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INSURANCE FOR A BETTER WORLD

New Care Models

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

CCRi Central Coast Research Institute for Integrated Care

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

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The Geneva Association

The Geneva Association was created in 1973 and is the only global association of insurance companies; our members are insurance and reinsurance Chief Executive Officers (CEOs). Based on rigorous research conducted in collaboration with our members, academic institutions and multilateral organisations, our mission is to identify and investigate key trends that are likely to shape or impact the insurance industry in the future, highlighting what is at stake for the industry; develop recommendations for the industry and for policymakers; provide a platform to our members and other stakeholders to discuss these trends and recommendations; and reach out to global opinion leaders and influential organisations to highlight the positive contributions of insurance to better understanding risks and to building resilient and prosperous economies and societies, and thus a more sustainable world.

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Foreword

The landscape of health and social care is not fit for purpose.

The prevalence and impact of non-communicable diseases (NCDs) – such as cardiovascular diseases, cancer, diabetes, and mental illness – are on the rise. NCDs affect older, middle-age and even younger populations alike, meaning a person may require disease care and management for decades of their life. Low-income populations are at special risk of unhealthy habits and exposures linked to NCDs.

Despite this greater occurrence of sickness, people are living longer. The World Health Organization projects that by 2050 there will be two billion older persons (people over the age of 60) worldwide, more than double the number in 2015. With decreased fertility rates, there are already more older persons than children under five years old. Older populations are often, of course, afflicted by comorbidities and have multiple care needs.

The cost implications of these trends for societies are severe. However, it is hardly worthwhile to think only about how to absorb care costs; we must rethink the nature of care itself, with the sustainability of the health and life insurance industry in mind.

New Care Models (NCMs), the focus of this report, carry a great deal of promise. First, by emphasising prevention, they help people mitigate the factors that contribute to the onset of disease. Second, they integrate all aspects of care needs, from health to age-related. Third, they aim to 'de-institutionalise' care by moving it out of expensive hospitals and facilities and into home- and community-based settings, often aided by digitalisation.

If implemented successfully, the improvements will be significant: a more positive care experience for people, better health outcomes, and less costly services for all stakeholders including insurers. As this report illustrates, insurers can drive the shift to NCMs, whether by steering how care is provided or expanding their own services into care provision. There is also a compelling case for hybrid life-health insurance products, not least to ensure that customers can access the most protection possible.

We hope this report supports insurers in advancing NCM initiatives and contributing – as they already do in so many ways – to a better, safer and healthier world.

Jad Ariss
Managing Director, The Geneva Association

1. Executive summary

Demographic and epidemiological shifts have made age-related and chronic illness a large part of healthcare expenditure. Episodic hospital and speciality care dominate in most health systems. Yet the shifts in consumer needs warrant a greater convergence of all levels of health and social care to improve consumer experience, health outcomes and cost inflation. Unlike traditional care approaches, New Care Models (NCMs) seek to better coordinate these three elements, the so-called 'the triple aim'. This report highlights how health and life insurers can adopt NCMs to influence care at all life stages seamlessly and to keep cost in check. It is organised in three parts:

- An outline of the evidence of health and cost outcomes, based on a literature review;
- A summary of key insights from 15 high-level interviews with key informants; and
- Recommendations derived from the literature review and interviews.

NCMs are driven by three major global trends:

- Shifting disease patterns caused by lifestyle and ageing resulting in an increase in the number of people living with multiple comorbidities and long-term care (LTC) needs, some of which are further exacerbated by social inequality.
- 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.

The literature reflects that NCMs can take many forms, but what they have in common is an emphasis on prevention and health promotion, proactive management of chronic disease, and collaboration across health and social care to deal with multiple comorbidities and seek home-based alternatives to hospitals or long-term residential care. Evidence suggests that NCMs improve care experiences and have the potential to reduce costs. However, evidence of improved health outcomes is still patchy. Varying contexts and ways in which NCMs are implemented make it harder to infer how consistently they can generate positive results. Hence, while there is good understanding of what constitutes effective 'building blocks' of NCMs, understanding to ensure that implementation is successful across different contexts is limited.

By moving away from being a passive claims processor to becoming a 'strategic payer', insurers can correct the common misalignments found between financial flows and provider incentives. Such contracting and payment models reward value over volume by balancing care between costly hospitals and speciality clinics and less costly primary/community-based settings.

This report outlines five purchasing approaches, each with its strengths, weaknesses and considerations regarding potential to improve health outcomes and consumer attractiveness, encourage rational utilisation and contain costs:

- **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 multidisciplinary providers takes 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.
- **The consumer-directed payments approach** where policyholders directly buy services they need based on a personal budget.

The literature review was complemented with 15 key informant interviews with representatives of some of the largest global life and health insurers, as well as experts working to implement NCMs. The interviews covered six broad themes, summarised below.

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. Few NCMs match this with the use of new governance and contracting models as well as value-based payments in order to make the most of the new services offered. While it is too early to assess the impact of such innovations, there are promising indications of improving customer experience and reducing the need for costly care, mirroring those seen in the broader literature.

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. As such, many consumers may still not fully realise the benefits of NCMs throughout their life course.

Four areas are considered vital for **NCM scalability**: 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.

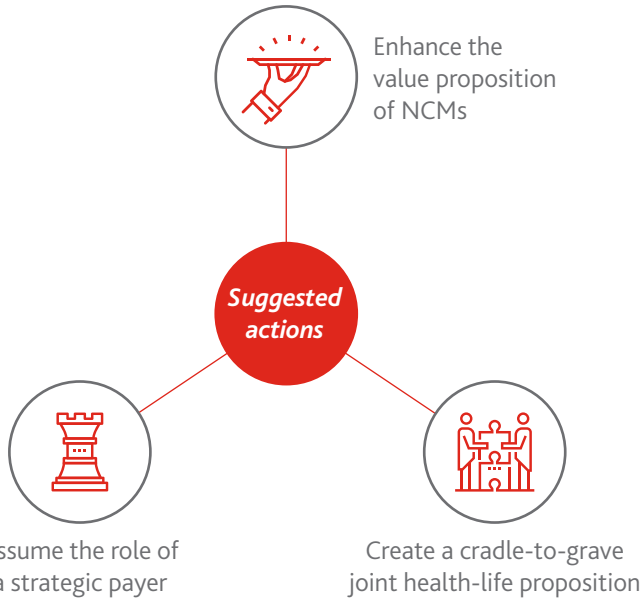
Based on these findings, this report proposes three actions:

1) **Insurers need to enhance the value proposition of NCMs.** While consumer attitudes will be central to shaping future services, the value proposition of NCMs will need to go beyond the simplistic notions of choice and convenience. The current narrative should evolve to reflect 'the triple aim' (i.e. improve consumer experience and outcomes and address cost inflation) to promote its value to consumers, distributors, providers and internally within companies.

2) **Insurers need to become a strategic orchestrator of services.** They will need to shift away from just paying claims and 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.

3) **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. This has already been achieved in parts of Asia. 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, insurers 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

2. Introduction

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. Increasingly, people are living with multiple health and social care needs but the delivery of 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. In the U.S., for example, between 2016–2018, hospitalisation accounted for 42% of the growth in health expenditure by private health insurers,[1] often driven by chronic conditions. As a result, people with complex chronic illness are increasingly faced with high deductible plans that exacerbate unmet need for care, a process that also makes it harder for insurers to grow their market. In low and lower- middle-income countries, over 40% of spending on health represents out-of-pocket expenditure, reinforcing the need to have more affordable models of care.[2]

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 age-related conditions such as dementia and neurological disorders grow in prevalence, there is also a growing need for LTC insurance to support people's social care needs, but few existing solutions tackle such fundamental concerns.

Left unaddressed, these issues will have far-reaching consequences, not only for health and life insurers, but also for the wealth and health of society. To address this, policies and programmes have emerged that encourage 'new care models', which seek to better coordinate health and care provision, enhance services closer to home and outside hospital settings and encourage interventions to promote good health. Whilst this has been a global endeavour, the emergence of NCMs has been incremental at best as those approaches have struggled to grow alongside predominating hospitalisation-based models of care.

Aims and objectives of this report

This report explores innovations in the planning, purchasing and delivery of health services. Specifically, it addreses how life and health insurers can directly influence how care is provided in order to reduce the future rise in costs for consumers and payers by assuming greater responsibility as **strategic payers** of care and/or expanding more directly into service provision.

Section 3 of the report is based on a review of the evidence on NCMs. Section 4 provides perceptions and experiences of representatives of Geneva Association member companies and thought leaders inside the health and life insurance industry on implementing NCMs. Section 5 sets out a series of recommendations for insurers.

1 Thorpe 2019.
2 WHO 2020.

3. The case for New Care Models

3.1 Changing demographics and disease patterns

Over the past two decades, a significant shift in global demographics has occurred in which age-related and long-term chronic conditions have replaced communicable disease as the most significant challenge facing all health and care systems. The economic toll of non-communicable diseases is set to cost the global economy USD 47 trillion between 2011 and 2030,[3] equivalent to 2.5% of annual global GDP.

