The health insurer of the future: Consumers' advocate, providers' partner

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The heart of the matter

The forces transforming the health industry — the shift toward value-based care, the rise of the consumer, the advancement of technology — show no signs of abating.[1] While some health insurers have started adapting to these shifts, the sector overall has been slow to embrace them. Many insurers' moves toward value-based care have been tentative, their attempts to appeal to consumers have missed the mark, and their adoption of technology has been uneven, and, at times, misguided.

To thrive in the New Health Economy, health insurers will need to embrace these trends. They will need to adopt new ways of doing business, rather than tinkering with the traditional model. PwC's Health Research Institute (HRI) has identified five models for the health insurer of the future. Each of the five models has a different center of gravity. Several models have insurers working more closely with healthcare providers, establishing themselves as sources of data and analytics to help manage population health and keep patients out of the hospital. Other models have insurers focusing more on consumers, cutting healthcare costs by giving enrollees sophisticated digital and human support to help them make better healthcare choices.

To develop these models, HRI conducted a survey of more than 100 health insurance executives after the 2016 election, in late 2016 and early 2017. HRI also conducted a survey of 1,750 American adults in September 2016 and interviewed healthcare leaders from across the industry.

The health industry, including the insurance sector, is experiencing significant uncertainty as powerful forces reshape it, and as a new administration settles into Washington, DC, promising change for the industry. To succeed in these uneven times, health insurers should make choices now about business model changes that will position them to prosper in the future. Strategies that build enterprise resilience will focus on what is known – healthcare's increasing drive to be value-based, consumer-focused and technologically-enabled – while preparing for the unknowns. To succeed, insurers should consider taking the following steps:

- ***Find a way to play.*** The model — or models — an insurer chooses to pursue should be based on identifying areas for innovation and opportunities for new capabilities by enhancing current strengths.

HRI's five models of the health insurer of the future

- ***Consumer Advocate***
- ***Bridge Connector***
- ***Lean Operator***
- ***Analytic Sensor***
- ***Care Integrator***

- ***Build trust.*** Consumers and providers continue to have low levels of trust in insurers, a major barrier to overcome, especially for incumbents.
- ***Balance technology with a human touch.*** The health insurer of the future should pair thoughtful digital tools used directly by consumers with technology investments that enhance interactions between client-facing employees — like customer service agents or care managers — and consumers.
- ***Invest in the workforce.*** The health insurer of the future will need workers with customer service and people management skills as well as those experienced in data analytics and advanced technologies like artificial intelligence and blockchain.

Why today's health insurer model won't work tomorrow

Health insurers have been slow to adopt value-based reimbursement models, providers say. "We've been willing to talk with insurers about total care risk, but we've seen very little interest on their part," Dr. Daniel Varga, chief clinical officer at Texas Health Resources, told HRI. "And this isn't an uncommon experience in our marketplace." In a survey of 1,500 clinicians conducted by HRI, 70% of clinicians reported that they do not participate in risk-based, incentive-based or shared savings reimbursement models.[2]

At the same time, employers — the largest line of business for some insurers — are questioning whether insurers are the only partners to help them manage costs and keep employees healthy, their biggest healthcare concerns. "Employers aren't convinced that all the best solutions are coming from insurers and increasingly are looking outside for innovators that are challenging the status quo," said Mike Thompson, chief executive officer (CEO) of the National Alliance of Healthcare Purchaser Coalitions. "It's not a given anymore that employers will go with the services insurers provide."

Consumers also are questioning their coverage's value. One-third of consumers surveyed by HRI don't think health insurance is worth what it costs.[3] Insurers have poured money into developing consumer-centric technologies, but 68% of consumers told HRI they rarely or never use those tools.[4] Nevertheless, insurers have yet to effectively use their troves of data. Many struggle to deliver essential consumer services, such as accurate, up-to-date provider directories. Late last year, the Centers for Medicare & Medicaid Services (CMS) conducted a review of online provider directories for Medicare Advantage plans and found errors in 46.9% of them.[5]

Health insurer executives recognize that these forces are not abating. Executives surveyed by HRI said the shift from fee-for-service to value-based reimbursement models will have the greatest impact on how they do business in the next five years.[6] With health spending continuing to outpace growth in gross domestic product, demands to tamp down costs and deliver more value will only increase.[7]

"There is a truism that needs to be acknowledged," said Rajeev Singh, CEO of Accolade, a Seattle-based healthcare technology company that helps guide consumers through the healthcare system. "We are spending one out of every five dollars on healthcare, and that's completely unsustainable. We can't have that grow to two out of every five dollars and expect to have a competitive economy." Pressure on stakeholders across the industry – including health insurers – to lower costs will continue.

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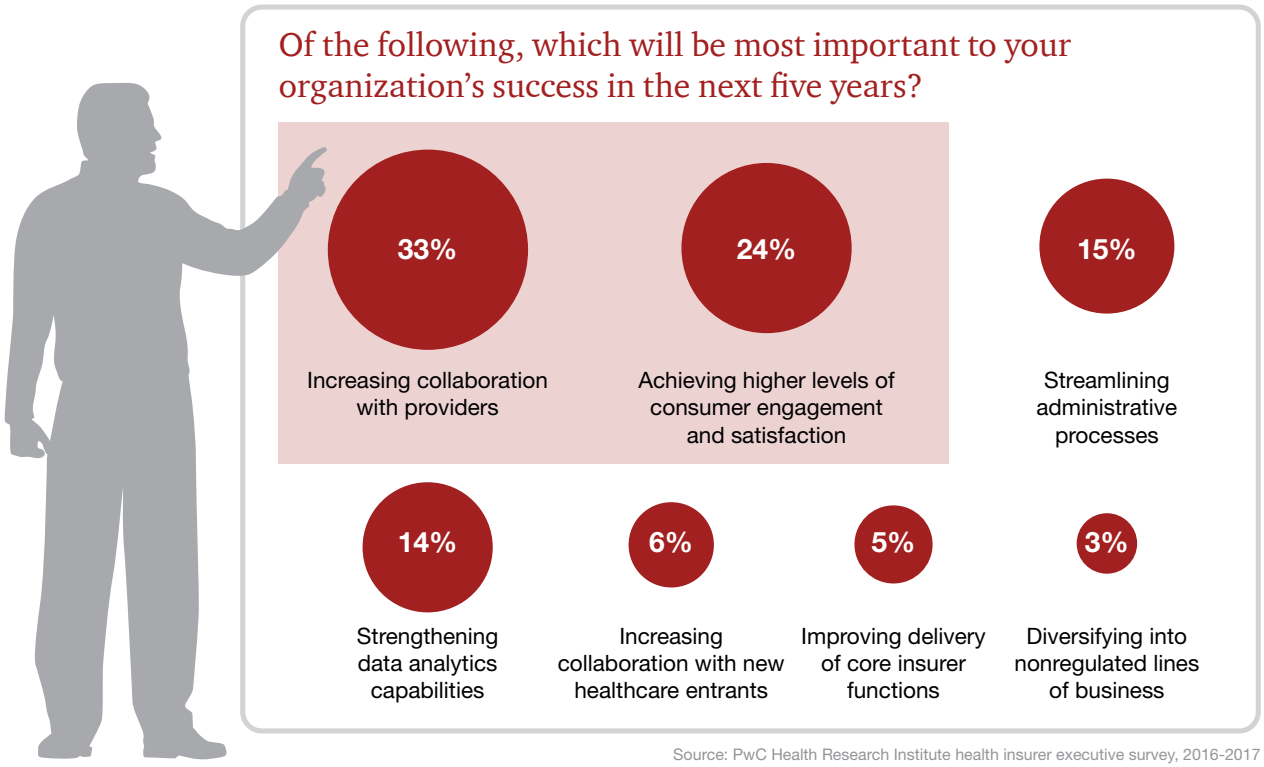
Sixty-nine percent of executives also told HRI that the consumerization of the industry and the shift of risk onto consumers and providers are only going to accelerate in the years ahead.[8] Health insurers know they will need to change how they do business to succeed. For instance, 56% said that data sharing partnerships with other organizations will be crucial, while 17% plan to be fully integrating health insurer and provider functions into a single organization in 2021, up from 8% who were already doing so in 2016.[9]

