The Health Insurer of the Future

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EY
Building a better working world

Introduction

- This talk is derived from intellectual capital developed by a global, multi-disciplinary, team at Ernst & Young

- Further background available online at:

http://www.ey.com/GL/en/Industries/Financial-Services/Insurance/ey-health-insurer-of-the-future

- My purpose today is to stimulate discussion about potential directions of evolution of the health insurance industry, and what this might mean for the actuarial profession

- Jurisdiction-specific regulatory considerations are significant and will likely impact the extent to, and pace at, which evolution can occur

Disruptive trends shaping healthcare

A phenomenal opportunity within health insurance driven by a once-in-a-lifetime confluence of trends

Six trends that are disrupting health insurance

New streams to supplement underwriting income

Offering that truly aligns incentives for long-run behavioral change

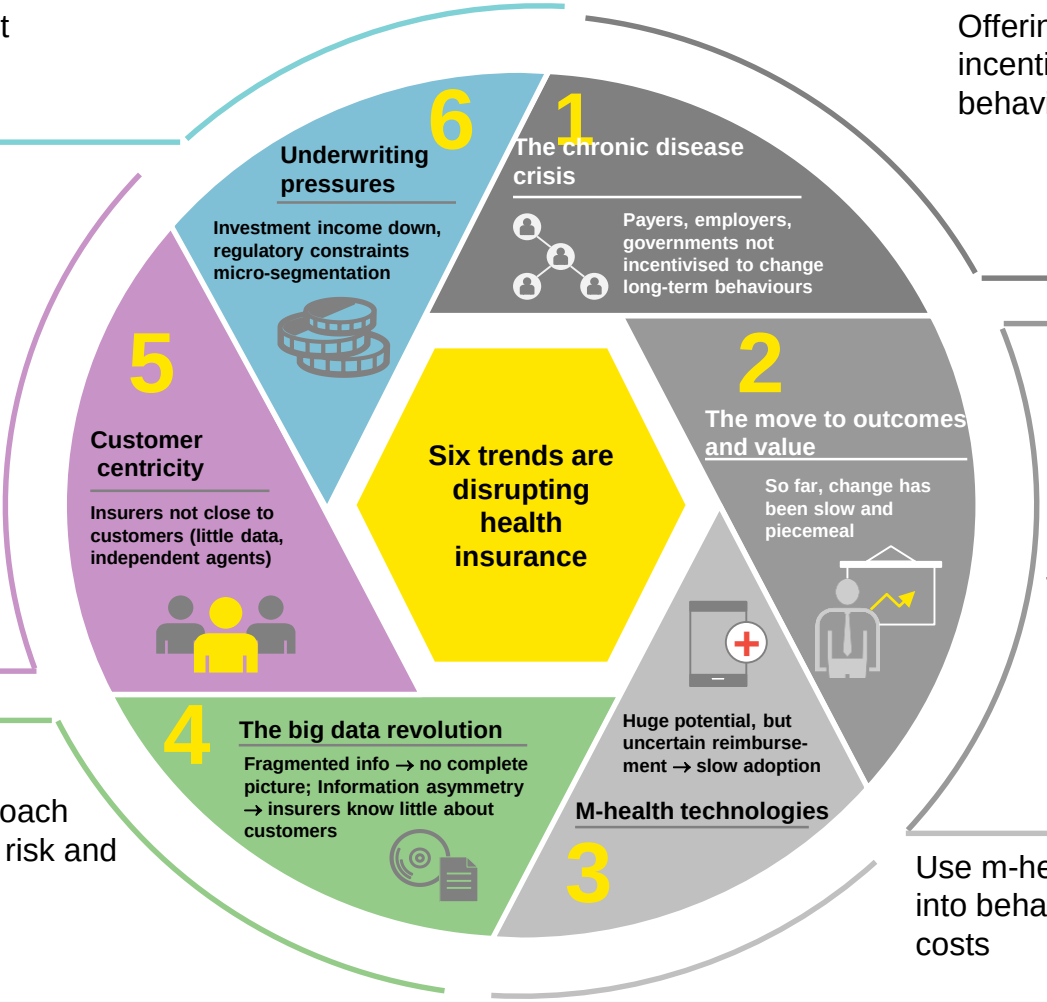
Use data, m-health to better understand customers

