



Health insurer of the future

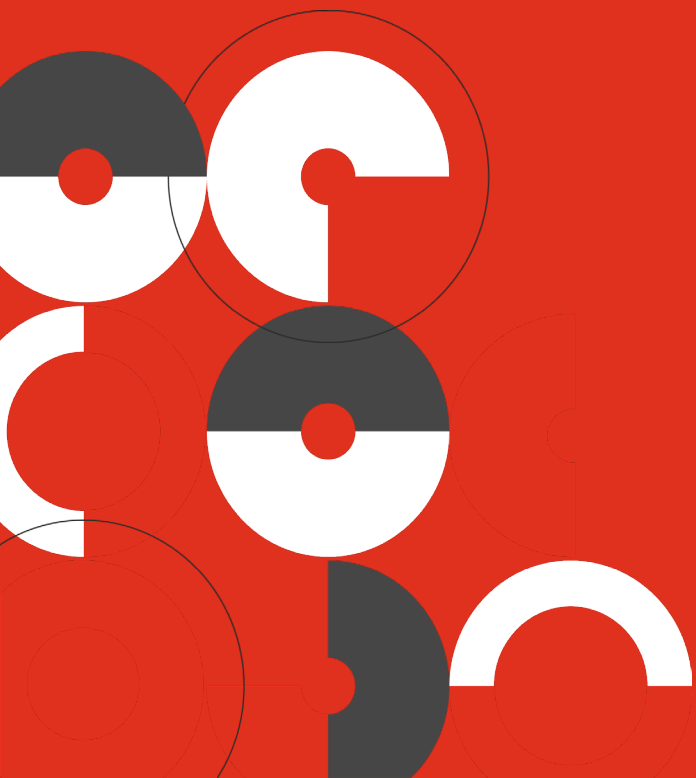
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Introduction

Health insurance is among the fastest growing industries globally, and the pandemic further accelerated its growth in the past two years. The pandemic has also driven health awareness among consumers and accelerated digital adoption and the evolution of healthcare ecosystems. Health insurers need to reinvent their business models to adapt to the rapidly evolving industry.

In this publication, we identify the major trends shaping the future of health insurance and explore the current state of insurer models across regions, outlining the challenges and opportunities faced in adopting these models. This report is based on insights and market knowledge from our internal network of professionals who work closely with health insurers across the world.





Major trends currently affecting the future of insurance¹



Widening health protection gap

The health protection gap refers to the financial burden faced by households, including hospital bills that are uninsured and avoidance of costly medical treatments. The gap is expected to worsen with the trend of increasing longevity and an ageing population. Based on PwC's *Insurance 2025 and Beyond*,² the global protection gap of US\$1.4tn in 2020 is estimated to widen to US\$1.86tn by 2025, with almost half of the risk attributed to the Asia-Pacific region.

Various healthcare stakeholders are working to bridge the gap by offering government health plans, microinsurance and improving access to affordable healthcare. Specifically, health insurers play an important part through their initiatives in targeted product offerings, digital distribution and raising health awareness among their policyholders.



Rapidly evolving customer needs and preferences

COVID-19 fast-tracked the adoption of telehealth support services such as virtual consultations, remote monitoring and digital patient engagement tools following the disruption to in-person healthcare. HealthDay news³ reported that compared to the pre-pandemic levels, the utilisation of telehealth increased by more than three times during the beginning of the pandemic, and further increased by close to four times one year later. Consumer willingness to use telehealth and investment in digital health have also increased. All in all, telehealth services are here to stay.

Furthermore, value-added services included in health insurance policies expanded from providing support at the point of claim (e.g. access to a second medical opinion) to providing lifestyle-related benefits such as early health screening and mental health support.



An increasingly digital and AI-driven world

Consumers also demand hyper-personalised clinical interventions through precision medicine and personalised treatments. In response, there has been steady adoption of genomics among healthcare providers when tailoring treatment plans and drug prescriptions. This helps improve clinical outcomes, reducing the cost of treatment and overutilisation due to relapses.