Costs related to chronic illness will only rise. A combination of fundamental structural trends – the ageing of the population and changes in lifestyle and living conditions described below – have created the preconditions for a continued expansion in the prevalence of chronic diseases in the future. Additionally, medical technologies for the diagnosis and treatment of chronic diseases continue to advance in sophistication and cost and will likely put greater financial burden on payers and consumers.

- **The ageing factor:** The growth in the numbers of people with complex chronic conditions is significantly associated with ageing populations. In the past two decades, global life expectancy has increased from 66 years to 73 years but health-adjusted life expectancy continues to lag behind.[4] It has been estimated that by 2050, more than 6% of all people in the European Union (EU) and the U.K., or 31 million people, will be over 85 years old.[5] The number of centenarians will be close to half a million by 2050 in the EU.[6] More than one fifth of those aged 85 and over will be living with five or more comorbidities.[7,8] Similar increases are projected globally. For instance, in China, 69.5% of middle-aged people were estimated to have multiple comorbidities.[9] In the U.S. this figure rises to 81% of people over the age of 65 years.[10] Indeed, 2018 was the first year that people aged 65 and older outnumbered children under the age of five globally.[11]

- **The need for LTC:** These changing demographics have not just impacted the nature of chronicity. They have also led to a dramatic increase in the use of LTC. For example, an analysis of LTC services in Europe projects dramatic increases in its use and costs (more than 300% in the case of Germany) between 2000 and 2050.[12] More recently, LTC spending in the EU was the only healthcare service registering a continuous increase from 2004 to 2016, despite the financial crisis, averaging between 2% and 4%.[13]

- **Mental health as a compounding factor:** Mental health conditions are projected to cost the global economy up to USD 6 trillion in the next decade.[14] Many people

3 Bloom et al. 2012.
4 WHO 2020.
5 Eurostat 2019.
6 Eurostat 2020.
7 Presence of multiple diseases (physical and mental).
8 European Commission and Economic Policy Committee 2009.
9 Zhao et al. 2021.
10 Buttorf et al. 2017.
11 United Nations 2020.
12 Comas-Herrera et al. 2003.
13 OECD 2020.
14 The Lancet Global Health 2020.

with long-term physical health conditions also experience mental health problems that can lead to significantly poorer health outcomes and reduced quality of life. The cost of comorbidity to healthcare systems is significant. By interacting with and exacerbating physical illness, comorbid mental health problems raise total costs by at least 45% for each person with a long-term chronic condition.[15] This means that 12–18% of all healthcare costs globally are linked to poor mental health and well-being, a figure that disproportionately impacts vulnerable and deprived members of society.

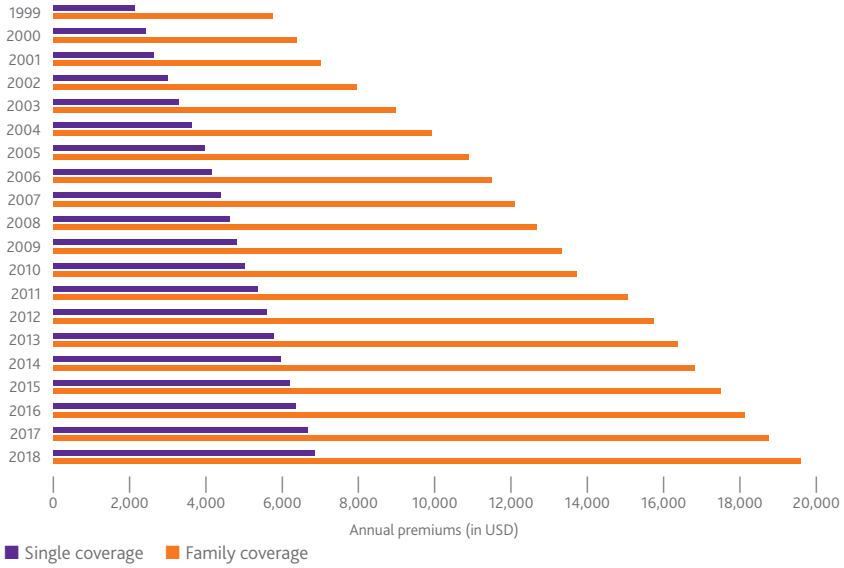
- **Deepening inequality:** The changing demand for health and social care is characterised by significant inequalities in health within and between countries.[16] Social factors are at the root of these health inequalities, including issues such as income and education disparities, unemployment, working conditions, food or water insecurity, early childhood development, social inclusion, and conflict.[17] Research shows that the socio-determinants of health account for between 30–55% of health outcomes. Inequalities in care are also characterised by basic barriers to access to affordable and quality health services. Often the most 'vulnerable' populations – those likely to benefit from a more coordinated approach to their needs – are least likely to benefit from innovations in care design.[18] Therefore, population groups with the greatest complexity of need – such as the frail elderly, the disabled, those living in rural and remote communities, and indigenous or ethnic minority groups – lose out. Such groups also tend to be most adversely impacted by the double burden of infectious and non-communicable diseases, as has been so cruelly exposed during the COVID-19 pandemic.

3.2 The rising costs of care

The World Health Organization's (WHO's) Global Spending on Health report shows that global spending on health continually rose between 2000 and 2018 and reached USD 8.3 trillion or 10% of global GDP[19] as a result of the demographic and epidemiological shifts discussed above. But this increase is also explained by the curative nature of services often occurring in high-cost care settings. In the U.S., hospital-based care (31%), physician services (20%) and prescription drugs (10%) are the key drivers of cost inflation due to the intensity and the cost at which it is delivered.

The result of this has been a significant increase in health and life insurance premiums internationally, along with out-of-pocket payments fuelled by a shift to high-deductible health plans (HDHPs). In Australia, for example, where private health insurance rate rises are regulated, there has been a 43.5% increase in industry-weighted premiums between 2012 and 2020.[20] In the U.S., a study by Claxton et al.[21] showed that the average premium for family coverage rose 20% over the past five years and 55% over the past ten years (Figure 2).

Figure 2: Average annual premiums for single and family coverage (U.S., 1999–2018)



Source: Claxton et al.[22]

15 Naylor et al. 2012.
16 Marmot 2005.
17 WHO (no date).
18 Øvretveit 2011.
19 WHO 2020.
20 Compare the Market 2021.
21 Claxton et al. 2018.
22 Ibid.

3.3 Implications for health and life insurers

The risks of ill health and old age, coupled with an episodic and costly health and social care system, straddles both life and health insurers. Some life insurers are attempting to ward off the risks by looking to health to support active ageing. Integrating risk, annuities and retirement products with health offers to avoid premature mortality or mitigate the risk of needing costly LTC in old age are some examples. Health insurers, on the other hand, are orchestrating care with increased focus on prevention and proactive disease management in order to tackle rising premiums and catastrophic expenditure. These initiatives are coming at a time where public finances are under substantial pressure, with increased scrutiny of the value of subsidy for private insurance uptake – a political risk that cannot be underestimated.[23]

Despite this confluence of issues related to health, elderly care and financial protection, traditional life and health insurances continue to maintain a firewall between their solutions, even though their risks have become interdependent. The industry is faced with a hard balancing act of managing these risks and countering the trend towards less affordable and less attractive health plans. At the same time, consumers increasingly demand innovative and accessible primary care services with better guidance for self-care. The insurance industry, therefore, needs a refreshed proposition and new purchasing and provision arrangements, without which premiums will continue to rise, resulting in reduced coverage and falling enrolments – especially among the younger generations.

3.4 What are New Care Models?

NCMs represent new ideas as to how care delivery can engage more in prevention and health promotion activities, become more proactive in managing people with chronic disease to improve consumer experience of care, and work collaboratively across health and social care disciplines to improve health outcomes and address cost inflation. This thinking has become known as 'the triple aim'.[24] This may include 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.[25, 26]

> NCMs represent an approach to care delivery with a 'triple aim': to improve care experiences and health outcomes and encourage more cost-effective service delivery.

Global support for such approaches is growing. Projections for future demand on health and long-term care systems are considered to be so acute that WHO passed a resolution of its 194 member states to adopt a *Framework on Integrated People-Centred Health Services*.[27] Their interim report argued that without a people-centred and integrated health services approach, healthcare will become increasingly fragmented, inefficient and unsustainable,[28] and called for a fundamental paradigm shift in the way health and care services should be funded, managed and delivered.

A range of strategies have been adopted globally to cope with growing demand. These strategies often focus on people with complex health needs; those who are frequent users of services; or people currently most dependent on multidisciplinary care support. These approaches are premised on the idea that good health and care can be delivered without always resorting to highly-specialised medical interventions. Rather, they require interventions that go beyond the 'traditional' health setting to include social care in order to improve the care experience efficiently. Internationally, continuum of care delivery models espouse the principles of NCMs.

23 Duckett and Cowgill 2019.
24 Berwick et al. 2008.
25 Leichsenring et al. 2013.
26 Bruin et al. 2020.
27 WHO 2016.
28 WHO 2015.

Box 1: A continuum of NCMs to address people's health and care needs

Supporting individuals, carers and families to live well and independently

- To individuals and families: health literacy; shared decision making, self-care, care assessments and planning.
- To communities: participation, awareness, user groups, volunteers, addressing factors that marginalise at-risk communities.
- To policy and decision makers: taking a life-course approach that focuses on promoting active and healthy living through tailored public health interventions.