Overall, health insurers believe that increasing collaboration with providers and better engaging consumers will be most important to their success (see figure 1). By reframing their models around these relationships, the health insurers of the future can fall in step with the rest of industry and establish themselves as critical players in meeting evolving demands.

Figure 1: Health insurers recognize they will need to increase collaboration with providers and better engage consumers to succeed moving forward.



Source: PwC Health Research Institute health insurer executive survey, 2016-2017

What will Donald Trump's administration mean for health insurers?

President Trump and Republican lawmakers have made repealing and replacing the Affordable Care Act (ACA) a top priority. The seven-year-old law contains complex tradeoffs for health insurers — restrictions and taxes on the one hand, millions of new customers, many of them subsidized by the government, on the other. Whatever strategy the Republicans embrace for repealing and replacing the law, their efforts could have significant short and long-term consequences for health insurers.

Short-term, the fate of the ACA exchanges remains unclear for the next enrollment season. In the coming months, insurers wishing to participate must give CMS rate tables for single risk pool coverage that includes a qualified health plan. With talk of repealing and replacing the law in the air, insurers have been uncertain whether to participate in the exchanges, and what participation will mean. Will healthy consumers drop out? Will their risk pools become even more costly? The industry has asked President Trump and Congressional leadership for help in stabilizing the exchanges in the short-term.

In February of 2017, the administration released a proposed rule aimed at shoring up the exchange markets.[10] The rule proposed tightening requirements for enrollment outside of the standard period, allowing insurers to collect past-due premiums before starting coverage for a new year and shortening the next open enrollment period. While these changes are consistent with some of the insurance sector's recommended approaches for stabilizing the exchanges, they do not address all of its concerns, including a lack of funding to fulfill payments under the law's risk programs.[11] Several insurers have already exited the exchanges and more have signaled they may do so at the end of this year.

Adding to the uncertainty is an executive order signed by President Trump in January asking agencies to do what they can to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act" that imposes a fiscal or regulatory burden on virtually any stakeholder in the healthcare industry. The IRS, which helps enforce the individual mandate, has said it is reviewing the order, as is the Department of Health and Human Services (HHS) and other relevant agencies.

Longer term, the future of the ACA remains uncertain. Republicans have launched a budget reconciliation process that would allow them to repeal and replace provisions of the law that deal with taxes, mandates and subsidies, including the Medicaid expansion, but not provisions such as guaranteed issue or the prohibition on imposing pre-existing condition exclusions. For lawmakers, the benefit of the process is that budget reconciliation bills only need a simple majority vote to pass the US Senate, where Republicans do not have the supermajority required to beat a Democratic filibuster. The downside is that it does not allow the party to replace the ACA wholesale, making the process more complex.

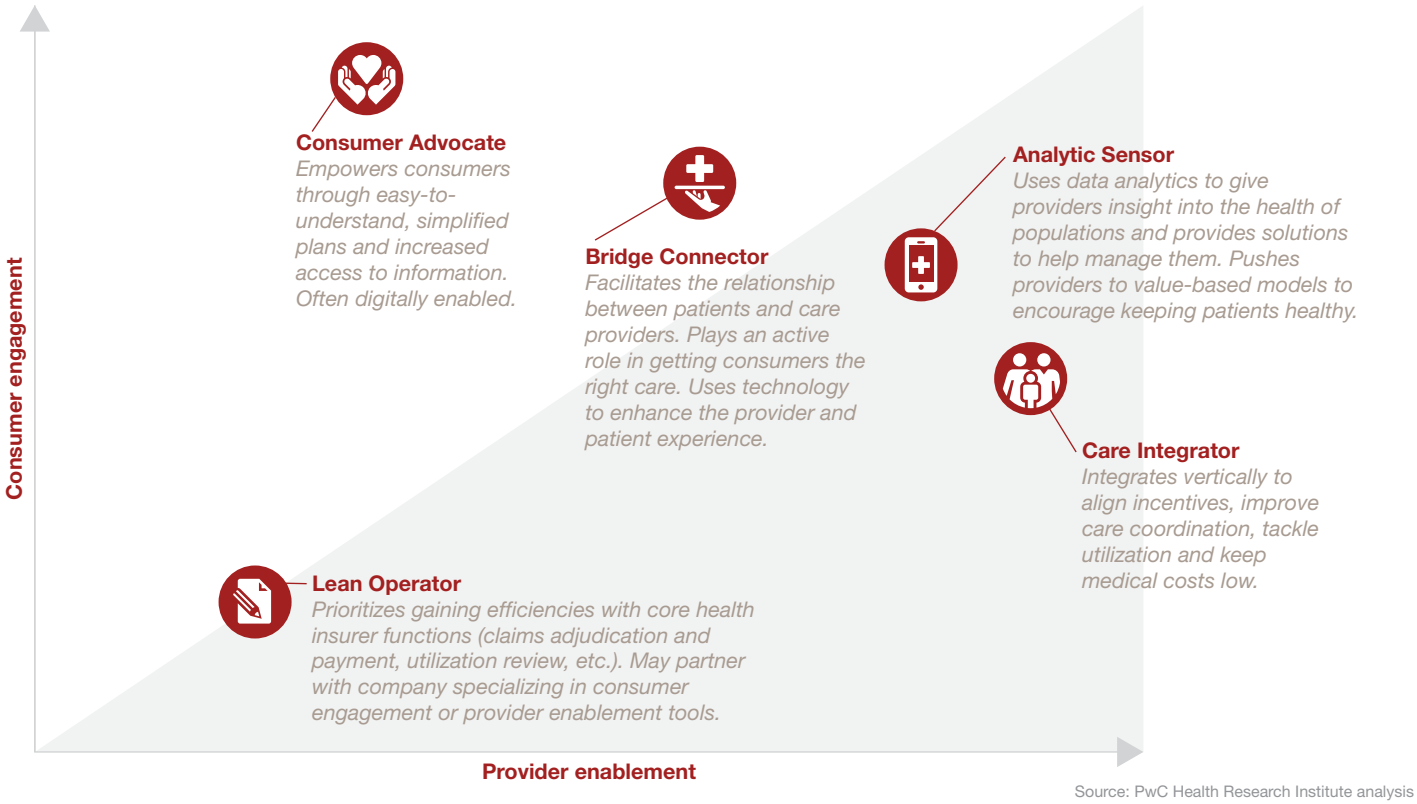
Depending on what President Trump and Republican lawmakers do with the ACA, the number of uninsured could spike, rise modestly or remain virtually unchanged. Not all payers will be effected in the same ways under any scenario. The non-group market accounts for 9% of the insured population under 65; the exchanges account for 4.9%.[12] Medicaid accounts for 25%. For insurers that have focused on the employer and Medicare markets, the fallout could be modest no matter what happens. However, some not-for-profit regional insurers and Medicaid managed care insurers that built their strategies around Medicaid managed care and the ACA exchanges could experience more severe impacts.

