



Their business renewals now at risk, insurers will need to make immediate and lasting changes that embrace consumer-facing attitudes, mindsets, and expectations to stay viable. The changes will need to be deep, strategic, and focused on rewriting and executing new value propositions for the individual market. A variety of technologies will be essential for facilitating this transition, and the need for innovation will create opportunities for forward-thinking investors to back valuable and disruptive solutions. But the heavy lifting will need to be done by the payers themselves, who will need to move away from everything they have ever done well to shift toward newly determined areas of differentiation—or face obsolescence.

Individual policies are expected to grow from 10% to 40% of the commercial insurance market.

A Fifty-Year Legacy on the Brink of Irrelevance

Prior to the ACA, insurers' value propositions overwhelmingly served the needs of employers, not individuals. This made sense: the employer was the customer, deriving value from an affordably priced group insurance benefit that covered its entire workforce without regard for pre-existing conditions and individual circumstances. Yet in creating a guaranteed-issue insurance market, the ACA draws a red line through much of that value proposition. The issuance of health insurance with minimum benefit tiers is now mandated (i.e., no individual policy underwriting), and pricing is regulated. This new reality is driving a growing share of the health insurance market toward individual policies, leaving insurers with a 50-plus-year legacy of business-to-business expertise and a strategy ill-suited to this new, consumer-facing realm. To remain competitive, insurers will need to rethink their value propositions and differentiate themselves and their services on parameters relevant to consumers, offering reimagined products for both the individual and employer markets.

The health insurance market is fast becoming B2C.

As the market dynamics shift to a 60/40 employer-individual ratio, the demands and expectations of the consumer market—including expanded product choice, high-touch service, and customer satisfaction—will spill over into the group insurance and self-insured

markets. Imagine the tense human resource (HR) meeting in which an employee expresses frustration at being locked into a staid plan with few options when his partner has a plethora of choices on the individual market or an employer-sponsored private exchange. Enough meetings like this, and the HR representative



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will be on the phone with the company's insurance sales representative, demanding a better consumer experience for the group. Employer-sponsored plans will therefore begin to mimic individual market dynamics, and these innovations will evolve as health plans experiment and differentiate themselves in competition for consumers.

This shift is already brewing in today's market in the form of new competitive ideas, such as benefit designs that allow consumers to buy up to richer health benefits, reward and incentive programs, value-based plan designs, and the use of wellness programs as platforms for consumer engagement. But there's much more to do if insurers want to truly differentiate themselves in the consumer market. They'll need to rebuild the insurance product as we know it today—a daunting, but essential task.

A New Value Proposition for Private Insurance

Insurers face a dire predicament: the individual market is here and growing, but few payers are ready for it. A health plan seeking to reinvent its value proposition for the consumer market will need to re-think every step of the value chain, as the chain that services individuals is dramatically different from the one that services employers. As a result, insurers will need to overhaul broad swaths of their capabilities—from research, product development, outsourcing, and supply chain management to provider network management, claims processing, marketing and sales, and customer service.



Some insurers have taken initial steps to address the consumer market, but progress to date has been largely superficial and focused mostly on marketing efforts designed to reposition their brands toward the consumer audience. Such efforts might work in the short term, but

In creating a guaranteed-issue market the ACA undermines much of insurers' traditional value proposition.

if the consumer experience post-sale does not live up to the expectations set by the rebranding strategy, they might do more harm than good.

The truth is, few health plan experiences are consumer-oriented. Most members interact with their health plans only during times of trouble, such as when they cannot access a desired doctor or even simply understand how their benefit works. Indeed, by design, the health insurance business is light on proactive and meaningful consumer marketing and service delivery. Fixing this will require material changes to core insurer operations in a reorientation from B2B to B2C. Imagine if Procter & Gamble, a consumer marketing behemoth for the past 150+ years, had to become an enterprise marketer and sell to corporations overnight. The situation is first a matter of survival, but then—for those who make it out alive—an important opportunity to drive market share.