Care in the home environment

- Strategies, such as respite care, that support carers and families to cope with the ability to manage people with complex needs at home.
- Providing home care services through specialist carers or trained nurses.
- Supporting assisted living through the use of telehealth and digital technologies and other approaches that promote independent living.
- Tackling social isolation and building active participation in local communities, including befriending.
- Investing in extra care housing and/or 'ageing-in-place' initiatives that promote age-friendly homes and naturally occurring retirement communities.

Access to care in primary and community care settings

- Improving access to general practitioners (GPs) and other primary care professionals.
- Establishing multi-disciplinary health and care teams to enable proactive and enhanced coordination of health and social care.
- Promoting care management in the community to people with high levels of functional disability through assessment, care planning, shared decision making, and coordinated delivery between providers through multi-professional teams.
- Enabling faster access to specialist support in the community, as well as for people with key needs such as mental health issues, neurological disorders, dementia and palliative care.

Intermediate care and care transitions

- Establishing facilities that enable short-term step-up and step-down care from hospitals to facilitate respite care and rehabilitation.
- Enabling smoother transitions of care between care providers and professionals through the use of named care coordinators to support people and their families as they navigate their way through complex care systems.
- Developing electronic health records to enable the smooth transfer of data between care providers for effective decision-making in real time.
- Managing the process of safe and secure care transitions from hospital to the home environment to shorten lengths of stay in hospital with specific individuals and teams.

Care in residential and nursing homes

- Ensuring that access to LTC for people with high needs is available when necessary, with the integration of care home support with effective management of older people's medical and nursing needs.
- Focusing on quality of LTC to prevent elder abuse and respectful care.

Medicines management

- Supporting GPs and other care providers with decision-support tools and methods to review quality of prescribing practices.
- Pharmacist and nurse-led interventions that provide educational information and outreach to reduce prescribing errors amongst high-risk patients.
- Supporting people and their carers with information to enable them to manage their medications effectively at home.

Dementia care

- Ensuring that dementia care services are available to older people living in the community, including access to specialist support and support at home tailored to different levels of severity.
- The development of centralised coordination of dementia care in the community with 24/7 care through rapid response and multidisciplinary teams.

End-of-life care

- Ensuring that palliative care services are available to older people living in the community to support dignity in dying in places of choice.
- The development of centralised coordination of end-of-life care in the community, enabling 24/7 care through rapid response and multidisciplinary teams.

Source: Goodwin[29]

29 Goodwin 2015.

Beyond the immediate needs involving formal health and care systems, NCMs are also associated with non-medical, community-based services. Home meals, modifications to living conditions, carer support through respite days, volunteers and neighbour support and befriending schemes are just some examples. To summarise, NCMs have led to a change in the way service provision shifts from the conventional hospital-centric or disease-management approach towards integrated care solutions (see Table 1).

NCMs have led to service-provision shifts from the conventional hospital-centric or disease-management approach to integrated care solutions.

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.[30]

3.5 The evidence on New Care Models

Key message: Early evidence of the efficacy of NCMs points in the right direction. However, their progress towards achieving the triple aim is not consistent and focus on design and implementation is needed.

For all of the strategies outlined in Box 1 there is good evidence that NCMs support improved care experiences, favourably influence outcomes and reduce, or at least limit, the rise in costs of care. For instance, 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.[31] 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 hospitals.[32] Another similar 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.[33] 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,[34] while other reviews point out that the effects on mortality remain unsubstantiated.[35] Moreover, there is good evidence to suggest that where these multiple strategies to support care coordination are combined – especially when led within primary and community care settings – then the likelihood of positive impact can be increased.[36] Indeed, the impact of NCMs can be highly significant

30 Goodwin et al. 2017.
31 WHO 2015.
32 Damery et al. 2016.
33 Baxter et al. 2018.
34 Rocks et al. 2020.
35 Liljas et al. 2019.
36 Davies et al. 2008.

in terms of costs and quality for core strategies such as chronic disease management (especially support for self-management), better care transitions to and from hospital (especially individualised and community-based follow-up) and ongoing care support to older people living at home (especially to people with complex needs such as dementia or towards the end of life).

However, the evidence for their success in consistently supporting improved outcomes, experiences and efficiency is mixed. This is due to the heterogeneity of the many approaches to NCMs, the varied contexts and demographics in which they have been applied, and significant issues related to the design of NCMs as well as the effectiveness of their implementation of NCMs as well as their design. Hence, despite the prima facie evidence for projects and programmes that have succeeded in making a significant impact, such impact is not always possible to replicate in other contexts and settings.

Put more accurately, while there is good understanding from the evidence of what the effective 'building blocks' of successful approaches to NCMs look like, there is limited understanding of how the implementation of such innovations, i.e. across the cycle from conception, design, implementation, evaluation, improvement and sustainability, will ensure success.[37] The recently published framework below demonstrates the possible 'winning ingredients' of NCMs (see Table 2).

Table 2: The Project INTEGRATE Framework: A validated set of characteristics associated with the successful impact of integrated care projects

Dimension of care	Strategies associated with successful implementation
Person-centred care	The active engagement of patients and carers as partners in their care. Key strategies include: health literacy, supported self-care, carer support, shared decision-making, shared care planning and access to health data
Clinical integration	How care services are coordinated with and around people's holistic needs. Key strategies include: multidisciplinary assessments and plans; active care coordination; care transition management; integrated care pathways; case management; a rostered/enrolled population; and involvement of community partners
Professional integration	How care professionals work alongside each other to meet people's multiple needs. Key strategies include: shared governance and accountability for care outcomes; interprofessional training and education; working in teams; formal agreements to collaborate; and a positive attitude towards working together
Organisational integration	How care providers work together across organisational boundaries to enable professionals to work together. Key strategies include: shared finance and incentive schemes; aligned governance, regulatory and performance frameworks; common organisational goals; and effective care networks
Systemic integration	How the care system provides the enabling architecture to support organisational integration – for example through shared information and data systems; deregulation; financial flows; workforce investments; and other policies supporting and embedding new models of care
Functional integration	The capacity to communicate data and information across the system manifest in key capabilities such as patient identifiers, shared care records, and effective communication and use of such data in decision-making and care delivery
Normative integration	The extent to which different partners in care share the same norms and values towards care integration, for example in terms of: having a shared purpose and vision; building social capital and trust; promoting shared and distributed leadership; and having a collective emphasis on population health

Source: Adapted from Calciolari et al.[38]

This evidence base may suggest that there is a 'maturity model' at play when it comes to the development of NCMs. For example, a recent systematic review of the economic impact of such models concluded that there were significantly improved outcomes at significantly reduced costs to be made, but that such savings were only prevalent in innovations that developed over a longer timeframe, i.e. beyond three years, an observation that is consistent with other evidence bases across Europe[39] and in the U.K.[40]

37 Goodwin 2019.
38 Source: Adapted from Calciolari et al.
39 WHO 2016.
40 Morciano et al. 2020.

What is promising, however, is that – given enough time – larger scale models seem to have significant potential to improve quality and reduce cost inflation. For example, the advent of *Accountable Care Organisations* (ACOs) in the U.S. and other countries have been associated with financial savings of between 6–25% when compared to standard practice.[41] 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. The impact can be particularly transformative where competitive insurance markets exist. For example, in Switzerland, the introduction of care models for chronic disease management was deployed with provider payment reforms to share risks with them, which reduced insurance costs by an average of 21%.[42]

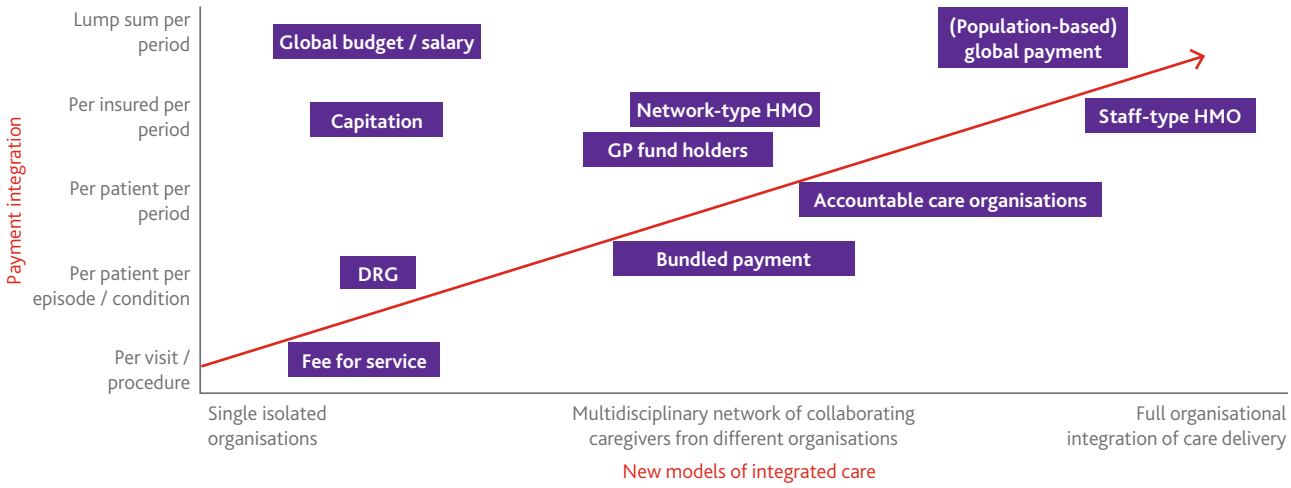
Overall, the evidence suggests that NCMs have significant potential to improve care experience, and outcomes and impact on comparative cost reduction – specifically through those enabling healthier and more independent populations supported through interventions that promote health and well-being and/or that seek to manage people's needs better in the home environment or primary- and community-care setting. Through such endeavours, it is possible to stabilise or reduce the continued rise in per capita cost, thereby positively influencing insurance premiums, lessening the pressures on privately- and publicly-funded healthcare budgets, and so being able to invest in more resilient and healthy risk pools. NCMs' holistic focus on prevention and well-being helps to attract younger age segments by creating an engaging and relevant proposition.