Make pay-for-performance the basis for new offering

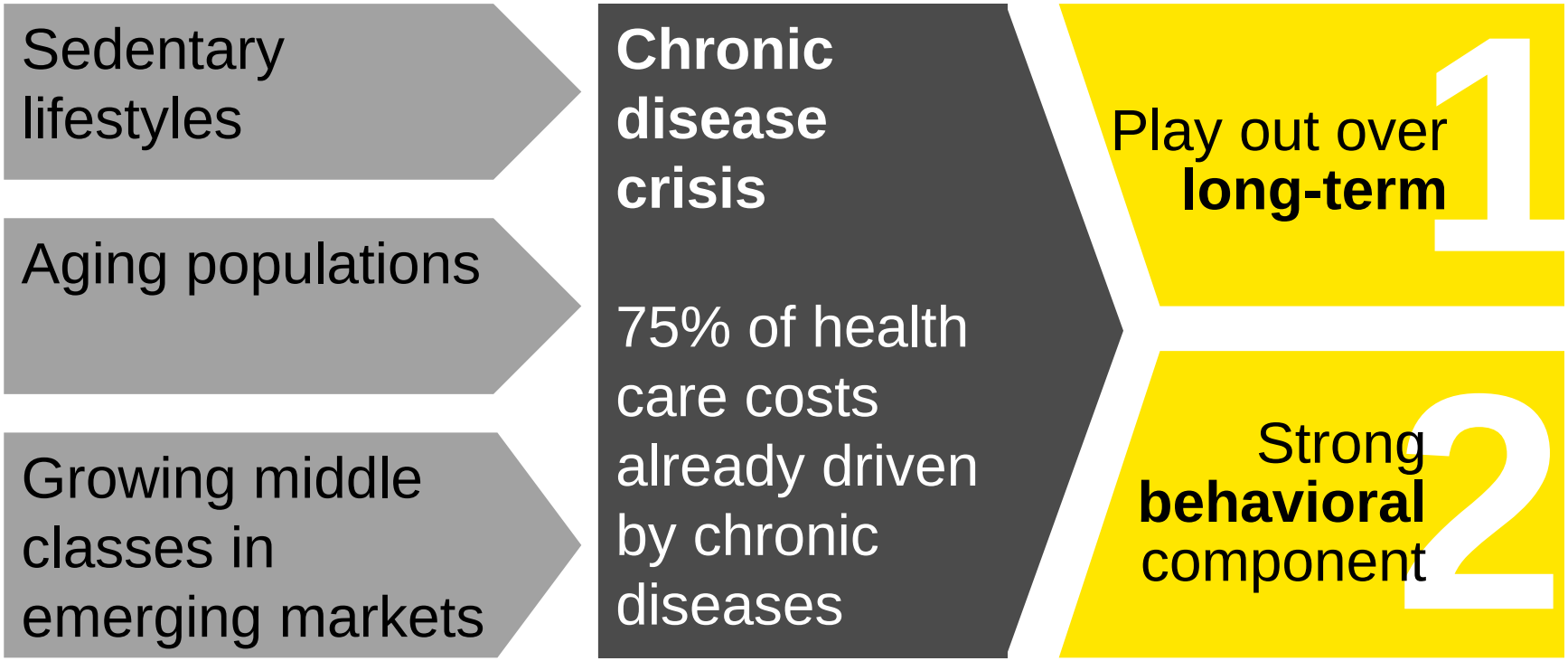
Transform the current disease care model and improve outcomes

Data core of new approach nudge behavior, lower risk and increase effectiveness

Use m-health to gain insights into behaviors, lower health costs



We face a looming chronic disease crisis…



1+2 → biggest need is **long-term behavioral change**

… but nobody is incentivized for long-term behavioral change

Patients: behavioral biases (hyperbolic time discounting, hot vs. cold states)

Employers: employee churn

Providers: fee-for-service (or pay-for-performance with short-term metrics)