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Overhauling the Health Insurance Value Chain

Rebuilding each component of the value chain is essential in order for insurers to differentiate themselves in the consumer market. Insurers must overhaul their business strategy and capabilities:



For health plans to become effective at competing for consumer business, each component of the value chain must be considered and addressed based on the following steps.

Research

To serve consumers, insurers must first understand them. Yet apparently insurers do not know much, other than the fact that consumers do not seem to like them. According to a 2012 Harris Poll in which Americans were asked which industries they trust least, health insurance ranked near the top along with big tobacco, pharmaceuticals, and oil. To change this sentiment, insurers will need to embrace consumer research to a degree not previously undertaken in order to understand what their consumers want and build products that reflect those needs.

Product Development

The lessons learned from consumer research will help shape product development. The ACA mandates baseline care and effectively commoditizes the core health insurance product. As a result, true product differentiation can only be achieved through modular extensions that add value to baseline plans. These add-ons could include the ability to purchase an expanded provider network and/or supplemental health benefits not covered as an essential health benefit under the ACA or as a state-mandated benefit. The one-size-fits-all model for family insurance will change as well. We see a future in which individual family members can tailor their own health benefits. In the not-too-distant future, an insurer website or exchange could closely resemble the checkout process used by Apple or Audi. In the case of an automobile manufacturer, the car is baseline, but consumers have the option to add premium packages or à la carte options like a GPS system, sun roof, and heated seats, resulting in a tailored purchase every time.

Health plans will also likely design products that include health insurance as part of a broader offering of



consumer health. Consider a value proposition in which the health plan serves as the advisor to a consumer looking to optimize the lifetime use of his/her healthcare dollars, including insurance premiums, out-of-pocket costs, and wellness. In this way, the health plan becomes a promoter not of insurance, but of overall cost-efficient “health.” Over time, research will determine whether or not such a competitive approach will work, but it—or other ideas like it—will create a wide array of higher-margin, value-added products in addition to the soon-to-be banal, ACA-regulated health insurance standard.

Outsourcing and Supply Chain Management

It is possible to build an entire health plan operation with outsourced products and services from third-party vendors. Most plans do not go that far, but over the past two decades, health plans have increased the number of core operational functions that they outsource. They usually keep marketing and plan designs for themselves as core competencies and possible sources of differentiation. Other functions, like pharmacy benefits management, care management, utilization management, and customer service, are often outsourced in

Greater price transparency for consumers could massively disrupt today's provider contracting model.

provider reimbursement to be proprietary information. In an employer-based service model, this works as long as employers are satisfied with the overall financial performance of the health plan. However, consumers faced with the prospect of larger out-of-pocket expenses (i.e., higher deductibles and co-insurance payments) have a legitimate need to know and manage differences in both cost and quality among providers. Thus, applications that promote price transparency have gained traction,

Because providers serve as the primary touch point when someone accesses his/her insurance benefit, the quality of a consumer's experience with a provider—something that is out of the plan's direct control for the most part—can significantly affect the perception of his/her health plan. If the current trend toward price transparency holds, health plans might begin to



For many health plans, strength in the area of provider network management creates a cost-based competitive advantage. As plans transition toward consumerism, the relationship between insurers and providers—to this point primarily based on negotiations around network inclusion and reimbursement—is subject to change as well.

structure benefit options that put provider choice completely in the hands of the consumer. Instead of locking into static networks, plans would allow consumers to choose a provider at the time they need care based on a value decision. In this model, out-of-pocket costs vary based on provider-specific pricing. Another variation could see an insurer partner with select providers to create unique and proprietary insurance products, in which the provider brand is leveraged to influence the consumer's purchasing decision. These and many other innovative provider strategies will evolve over time, as the consumer market becomes better understood.

Operations

Historically, the core component of an insurer's operations has been focused on paying, validating, and adjudicating claims. This is the area of the value chain in which the health plan most frequently interacts with its customers; unfortunately, these interactions generally occur when customers are also dealing with issues related to their (or their family member's) acute or chronic health conditions. Like most other consumer-facing industries, business transactions, including the arcane, paper-based "explanation of benefits," will need to move online. Customer service will need to be offered in real-time, 24/7, and be accessible via multiple platforms. More customized product designs will require insurers to overhaul many aspects of claims operations that are currently set up to handle only a finite number of benefit structures in an efficient (i.e., automated) manner.