3.6 Enabling New Care Models: The need for a strategic payer

Instilling the ingredients discussed above, while exerting cost control through the development of new financing and contracting models, requires a 'strategic payer'. Health and life insurers are well placed to adopt such a role to achieve the triple aim. The strategic payer acts as the proactive 'integrator' of the care system, thereby accepting responsibility for improving care experiences and outcomes, as well as containing costs for the enrolled population. This new role can help to correct the common misalignments seen between 'traditional' financial flows and provider incentives.

Strategic purchasing avoids the rigid budget lines and open-end, fee-for-service payments by shifting towards a mixed-payment system to balance care that occurs between costly hospitals/speciality clinics and care in primary and community-based settings. Payment methods include blending (e.g. partial per capita payment with some fee-for-service for priority services of high effectiveness), bundling payments (for specific conditions or across-care pathways) as well as population-based payments where providers assume joint responsibility for population health in a multidisciplinary and coordinated way – often in a risk-share relationship with the funder/insurer, as seen in Figure 3.[43]

Figure 3: Payment approaches for risk sharing[44,45]



Source: Tsiachristas[46]

41 Pimperl 2018.
42 Reich et al. 2012.
43 Tsiachristas 2016.
44 Diagnosis-related groups (DRGs) is a classification system used to make a predetermined payment to hospitals/providers based on the average cost of treating any given condition to improve efficiency and contain costs.
45 Staff-type health maintenance organisations (HMOs) refer to those where the healthcare professionals are directly employed by the HMO. In a network-type HMO these providers are contracted by the HMO to provide a range of services to the eligible population.
46 Tsiachristas 2016.

In most healthcare systems, including those funded through private insurance, the strategic purchasing function has not been universally adopted to drive forward the adoption of NCMs. However, it is also acknowledged that comprehensive payment and delivery systems entail considerable transaction costs since new payment models and capabilities take time to develop. Therefore, any reform strategies by health and life insurers may well be incremental to match system capabilities. Otherwise, sudden changes in provider income may result in significant resistance from the provider market, leading to adverse and unintended consequences. It is also worth noting that the role of the strategic payer goes beyond the development of new methods of financing and contracting. A strategic payer seeks to plan and lead a care system and purchase services in partnership with its network of providers and with the people of the community that it serves.

Figure 4: Competencies of the strategic payer

Source: Adapted from Goodwin[47]

3.7 Approaches to strategic purchasing

For many health and life insurers, becoming a strategic payer that proactively plans and purchases healthcare services is a new or an emerging role. As section 4 of this report reveals, most insurers are still in the early stages. However, as the agenda has moved forward, albeit incrementally, new organisational forms for commissioning and contracting care have emerged. This section of the reports reviews the five different ways in which public and private health insurers, and in some cases providers, have sought to move into strategic purchasing to promote NCMs.

3.7.1 The 'traditional' approach to procurement

One of the ways that health insurers have traditionally sought to promote NCMs has been through expanding coverage through service procurement. This approach sees the insurer working to establish a 'health network' through the development of multiple contracts across a range of providers that cover all the elements of care across the continuum – for example, across hospital, community and primary care as well as long-term care. The funding usually remains on a fee-for-service basis.

Box 2: The Henry Ford Integrated Healthcare System

As a 'vertically integrated' healthcare system in Southeastern Michigan, it sought to integrate healthcare coverage through external contractual partnerships. The 'care plan' that it offered to clients provided an integrated set of hospice programmes and an ambulatory care network at more than 70 sites. Its design included centralised decision-making between provider organisations; care integration packages; and integrated information technology and purchasing. The system was ranked as the third most integrated system in the U.S. in 1999, yet faced considerable financial difficulties, showing a net loss of USD 43.8 million in 1998 compared to a net gain of USD 38 million in 1997. The non-strategic payer characteristics of the original system were not economically efficient or profitable.

Source: Bellandi and Goodwin et al.[48]

47 Goodwin 2017.
48 Bellandi 1999; Goodwin et al. 2005.

Common in the U.S since the mid-1990s, the model was motivated by a range of organisational strategies,[49] including enlarging the network size (corporate strategy); venturing into non-hospital provision (business strategy); integrating information systems and financial arrangements for cooperative purchases; and integrating clinical care through case management (functional strategy). However, with a non-strategic payer function, the procurement model has led to little change to the nature of funding and incentives across provider networks. Hence, evidence suggests that care delivery has largely remained fragmented and benefits to the health insurer have not been compensated by the additional costs of maintaining the provider network.[50]

3.7.2 The accountable care organisation

A core trend in both public and private healthcare systems has been the promotion of NCMs through the development of accountable care organisations (ACOs). As previously described, the evidence suggests that ACOs (and their variants, described below)[51] have the potential to improve care outcomes and reduce costs at scale. An ACO is a group of healthcare providers that agree to take on a shared responsibility for the care of a defined population while assuring the active management of both the quality and cost of that care (see Figure 5). ACOs are based on the concept of care becoming more person-centred and, in the U.S., often take the form of the 'health care home' model. This organised constellation of providers helps consumers navigate the care they need more efficiently.

Figure 5: Operational structure of an ACO

Source: Premier[52]

Typically, health insurers, as a strategic payer, work with and alongside ACOs to develop financial incentives that promote NCMs. Per capita-based funding is favoured, with risks/benefits being shared between the strategic payer and the ACO provider group. Most models employ a shared gain approach. Typical examples of ACO models include multidisciplinary

49 Wan et al. 2001.
50 Goodwin et al. 2005.
51 Addicot 2014.
52 Premier (no date).

group practices and providers; independent practice associations (networks or alliances); physician-hospital associations (joint ventures); or integrated delivery systems in which the strategic payer and the provider network work so closely that they form joint governance arrangements.

ACO–prime contractor model

In the prime contractor model, the health insurer contracts with a single organisation which subcontracts and manages the relationship with individual providers delivering care. The health insurer holds the prime contractor to account for the totality of the services they have commissioned. The prime contractor takes responsibility for designing and delivering NCMs that will effectively meet the terms of the contract using contractual incentives across the provider network to influence the behaviour and performance it wishes to see. Typically, the prime contractor would receive a per capita budget with linked performance incentives. Often the health insurer and prime contractor might seek to enter into a risk-sharing arrangement.

Gesundes Kinzigtal, Germany is one example of this approach, where Optimedis AG, a health management company, works in cooperation with a network to take contractual responsibility from the health insurer (AOK) to serve a community of nearly 40,000 people using a holistic approach. The programme's provider network goes beyond GPs, specialists and hospitals to include psychotherapists, nursing homes, ambulatory home health agencies (social care), physiotherapists, pharmacies, sports clubs, self-help groups and work places, amongst others. It has adopted a 'shared health gain' approach by means of which any savings made by the sickness fund through greater efficiencies are shared with the insurer and stakeholders in the network.

Evidence has shown higher levels of patient satisfaction, positive changes in health behaviour and quality of life and reduced risk of mortality. At the systems level it has lowered lengths of stays in hospitals; improved contribution margins in the first three years of operation; and reduced overall costs to the insurer, including a morbidity-adjusted efficiency gain between 2007–2010 of more than 16% of total costs.[53]

The ACO–prime provider model

In the prime provider variant, the contracted organisation also delivers care directly as part of the agreement. Typically, the prime provider would receive a per-capita budget with performance incentives. The prime provider might seek to deliver care directly, or to 'buy-in' additional services that it cannot deliver directly.

AXA OneHealth in Egypt is one close example of this. It seeks to promote a payer-to-partner strategy that combines – in one offer – services normally delivered by multiple providers into a direct access service to customers.[54] AXA OneHealth medical centres provide easy access to an advanced range of primary and specialist services in a network of dedicated locations, including a digital app to manage appointments. A similar approach has been taken by Aetna in India through the India Health Organisation, where a health partners network in 38 cities provides Aetna primary care services, including a virtual health programme across rural India.[55]

The ACO–network or alliance model

In an alliance model, a set of providers enters into a single arrangement with a health insurer to deliver services. The health insurer and providers are legally bound together to deliver the specific services laid out in health plans, and they collectively share risks and responsibilities. The purchaser-provider function is therefore integrated to the extent that both have the collective incentive to innovate and identify efficiencies across the system rather than solely within their respective organisations. Alliances are more reliant on trust-based relationships and collective governance rules.

