RESEARCH BRIEF

New Care Models

How insurers can rise to the challenge of older and sicker societies

THE GENEVA ASSOCIATION

INSURANCE FOR A BETTER WORLD

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Driven by broad shifts in demographics and disease status, age-related chronic and complex medical conditions now account for the largest share of healthcare budgets across the globe. The delivery of health and social care services remains episodic and often concentrated in hospital and speciality settings, leading to the inefficient use of finite health resources. The result is a reduction in the quality-of-care experiences and outcomes for consumers as well as uncontrolled cost inflation as complexity in demand is unmet by 'traditional' models of care.

Insurers and consumers are increasingly shouldering the burden of this evolving risk landscape and people with complex chronic illness are often faced with high deductible plans that exacerbate unmet need for care, a process that also makes it harder for insurers to grow their market.

At the same time, in a protracted low-yield environment, life insurers face stagnation in the demand for retirement and long-term savings solutions at the very juncture when this is needed to address the long-term health and well-being needs of ageing populations. As conditions such as dementia and neurological disorders grow in prevalence, there is also a growing need for long-term care (LTC) insurance to support people's social care needs, but there remain very few solutions.

We outline how health and life insurers can adopt New Care Models (NCMs) to influence care at all life stages seamlessly and to keep cost in check, drawing on the findings of a literature review and 15 high-level interviews with key informants.

NCMs are driven by three major global trends:

- **Shifting disease patterns caused by life style and ageing** resulting in an increase in the number of people living with multiple comorbidities and LTC needs.
- **The rise in the cost of care** resulting in unsustainably high premiums and high-deductible plans and catastrophic costs for consumers.
- **Increased pressure on public finances**, with many policymakers now looking at private-sector collaborations.

What are New Care Models?

NCMs represent an approach to care delivery with a 'triple aim':[1] to improve care experiences and health outcomes and encourage more cost-effective service delivery. They employ a variety of approaches that emphasise disease prevention and health promotion, proactive management of people with chronic disease to improve consumer experience, and collaboration across health and social care disciplines to improve health outcomes and address cost inflation. This may involve multi-professional partnerships that coordinate care and support for people with physical and mental health needs, or community-based and home-based alternatives to institutionalisation in hospitals or residential homes.[2, 3]

1 Berwick et al. 2008.
2 Leichsenring et al. 2013.
3 De Bruin et al. 2020.

Table 1: Distinguishing NCMs from conventional healthcare and singular disease-focused models

Conventional medical-based care	Disease management programmes	New Care Models
Focus on illness and cure with some population health at primary care level	Focus on priority diseases	Focus on holistic care to improve people's health and well-being
Relationship limited to the moment of consultation	Relationship limited to programme implementation	Continuous care to individuals, families and communities across the life course
Episodic curative care	Programme-defined disease control interventions	Coordinated and people-centred care integrated around needs and aspirations
Responsibility limited to effective and safe advice to the patient at the moment of consultation	Proactive management of a patient's risk factors to meet targets	Shared responsibility and accountability for population health, tackling the determinants of ill-health through intersectoral partnerships
Users are consumers of the care they purchase	Population groups are targets of specific disease-control interventions	People and communities are empowered to become co-producers of care at the individual, organisational and policy levels

Source: Adapted from Goodwin et al.[4]

The evidence on New Care Models

There is good evidence that NCMs support improved care experiences, favourably influence outcomes and reduce or limit the rise in costs of care. An evaluation of an integrated care programme in Alaska for indigenous communities showed substantial improvement in consumer and staff satisfaction, and a 36%, 42% and 58% reduction in hospital days, emergency department visits and specialist treatment, respectively.[5] A global systematic review by Damery et al. reported a 15–50% reduction in emergency admissions, 10–30% reduction in readmission and 1–7 reduced number of days in hospital.[6] Another review by Baxter et al. of 167 programmes found strong evidence of improved access to care, patient satisfaction and enhanced perception of quality of care.[7] The effects on health outcomes remain more mixed. While some reviews have shown statistically significant improvements in outcomes overall, they have varied by subgroups and the length of the programme[8] and in some cases remain unsubstantiated.[9]

Larger scale models seem to have significant potential to improve quality and reduce cost inflation. The advent of *Accountable Care Organisations* (ACOs) in the U.S. and other countries[10] has been associated with financial savings of between 6–25% when compared to standard practice.[11] In part, this success has been as a result of the change in relationship between the insurer/payer and provider – models that bring them closer together into risk-sharing arrangements where pooled funds can be used in innovative ways. However, the varying contexts and ways in which NCMs are implemented make it harder to infer how consistently they can generate positive results.