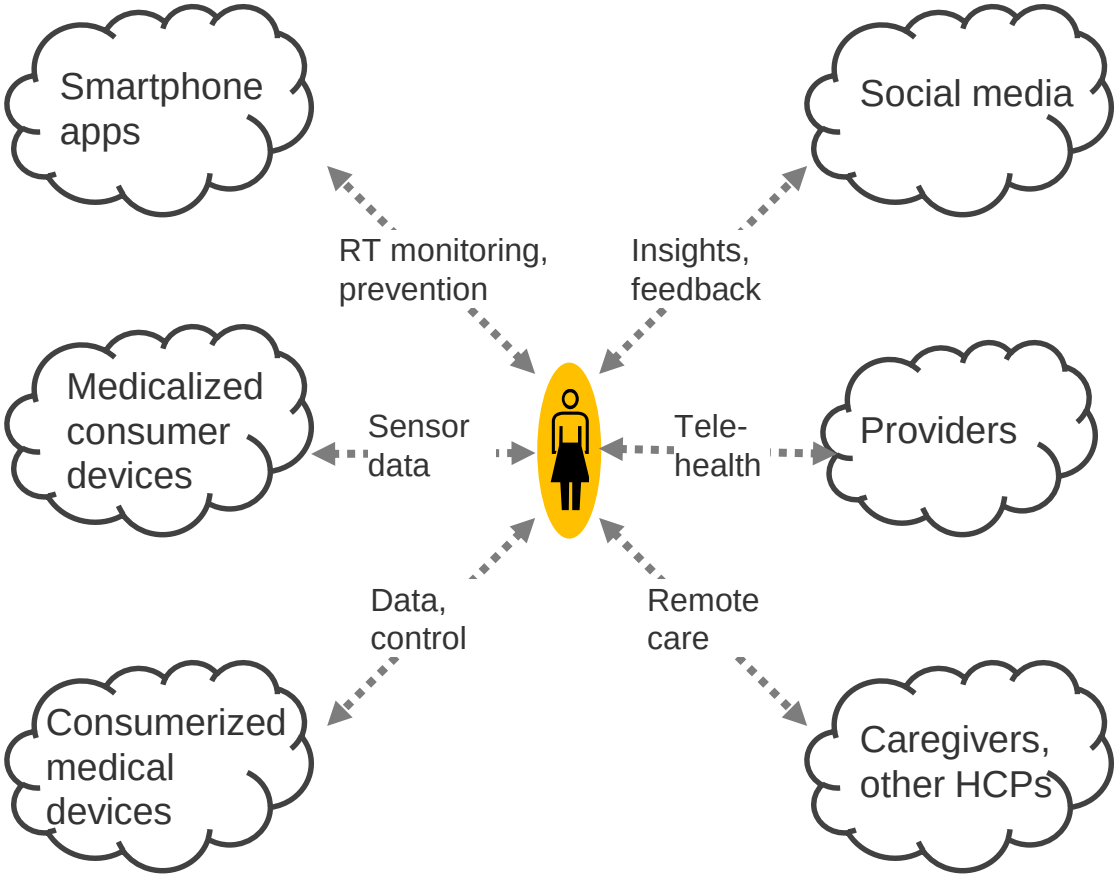
Health insurers: short-term contracts

Governments: short-term budgetary costs vs. long-term benefits; focus on election and budgetary cycles

Disruptive idea: an offering that, for the first time, truly aligns incentives around long-term behavioral change

M-health has huge potential in chronic diseases… but limited adoption

- **Real-time monitoring**
- **Prevention, behavior**
- **Transparent information**
- **More cost effective**



- **Little reimbursement in fee-for-service**
- **In P4P, transferring risk to providers, who may not always adopt m-health**

Disruptive idea: approach powered by m-health → greater insight, behavior change, lower costs

Big data has transformative potential, too… but insurers are in the dark

Data fragmentation

- Organizational silos
- Privacy/security concerns
- Regulatory constraints

Nobody has the "complete picture"

Information asymmetry

- Insurers underwrite with very little information on customers
- Imbalance exacerbated by personal genome sequencing, m-health, etc.

