capabilities were most difficult to stand up organically within a very provider centric enterprise? Where did you underestimate the lift? Whether it was in talent, infrastructure, you did mention technology or the cultural shift.

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[00:09:14] Don Antonucci: Well, that last part that you just hit was huge. The cultural shift is huge. It goes from a place when I say, when I said brilliant, the basics health plan, I think that's also a signal for the culture had to shift where we had to be, you know, really brilliant at those basics. In terms of all the things that you would expect a health plan to be able to do. You pointed out actuarial and pricing huge.

That is a significant one, especially with the disruption that's been happening on the provider side. You know, today 30% of our utilization is through Providence as our key partner and delivery system. 70 outside of it, we also have our own pharmacy benefit manager. We don't call a pharmacy benefit manager, we call it pharmacy services.

But it's a transparent model that we're proud of. But when you really look at the pressure on the financials as a health insurer and wanting to create affordable care and deliver on that mission and promise that I talked about, you have to have a culture that's different than it was for sure 42 years ago, let alone five years ago.

And you also have to make sure that all the things you talked about, Medicare, stars, risk adjustment, actuarial pricing, technology, we use the facets claims platform, all of that has to be really humming on all cylinders to be able to get the type of performance that we need inside of a provider owned plan.

[00:10:36] Craig Savage: In the paper we also challenge what we call the false neutrality trap. Don, that's the idea that plan losses can be rationalized because of hospitalization offsets them. On the surface it can look very much like a left pocket, right pocket transfer. But once you account for leakage, administrative overhead and regulatory reserves tied up under RBC requirements, the enterprise economics often tell a very different story.

So when you stepped into your role at Providence, did you have a Truly unified enterprise pm, PM view that fully integrated your plan and provider performance, both of those, a full enterprise view. And if not, how did you go about creating that transparency across the balance sheet?

[00:11:22] Don Antonucci: Well, so the answer is no, we did not have that full enterprise view. And I would even go as far as to say we didn't even have a true health plan sort of standalone view. And what does that really look like? Where are we maybe not as efficient as we should be. Where do we need to be more efficient?

So through that four and a half years, through a lot of hard work with my team, where we are now is we have a really clean view of the P and L of the health plan.

And what I would say we still don't have, and I don't hear many that fully have this, is that full enterprise integrated view. So just to be clear, it gets really tricky and part of that is literally because there's been so much work that the provider side has to do to be able to serve their business, especially at a time of high pressure and that the health plans had to do while we have some of that, and we've had some of that for years. But getting that to the place where it can be is the real value here. Now, I did mention 30% of our of our business is through Providence and that's where we also have pharmacy, you know, business that's separate. We also have 70%, you know, other providers. So I think there's challenges and advantages of being a provider on health plan. The challenges are things that you're talking about with how do you look at the financials? Many times the goals of a payer are going to be very different than that of a provider. And the opportunity though is what you talked about is how do you actually move towards more population health? How do you move more towards value based care? We have an opportunity, a much deeper level of communication. We can see things. I could see some of these things that were going to happen from a contractual standpoint more broadly in the marketplaces, because I understood uniquely from a provider perspective, which I didn't have before my four and a half years here, of the pressures that they were facing. And now we're seeing things like contracts that used to be resolved between payers and other providers, just not ever coming together where they'd always come together at

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the last minute. We're seeing providers start to say, you know what, I can't serve all of these Medicare Advantage plans. I'm going to be selective or I'm not going to. There's Examples of some right in other regions outside of Providence that have totally pulled out of government programs like Medicare Advantage from a provider standpoint. So those things can be advantages in terms of being able to kind of see where the puck is going and be able to skate to it. But there is also those unique challenges that come with being a much smaller piece of a very heavily driven provider organization, which is what Providence needs to be able to do to be able to serve patients.

[00:14:04] Mike Epstein: So you, you said that when you joined there wasn't good reporting and visibility. So what have you put in place, you know, over the last four and a half years? And how is that influencing decisions between you and the health system?

[00:14:20] Don Antonucci: It's really been a lot of what I would almost call if you're a standalone payer, where I've been, I've worked with a lot of blue plans over the years and other places.

It's really just back to that brilliant the basics notion for finance, for actuary, for underwriting. It's making sure that those people have the right technology underneath them so that they're not just guessing at what the pricing is going to be. The other big, big achievement that we had, and we were able to complete this at the end of last year, and not a lot of health plans can say this, let alone provider sponsored plans, is there's a lot of talk out there about AI. There's a lot of talk out there about all these opportunities that exist with data.

We spent over a year focusing on getting clean data for the health plan through a lot of effort and some partners, and I'm very lucky to have another senior executive that had been there done that at other plans. And so we now have clean data sets that we can use either to enable AI or to enable financial reporting and underwriting tools that we didn't have before.

So it's been a very focused investment on those areas. And then I would say also quite a bit of investment and focus on just our operations and, you know, how many claims are we processing and auto adjudicating? What are customer service key performance indicators? The interesting thing about that though is because of our mission and our promise and who we are, Providence Health Plan has always had the most amazing people and reputation in the market. However, when you start to look behind the scenes four and a half years ago, there was a whole lot of additional work happening to get to that place where we could serve our members. So the idea has been also how do we bring the right tools and technology to make it easier for our employees, which we Call caregivers at Providence Health Plan along with the rest of Providence. Easier to be able to serve that promise that we talk about with our members. That's great.

[00:16:18] Mike Epstein: The paper also outlines five pathways CFOs can choose, each with capital and liquidity implications as they're evaluating, you know, the, the opportunities and growth. You know, one's doubling down. Second one is joint ventures or outsourcing. Other is consolidation for scale, exiting markets and then refocusing on self funded ERISA plans. Looking forward, are there specific options you at Providence are considering and why?