Health insurers will need to remain nimble, monitor developments closely and consider near-term strategy adjustments to take advantage of opportunities as they arise. However, it will be equally important to focus on planning for that which is known as the major forces transforming healthcare are unlikely to change. "There are changes underway that are not dependent on election outcomes," said David Merritt, executive vice president of public affairs and strategic initiatives at America's Health Insurance Plans. "Public programs can accelerate or decelerate these trends, but the market is working towards the goals of better, more efficient care regardless."

The health insurer of the future

Successful health insurers of the future will align with one or more of five models that balance better engaging consumers and collaborating with providers to help keep the cost of care down. They will become specialists in delivering consumer services, serve as bridges between providers and their patients, become sources of data and analytics to help providers manage populations' health, align with providers to reduce medical costs, and/or enhance efficiency to tamp down administrative costs (see figure 2).

Figure 2: HRI's five models of the health insurer of the future.



Source: PwC Health Research Institute analysis

Consumer Advocate

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

Why should you pursue this model?

- Addresses the consumer's increasing role in healthcare.

What health insurer today should consider these models in the future?

- Focus in the individual market.
- New entrants in the market (i.e. health insurance start ups).
- Strong technology capabilities.
- Locally or regionally focused.

What are potential investments to be made?

- Simplified plan design.
- Price transparency tools.
- Artificial intelligence technology.
- Self-service solutions and other consumer-facing technologies.

Which markets could be targeted?

- Tech-capable consumers to include healthy adults, seniors and families.

Consumer Advocate: Like the Amazon.com of health insurance, the Consumer Advocate model simplifies plan designs and offers consumer-friendly tools such as instant pricing, allowing consumers to compare true prices for treatments.[13] By catering to consumers' needs, these health insurers may have a leg up on attracting and retaining members while reducing costs by helping members make smarter healthcare choices. Tech-capable consumers who prize simplicity and streamlined processes will likely find Consumer Advocate insurers particularly appealing.

In addition to making it easier for consumers to shop for coverage, simplified plan designs can reduce costs for Consumer Advocate insurers by streamlining product management. These health insurers may also consider other strategies such as wellness incentives to help reduce premiums — consumers' most important consideration when choosing a plan — or greater first-dollar coverage so consumers feel it's worthwhile to pay their premiums.[14] Understanding that health coverage is often first a financial decision for consumers, Stride Health — a newcomer that helps independent and part-time workers select health plans and file their taxes — generates personalized forecasts that let consumers compare likely annual spending for different plans.

Insurers experienced in selling directly to consumers are well suited to the Consumer Advocate model. That includes those with a strong presence in the individual market, experience in Medicare Advantage (in which aging seniors are staying healthier and active longer), or that work with employers whose employees are in a private exchange. Health insurers with strong brand recognition or new entrants that don't have a reputation to overcome also will have a head start in building rapport with consumers and winning them. Given the focus on technology-enabled experiences, insurers interested in becoming Consumer Advocate insurers also will need strong technological capabilities.

Humana is already shifting its business to put the consumer at its center, investing in services and tools that help reduce friction between members and the healthcare system. "We've tried to pre-empt any extra effort on the part of the consumer," Jeff Reid, Humana's executive vice president of digital enterprises, told HRI. "It's our goal to meet consumers where they are." The insurer has adopted artificial intelligence technology in its call centers; it measures dead space, conversational cues and call cadence to identify poor member experiences and coach call center agents in real time. As of December 2016, issue resolution had increased 6%, average handle times had dropped by seven seconds, agent engagement had increased 60% and the company's net promoter score — a measure of consumer satisfaction — had improved, said Geeta Wilson, Humana's vice president of consumer experience.

Bridge Connector

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.

Why should you pursue this model?

- Reduces medical costs for potentially expensive populations through increased communication between providers and patients.
- Meets providers' demand for deeper connection with patients.

What health insurer today should consider these models in the future?

- Focus on Medicare and Medicaid.
- Strong presence in communities with access to community resources and strong provider relationships.
- Locally or regionally focused.

What are potential investments to be made?

- Data analytics.
- Non-clinician health professionals.
- Retail storefronts to create consumer touchpoint.
- Telehealth to connect consumer and provider.

Which markets could be targeted?

- Consumers with complex chronic conditions or a desire for high-touch care, such as the frail elderly.

Bridge Connector: While consumers and providers have often considered health insurers roadblocks to obtaining healthcare thanks to processes like prior authorization, Bridge Connector insurers are seen as active facilitators, proactively helping consumers obtain care. They position themselves as more attractive partners for clinicians, who — as they take on more risk — are looking to understand and manage patients' risk factors and care needs better, reducing medical costs. "The provider is the most important partner we have in delivering value," Max Barry, vice president of enterprise strategy at Aetna, told HRI. "And we need to transform how we engage with that community, because the old way was just fraught with tension."

Insurers pursuing a Bridge Connector model prioritize technology investments that support providers. "It's a lot to ask people to be experts in understanding and managing their own health, especially if they're dealing with multiple conditions," said Kris Gale, chief technology officer of Clover Health, a health insurance startup focused primarily on the Medicare Advantage market. "Instead of putting the burden on consumers to be experts in managing their care, we want to empower clinicians and others to fill in the gaps." Clover has invested heavily in building its own data platform integrating clinical, claims and demographic data. These data help providers build engagement strategies that anticipate consumers' needs, as opposed to consumers being responsible for contacting providers after a need arises.

Clover also has its own team of care managers, social workers and community health workers to help providers execute those engagement strategies. With an eye toward the social determinants that affect health — such as socioeconomic status, education, and physical environment — these professionals seek to tackle the root causes of health problems. They conduct home visits, provide education, schedule appointments, connect patients with community resources and monitor adherence to care protocols. They become consumers' advocates and help providers understand their patients' daily lives better, helping overcome barriers that might prevent someone from following clinical advice. "There is a lot of rich dialogue to have with providers that will allow them to better serve their patients," Kara Trott, CEO of Quantum Health, another company dedicated to improving consumer engagement, told HRI. "No one gets through the healthcare journey without getting stuck. Most often the reason people get stuck are due to barriers that have nothing to do with clinical care — home or family situations, transportation, claim challenges, financial limitations, etc. — and unless the barrier is addressed, the person's clinical success is adversely impacted. These are the problems consumers and their providers need navigation to solve."