Even as health care moves to big data and patients gain more information, insurers are in the dark

Disruptive idea: data a central component → complete picture, better understand and influence risk

Customers have higher expectations…

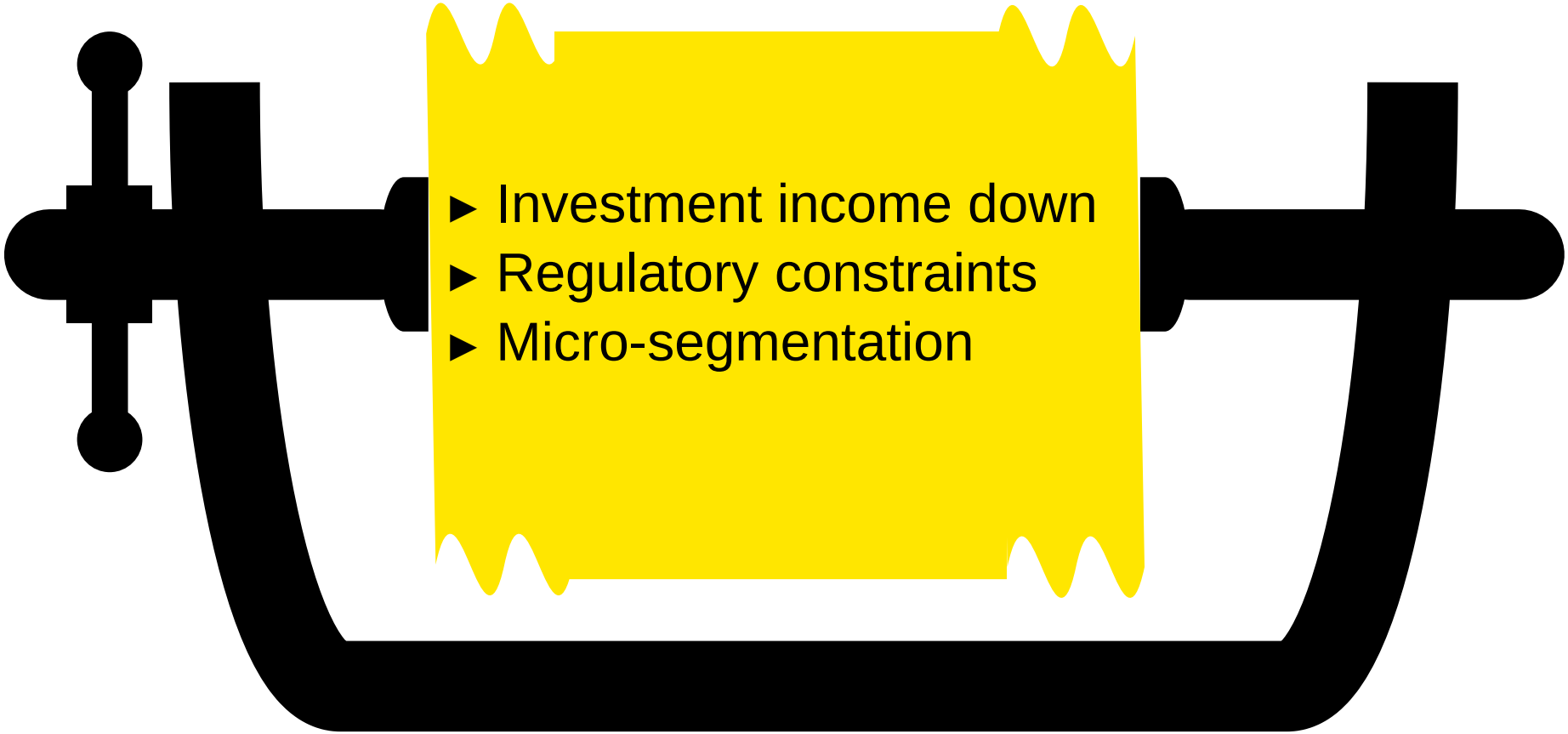
- More information
- Freedom of choice
- Experiences elsewhere shaping expectations in health care, insurance

… but insurers can't deliver

- Not close to customers
- Cut off by independent agent model

Disruptive idea: place customer in center → data to understand needs, m-health to build relationships, guide behavior