Alliance models tend to be more prevalent in government-led health systems, rather than in commercial insurance. A good example is the Wollondilly Health Alliance in Australia where, from 2014, a partnership was developed to promote NCMs to improve health outcomes for the region. The alliance brings together the range of local payers (i.e. insurers, health authorities, primary health networks, local councils, etc.) with local providers and community groups to develop a joint governance structure. Based on a share of risks and rewards, the partners in the alliance focus on common priorities – in this case, things such as technology to help people manage their care needs at home, providing a bus to support mobile lifestyle interventions (the 'Dilly Wanderer') and other shared projects to promote

The three ACO models are able to enhance care quality and experience, reduce hospital admission rates and unnecessary medications and treatments, improve health outcomes, and enable sustained cost reductions.

53 Groene and Hildebrandt 2017.
54 AXA (no date).
55 PRNewswire 2018.

well-being but that also help to use scarce resources more effectively. Evidence of impact has included more engaged and empowered people active in their health, greater participation in preventative health activities, and reduced hospitalisations and costs.[56]

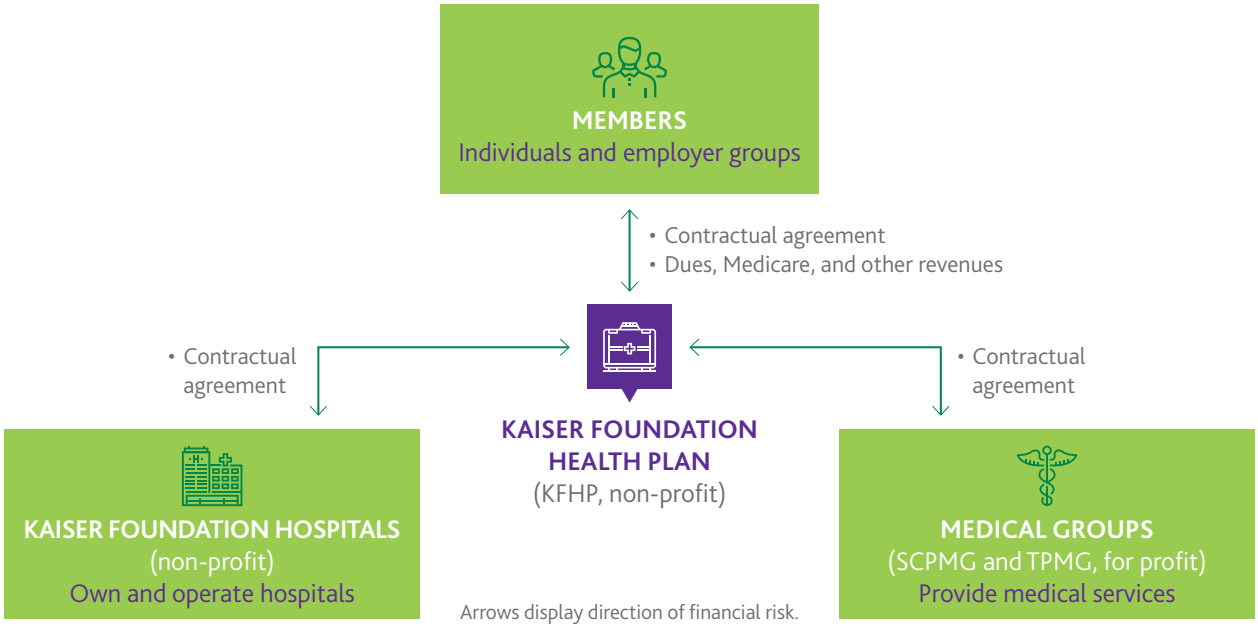
Evidence suggests that the three ACO models described above, when delivered well, are able to enhance care quality and experience, reduce admission rates to hospital, reduce unnecessary medications and treatments, improve health outcomes, and enable sustained cost reductions over time when costs of initial investment to build systems are recovered.[57]

3.7.3 The fully integrated model

The fully integrated model is where the roles of health insurers and health providers sit under a single structure of governance and accountability, and all providers share a global budget offered by the insurer. The most successful example of the fully integrated model is Kaiser Permanente (KP) in the U.S. KP is one of the largest HMOs, accounting for more than 9.6 million members in eight regions of the country.[58] It consists of three interrelated entities (Figure 6):

- A non-profit health plan that bears insurance risks (Kaiser Foundation Health Plan).
- A self-governed network of for-profit physician medical groups (Permanente Medical Groups).
- A non-profit hospital system (Kaiser Foundation Hospitals).

Figure 6: The Kaiser Permanente structure



Source: Haslam[59]

All three components hold mutual exclusivity towards purchasing and providing services and are unified by a common mission, representing a mixture of systemic and normative integration.

This model is focused on chronic care and multispecialty practice, where generalists work alongside specialists to deliver care with an emphasis on prevention, self-care, disease and case management, and case management for members with multiple conditions.[60] The KP model deploys these services in a targeted manner based on stratifying the risks among its enrolees and according to needs.

All entities within the KP group are mutually accountable for a patient's outcomes, and positive patient experience and provider incentives are linked to quality of care and patient satisfaction. In this regard, an episode of acute hospital admission or readmission is seen as failure of the entire system.

56 NSW (no date).
57 McClellan et al. 2014.
58 Pines et al. 2015.
59 Haslam 2019.
60 Curry and Ham 2010.

Active management of patients in hospitals is ensured through clearly-defined and evidence-based clinical pathways and protocols. The model has also been innovative by creating new professional groups such as hospitalists, discharge managers, various nurse profiles and care coordinators, allowing the efficient use of human resources and seamless transitions of care between settings supported by the HealthConnect Programme – a system-wide information system.

KP's success is the alignment of payments through mutually-exclusive contracts between the providers and the health plan. This level of alignment may not be easy to replicate in other insurance markets. Restructuring provider reimbursement away from volume-based payments, as is most prevalent now, towards value-based (outcome) payments could be met with a large amount of resistance. The principles behind KP's organisational and structural reform may hold important lessons for insurers operating in different markets.

3.7.4 The direct-to-provider approach

In this case the providers may work fully independently from a health insurer to provide products and services direct to consumers, often on a subscription basis. A good example is Direct Primary Care (DPC), which emerged in the mid-2000s in the U.S. as a means for consumers to gain access to new models of care without the need to invest in 'expensive and confusing' health insurance plans. Examples of this can also be seen in Eastern and Central Europe as well as South Asia with consumer- or employer-funded plans.[61,62] DPC is a financial arrangement made directly between the patient and healthcare provider that removes the need for both patients and providers to file insurance claims. Rather, they rely on a monthly subscription.

The model is appealing to younger consumers or families but not to people with significant, complex needs. The primary drawback for consumers is that most people will still need health insurance for services which are not covered, and DPC arrangements are also non-tax deductible compared to health plans. However, the popularity of the model among the younger population often by-passing insurance may raise the average risks for insurers as it curtails the level of cross-subsidy that can be achieved between the old and the young. A good example of the emergence of DPC is Babylon Health U.K., which represents a successful example of a business focusing on fast access to treatments for common conditions and ailments with a strong digital front end. The pros to most consumers who can afford it are the upfront pricing and fast access. Concierge medicine is another version of such a model that helps to triage cases more effectively and direct them to the appropriate setting of care. As these models gain traction among younger cohorts, insurers will have the opportunity to think how to create linkages with DPC models that seamlessly connect with their own NCMs/health plans.

61 CODEC (no date).
62 MEDICOVER (no date).

3.7.5 *Consumer-directed payments*

Under the 'direct payment' model, the health insurer enables consumers to directly purchase health and care services, usually from a preferred provider though a personalised budget or cash payment in lieu of formal care. The 'direct payment' supports independence in how people choose, manage and pay for their own health and social care. It is seen as attractive for many consumers since it enables them to integrate the way services are provided around their personal needs or lifestyles, often from an evidence-informed 'care menu' tailored to their unique circumstances. Such an approach may enhance choice but necessary structures would need to be put in place to counter the informational asymmetry commonly seen between consumers and providers, rendering it unsuitable for people with multiple and complex care needs.

3.8 Advantages and disadvantages of the different models of care

The different approaches to strategic purchasing described above, and the NCMs associated with them, are presented here as idealised versions of the many and different ways that have been attempted. In reality, most approaches are hybrids of these models and vary in their implementation. Table 3 compares some of the strengths and weaknesses of the different models according to eight criteria.

Table 3: The potential strengths and weaknesses of NCMs

		Models of care						
		Traditional approach to procure-ment	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

4. Highlights from key informant interviews

The literature review above was complemented with 15 key informant interviews with representatives of some of the largest global life and health insurers and experts working in close collaboration with them to implement NCMs. Respondents represented a wide geographical spread of mature and emerging markets for life and health insurance across Asia and the Pacific region, Europe, North America, Southern Africa and those with a global footprint. Questions to interviewees focused on six broad themes: their rationale for implementing NCMs, characteristics of the NCMs implemented, the level of market buy-in for such models, new market opportunities posed by NCMs, how NCMs have influenced the insurance value chain and considerations for their scalability. This section summarises their responses.

> *… on the savings side, it helps us to send a consistent message to our customers until their retirement which is … we want you to adopt a healthier life style now to live retirement in good health. As a business we can then ensure some customer persistency and then recapture these clients with new products and services when they reach retirement.* **Generali**

4.1 Rationale for implementing New Care Models

There are four reasons for implementing NCMs: consumer-centric, business-centric, ecosystem-centric, as well as pressures owing to demographic and epidemiological shifts.