Wearables have long been used in health insurance, capturing physical activities and health measurements (blood oxygen saturation, breathing rate and heart ECGs). They provide ongoing insights into customers' health and lifestyle data. This allows for continuous risk assessment throughout a customer's insurance policy for insurers, in contrast to relying on medical records that are available only at the point of claim.

Pairing artificial intelligence (AI) with this new source of data, advanced data analytics can provide deeper insights into the medical claim cost and employ these outcomes for management of provider networks, claims, pricing and risk management. AI is also often used to improve customer service engagement through chatbots and to improve operating efficiency through robotic process automation, claims adjudication and predictive analytics.

¹ <https://www.pwc.com/gx/en/financial-services/fs-2025/pwc-insurance2025.pdf>

² Ibid.

³ <https://consumer.healthday.com/telemedicine-2658609541.html>



Focus on ESG

Recent years have seen increased awareness about value-based care that aims to prioritise preventive services and benefits that are cost-effective in the long run. This ultimately avoids unnecessary and excessive treatments and contributes to reducing the large carbon footprint of healthcare systems.

Aside from the environmental impact, insurers bear a large social responsibility to their stakeholders. To strengthen the 'S' pillar, the key focus is caring for staff beyond employee benefits and wellness. Workplace safety, employee engagement, diversity and inclusion are additional factors for management consideration. Likewise, these aspects should be extended to agents and distributions.

A robust ESG plan for health insurers should encompass:

- contributions towards the development of microinsurance, rural and social sector coverage, and government-led programmes
- setting of terms and rates based on the insured's or reinsured's adherence to ESG
- implementation of strict discipline in the supply chain and sourcing policy for vendors, distribution partners and bancassurance deals.



Convergence, collaboration and competition

In today's customer-centric business environment, insurers need to continuously create new value propositions for customers. No longer driven by competition for market share and unhealthy price wars, insurers need to identify and explore new avenues to reinvent themselves. This comes in the form of collaborations with other insurers, InsureTechs and healthcare providers, creating a new ecosystem in the process.

Developing an ecosystem business model requires a new strategic approach. An insurer can choose to be the orchestrator who leads and shapes the ecosystem, acting as the connecting hub facilitating and encouraging customer interactions while managing the web of partner organisations. Or an insurer can be a partner who provides a service or product to the customers of the ecosystem, integrating its service with the orchestrator platform and with the services of the other partners to provide one seamless proposition.





Current state of the health insurer

While understanding the current state of health insurers across regions, we have referred to the five models that PwC's Health Research Institute (HRI) identified.⁴ Health insurers are searching for that optimal model that balances customer satisfaction and provider relationship management while keeping their cost manageable.



Consumer Advocate

Current take and highlights

Empowers consumers through easy-to-understand, simplified plans and increased access to information. Often digitally enabled.

Health insurers initially adopted the Consumer Advocate model by setting up a direct distribution channel through their own website. They focus on selling simplified plans with minimal underwriting, allowing for a straight-through process without agent intervention. However, the additional cost and effort required to set up integration with legacy systems, staff training and low product profitability have hindered larger traditional insurers from growing this segment. Instead, it has attracted start-ups with strong digital capabilities to enter the market.

Over time, many traditional health insurers embarked on a digital transformation journey to expand their digital capabilities. Digitally enabled, health insurers' roles shift from sellers of insurance products to active health advisors. Customer mobile apps are elevated to a core digital platform that measures, maintains, and improves quality of health throughout the lifespan of a customer journey. With ecosystems enabling control of patient care quality, costs and information, health insurers are able to position themselves as fully integrated health and wellness companies, creating an all-encompassing engagement beyond the risk cover.

AI-powered mobile apps allow for personalised product offerings and communication according to the customer's needs and behaviour pattern. Based on how customers proceed through the buying process, richer benefits can be added on to the simplified base plan. Similarly, automated communications or offers can be triggered based on certain event changes, segment changes, profile changes or behavioural changes. Tailoring the traditional insurance experience of buying, policy servicing, claims and renewals for the individual customer helps in increasing the level of customer engagements, as well as cross-sell opportunities.