Health insurers that have strong provider relationships and deep local connections should consider the Bridge Connector model. With their hands-on approach, Bridge Connector insurers could excel especially in serving populations with more complex healthcare needs. This model would be competitive in markets where profitability is highly dependent upon strong population health management, such as Medicare Advantage and Medicaid managed care, two markets in which enrollment has been steadily climbing over the last decade.[15, 16]

Lean Operator

Prioritizes gaining efficiencies with core health insurer functions (claims adjudication and payment, utilization review, etc.). May partner with company specializing in consumer engagement or provider enablement tools.

Why should you pursue this model?

- Reduces costs by eliminating inefficiencies within core insurance and administrative functions.

What health insurer today should consider these models in the future?

- Focus on providing administrative services to self-insured.
- Strong leadership to reach administrative targets.
- Broad geographical reach with large market share.

What are potential investments to be made?

- Blockchain to streamline claims processing.
- Identifying points of inefficiency.
- Partnering with companies that specialize in provider or consumer relations.

Which markets could be targeted?

- Self-insured employers looking to access core insurance functions and use other vendors to access additional services such as consumer engagement tools.

Lean Operator: Most similar to today's insurer, the Lean Operator seeks to maximize efficiency in, and reduce costs of, administrative tasks such as claims administration, utilization review, premium collection and enrollment oversight. Instead of building capabilities to connect with consumers and improve care delivery, Lean Operators seek partnerships with new entrants that achieve those goals.

These health insurers may be early adopters of technologies, such as blockchain, that are poised to disrupt healthcare. Blockchain can be used to streamline and increase the security of administrative tasks, which otherwise would require a lot of back and forth. For example, the technology can help substantiate claims handling. Blockchain provides secure, distributed data storage in which all of a consumer's medical and billing data can be tracked, managed and updated in real time. The validity of claims can be instantly verified, efficiently identifying fraud attempts and increasing transactions' accuracy and speed.

Blockchain's long-term potential promises to go beyond these benefits. One of its founding tenets is that it removes the middleman from transactions. This means it can create a secure, transparent and efficient way for consumers and providers to conduct business with each other directly, without the need for an insurer to mediate. If Lean Operators adopt and master the technology early, they can position themselves to define standards for its use and carve out a role for themselves in industry applications, disrupting from within. Thirty-two percent of health insurer executives surveyed by HRI said they were considering implementing blockchain technology in the next five years. Twelve percent said they are already using it (see figure 3 on page 10).

Thirty-two percent of health insurer executives surveyed by HRI said they were considering implementing blockchain technology in the next five years.

Figure 3: While insurers to date have largely invested in more traditional technology capabilities such as cybersecurity and data analytics, they are considering investments in some emerging technologies in the next five years.

Source: PwC Health Research Institute health insurer executive survey, 2016-2017

Reflecting the Lean Operator ethos, Blue Cross and Blue Shield of Vermont aspires to decrease administrative costs to 5% of premium. The leadership team set clear cost-savings targets and started a program inviting employees to help improve processes and generate savings. In five years, the organization has reduced the company's total per member per month administrative costs by 25%.[17]

Comcast — among other self-insured employers — is unbundling its employee benefits program. Instead of using one company for all functions, it's creating a network of best-in-class vendors, each of which focuses on a particular capability. For instance, the company contracts with Accolade for consumer engagement services and technologies, Castlight Health to help employees compare prices and track spending, and Doctor on Demand for telemedicine.[18, 19, 20] These employers would consider Lean Operators attractive partners to handle core administrative tasks.

Insurers that have focused primarily on delivering administrative services for self-insured employers should consider the Lean Operator model. They should have a broad geographical reach to cater to large national employers and achieve the scale necessary to see a return on technology investments.

Analytic Sensor

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.

Why should you pursue this model?

- Addresses demands for data analysis and increased focus on population health management.
- Provides opportunities for diversification into non-regulated lines of business.

What health insurer today should consider these models in the future?

- Strong relationships with providers.
- Strong technology platform and analytics, or capital to invest in them.
- Broad geographical reach with large market share.

What are potential investments to be made?

- Data integration and analytics.
- Relationships with community resources.

Which markets could be targeted?

- Employers and providers looking to deploy population health strategies and individuals looking to reap benefits from leading a healthy life.

Analytic Sensor: Analytic Sensor health insurers capitalize on the industry's appetite for data and analytics by positioning themselves as a source of these essentials. They offer technology platforms that give clinicians and other stakeholders insights into the health of patients and patient populations. According to HRI's survey, health insurers anticipate that their relationships with healthcare providers will increasingly focus on sharing such insights (see figure 4).

Analytic Sensor health insurers also help providers use those insights. This could mean including medical, social and public health resources such as lifestyle coaches and nutrition counseling in their plan offerings. The aim is to keep patients healthy to forestall the need for more expensive services. Such insurers, for example, may offer members incentives to adopt healthy lifestyle changes. They also are likely to offer quality bonuses to providers or put some of their compensation at risk to further incentivize keeping patients out of hospitals.

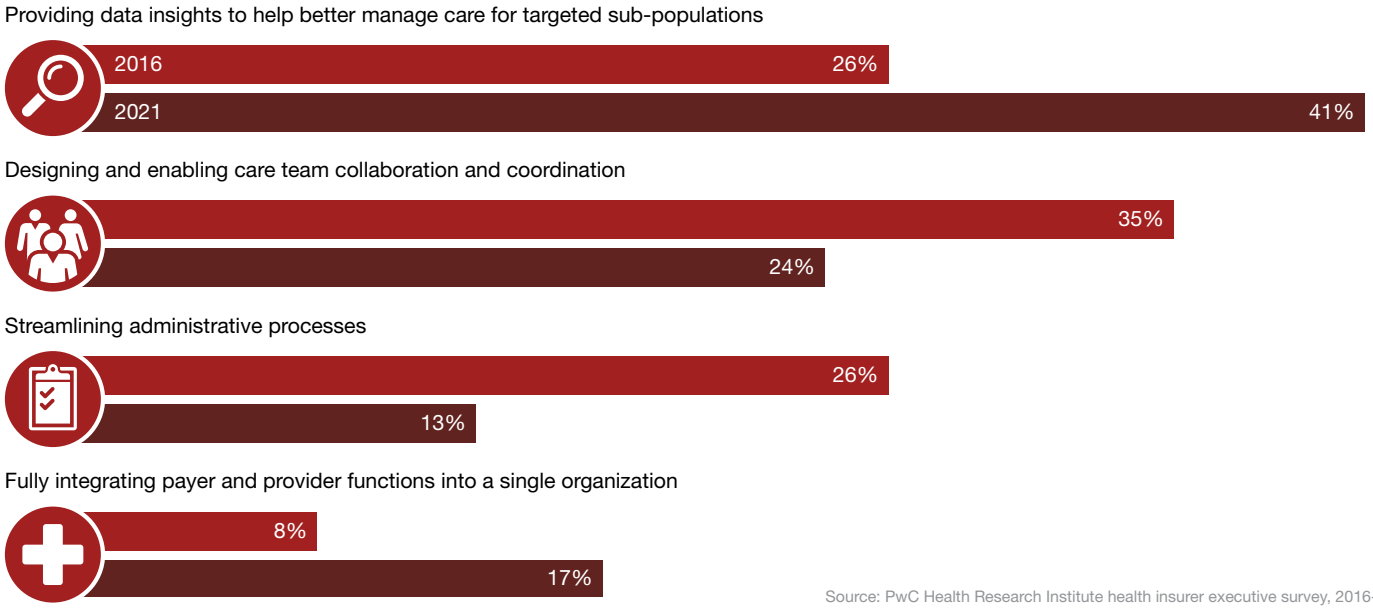
These insurers also can bundle their solutions into a higher-margin service offering. By selling health management and data analytic tools to providers, pharmaceutical companies, employers and other healthcare organizations, they can diversify their portfolios and establish a non-regulated line of business where profits are not subject to the same regulatory pressure.