> *Traditionally, life insurers have sold a policy and then money is available to help in the event of death or for rainy days. Rather than focusing solely on providing financial protection for families after death, we wanted to make life insurance about living.* **John Hancock**

As a reinsurer we want to create a resilient customer base for our clients. We also share the liability with insurers, so we have an interest in efficiency. We want to help insurers sell more but also sell it better to optimise good outcomes.
Swiss Re, Asia

Improving customer experience and health outcomes is the most frequently cited reason for implementing NCMs, closely followed by the need to review business models to tackle cost inflation and expand market footprint. Reasons such as aligning with the broader ecosystem or ageing and non-communicable diseases feature less frequently. For the latter it may be possible that discussants made an implicit assumption of these factors in their effort to improve consumer experience.

Life insurers reflect a growing appetite for adopting NCMs to not only mitigate the risk of mortality in risk-based products, but also to encourage active ageing and reduce the risk of expensive long-term care in savings-focused products.

Table 4: Commonly-cited reasons for implementing NCMs

Consumer-centric	Business-centric	Ecosystem-centric	Demographic and epidemiological shifts
Influence how people stay well	Corporate responsibility to do things well	Significant pressure on public finances; hence, commercial insurance has a complementary role to play	Ageing and non-communicable diseases require a new approach
Expand the range of services/consumer choice	Shift away from being a passive claims payer	NCMs are key to how life insurers provide well-being services because regulations pose a hurdle for adopting conventional models of care	Need to manage chronic illnesses better
Give consumers control over their well-being, and reward them for doing the right thing	Extract value and technical profitability through fewer claims and reduce costs over time	The system is too polarised with either a fee-for-service system or a totally managed service system; there is a need for a middle ground for insurers through NCMs	Lower the risk of mortality and ensure a healthier and more active ageing process
Diversify and improve consumer experience of insurance and healthcare	Generate a surplus for insurers and policyholders and reward providers through innovative reimbursements and a better working environment	Objectives and incentives need to align across insurers and providers	
Provide better quality care at lower costs	Balance liability with efficiency in services and ensure they optimise outcomes (reinsurance)	The system has a medicalised view of health and well-being; needed care often falls outside hospital or specialty care	
Improve health outcomes	Tackle unsustainable increase in the amount paid in premiums		
	Care and cost considerations both warrant a shift away from a disease (critical care) focus to wellness		

Source: The Geneva Association 2021 key informant interviews

4.2 Characteristics of and the emerging evidence from New Care Models implemented

There is no universal approach to the way NCMs are implemented. However, there is a a strong inclination towards service innovation (i.e. expanding the range and scope of service either through online, offline or hybrid models). Only a few NCMs focus on matching these service innovations with strong supply-side and financing interventions to encourage allocative efficiencies, tackle moral hazard and align payer-provider incentives. This is a particularly notable observation in light of the importance of a strategic-payer function highlighted in the literature review in order to optimise NCMs. While there is a clear acknowledgement that this focus is necessary, the maturity of markets and longevity of NCMs are often determining factors for this to happen on any significant scale.

> *We estimate roughly 2% of our policyholders (accounting for 30% of our claims) fall in this [high risk] category and they go in and out of hospitals. Here we have invested in nurse coordinators who are placed in call centres as well as tasked with coordinating the care for the customers with GPs, community nurses, geriatric specialists amongst others.* **Discovery**

NCMs have a few consistent themes, with many focused on easy access to care, disease prevention and proactive management of chronic illnesses. Examples of services include one-stop-shops for better navigation of care, telemedicine, back-to-work plans following a critical care episode, incentivising active lifestyles, tracking prescription refills as well as specific interventions for chronic and degenerative illnesses. But the use of a risk stratification to target these services towards specific cohorts (as seen in the KP example in section 3.7.3) is limited to a minority.

> *In Brazil within one year of implementation of this model we lowered hospital admission by 26% and ICU admission by 17%.* **UnitedHealthcare**

With many NCMs in their early stages of implementation, their impact on the triple aim is less clear. However, there are indications of increased customer satisfaction leading to more sales and better retention. Some early evidence also points to reduction in the use of expensive institutional care such as nursing homes and hospitals and improved outcomes for users and carers, which mirrors the findings from the literature review.

4.3 Stakeholder buy-in for New Care Models

When implemented by insurers, NCMs have four important stakeholder touchpoints: consumers, providers, distributors and policymakers. However, the majority of stakeholder accounts focus on consumers and, to a lesser extent, providers.

> *…as a commercial [life and health] insurer we have to be sure of delivering what we are promising. For instance, we can sell policies with new care models, but we need a fairly healthy demand and utilisation of such services to keep prices sustainable as well as allow a provider network to get used to this way of working to make a real impression on our customer's outcomes and experience. This feeds into the consumer engagement discussion as well. Otherwise, we can promise a lot but in reality, not much would be different.* **AIA**

- The overall **consumer** response to NCMs is viewed in a positive light given their ability to deliver care more conveniently, especially as many initiatives feature digital front ends. As such, their popularity is quantifiable through the number of downloads.

> *While we want to standardise as much as we can, we have to be mindful of market dynamics. For instance, if I develop a comprehensive cancer solution but leave out some of the top well-known specialists from my policy, there will be little interest in the product. If consumers trust us and see that we offer the choice to visit top specialists if they need to, they are more likely to forego some choice for standardisation, knowing that there is top quality care waiting for them should they need to access it.* **RGA**

However, in order to bolster and sustain consumer loyalty further, a few framing considerations around consumer choice are underscored. For instance, while standardisation of care is inherent in NCMs to assure cost-effectiveness and quality, framing them as not restrictive of choice is a key factor in uptake. While the vast majority of consumers are willing to accept some trade-offs between choice and lowered costs through standardised services, they also need some signals about the added value of NCMs on offer. Similar effort is needed to actively frame NCMs as a service (as opposed to a risk product/health plan) to counter the historically-held indifferent or negative perceptions of insurers.

This idea that there is a payer and there is a provider and never the twain shall meet won't work. **UnitedHealthcare**

- **Provider** receptiveness of NCMs is mixed. On the one hand, providers perceive NCMs as being able to generate a sizeable volume of consumer traffic when implemented by a large insurer. On the other hand, providers are less familiar with the strategic objectives of NCMs. Once again, this iterates the need for insurers to focus on shaping the supply side of NCMs by: a) familiarising themselves with the provider landscape, b) reducing reliance on conventional third-party administrators (TPAs) in favour of strategic partners who can aggregate providers and pair it with financing innovations, and c) adopting a more collaborative approach to developing care pathways and protocols to ensure compliance and quality of provision.

We spent a lot of time relationship-building with our providers which eventually gave us some power to shape the market. But we had to build this power muscle by muscle. We got a lot of pushback initially, but that makes it even more important to make investments upfront and put actual dollars on the table. Providers can then see it is real and that they are being rewarded. **Discovery**

4.4 Market opportunities and challenges posed by New Care Models

NCMs pave the way for a number of new market opportunities for insurers, provided enough time is allowed for the models and related institutional structures to mature. The opportunities are categorised in Table 5 below.

Table 5: Market opportunities presented by NCMs

Opportunity	How/what	In order to…
Use real-time health and life data	to study consumer needs and behaviour more deeply	enhance existing products, persistency and sales.
Package key competencies developed through NCMs as service offerings for	population health management[63] provider market understanding programme design and implementation off-the-shelf wellness solutions	improve business to business (B2B) and business to government (B2G) opportunities where national insurance plans are being implemented.[64] support reinsurers to target large provider networks already managing risks through direct subscription models (see direct to provider model above).
Increase risk thresholds (beyond safe cohorts) to	direct tailored products to certain risk groups (e.g. diabetes) and	move beyond the 'safe population' segment to adjacent markets and reach more customers.
Diversify and move beyond risk-based products to service-based products to	actively develop/shape existing provider networks based on granular understanding of needs and incentives and	reduce reliance on conventional volume-based TPAs and align payer and provider goals.

Source: The Geneva Association 2021 key informant interviews

63 A process of using historical and current data to understand health and care needs for a defined population in order to develop proactive and holistic models of healthcare delivery in partnership across sectors.

64 MAPFRE's work in the Dominican Republic is one example of how commercial insurers are working with national health insurance using a B2G model. The Dominican Republic features a statutory health insurance scheme known as the Family Health Insurance (FHI) serving workers across the public and private sectors, pensioners and their families. FHI pays a per capita sum to independent Health Risks Administrators (HRAs) who are public and private entities/insurers to administer the scheme on behalf of the government. MAPFRE is one of the HRAs who receives per capita income from FHI based on the number of enrollees with MAPFRE and oversees overall risk management and service delivery with a focus on the whole healthcare continuum.

But discussions also lay bare four areas of concerns, all of which have linkages.