On top of improving the core insurance experience, the super-app integrates with various service providers in the ecosystem to provide all-rounded health solutions. A robust health ecosystem covers the customer journey at various stages of pre-claim, point of claim and post-claim. Such solutions include nutrition monitoring, fitness tracking, health check-up appointment booking, mental wellbeing, tele-consultation and second medical opinion.

Success stories

We have seen successful digital health ecosystems globally, such as Pulse by Prudential in Asia and Ping An in China. These platforms share the following success themes:

- delivering customer-centric services for the full customer lifecycle
- using data analytics to deliver personalised solutions
- developing ecosystems across the value chain with healthcare providers.

⁴ <https://static1.squarespace.com/static/599cb1c76f4ca34c4160199f/t/5a80ec478165f5c700b891ed/1518398537812/pwc-hri-payer-of-the-future.pdf>



In China, Ping An and Zhong An both gained success through their ecosystem model by playing different roles.

Ping An Insurance orchestrated five ecosystems on which it sells its products: finance, auto, health, real estate and smart cities. Its strategic health platform, Good Doctor, is the first app to enable multi-channel provider offerings. The AI-based app offers various medical services, including 24/7 online consultation, preventative care, post-diagnosis services, chronic disease management and medical alerts. The platform matches 70 million monthly active users with almost 100,000 medical providers.

Online-only insurer Zhong An focuses on the integration of technology into the value chain of insurance. Through its business model of partnership strategy, it has positioned itself in an ecosystem with over 330 partners, which enables it to efficiently serve the needs of its

customers. In recent years, Zhong An has started offering its core insurance technology to other insurers, facilitating digital transformation in the Asian and global insurance ecosystems.

While personalisation is available, hyper-personalised healthcare is still limited in the current model. Health data is highly sensitive – do customers trust insurers with their medical records and genetic data? To strengthen trust and confidence among consumers, health insurers can provide guarantees that no penalties will be imposed on people who are unhealthy. This creates an opportunity to tap into the impaired lives segment by offering impaired-specific wellness such as disease management programmes. This is also aligned with the industry’s ESG focus.



Bridge Connector

Current take and highlights

Facilitates the relationship between patients and care providers. Plays an active role in getting consumers the right care. Uses technology to enhance the provider and patient experience.

Health is a sensitive topic and today’s consumers still rely heavily on professional medical advice for guidance. A Bridge Connector health insurer aims to help patients understand the different treatment options and provide guidance in selecting the best care solution.

Traditionally, health insurers form a network of preferred providers, in which patients are awarded with reduced premium or richer benefits for visiting. By managing the provider network, insurers have control over the doctors and hospitals recruited into the network, hence giving them control over the cost and quality of patient care. Furthermore, health insurers leverage appointment booking services to steer patients to the right care. However, patients may feel that insurers have a vested interest in their recommendations as these relationships are usually bound through contracts – providers offer a lower consultation cost in exchange for volumes.

Health insurers need to promote transparency when forming the preferred network, with careful consideration of a wide range of clinical specialist areas, locations, reputations and options to better manage customer expectations.

In response, health insurers set up data platforms to facilitate provider selection by integrating clinical, claims, demographic and lifestyle data. The key challenges in building these analytical platforms include:

- regulatory restrictions on sharing medical data
- data integration between insurance and medical data
- integration of data analytics and clinical health knowledge.

Non-traditional partnerships between health insurers and healthcare services are growing. Strategic partnerships with providers of telemedicine, second medical opinion, chronic care management and ageing care allow insurers to better serve complex healthcare needs. In China, Munich Re established a health management platform connecting insurers and medical service providers seamlessly at low cost and high efficiency. The platform provides health advice, chronic disease management, medical VIP and concierge services.

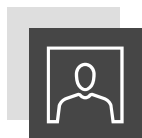


What is the proposition for providers?

The health industry is shifting towards the population health management model. Consumers are proactively managing their health by focusing on preventive care and investing in healthy activities such as exercise and diets to avoid the need for medical treatment. While this may initially be seen as shifting the power away from healthcare providers given the reduction in medical treatment, we have seen healthcare providers restructure their approach towards providing preventive care by featuring proactivity and personalisation.