UnitedHealth Group, for instance, runs Optum, a health services division that delivers a comprehensive suite of solutions — ranging from health management to data analytics to pharmacy benefits — aimed at modernizing healthcare's infrastructure, advancing care and improving the consumer experience. In 2016, Optum's revenues grew nearly 24%.[21]

National insurers with large provider networks and strong relationships within them are likely candidates for this model. In addition to their own claims data, these health insurers are likely to have greater access to clinical data because of their provider relationships. Analytic Sensor health insurers also need a solid technology infrastructure to integrate data from multiple sources and robust data analytics tools — or the capital necessary to build these.

Figure 4: In the next five years, most health insurers will focus on supplying providers with data insights to manage the health of populations.

Which best describes the work your organization is primarily doing with providers today? Which will best describe the work your organization expects to primarily be doing with providers in five years?



Source: PwC Health Research Institute health insurer executive survey, 2016-2017

> *"The provider is the most important partner we have in delivering value. And we need to transform how we engage with that community, because the old way was just fraught with tension."*
>
> *— Max Barry, Vice President of Enterprise Strategy at Aetna*

Care Integrator

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

Why should you pursue this model?

- Reduces medical costs due to lack of provider-payer alignment.
- Addresses providers' interest in provider-sponsored health plans and vertical integration.

What health insurer today should consider these models in the future?

- Robust financial reserves and revenue sources.
- Strong leadership.
- Locally or regionally focused.
- Densely populated market with strong market share or a provider with strong brand.

What are potential investments to be made?

- Acquisition of providers (hospitals, clinics, physicians) to integrate along care continuum.
- Data integration.
- Technology focused on enhancing continuity of care.

Which markets could be targeted?

- Consumers who highly value continuous care and convenience, to include healthy families as well as consumers with complex care needs.

Care Integrator: The Care Integrator health insurer is merged with a provider, sharing risk while controlling cost and quality. These health insurers are the natural outcome of providers' surging interest in starting their own health plans and of industry's push to value-based care. The number of provider-sponsored health plans has more than doubled since 2014.[22] Tighter margins and greater sums of money at risk have spurred many providers to seek better ways to cut spending and find new income sources.

To avoid building insurance capabilities from scratch, some providers are looking to launch plans through acquisition or joint ventures with veteran health insurers. These insurers bring essential insurance experience and assets to the partnership.

By combining health coverage and care delivery under one roof, the Care Integrator model aligns insurer and provider economics, giving incentives to reduce unnecessary care, improve outcomes and keep the total cost of care in check.

Delivering seamless coordination, convenience and simplicity has helped Kaiser Permanente, an integrated delivery network, win consumers. It has led the health insurance industry in customer loyalty rankings for five consecutive years. In 2015, its score was 19 points higher than the industry average.[23] The goal of every insurer is to create long-term relationships with members, limiting loss of members and the costs associated with acquiring them. Loyal customers also are more likely to recommend the health insurer to others.

Newcomer ZOOM+ has created an integrated health system built on a health plan and urgent care. The company has layered a network of neighborhood urgent care clinics with primary care physicians, specialists and ancillary services, including dental cleanings, mental health services, nutrition counseling and parenting coaching. Introduced in 2015, ZOOM+ has been gaining traction in the small group market with businesses that are seeking innovative benefits to attract and retain millennials and to control cost. The company decreased small group rates twice in the last year — by 11% and then again by 8% — and anticipates reducing them again in the year ahead.[24]

Care Integrator health insurers must start with strong leadership and robust financial reserves and revenue sources. This is because successful integration with a provider demands a high degree of collaboration, meaning fundamental operational and governance changes and assimilation of data platforms. Health insurers that are regionally focused in densely populated markets are positioned well for this model. Insurers considering this model will need a strong footprint in the market or a provider partner with strong name recognition to attract sizeable market share.

What do American consumers want?

Each of the five models of the health insurer of the future has a distinct strategy for surviving in the changing healthcare landscape. Those that thrive, though, will recognize that a one-size-fits-all approach won't sufficiently meet consumers' needs and expectations. "Everyone is looking for something that is unique and customized to them, which is something healthcare hasn't historically delivered on," said Noah Lang, Stride Health's CEO.

The most successful health insurers of the future must understand consumers' demands and tailor their strategies accordingly. New entrants such as Accolade and Quantum Health have already demonstrated the value of customizing solutions to consumers' needs. Accolade — with its robust technology infrastructure — and Quantum — with extensive research into consumer behavior — first get to know consumers holistically and intimately. They learn not only about consumers' health issues, but also employment, family and personality traits. This information is then used to deliver a personalized experience to each one. By doing so, these companies have achieved consumer satisfaction ratings that surpass those of many leading consumer brands and are producing savings for their clients.[25, 26]

The health insurer of the future will have honed a sophisticated sense of who its members are and what they want, which will begin with segmenting them by health status. Consumers living with different health issues have very different requirements when it comes to what they expect and need from their insurance company (see figure 5 on page 15 and Appendix B on page 20 for additional research).[27]

For example, consumers with complex chronic and chronic conditions are among the least willing to use wearables and virtual consultations, according to an HRI consumer survey. Health insurers of the future focused in the Medicaid market — which has a large population of these patients — should take note. Bridge Connector insurers, for instance, may want to consider devoting more resources to a deeper bench of care managers than to virtual care options. Complex chronic and chronic consumers also are the least interested in receiving nutrition support, despite the fact that they could benefit greatly from it. Insurers should see this as a barrier they need to overcome and be prepared to create strategies to increase those consumers' receptiveness.

On the other hand, healthy enthusiasts value wellness services and are dutiful about getting recommended screenings. However, they are less adventurous when it comes to where they receive care. According to HRI's consumer survey, healthy enthusiasts are the least likely to use a retail clinic in the future and to check vital signs at home with a medical device attached to a smartphone, even if it reduces the cost of care. These consumers also prefer researching and purchasing insurance in-person over using a smartphone to do so – an important consideration as Consumer Advocate and Analytic Sensor insurers looking to capture these ideal enrollees strategize around marketing and outreach.