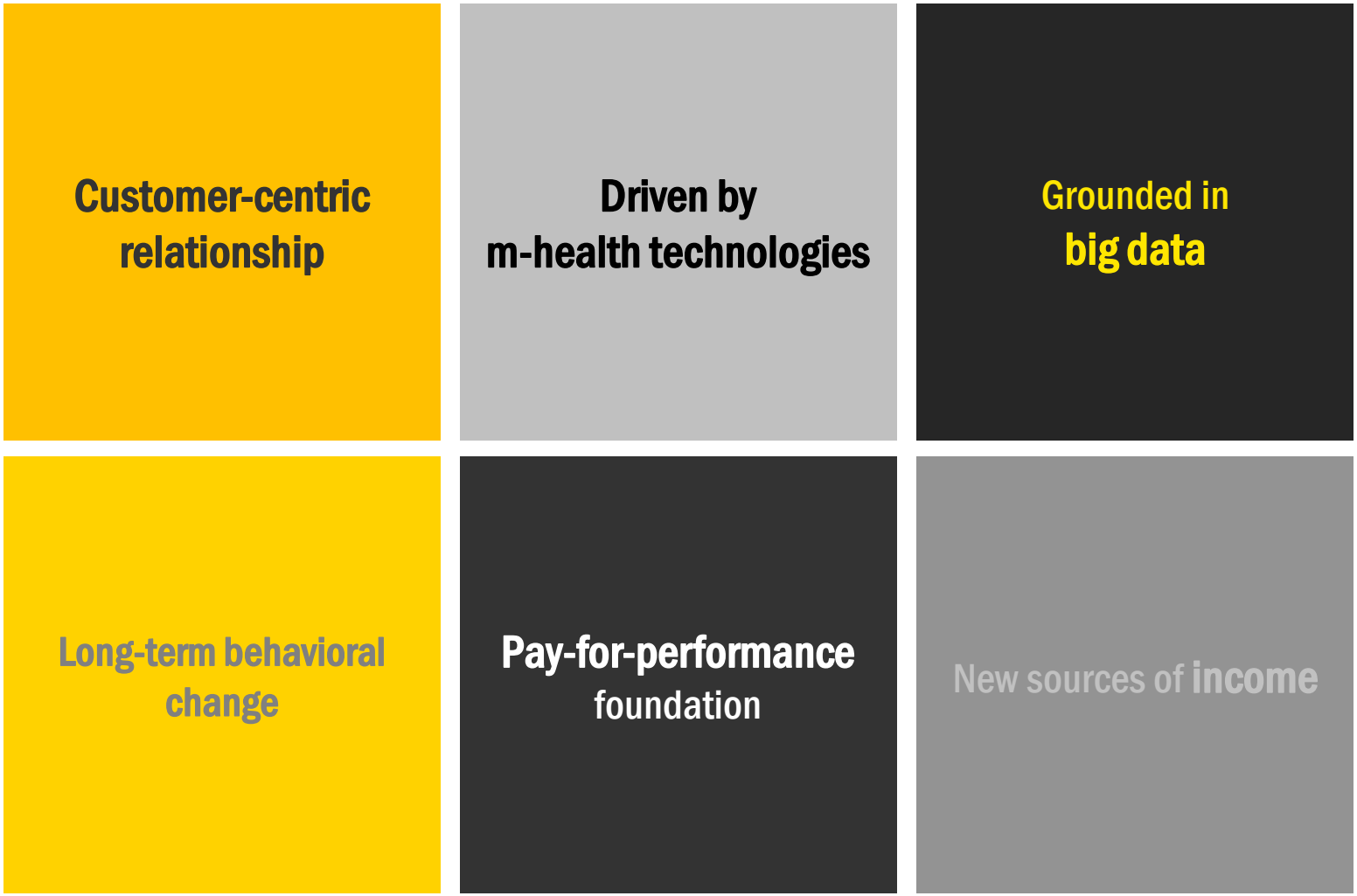
Underwriting pressures



Disruptive idea: new income sources to supplement core underwriting business

A customer centric value proposition

These give rise to a new model that brings all of the pieces together



… in a completely different approach to health insurance, risk and services …

Old model

Quantify risk

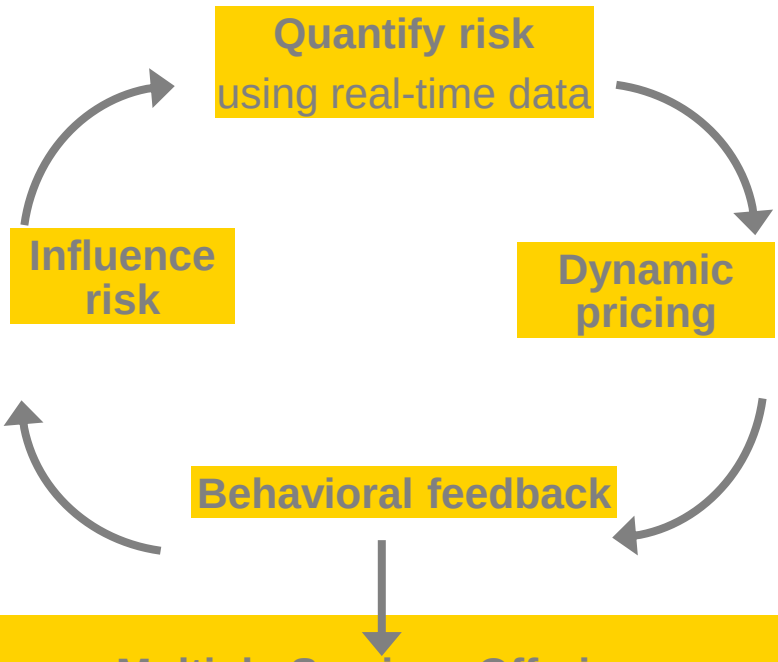
- Poorly understood
- Static

Price risk