Enabling New Care Models: The need for a strategic purchaser

We outline five purchasing approaches, each with its strengths, weaknesses and considerations regarding potential to achieve the triple aim:

- **The traditional approach to procurement** where insurers work with a constellation of providers to form a network through multiple contracts;
- **The accountable care approach** where a group of multi-disciplinary providers take on shared responsibility for a defined population using different governance and contractual models with payers;
- **The fully integrated model** where the insurer and providers operate under a single governance structure and a global budget;
- **The direct-to-provider approach** where providers offer a package of services directly to consumers on a subscription basis, often bypassing primary insurers – notable for its implications for insurance sales and coverage; and
- **The consumer-directed payments approach** where policyholders directly buy services they need based on a personal budget.

By moving away from being a passive claims processor to become a 'strategic payer', insurers can correct the common misalignments found between financial flows and provider incentives.

Many of these purchasing approaches reward value over volume by balancing care between costly hospitals and speciality clinics and less costly primary/community-based settings.

4 Goodwin et al. 2017.
5 WHO 2015.
6 Damery et al. 2016.
7 Baxter et al. 2018.
8 Rocks et al. 2020.
9 Liljas et al. 2019.
10 Reich et al. 2012.
11 Pimperl 2018.

Table 2: The potential strengths and weaknesses of NCMs

		Models of care						
		Traditional approach to procurement	ACO-prime contractor	ACO-prime provider	ACO alliance	Fully integrated	Direct to provider	Consumer-directed payments
Impact criteria	Improving health outcomes	Medium	Medium	Medium	High	High	Low / Medium	Low / Medium
	Potential consumer market	Medium	High	High	High	High	Low	Low
	Potential consumer attractiveness	Medium	High (to groups with specific needs)	High (to groups with specific needs)	High	High (to groups with specific needs)	High (to groups with specific needs)	High (to groups with specific needs)
	Provider management capability	Low	High	Very High	Medium / High	Very High	Medium	Low
	Influence over care utilisation patterns	Low / Medium	High	Very High	Medium	Very High	Very High	Low / Medium
	Required new organisational capability	Low	High	High	Medium / High	Very High	Medium	Medium
	Risk to insurer	High	Low / Medium	Low / Medium	Low / Medium	Low	N/A	Low / Medium
	Potential for cost containment	Low	High	High	High	Very High	Medium	Low

Source: The Geneva Association

Findings from stakeholder interviews

Improving **customer experience** is the most common rationale for implementing NCMs, closely followed by the need to evolve business models to tackle cost inflation. Life insurers in particular show a strong pivot towards health solutions to address mortality in risk-based products and the high cost of comorbidities in long-term savings products. NCMs have a strong predisposition towards **service innovation**, i.e. expanding the range and scope of service, with only a few matching them with the use of new governance and contracting models to make the most of the new services offered. While many NCMs are new, there are promising indications that they improve the customer experience and reduce the need for costly care.

While overall **buy-in for NCMs by consumers and providers** is favourable, there is a need to: a) balance consumer preference for choice with service standardisation to make NCMs competitive; and b) dedicate time to improving provider understanding of NCM objectives and associated benefits.

New market opportunities afforded by NCMs include the use of data to improve existing products, the ability to package and sell new competencies enabled by NCMs, improving risk thresholds through better targeting to previous untapped groups and diversifying from risk-based products to service-based products. Marketing and distribution are the most commonly cited functions in the **insurance value chain** influenced by NCMs, helping to open up untapped customer segments. However, the sophistication of NCMs is still unsupported by traditional distribution channels, which remain transactional.

NCM scalability depends on: 1) conducive regulatory environments, with a focus on licensing rules for life insurers, data protection and provider market reform; 2) collecting, storing and analysing data to allow targeting and monitoring of NCMs in real time; 3) leadership and cultures that enable companies to take risks and allow longer-term horizons for NCMs to mature; and 4) a concurrent focus on key supply-side aspects, such as provider management and payment reforms, to ensure NCMs do not fall short in delivering the desired outcomes.

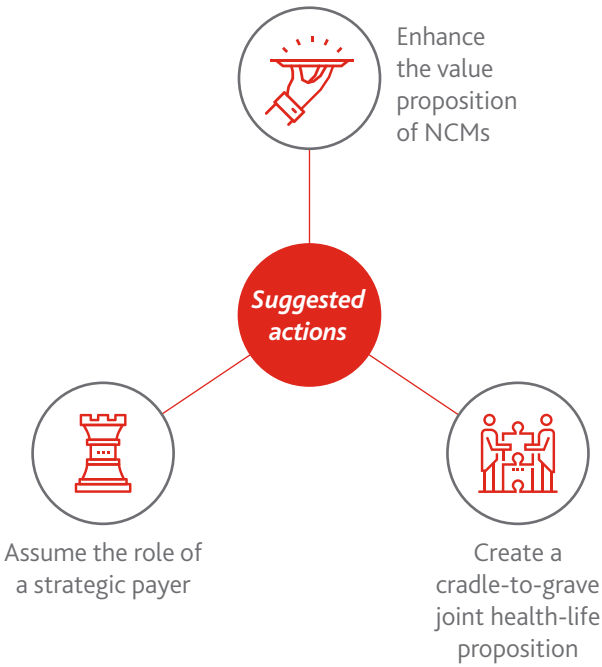
Recommendations

- Insurers need to **enhance the value proposition** of NCMs to go beyond the simplistic notions of choice and convenience. The current narrative should evolve to reflect the triple aim to promote its value to consumers, distributors, providers and internally within companies.