While many providers are already offering health-screening packages, the results are usually not included in medical records or utilised for further intervention. With the restructuring, physicians now refer eligible patients for community-based intervention, such as smoking cessation or physical activity programmes. These preventive care visits can be enabled by a data platform that helps track, schedule and evaluate care activities.

Other structured programmes include those for patients and families at high risk of type 2 diabetes mellitus. Preventive strategies can be initiated early by family physicians through lifestyle interventions such as changes to diet and physical activity, medication and metabolic surgery.



Lean Operator

Current take and highlights

Prioritises gaining efficiencies with core health insurer functions (claims adjudication and payment, utilisation review, etc.). May partner with companies specialising in consumer engagement or provider enablement tools.

Reducing inefficiencies

Many health insurers are working to reduce cost by eliminating inefficiencies. The Lean Operator model tackles inefficiencies such as legacy policy administration and claim fraud.

Administrative costs such as claim administration and premium collection are the main avenues through which health insurers are cutting costs. Straight through processing for insurance allows the insurer to automatically process transactions without manual steps taken by an agent or intermediary. Processes which can be automated include background checks, medical screening and claim processing. Automation and algorithms take care of the entire process, offering consistency, productivity, lower operational costs and additional data. This automated approach eliminates back-and-forth communication which works well with millennials or Generation Z consumers.

Legacy policy administration systems (PAS) continue to hamper insurance companies' ability to grow. A PAS transformation provides the digital core needed to facilitate an agile and innovative organisation, a platform to improve customer and partner engagement, and to make advanced data analytics an integrated component of the business process.

With information now being stored almost solely electronically, it is important insurers develop specific competencies in line with developing technologies. Fraud is an ever-increasing threat to insurers. Applying advanced data analysis techniques can help with the identification of fraudulent transaction patterns and fraud networks. Cloud technology provides a further opportunity for digitisation – acting as a great enabler by helping carriers to configure and integrate quickly for innovation. Carriers that can scale up effectively, reduce costs, and offer competitive prices have a strong competitive advantage.



The Lean Operator requires strong leadership to reach its targets. A well-thought-out roadmap and sponsorship for the different cost-saving initiatives are essential to reach the finishing line. Strategic priorities, organisational resets and new ways of operating are all on the table as companies balance cost cutting with reinvestments for growth. Five steps to help cut costs in the right ways are:⁵

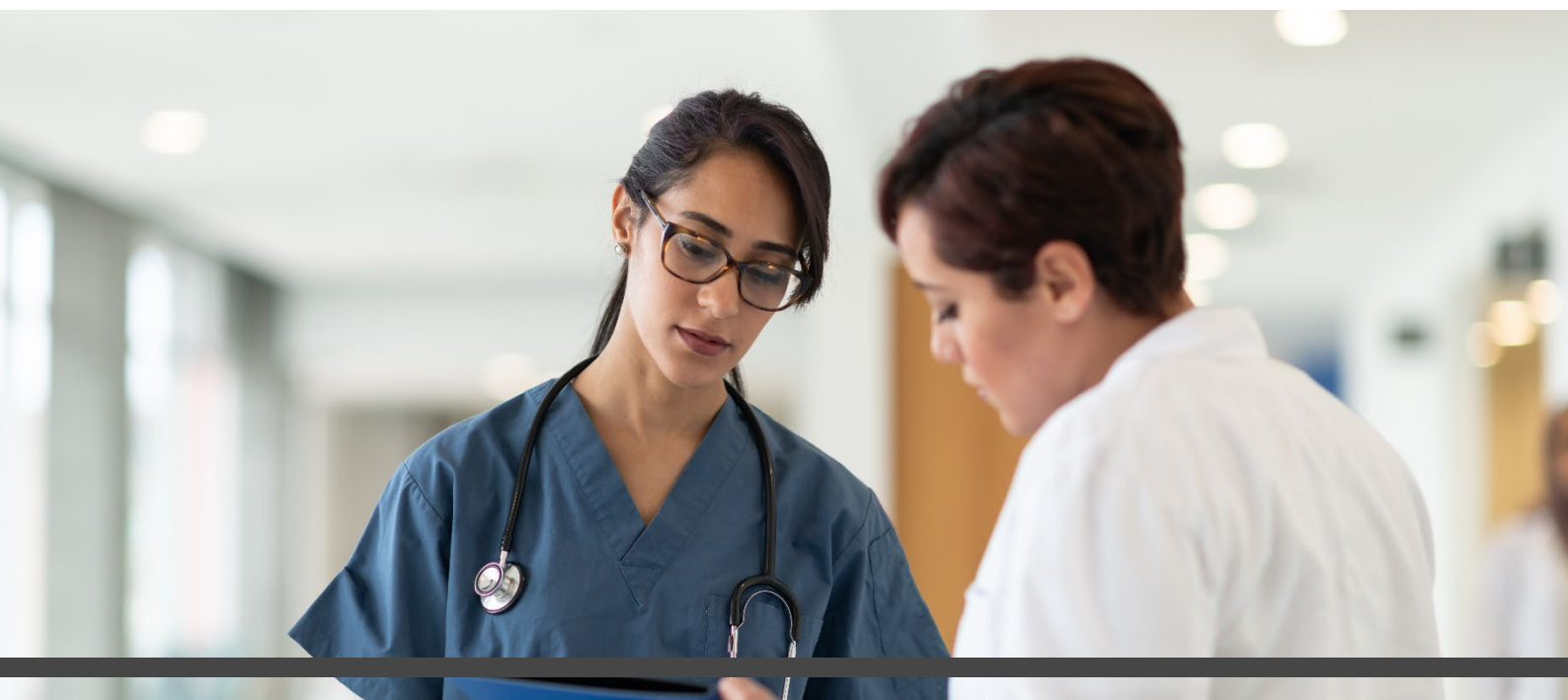
1. Start with strategy.
2. Align costs to strategy.
3. Aim high.
4. Set direction and show leadership.
5. Create a culture of cost optimisation.