Limited Services

- Traditional Health Care Options
- Expensive

New model



Multiple Services Offerings

- Digital Market Place
- Traditional Health Care Options
- Non Traditional “Digital” Care (Teledocs, Predictive & Preventative Care, Health 2.0)

… and a fundamentally different value proposition

Old value proposition

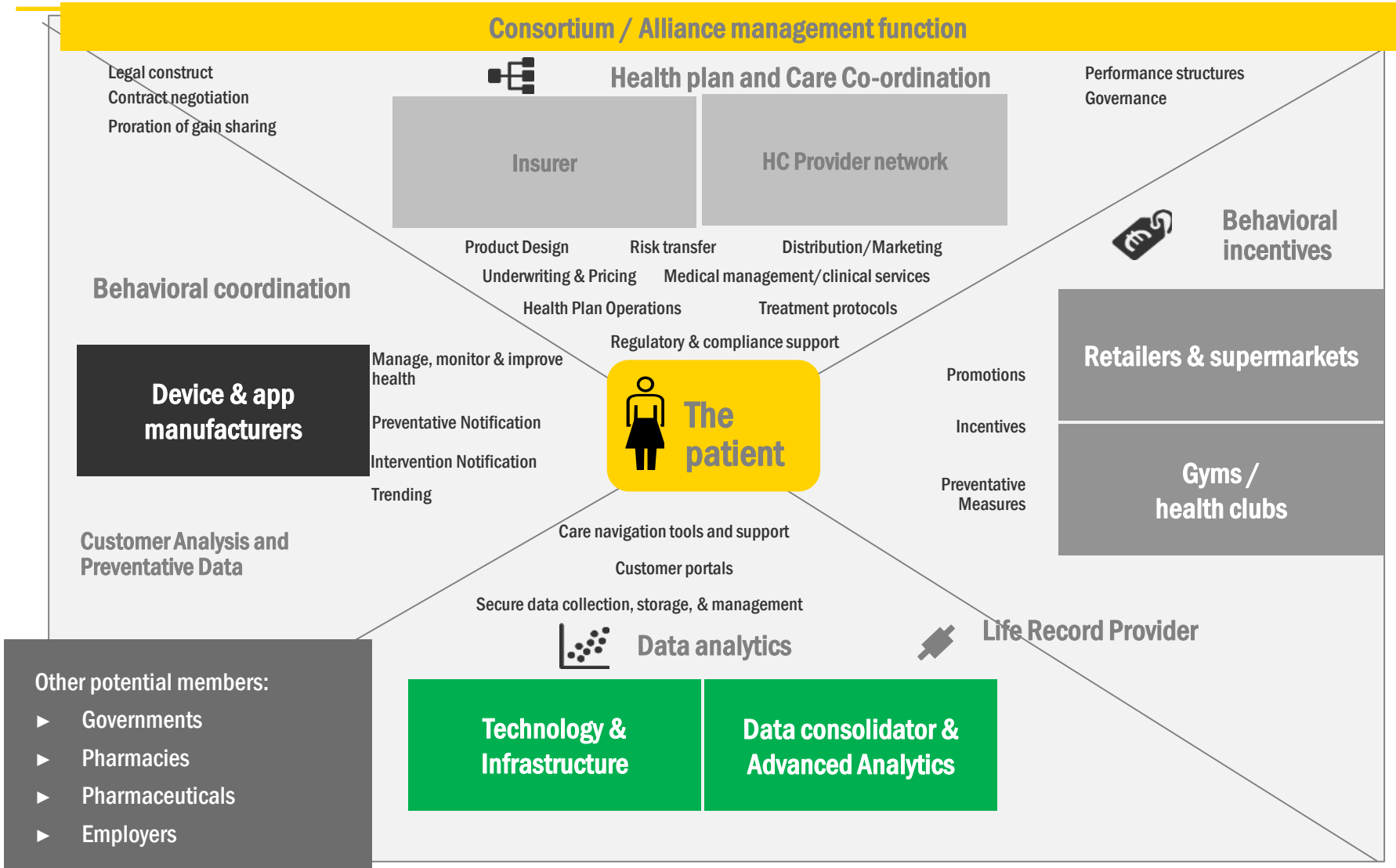
- Pay your premiums on time
- We'll cover you if you need medical care