- Insurers need to **become a strategic orchestrator** of services. They will need to shift away from just paying claims, start assuming the role of a 'strategic payer' and ensure a favourable supply-side condition that can fulfil the promise of NCMs made to policyholders. This entails stratifying the risks to understand the pressure points; building the foundations to start sharing risks with providers; shifting towards value-based payment; and planning the journey incrementally using a maturity model.

- Insurers need to **capture the opportunities afforded by the convergence of life and health products and solutions**. NCMs provide an opportunity to create a seamless cradle-to-grave system. As both life and health insurance solutions try to expand by becoming attractive to new market segments and ensuring enough cross-subsidisation in their risk pools, it paves the way for a joint health-life service proposition. Internally, insurers would need to identify the strategic touchpoints of the two business lines. Pooling, analysing and sharing data in real time as well as a joint marketing and distribution plan are the obvious starting points. Externally, they need a clear plan that navigates the issues around health licences, price caps, provider and payment reforms and the local ethical and legal climate before engaging with policyholders.

Figure 1: Recommendations for insurers



Source: The Geneva Association

References

Baxter, S., M. Johnson, D. Chambers, A. Sutton, E. Goyder, and A. Booth. 2018. The Effects of Integrated Care: A Systematic Review of UK and International Evidence. *BMC Health Services Research* 18: 350. https://doi.org/10.1186/s12913-018-3161-3

Berwick, D.M., T.W. Nolan, and J. Whittington. 2008. The Triple Aim: Care, Health, and Cost. *Health Affairs* 27 (3): 759–769. DOI: 10.1377/hlthaff.27.3.759. PMID: 18474969.

Damery. S., A. Flanagan, and G. Combes. 2016. Does Integrated Care Reduce Hospital Activity for Patients with Chronic Diseases? An Umbrella Review of Systematic Reviews *BMJ Open* 6: e011952. DOI: 10.1136/bmjopen-2016-011952. https://bmjopen.bmj.com/content/6/11/e011952.info

De Bruin, S.R. et al., on Behalf of the SUSTAIN Consortium. 2020. Different Contexts, Similar Challenges. SUSTAIN's Experiences with Improving Integrated Care in Europe. *International Journal of Integrated Care* 20 (2): 17. http://doi.org/10.5334/ijic.5492

Goodwin. N., V. Amelung, and V. Stein. 2017. What is Integrated care? In *Handbook Integrated Care*, ed. V. Amelung, V.Stein, N. Goodwin, R. Balicer, E. Nolte and E. Suter, 3–4. Springer International Publishing.

Leichsenring, K., J. Billings, and H. Nies. 2013. *Long-term Care in Europe. Improving Policy and Practice.* Basingstoke: Palgrave Macmillan.

Liljas, A.E.M., F. Brattström, B. Burström, P. Schön, and J. Agerholm. 2019. Impact of Integrated Care on Patient-Related Outcomes Among Older People – A Systematic Review. *International Journal of Integrated Care* 19 (3): 6. http://doi.org/10.5334/ijic.4632

Pimperl, A. 2018. Re-orienting the Model of Care: Towards Accountable Care Organizations. *International Journal of Integrated Care* 18 (1): 15. http://doi.org/10.5334/ijic.4162

Reich, O., R. Rapold, and M. Thöni. 2012 An Empirical Investigation of the Efficiency Effects of Integrated Care Models in Switzerland. *International Journal of Integrated Care* 12 (1). http://doi.org/10.5334/ijic.685

Rocks, S., D. Berntson, A. Gil-Salmerón, M. Kadu, N. Ehrenberg, V. Stein, and A. Tsiachristas. 2020.

Cost and Effects of Integrated Care: A Systematic Literature Review and Meta-analysis. *European Journal Health Economics* 21: 1211–1221. https://doi.org/10.1007/s10198-020-01217-5

WHO. 2015. *People-centred and Integrated Health Services: An Overview of the Evidence. Interim Report.* http://apps.who.int/iris/bitstream/handle/10665/155004/WHO_HIS_SDS_2015.7_eng.pdf?sequence=1