Rising healthcare costs

Rising healthcare costs are a global problem, with constant pressure to reduce these costs. Increased costs are driven by ageing populations, specialised treatments, overhead costs for digitalisation and inflation. Global healthcare expenditure as a percentage of GDP increased over the past decades from 8.5% per year in 2000 to 9.8% in 2019, according to the World Health Organization.⁶ COVID-19 brought about a spike in global health expenditure, as resources were steered towards fighting the pandemic. Future healthcare costs are expected to continue growing, but at a more stable rate. Moving forward, healthcare costs are likely to be due to prevention, diagnostics and digital solutions, instead of treatment and care.

Inflation has reached a level not seen in decades due to rising energy costs following Russia's invasion of Ukraine and economies opening up again after long lockdowns resulting from the COVID-19 pandemic. Healthcare costs have not yet risen at the same rate as other forms of consumption because costs of health services, prices and labour are set two to three years in advance. However, when these contracts are due to be renewed, the costs are expected to rise in line with inflation levels seen by general consumers. Healthcare providers will seek compensation for higher costs of healthcare delivery systems from healthcare payers, including health insurers.⁷

The Lean Operator model plays a small role in reducing healthcare costs, such as claim adjudication. The key solutions, for instance, provider management and product proposition, lie in the other four models. In the long run, it is key to be fully technology enabled, ranging from client-facing services to business and internal processes. This will help in creating an agile and innovative organisation that makes optimal use of data.



⁵ <https://www.pwc.com/gx/en/insurance/publications/firing-on-all-cylinders-five-steps-to-strategic-cost-reduction.pdf>

⁶ <https://apps.who.int/iris/bitstream/handle/10665/350560/9789240041219-eng.pdf>

⁷ <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/consumer-prices-are-rising-fast-and-healthcare-isnt-far-behind>



Analytic Sensor

Current take and highlights

Uses data analytics to give providers insight into the health of populations and provides solutions to help manage them. Pushes providers to value-based models to encourage keeping patients healthy.

Big data and health insurance analytics are a norm in the industry. They allow deeper understanding of customers, what they value, what challenges they face and their lifetime value – enabling personalised experiences and anticipation of needs. Investing in data analytics technology enables health insurers to be both an Analytic Sensor and Consumer Advocate.