By developing a robust understanding of consumers, health insurers of the future will be positioned to deliver a supply of solutions to meet markets' demands. Creating value against consumers' needs will help reinforce the insurer-consumer relationship and cement insurers' place as consumers' advocates.

Figure 5: Comparing consumer groups: What consumer groups want from their health insurer and healthcare.

Consumer group	US population in category	Insurers that appeal to them	Health insurer of the future model that fits best
 **Frail elderly** *Over the age of 75, living at home, facing health issues related to falls or dementia and suffering generally poor health.*	5.9M	Cost managing plans will appeal most. They are likely to switch insurers to save money. They are willing to try new locations for care such as retail clinics.	• Bridge Connector • Care Integrator
 **Complex chronic** *Have one or more chronic diseases affecting multiple body systems and often requiring complicated disease management (e.g. CHF, COPD, DM with end-stage renal disease).*	24.8M	Plans providing the coverage of services and medications needed will draw these consumers. They are more resistant to change, and seem to be most loyal to their carriers.	• Bridge Connector • Care Integrator
 **Chronic** *Have problems affecting a single body system such as hypertension and require uncomplicated disease management.*	175.1M	Plans providing the coverage of services and medications needed will draw these consumers. While loyal to their carriers, they seem reluctant to use retail clinics or telemedicine services.	• Bridge Connector • Care Integrator
 **Mental health** *Mental illness is primary health issue versus comorbid condition. Face depression and mood disorders, post-traumatic stress disorder, addictions and suicidal ideations.*	9.4M	Managing healthcare costs is difficult for them. A high percentage would switch insurers to save money. Coverage of mental health services is most important.	• Bridge Connector • Care Integrator
 **Healthy families** *Households with healthy dependent children under the age of 18.*	65.4M	Cost conscious but also one of the most adventurous groups. Willing to use retail clinics for their own and their families' care. Generally amenable to alternatives to traditional care, like sending a photo of a rash for diagnosis.	• Consumer Advocate • Care Integrator • Lean Operator
 **Healthy enthusiast** *Value a regular physical, wellness/ coaching services, and get recommended screenings.*	22.6M	Generally do not find it difficult to manage healthcare costs but are still concerned over the cost of their monthly premium. They are most satisfied with their insurance plans' coverage of services and medications.	• Consumer Advocate • Analytic Sensor • Lean Operator
 **Healthy skeptic** *Generally avoid interacting with the health system and are less likely to have health insurance than other consumer groups.*	12.5M	The least likely to say they are satisfied with their insurance. They think they are healthy enough that they don't need health insurance. Plans with first-dollar coverage will appeal most.	• Consumer Advocate • Analytic Sensor • Lean Operator

Source: PwC Health Research Institute analysis of 2013 Medical Expenditure Panel Survey and Health Research Institute consumer survey, 2016

What this means for your business

Continued success in healthcare demands resilience — an ability to navigate and overcome the uncertainty of continued disruption which can be achieved by honing in on that which is known. By aligning with the five models of the health insurer of the future, insurers will zero in on healthcare's constants – the shift to pay for value, growing consumerism and advancing technology.

While an insurer should consider its existing strengths when selecting the model, or models, it pursues, becoming the health insurer of the future will require investing in new capabilities and strategies. Some will be unique to each model, but others will be table stakes for all.

- ***Focus on the fundamentals to build trust.*** Consumers have historically interacted with health insurers when they needed prior authorization for a service or when a claim was denied. As a result, they have come to see insurers as a barrier to care, not an advocate. "The challenge health insurers have had is that actually influencing consumers requires not just information and tools but also trust," said Thompson of the National Alliance of Healthcare Purchaser Coalitions. "And they haven't always had that with consumers, deserved or not. This is one reason outside forces have been successful, because they can say 'we're not them.' "

  Insurers recognize this problem. Ninety-seven percent of health insurer executives say building consumer trust will be somewhat or very important to their consumer strategy in the next five years, according to HRI's survey. When PwC asked consumers to assign points to a series of attributes that matter most to them, simplicity and trusted advice accounted for almost 60% of what drives consumer satisfaction and loyalty.[28] With digital tools, this means being certain that the interface is easy to use. A PwC survey on the evolution of customer care found that bells and whistles such as personalization and notifications are not nearly as important as being able to navigate a site easily.[29]

  Insurers also must address factors that have led to lack of trust. "At the end of the day, members are not persuaded by trinkets, they are persuaded by a feeling that you care about them," said Dr. Tom Lutzow, CEO of iCare Independent Care Health Plan, which focuses largely on delivering managed care to people with complex health and social needs. "This is the secret sauce, the conviction that they carry that you care about them and their well-being."

  This means potentially rethinking some of insurers' core processes, such as prior authorization, claims administration and eligibility determination. Historically, insurers have used these processes as "sticks" to manage access to care. Health insurers of the future, to build trust, must think about using carrots instead to attract them to the appropriate care. With the right consumer first mindset and incentive structure, health insurers can achieve trust and the right to influence consumer's decisions without the stick. Building trust is essential for any insurer, but failing to do so would be a nonstarter for Consumer Advocate and Bridge Connector insurers.

- ***Layer technology with human support.*** Consumers want to speak to a person when making health decisions. The most used and preferred customer service channel is speaking with a live customer service agent on the phone, according to PwC's survey on customer care evolution.[30] "When it comes to their health, consumers respond well to gentle, human-touch nudges, reassuring them that they are making the right decisions," said Catherine Hamilton, vice president of consumer services and planning at Blue Cross and Blue Shield of Vermont. These interactions cannot be replaced by technology.[31] The health insurer of the future should, instead, invest in technology that supports and enhances such interactions. For instance, an employee speaking with a member should be able to retrieve a broad picture of that member. That entails integrating claims data, actuarial analysis, case management information and other types of data, which requires flexible data platforms and business intelligence tools.