[00:16:52] Don Antonucci: We are considering all of the above at any point in time and continue to work towards those. Because we understand in the past when somebody said is scale important? What I would have said is yes, scale is important, but we can also partner and get some of that scale. I think it's becoming more and more difficult to be able to do that. So we continue to look for different innovative partnerships opportunities. We're always having conversations and at the end of the day, what actually makes me feel really good about this is it seriously. I know I keep repeating this comes back to our mission and to our promise. What is really best at the end of the day for a member or for a patient and are we uniquely served to be able to do that? You know, I always talk about just in business overall, people do business with people that they know, that they like and that they trust. But that's not enough.

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You got to have perceived differentiation and the way to have that is actual true differentiation. So what is that? I'll give you an example because you mentioned self funded. We realized pretty quickly that the demands of self funded employers, which we know are immense around digital capabilities, around point solutions, around making sure that that's integrated with something. Because we are a provider sponsored plan that we did not have the capital to go and invest in, nor the time to spend five years or whatever it might be to get to that point. So we created in this case a partnership and moved all of our self funded business and have been moving it to a third party administrator called Collective Health and we call it Providence Health Plan powered by Collective Health. We did that because overnight through that partnership we were able to get those digital capabilities and we were able to get some of the things that we were hearing in RFPs that we needed. Now I tell you back to cultural, that was really tough because that meant customer service or self funded business, that meant utilization management, all that moves over there. And there's always bumps in the roads with transitions like that. Right. So we're Working through, continuing to work through those as we move some of our largest business.

But that's an example of where we've looked to pick for partners that were aligned with our values and also brought the capabilities and the scale because in that case they have scale in a different way on the self funded side. So all the things that you mentioned we consistently look at and I would say because we're now in this position with the four stars, the operational brilliant, the basics and who we are, we're much better positioned to be able to take advantage of the opportunities as they come up and as those conversations continue.

[00:19:19] Craig Savage: Thank you Don. One last reference to white papers. So in the white paper we outline a series of viability gates scale, Capital adequacy and RBC strength stars trajectory, peer grade leadership depth and a fully integrated enterprise PMPM view. These sets of gates are determined whether a plan is functioning as a strategic bridge or operating as an anchor. If you pressure test your plan against those gates today, where does it land? What deliberate moves, whether it's capital, talent, governance or portfolio strategy enabled you to reach this position? And as you look ahead, what strategic refinements are still necessary to sustain that classification over the next three to five years?

[00:20:04] Don Antonucci: Yeah, well it's about continuing on the trajectory that we got with the health plan. It's about making sure that the financials not just in Medicare Advantage but every single line of business line up for us. It's about even though we're not quite there yet from a week by week, month by month, integrated P and L or integrated per member per month, how do we start to move towards that now that we have that clean data on the health plan side? And then what are those opportunities in interoperability with the provider side, whether it's Providence or other, other ecosystem partners focused on population health. So that to me is that and that's the last mile really for us and anybody is who's going to do that best to actually be able to care for the health of a population with all the pressures that we're seeing, like I mentioned, I mean we've talked about a lot here but there's the provider pressures, there's the payer pressures, there's the government reimbursement pressures and unknown, you know, future. There's HR1 that's come out and as people know as more pressure goes on Medicaid and more people are learning, guess what, somebody has to go to the ER and they don't have Medicaid where they're going to the ER still. And Guess what? That's picked up as uncompensated care. And then that cost shift continues. So we're at a point in health care, let alone whether it's Province Health, my providence or anybody in the country, that this is a system, from my perspective, that's broke. And we now have this window of time. And when I look at Oregon and what's happening with leaders and starting to come together and figure out how do we start to close some of these gaps in the state, we're in this window of time where everybody's got to perform at their best in each one of these categories. I think what's changed for me is just the speed with which this has to happen.

And that integrated PMPM that you're talking about, you know, you could talk about that more broadly, is the last place where I think, and that really starts to speak to value based care that we have to get to. And that's at a time, you know, from my perspective today, I don't see a whole lot of providers wanting to take on additional risk at this point. So something's going to have to shift and change because, you know, I

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think there's, like I said, the payers are under pressure now as well. We see the pharmacy costs going through the roof. So something's got to shift and change. And that's what also makes me optimistic here is because as people continue to look at opportunities with AI, with technology, with improving operations, with taking cost out, then that's the only way that we're going to get to the other side of this, to a place that would serve as a health plan or a health care experience that you would want for your family, for your friends. And we just don't have that today consistently.

[00:22:51] Craig Savage: Yeah. Well, Don, thank you. Really appreciate spending a little bit of time with you today learning more about the Providence Health plan. Two things that really stand out for me coming out of this conversation. One is the importance of being brilliant at the basics. And then secondarily, which I think is really important for provider sponsored health plans, is continuing to be anchored to your mission. And I think those two sort of principles, if you will, really, it sounds like to me underpins the last four to five years and what you've been able to build at Providence Health Plan. So again, thank you for your time today. It's been a pleasure.

[00:23:32] Don Antonucci: Thank you for having me here. Really appreciate it.

[00:23:35] Mike Epstein: Thanks Don, for joining us. You know, your story really highlights what's possible in a provider sponsored health plan when you lead with purpose, innovation and more importantly, commitment to patient and member outcomes. I'm hopeful that other plans will listen to this conversation, reflect on your journey, and find inspiration on what they can apply within their organizations.

[00:23:59] Don Antonucci: Thank you.

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