Another operational imperative will involve the ability to procure, install, and manage a completely new, enterprise-wide IT infrastructure. This is an area in which the health insurance industry is decades behind other industries. Those that innovate quickly will be in the best position to acquire, maintain, and service the oncoming wave of individual insurance purchasers. The need to integrate features such as personalized health portals, notification and messaging capabilities, coverage and claims viewers, reward-based engagement programs, and quality customer service processes are just the beginning of the complete and necessary information systems overhaul designed for the consumer experience.

*Most direct sales
will be replaced by
B2C marketing.*



Marketing and Sales

Today, private health insurance is typically sold based on a segmentation of employers by size and whether the desired product is group insurance or self-insurance. Small group insurance is sold by a network of independent brokers whereas large groups and self-insured customers are sold by a direct sales force. Much of the small group market is expected to shift to the exchanges, be they private or public, and some meaningful percentage of the large group and the self-insured market is expected to eventually migrate over to private exchanges as the value proposition for group insurance dissipates. This will reduce the need for a direct sales capability in favor of B2C marketing.

For health plans, this represents a completely unfamiliar customer-acquisition platform. Some insurers have cut their direct-to-consumer marketing teeth on their Medicare products; now they will have to explore alternate channels and articulate a compelling value proposition to the various segments of the under-65s, where most current insurance brands carry little weight. Insurers will have to differentiate themselves on parameters other than price and the platinum–gold–silver–bronze metal structure of the ACA-mandated benefits. In the post-ACA environment, maintaining existing customers will be essential, again pointing to the need to build a customer service wrapper around a health plan's entire operation.

Technology Innovation Will Drive New Investment Opportunities

Rewriting the value proposition for health plans requires technological innovation at every step, which in turn opens the door to investment opportunities. New software, infrastructure, and services can play a key role throughout the value chain: customization and the shopping cart approach to product sales cannot occur without the necessary technology—e-commerce, database back-end, advanced and fully automated claims processing—to facilitate those transactions. Likewise, the shift in provider network management, from reimbursement negotiations to transparency, consumer engagement, and provider partnership, necessitates solutions that can link payers and providers as well as support communications and shared applications. From an operations perspective, improved call center software, telecommunications, automated claims adjudication and payment, and other approaches support insurers' efforts to optimize their customer service and manage their consumer brands. Mobile strategies will enable insurers to reach consumers on their own terms and hopefully create value-added interactions. These might initially include mobile messaging and care management solutions to improve patient adherence with prescriptions or evidence-based treatments, but will eventually evolve into major customer retention tools, with a comprehensive range of applications designed to allow consumers to manage their "total health."



Psilos Investing in the Reimagined Payer Value Chain

Psilos' investment thesis is to seek solutions that fit into this reimagined payer value chain. One of our investments, SeeChange Health, is leading the way in clinically driven health improvement and consumer engagement as an enterprise service. Another investment, HealthEdge, is providing next-generation, business-transforming core administration and care management technology platforms to the healthcare payer market. Yet another portfolio company, Extend Health, pioneered the private healthcare exchange model and was ultimately acquired by Towers Watson in 2012 for \$435 million.

Change is the Only Choice

Insurers are faced with the proposition of dramatically revamping their business models, and they must start down that long road now if they expect to withstand the turmoil and survive the transition to an insurance market in which the individual consumer's influence is paramount. The change has already begun, and forward-thinking organizations will take the lead—and be in a good position to maintain their leadership—only if they are proactive. They will not have to do it alone; there is huge opportunity for innovation to help insurers, providers, and patients navigate these uncharted waters and aid in the change reshaping America's healthcare system.

As healthcare investors, we are optimistic that payers will be able to make the shift and that the result will be a more outcomes-based healthcare system in which the patient is the focal point.



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