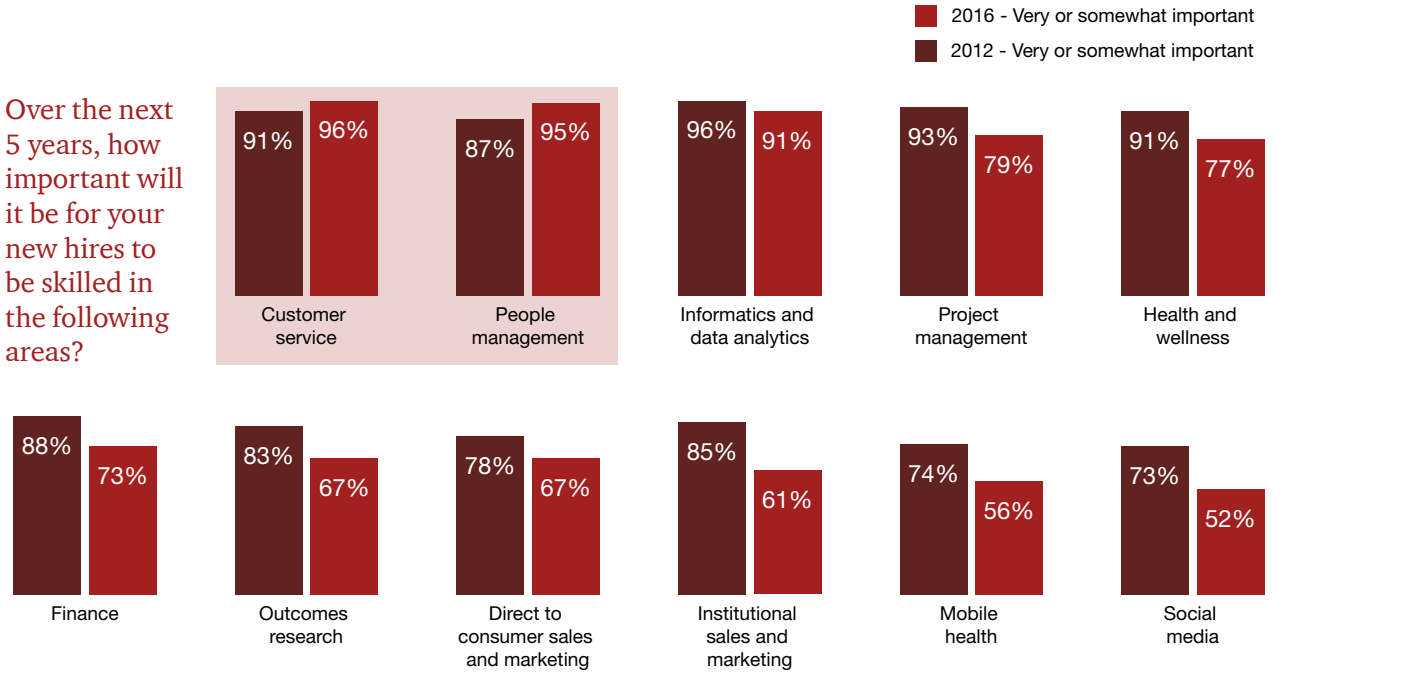
- ***Help providers focus on delivering care.*** Areas such as patient eligibility, obligation determination and prior authorization have grown more complicated with the rise in cost-sharing and growth of new network arrangements. Earlier this year, the American

Medical Association, American Hospital Association and 14 other healthcare organizations formed a coalition to lobby health insurers to streamline prior authorization processes.[32] At the same time, the shift from volume to value is increasing the burden of reporting requirements. According to one study, physicians are spending an average of 785 hours each and a total of more than $15.4 billion a year on quality measure reporting.[33] Many of these tasks frequently entail tedious manual workflows.

By supporting and automating these processes when possible, health insurers can relieve some of providers' administrative burdens. Doing so will help insurers establish goodwill with providers — sending the message that they are partners — and will give providers more time to focus on their most important job: caring for patients. In 2016, 86.1% of physicians felt they did not have the time to provide the highest quality of care.[34] More time to treat and see patients can result in more accurate diagnoses, more appropriate care plans and better care coordination — all of which can help to tamp down medical costs. Health insurers of the future working most closely with providers, including Care Integrator, Analytic Sensor and Bridge Connector insurers, stand to gain the most from streamlining physicians' administrative requirements.

- ***Hire – or borrow – the right talent.*** The health insurer of the future, no matter the model, will need to diversify its workforce with people from industries such as tech, hospitality and social services. Because building trust is important for almost any health insurer, hires who interact with consumers will need strong personal skills. These assets top health insurers' list of what they will be looking for in new hires over the next five years, a change from 2012, when health insurer executives said they were looking for people with data and informatics backgrounds (see figure 6).[35] Some health insurers – especially Lean Operators – may acquire these skills through partnerships with consumer-focused companies. Instead, Lean Operators may focus hiring more on talent with experience in advanced technologies like blockchain.

Figure 6: Today, health insurers are more focused on finding new hires with people management and customer services skills than they were in 2012.



Source: PwC Health Research Institute human resources survey, 2012 and health insurer executive survey, 2016-2017

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Appendix A: Comparison of HRI's five health insurer of the future models

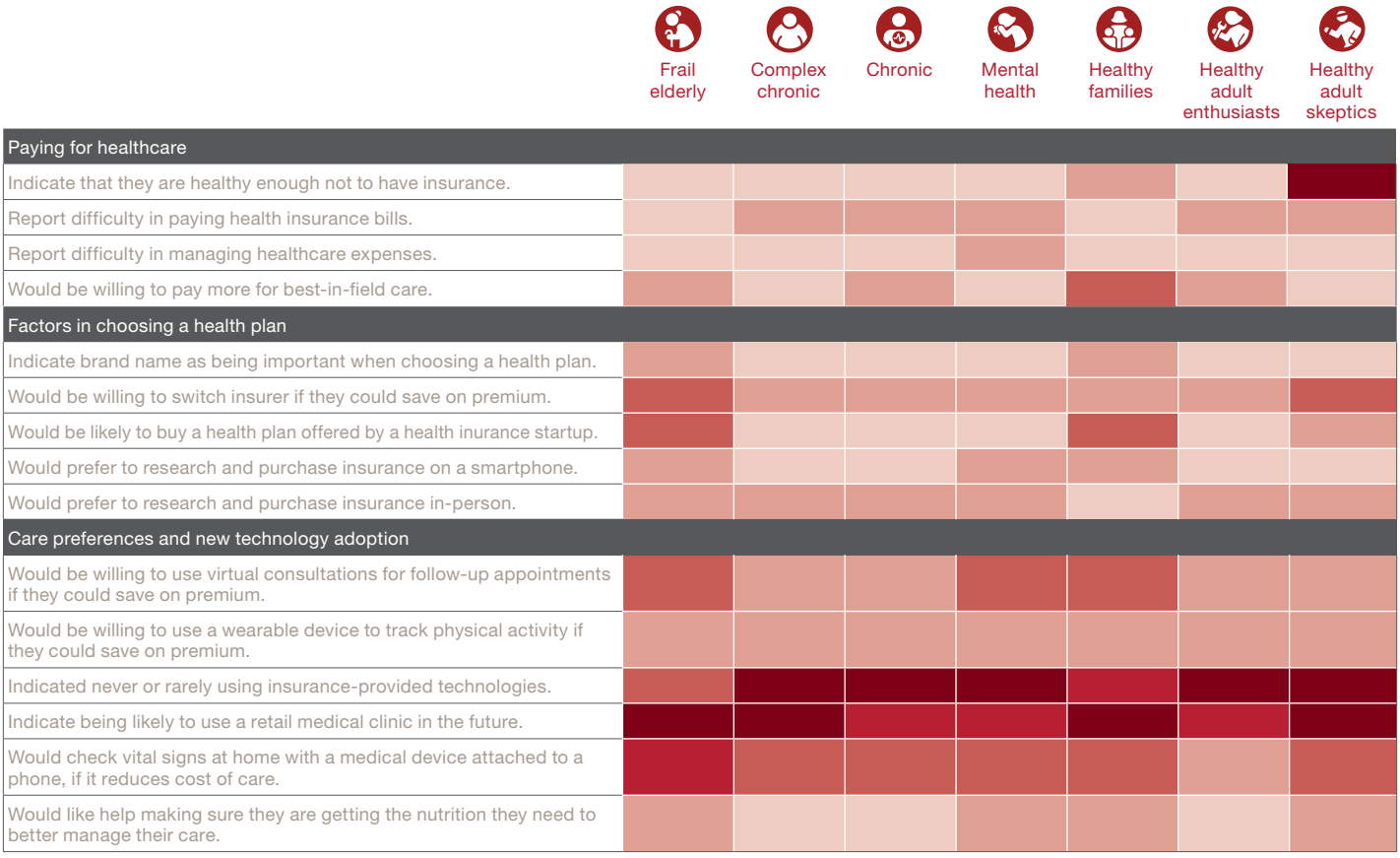
	Why should you pursue this model?	What health insurer today should consider these models in the future?	What are potential investments to be made?	Which markets could be targeted?
Consumer Advocate *Empowers consumers through easy-to-understand, simplified plans and increased access to information. Often digitally enabled.*	Addresses the consumer's increasing role in healthcare.	Focus in the individual market. New entrants in the market (i.e. health insurance start ups). Strong technology capabilities. Locally or regionally focused.	Simplified plan design. Price transparency tools. Artificial intelligence technology. Self-service solutions and other consumer-facing technologies.	Tech-capable consumers to include healthy adults, seniors and families.
Bridge Connector *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.*	Reduces medical costs for potentially expensive populations through increased communication between providers and patients. Meets providers' demand for deeper connection with patients.	Focus on Medicare and Medicaid. Strong presence in communities with access to community resources and strong provider relationships. Locally or regionally focused.	Data analytics. Non-clinician health professionals. Retail storefronts to create consumer touchpoint. Telehealth to connect consumer and provider.	Consumers with complex chronic conditions or a desire for high-touch care, such as the frail elderly.
Lean Operator *Prioritizes gaining efficiencies with core health insurer functions (claims adjudication and payment, utilization review, etc.). May partner with company specializing in consumer engagement or provider enablement tools.*	Reduces costs by eliminating inefficiencies within core insurance and administrative functions.	Focus on providing administrative services to self-insured. Strong leadership to reach administrative targets. Broad geographical reach with large market share.	Blockchain to streamline claims processing. Identifying points of inefficiency. Partnering with companies that specialize in provider or consumer relations.	Self-insured employers looking to access core insurance functions and use other vendors to access additional services such as consumer engagement tools.
Analytic Sensor *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.*	Addresses demands for data analysis and increased focus on population health management. Provides opportunities for diversification into non-regulated lines of business.	Strong relationships with providers. Strong technology platform and analytics, or capital to invest in them. Broad geographical reach with large market share.	Data integration and analytics. Relationships with community resources.	Employers and providers looking to deploy population health strategies and individuals looking to reap benefits from leading a healthy life.
Care Integrator *Integrates vertically to align incentives, improve care coordination, tackle utilization and keep medical costs low.*	Reduces medical costs due to lack of provider-payer alignment. Addresses providers' interest in provider-sponsored health plans and vertical integration.	Robust financial reserves and revenue sources. Strong leadership. Locally or regionally focused. Densely populated market with strong market share or a provider with strong brand.	Acquisition of providers (hospitals, clinics, physicians) to integrate along care continuum. Data integration. Technology focused on enhancing continuity of care.	Consumers with complex care needs or families where continuous care and convenience are highly valued.