Many insurers offer incentive-based health and wellness programmes, aiming to encourage a healthier lifestyle by incentivising customers through rewards. These are usually monetary rewards through reduced premium or an indirect reward through coaching for well-being. For example, in India, Aditya Birla Health offers up to 100% return of premium if a policyholder remains active for an adequate period. Yet, do these programmes actually improve health and reduce claims? The early detection and preventive approach helps a health insurer manage medical costs. From a life insurer perspective, maintaining a healthy lifestyle is expected to improve longevity which may act as a double-edged sword.

There has been a general global increase in the adoption of electronic health records (EHRs). EHRs digitally capture every source of information on a patient into one database, including medical history, data from treatments, diagnoses, prescriptions and immunisation records. This massive volume of data enables EHR analytics, mining data for insights to improve quality of care. It also helps reduce medical errors, provide more accurate treatment and preventive care, and predict the cost of treatment.

The sharing of insights between insurers and providers may reshape the health insurance value chain. Sharing healthcare information helps both parties increase administrative efficiency, improve care coordination and patient outcomes, hence reducing costs and enabling value-based care.

However, there remain significant barriers to data sharing – concerns about data security, patient privacy and fear of giving up a competitive edge. Insurers and providers must work together to overcome the challenges, in particular for value-based care models where providers and payers must collaborate deeply to improve care quality and reduce costs. It is important to advocate for regulatory mandates, implement strong privacy policies and data encryption, and use health information technology to ensure secure data sharing.

Value based-care

Value-based care aims to provide cost-effective care that links to better clinical outcome and patient's reported perspective post-treatment. COVID-19 has caused a major disruption in the healthcare system, specifically in elective and chronic care services. It eliminated the overuse and abuse of unnecessary medical treatment, to focus resources on the most important cases. It is expected to accelerate the adoption of value-based care.

The demand for value-based care has grown in recent years, with the growth of the ageing population challenging healthcare resources, along with a shift towards population health management and an integrated care delivery model, and rising demand for personalised experience, choice and informed shared decision making.

The major funding models include:

- Fee-for-service: Payment is for each service provided.
- Outcome-based Funding: Payment is outcome-orientated.
- Shared savings: Incentivise healthcare providers by giving them a proportion of the actual savings achieved, based on accomplished pre-defined outcomes.
- Capitation-based funding: Payment is based on the performance of healthcare providers in terms of quality, costs, coordination and prevention.



Moving towards a value-based funding model shifts the risk from the health insurer to the healthcare provider. Under the commonly used fee-for-service model, health insurers face the highest financial risk. The financial risk is expected to reduce as the funding model starts accounting for the outcome of medical care and is minimised under the capitation-based funding model. The shared savings model is expected to most evenly split the risk between health insurer and healthcare provider, depending on the level of profit sharing agreed.

A successful implementation of value-based care should prioritise a patient's perceived state and feeling post treatment and be engaged to collect information on what outcomes matter to them.



Care Integrator

Current take and highlights



Integrates vertically to align incentives, improve care coordination, tackle utilisation and keep medical costs low

Conflict between payer and provider has always been an issue in the health insurance industry. Health insurers attempt to interfere with medical treatments by implementing pre-authorisation and step therapy. While these initiatives help insurers control overcharging and over-treatment, it restricts providers in recommending the best treatment to patients due to cost constraints.

The care integrator health insurer combines both health coverage and care delivery under one roof, aligning KPIs of both parties and sharing the risk of insurance and provider performance. Unlike the Bridge Connector, health insurers are repositioning themselves from merely a payer to a payer-provider. Health insurers can better manage costs with transparency of health protocols and actual medical costs incurred. They are well positioned to align and coordinate members' health coverage with appropriate treatment plans and hence have control over customer satisfaction with better care. Tapping into the value pool of providers enables diversification for long-term success and sustainability.