New value proposition

- We'll ***partner*** with you to keep you **healthy** for the rest of your life (or as long as you stay with us)
- You'll be **empowered** with apps, technology, data to manage your health
- Over time, your **premiums** will increase more **slowly** than average
- You could get **other benefits** for proactively managing your health

…delivered by a consortium where parties with complementary assets & skills, collaborate around a common objective

Consortium Delivery



The common objective may well be to ……

Lower claims	✓
Behavioral change: prevention	✓
Population and condition management	✓
More efficient care delivery	✓
Data monetization	✓

Variations on the theme

US individual market (post-ACA)

- **The Affordable Care Act (ACA) introduced major changes to the US individual market, including:**
  - guaranteed-issue with no medical underwriting
  - expanded universe of market participants due to government premium subsidies
  - the introduction of Exchanges/Marketplaces
  - annual product filing / pricing / open enrollment cycle
  - pricing restrictions (e.g., gender-neutral, 3:1 age band limit)
  - prospectively risk-adjusted premiums
- **How do these regulatory conditions impact the viability of the core model?**
  - risk-adjustment tends to negate the impact on insurer profitability of attracting/retaining a lower-risk customer base
  - annual open enrollment cycle may make it harder to retain customer base for the long term
  - much of customer base are unaccustomed to private health insurance
  - payoff from prevention focus is limited due to risk adjustment and customer churn
  - technology-enabled model may be more attractive to younger consumers, which anecdotally have been difficult to attract to the Exchanges (hampered by age band considerations)
  - data monetization remains viable

US large employer segment

- **Historically, large US employers provide health benefits to their employees through either insurance or self-funding**
  - prevalence of self-funding increases with employer size
  - when self-funding, the employer typically contracts with a major insurer to gain access to provider contracts and adjudicate the benefits
  - when self-funding, the employer may or may not “reinsure” its risk via a stop loss contract (with the insurer administering the benefits, or with another insurer)
- **How do the nuances of this segment impact the viability of the core model?**
  - employee churn
  - employer churn
  - employee choice (‘private exchanges’)
  - traditional self-funding model doesn’t give the insurer participation in the upside from long-term employer morbidity improvement
  - no regulatory risk adjustment (but, risk adjustment via ‘private exchanges’?)
  - data monetization may remain viable