Source: PwC Health Research Institute analysis

Appendix B: An in-depth comparison of health consumer markets

Medical, social, behavioral, lifestyle and consumer preference characteristics.

	Frail elderly	Complex chronic	Chronic	Mental health	Healthy families	Healthy adult enthusiasts	Healthy adult skeptics
Description	Over the age of 75, living at home, facing health issues related to falls or dementia and suffering generally poor health.	Have one or more chronic diseases affecting multiple body systems and often requiring complicated disease management (e.g. CHF, COPD, DM with end-stage renal disease).	Have problems affecting a single body system such as hypertension and require uncomplicated disease management.	Mental illness is primary health issue versus comorbid condition. Face depression and mood disorders, post-traumatic stress disorder, addictions and suicidal ideations.	Households with healthy dependent children under the age of 18.	Value a regular physical, wellness/ coaching services, and get recommended screenings.	Generally avoid interacting with the health system and are less likely to have health insurance than other consumer groups.
Insurers that appeal to them	Cost managing plans will appeal most. They are likely to switch insurers to save money. They are willing to try new locations for care such as retail clinics.	Plans providing the coverage of services and medications needed will draw these consumers. They are more resistant to change, and seem to be most loyal to their carriers.	Plans providing the coverage of services and medications needed will draw these consumers. While loyal to their carriers, they seem reluctant to use retail clinics or telemedicine services.	Managing healthcare costs is difficult for them. A high percentage would switch insurers to save money. Coverage of mental health services is most important.	Cost conscious but also one of the most adventurous groups. Willing to use retail clinics for their own and their families' care. Generally amenable to alternatives to traditional care, like sending a photo of a rash for diagnosis.	Generally do not find it difficult to manage healthcare costs but are still concerned over the cost of their monthly premium. They are most satisfied with the coverage of services and medications of their insurance plans.	The least likely to say they are satisfied with their insurance. They think they are healthy enough that they don't need health insurance. Plans with first-dollar coverage will appeal most.
Health Insurer of the future models that fits best	• Bridge Connector • Care Integrator	• Bridge Connector • Care Integrator	• Bridge Connector • Care Integrator	• Bridge Connector • Care Integrator	• Consumer Advocate • Care Integrator • Lean Operator	• Consumer Advocate • Analytic Sensor • Lean Operator	• Consumer Advocate • Analytic Sensor • Lean Operator
Number of people in US population	5.9M	24.8M	175.1M	9.4M	65.4M	22.6M	12.5M



Source: PwC Health Research Institute analysis of 2013 Medical Expenditure Panel Survey and Health Research Institute consumer survey, 2016

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About this research

Following the 2016 presidential election, late November 2016 through January 2017, PwC's Health Research Institute (HRI) commissioned a telephone survey of 101 executives from commercial insurers, Medicaid managed care insurers, Medicare Advantage insurers, provider-owned health insurers, third party administrators, and consumer operated and oriented plans. Executives represented insurers of varying size (number of lives covered), revenue and geographic reach (national/regional). Respondents were asked about their beliefs on overall shifts in the healthcare industry and the strategies and investments their organizations are pursuing for the future. In addition, HRI conducted interviews with healthcare executives from throughout the US industry.

This report is also based on insights from a fall 2016 HRI survey of 1,750 US adults representing a cross-section of the population in age, gender, income and geography. Respondents represent seven consumer markets as first defined in HRI's paper "Primary care in the New Health Economy: Time for a makeover." Those consumer markets were defined using the 2013 Medical Expenditure Panel Survey reported by the Agency for Healthcare Research and Quality.

About PwC's Health Research Institute

PwC's Health Research Institute (HRI) provides new intelligence, perspectives and analysis on trends affecting all health-related industries. The Health Research Institute helps executive decision-makers navigate change through primary research and collaborative exchange. Our views are shaped by a network of professionals with executive and day-to-day experience in the health industry. HRI research is independent and not sponsored by businesses, government or other institutions.

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