With the industry's push towards value-based care in the United States, there are many successful case studies to leverage. In particular, Kaiser Permanente offers both insurance and healthcare. Its success is driven by a few overarching principles:

- All parties share the same goal to deliver extensive and synergetic healthcare services to keep patients as healthy as possible
- Close coordination between primary, secondary and tertiary care. It provides seamless care delivery for members and improves quality of care with communication across healthcare providers.
- A good IT system that allows data integration across the entities. In particular, data integration challenges would be easier to overcome under one roof. It stores all medical information of the patient, including past treatments, tests results and appointment bookings.
- Work closely with hospitals that are not owned by the group, deeply integrating with the hospital operations and proactively tracking medical costs to facilitate rate negotiation.
- Extensive use of care pathways that outlines the roles and responsibilities of each healthcare staff member, i.e. physicians, nurses and pharmacists, to support clinical decisions.

Alternatively, health insurers can invest in smaller healthcare providers such as daycare centres, imaging laboratories and emergency centres, which require a much lower cost than acquiring a large hospital. In the United States, mergers and acquisitions across insurer and healthcare providers are creating an integrated healthcare powerhouse – CVS and Aetna merger, UnitedHealth Group's Optum acquiring doctor groups and physician practices, and others venturing into primary care clinics, home health and hospice assets.

In other parts of the world, health insurers are still holding onto the traditional provider network concepts with enhanced preferential treatment and forming strategic alliances as per the Bridge Connector model. Countries such as the Netherlands and Thailand have strong jurisdiction that disallows vertical integration in the healthcare ecosystem. Other countries lacking government policies on vertical integration do not incentivise health insurers or providers to invest in this model. On the other hand, in Sweden and Singapore, local regulators are advocating for value-based care nationally, hence pushing the demand in the region.

Adopting the Care Integrator model requires a high level of investment – health insurers need to ensure a steady stream of revenues, strong solvency position and a long period of discovery to identify the right acquisition or partnership. Additionally, the full integration process on operations, governance and data is a long-term project that requires strong leadership at the top to drive collaboration between both parties.





A comparison of the health insurance models



High

Low

	Consumer Advocate	Bridge Connector	Lean Operator	Analytic Sensor	Care Integrator
Model adoption					
APAC					
EMEA					
India					
Expected outcome					
Customer satisfaction					
Medical cost					
Quality of care					
Investment					
Digital transformation	✓			✓	
Health ecosystem	✓	✓		✓	✓
In-house medical professionals	✓	✓		✓	✓
EHR	✓	✓		✓	✓
Hyper-personalisation	✓				✓
Core PAS transformation	✓		✓		
Internal cost transformation			✓		



	Consumer Advocate	Bridge Connector	Lean Operator	Analytic Sensor	Care Integrator
Challenges					
Data privacy	✓	✓		✓	
Data integration	✓	✓		✓	
High implementation cost	✓			✓	✓
Long-term commitment					✓
Regulatory constraint					✓

Note: The information above is based on insights and market knowledge from our internal network of professionals who work closely with health insurers across the world.





Conclusion

While it was always important, widespread health insurance coverage has become more critical than ever during and post the pandemic. Consumers, insurers, and regulators are all focusing on how coverage can be better and more effective.

There is an urgent need to improve payer-provider collaboration in order to facilitate customer/patient interaction as well as provide the best value to policyholders. Globally, insurers are putting health at the centre of their strategy and roadmap and are looking at investing and allying with the provider side to bring additional value.

It is amply clear that the health insurance industry is seeing a shift. Whether it is migration to one of the models described in the paper or developing new models of pay and care, insurers are moving forward, and standing still is no longer an alternative. The significant trends being observed are as follows:

- integration of the payer and provider model
- choice of being a bystander payer or adopting a clinically involved customer interface model
- alliances with ecosystem players on clinical and non-clinical customer engagement programmes
- race towards efficiency in claims management
- focus on ESG
- focus on fraud detection, prediction and mitigation
- product innovation
- regulatory compliance.

Health insurance is a primary societal tool for equalising access to healthcare for all – and as such it is as important a pillar of modern life as banking or transportation. A higher level of focus by governments is needed to make insurance a primary consideration across all demographic segments.

We are passing through a pivotal phase, right after the heightened awareness arising out of the pandemic. Collective human memory of unpleasant incidents is normally shortlived, as is evident from the case of past natural disasters and stock market depressions. It is imperative that the new-found awareness carries through and penetration of health insurance along with healthcare and health maintenance services permeates all levels of society.





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