- **The value proposition:** Communicating the added value of NCMs to consumers remains a challenge, especially given traditional insurance plans continue to cover the very health conditions covered by NCMs.
- **TPAs:** One important structural hurdle is insurers' overreliance on conventional TPAs, which run programmes based on the volume of services rather than outcome. These often lead to misalignment between the objectives of NCMs and their implementation.
- **Return on investment (ROI):** There are considerable pitfalls in using traditional care models and cost structures as a comparator to understand the ROI of NCMs because of the different assumptions they are built upon. Moreover, the lack of longitudinal data also makes it harder to unpack the ROI. As a result, insurers tend to err on the side of caution by taking small incremental steps instead of formulating a more comprehensive plan.
- **Adverse selection:** Targeting specific age groups or disease cohorts in the face of voluntary enrolment has the potential to lead to increased adverse selection. Policyholders with preconditions tend to stay for long periods with their insurers, unlike their healthier counterparts who shop around.
- **Churn in the market:** Short-termism poses a significant barrier to the coherent implementation of NCMs. Therefore, improved consumer engagement and persistency alone would justify a business case for NCMs.

…let's start with a stable care model first and then see what happens. If the care and the experience of receiving care is good, this churn will likely even out over the long run. There is a free rider problem, too. Many argue that insurers who invest in providers/provision benefit their competitors, as they contract the same provider to deliver services. Yes, that may be true, but again it is a short-term view. The entire health system sustainability is a key here, and it benefits everyone over the long run when New Care Models become the norm. **UnitedHealthcare**

We also have to be mindful about the incentive structures. Many of the conditions covered by a NCM plan is covered by a traditional insurance plan, too. So, consumers don't really have a strong incentive to do things differently. These are deep-seated issues and it needs time and investment from an insurer to resolve. **RGA**

4.5 New Care Models and their effect on the insurance value chain

Marketing and distribution are the frontrunners when it comes to the functions most influenced by the development of NCMs. NCMs are seen as a way to open up previously untapped sections of the market. They also enable more touch points with customers compared to traditional life and health insurance products, especially as many develop a digital interface. However, the sophistication of these models in cases of managing more serious health conditions is less clear in the eyes of a consumer.

Marketing and distribution needs modernising. Some of this is happening already as a result of digitalisation to directly engage consumers. But we also have to be mindful of the fact that we have thousands of intermediaries selling our products across Asia. They now need to move to selling holistic solutions rather than static products. In reality we have little idea or control over how intermediaries sell to consumers and we have to think through what NCMs mean for this channel. **MetLife Asia**

Both these observations provide compelling reasons for insurers to evolve their distributional channels. While digital channels have a clear role to play for direct-to-consumer marketing and distribution, this has to be delicately balanced with the already established and widespread intermediary-led channels, which are crucial for reaching specific population segments and selling big-ticket items.

Young people are not interested in disease management and they don't want to think of chronic illnesses and catastrophic payments further down the line yet, we need them to keep our risk pools balanced. We haven't found the best solution yet to make this an attractive offer for them, but we are working on it. **AXA Germany**

Other functions of the value chain, such as **underwriting, pricing, claims and management of provision** feature less, although there is an overall consensus that NCMs have the potential to transform all four areas through the use of

data. However, examples of application of real-time data analytics to aid such functions are limited to just a handful which use consumer engagement with digital wellness tools as a proxy for determining the risks and pricing.

These findings continue to cast doubt on whether insurers are doing enough beyond active marketing of products to attract consumers. The lack of focus on institutional structures to influence other parts of the insurance value chain, including those that govern the quality of the supply of care, risk undermining the extent to which NCMs can deliver on the triple aim.

> *The challenge however, is the general familiarity of insurers with health markets. Historically, we have not been so closely involved with provision and insurers particularly have limited knowledge when it comes to health provision – a highly specialised area.* **Ping An**

Some of these limitations may, however, be explained by the regulatory barriers faced in some jurisdictions, especially by life insurers. In some instances, life insurers have to rely on conventional TPAs because they are restricted from directly taking control of health products and provisions. Other insurers have circumvented these issues by partnering with a new breed of health management platforms focused on improving selected outcomes. Examples include partnering with pharmacy chains to streamline medication or contracting data-driven health management companies to manage provision when insurers themselves are unsure about the clinical risks posed or unfamiliar with the market. OPTUM is one example of such a platform.[65]

4.6 What are the critical ingredients for the scalability of New Care Models?

- **The regulatory environment:** Life insurers with an interest in health and wellness solutions are faced with licensing barriers in many markets and are therefore not allowed to sell health solutions/ products even when they have a vested interest in averting mortality and morbidity. In some cases, life insurers are also faced with a ceiling on how much added-value health services (free services) they can provide to beneficiaries and restrictions on how actively they can engage with them to increase uptake of such products. This results in life insurers being able to play only a passive role in consumers' well-being – much to the contrary of NCMs' objectives.

  General voluntary (health) insurance regulations also include clear demarcations about which products insurers can offer to supplement or complement statutory schemes, and how they use consumer information is still considered highly sensitive, especially because of its association with cream-skimming. Additionally, regulatory barriers are particularly pronounced with regards to reforming the provider market. Unions remain strong and, as a result, well-thought-through ideas and progressive payment models become harder to negotiate and implement.

  > *Regulators still want providers and payrolls at arm's length.* **Aetna International**

- **The use of data:** The three key pillars for effective data collection are 'identifying' whose data (the target group), 'deciding' which data (the information needed for the intervention) and 'finding' the appropriate channels to collect them. Presently, most data continues to sit in siloes across the insurance value chain, making it hard to form a unified picture of the marketing, implementation and ongoing performance of NCMs. Equally, investment is warranted to upgrade legacy IT systems and data analytics capacity so insurers are able to offer digitally-savvy solutions to engage and understand consumers and support self-care.

- **Leadership and culture change:** In addition to the needed technical capacity, a notable number of informants highlight leadership or stewardship and internal culture change[66] as important ingredients for enabling NCMs. Considering that many NCMs are nascent, investments are often made with limited insight on how they will immediately impact revenue. More risk-taking and longer time horizons to learn, adapt and scale up are essential.

- **Balancing act between supply and demand:** While there is consensus on the need to improve understanding of consumer needs and respond through NCMs, it is increasingly acknowledged that more attention is needed on the supply side, focusing on the intrinsic motivation of providers versus monetary ones. As such, alongside expanding the scale and scope of benefits for consumer choice and accessibility, it is vital to match these with provider engagement, management and payment reforms to ensure success.

  Also rated a high priority is the need to create capacity in the current workforce to understand the concept of a health ecosystem, including local distributors and the provider landscape. One way forward is to bring in talent from industries with a track record of strong marketing and technology for this purpose.

65 OPTUM 2020.
66 Generali 2018.

5. Recommendations for insurers

On one hand, NCMs challenge policymakers, payers and providers to seize countless opportunities to innovate service provision across the healthcare continuum. On the other hand, our findings show that NCMs, when implemented by commercial insurers, still have some way to go before they can consistently and efficiently deliver better health outcomes. A long-term horizon is required to allow a dynamic interplay between the demand side, the supply side and financing functions. This report proposes three actions as a starting point for this process.

1. Enhance the value proposition

Firstly, while consumer attitudes will be central to shaping future services, for commercial insurers the value proposition of NCMs will need to go beyond the simplistic notions of choice and convenience. The biggest opportunity with NCMs is to create a sustainable business through an ecosystem of health and social care provision to achieve **'the triple aim'** – improve care experiences and outcomes and realise more cost-effective service delivery. Correspondingly, the current narrative should evolve to reflect this holistic view so as to promote its value not just to consumers but also to distributors, employers (for group plans), providers and internally, within insurance companies. While the key informant interviews signpost several ecosystem factors as rationales for implementing NCMs (Table 4), subsequent accounts show that implementation falls short of alignment.

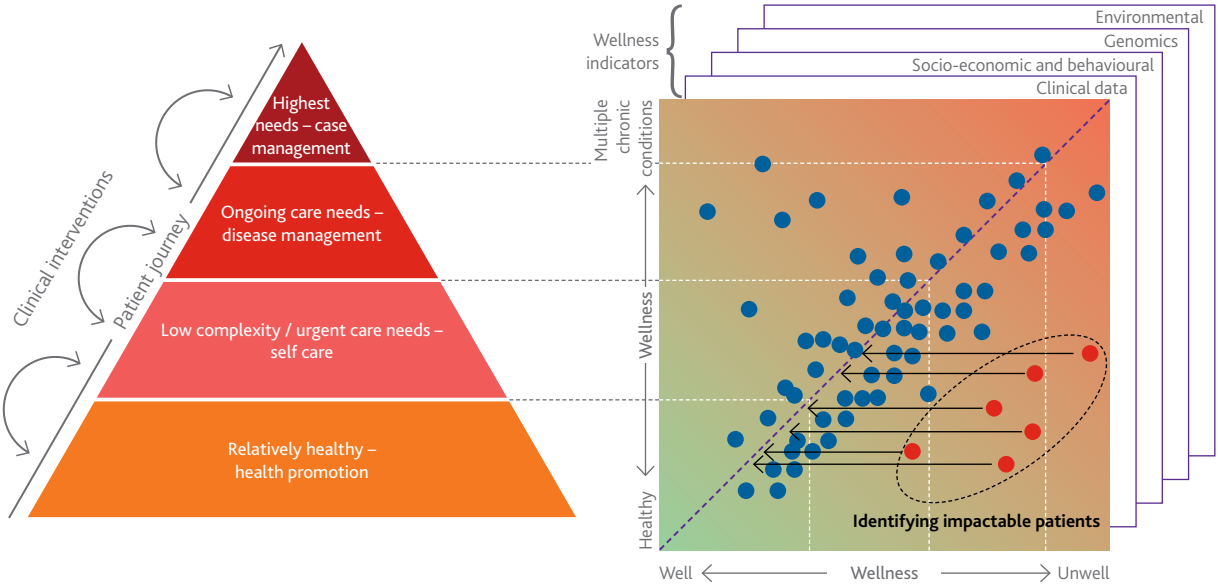
Secondly, asking consumers to choose better and more efficient care models will need a refreshed marketing and distribution strategy. There remains mistrust and fatigue in the system, which need to be dispelled. While some insurers are advancing in this direction, greater thought and investment is required across the industry to develop marketing and distribution channels that can adequately engage consumers in understanding these dynamic products and relay the positive externalities of NCMs over traditional models of care.

2. Become a strategic orchestrator of services

Expanding NCMs might vary depending on how health systems are financed and organised and the role played by private insurance. Insurers will need tools to navigate the health ecosystem and start assuming the role of a **strategic payer**. This involves not just understanding how to increase demand but ensuring favourable conditions that can fulfil the promises made to policyholders sustainably and in harmony with publicly-sponsored services. For this, three shifts would be necessary:

- **Stratify the risks:** Tools for understanding where the risks come from and where they are likely to come from in the future are key to effective **population health management** yet they remain underused. This includes collecting the right data across risk pools, stratifying them to understand the distribution of the risks, attributing costs across the risk segments and designing differentiated services with clearer goal posts. This is more than having one blanket NCM product or plan across all policyholders or managing a single chronic condition. Figure 7 illustrates this stratification, where the bottom of the pyramid represents the bulk of the insured, low-risk cohort benefiting from proactive well-being services. The upper segments represent a growing chronicity and risk of disease that require targeted support for self-care, disease management or overall case management.

Figure 7: Stratifying the risks for NCMs



Source: National Health Service[67]

- **Build foundations to start sharing risks:** The fundamentals of a purchaser-provider split, where payers are organisationally separated from provision, needs to be revisited. For life and health insurers who currently share most of the risks of ill health, it is now important to ensure providers have 'skin in the game'.

  Investment is needed to better understand the local supply market, with not just a view to expanding services by empanelling as many providers as possible but with a view to matching them to the needs and risks arising from the stratification described above. In some cases, this may mean insurers directly create/acquire a provision arm to control services where they have the capacity, and in contexts where it is permissible, **'the build option'**. In other settings it could mean moving towards identifying providers and grouping them as integrated networks or alliances – **'the buy model'**. This also implies the need for an overhaul of the traditional model of relying on TPAs and examining the dynamic between public and private provision to avoid any perverse provider incentives that skew statutory health provision.

- **Begin to share risks through value-based payments:** The high prevalence of volume-based, fee-for-service reimbursements suggest that insurers are settling claims for necessary as well as unnecessary care. For example, a screening programme is of little value if it still leads to recurrent hospital admissions, visits to speciality clinics or multiple tests leading to costly claims. As such, provider-payment incentives need to be aligned to ensure specialist and hospital care shift away from being revenue centres to cost centres and encourage intervention and management in low-cost settings.

  A **mixed payment approach** is necessary to balance volume with efficiency. For instance, insurers could start by blending fee-for-service payments with bundled payments for chronic disease management by family physicians or may decide to pay hospitals using DRGs for low-risk, high-volume services to bring down the average costs over time.

67 NHS 2017.

- **Plan the journey:** NCMs need to be planned at an appropriate scale and pace, employing a 'maturity model' or cycle of learning that nurtures, investigates and grows new capabilities. Keeping the bigger picture in mind, insurers should start with small tests of change that have the opportunity for early success – for example, focusing on targeted case management programmes or **coordinated care pathways** before more ambitious projects addressing population health.

3. Focus on the convergence of life and health insurance

As the demand for health insurance to cover long-term chronic conditions rises, the demand for associated LTC insurance products may also rise. NCMs provide an ideal platform to create a cradle-to-grave system that wraps services around consumers. While there are already hybrid solutions to combine LTC and life insurance, there is now potential for an increased interface with health insurance to attract new market segments, paving the way for a **joint health-life service proposition**.

In reality, this could mean that the diabetic cohort, previously excluded from life insurance, can get life coverage in return for maintaining blood glucose levels through a wearable devise as well as access podiatry, nutrition, ophthalmological services and clinical advice through health insurance. Conversely, a person in need of ongoing care cannot only access medical services through health insurance, they and their carers can access income protection, retirement support, help with adapting housing conditions and associated psycho-social support by life insurers to avoid resorting to long-term, costly, facility-based care. This approach enables life insurers in particular to tap into a consumer base that is being kept healthy through NCMs, thereby making them an attractive pool of 'active' retirees and enabling both solutions to cross sell. But this cradle-to-grave system needs time to develop and a dynamic interplay between health and life solutions where each can work within their remit yet the services appear seamless to consumers. This requires two interventions:

- Internally, insurers would need to identify the strategic touchpoints of the two business lines and address the siloes alluded to by many informants. Pooling, analysing and sharing data in real time, as well as a joint marketing and distribution plan, are the obvious starting points, while maintaining the necessary firewalls needed for underwriting, claim processing and other functions.
- Externally, regulators would be key to rolling out such a model. In order to engage in dialogue with them, insurers need a clear plan that navigates the issues around health licences, price caps for added-value services for life insurers, provider and payment reforms and the ethical and legal climate in local markets.

Box 3: The integration of health and life/LTC solutions through NCMs: the case of Japan

Japan offers a glimpse into what might be possible, with adjustments, in other settings. Until 2000, publicly-funded social care to support older people was non-existent, leading to poorer health outcomes and inefficiency. For example, significant growth in 'social hospitalisation' was observed as older people needed hospitalisation due to their frailty and dependency problems.[68] In response, alongside statutory health insurance, the government started offering LTC to those aged over 65 based on needs. It aimed at reorientating the care systems from siloed health, medical and welfare services to one in which users receive comprehensive care from a variety of providers of their choice, promoting prevention and home care, thereby releasing pressure from over-stretched hospitals.[69] Its implementation was incremental.

Often driven by large hospitals, the approach advocates the provision of housing, medical care, LTC, preventative services, outreach, counselling and livelihood support in an integrated manner, expanding the choices for people to live independently at home, even at the end of life. After introducing the public LTC system, establishing community-based integrated care centres was promoted. These centres are operated by health nurses, social workers and care managers supported by pooled insurance funds that are supplemented by government taxes.[70]

Evidence suggests that this has enabled greater provision of care at lower cost.[71] Keeping costs manageable has been a constant preoccupation – achieved by placing the lowest need people (about 25%) into a programme of preventative care, with restrictions that made it less expensive to provide services as well as lower the utilisation of costly care.

68 Curry and Holder 2013.
69 Houde et al. 2007.
70 Tan 2015.
71 Tamiya et al. 2011.

6. Conclusion

Chronic diseases kill over 40 million people annually and 15 million of these deaths are premature.[72] The COVID- 19 pandemic has further amplified and accelerated these risks. As of July 2021, four million people have perished, and there is good evidence to suggest chronic diseases and old age significantly increase the risk of severe illness due to COVID 19.[73,74]

The crisis has also highlighted the gaping holes in health and social care systems globally regarding their ability to prevent diseases, deal with health shocks and protect the most vulnerable. While these stress signs have been there throughout, we have failed to heed the warning adequately until now. The latest crisis lay bare the urgency with which heath and care systems need to be reconfigured to deal with new realities.

> Insurers will have to move away from a transactional business model of selling policies to developing longstanding partnerships with customers as well as players in the health and care ecosystem.

Managing this aftermath requires a multifaceted solution. While hospitals, specialist clinics, medical technology and digitalisation are powerful tools in our armoury, these alone won't be enough and they're not financially sustainable. Now more than ever, there is a need to orchestrate a more holistic approach that wraps services around consumers no matter where they are in their life course – at homes, in communities, at workplaces, local clinics and social care settings – strengthening the system from the bottom up. This means insurers will have to move away from a transactional business model of selling a policy/health plan to one that promotes a longstanding partnership with consumers as well as players in the health and care ecosystem. NCMs are a key enabler of this approach.

While the unknowns are daunting, COVID-19 has created a rare window for experimentation and innovation across all sectors. Health and life insurance can now come forward with new, more joined-up solutions to bolster health and financial protection as societies navigate their way to recovery.

72 WHO 2021.
73 European Centre for Disease Prevention and Control 2021.
74 UN Interagency Taskforce on NCDs 2020.

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Population ageing, shifting disease patterns and rising costs of care are putting traditional healthcare systems under increasing pressure. New Care Models (NCMs) aim to tackle the problem through better coordination of health and care provision, by enhancing services closer to home and outside hospital settings, and encouraging interventions to promote good health. Insurers can enable NCMs by moving away from just passively processing claims to become 'strategic payers' who proactively plan and purchase healthcare services, helping to correct the common misalignments found between financial flows and provider incentives in traditional models of care.

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