# Capgemini

# Top Trends in Health Insurance: 2020

**What you need to know**

# TABLE OF
# CONTENTS

# Introduction

### Health payers must stay in tune with a changing industry landscape

Health insurance dynamics are in flux – from new and increasing risks to changing customer preferences, and more transparent business processes. The cost of healthcare continues to rise, even faster than inflation. What's more, pressure from health insurance commoditization makes it difficult for insurers to maintain margin integrity. The result? Profitability is becoming a challenge.

The risk landscape is shifting for both health insurers and policyholders because of rising instances of complex medical conditions and an aging population. Insurers are working to influence policyholder behavior and to improve medication adherence for managing members' health and health outcomes better. They are also developing more accurate risk profiles to enhance underwriting. Proactive involvement with policyholders helps keep costs in check, while operational efficiencies can grow profitability.

Evolving customer expectations are pushing insurers to react swiftly or risk losing market share. Forward-looking insurers are providing a holistic customer experience via a range of value-added services to improve engagement, which may bolster brand awareness, improve customer retention, and spur new revenue opportunities.

Advancement in technologies such as artificial intelligence (AI), connected devices, and data science has accelerated the shift in the industry and is enabling insurers to become a partner to customers, a preventer of risks, all the while continuing to be a payer.

Industry players are reacting to a changing business environment by shifting their value proposition to improve customer-centricity, operational efficiency, and flexibility.

These initiatives will help health insurers manage the evolving landscape and develop competencies to survive in the near term and thrive in the long run.

# Health insurance industry landscape

Health insurance is evolving and undergoing significant changes. As the **risk landscape** shifts, it is necessary to improve **operational efficiencies,** cater to evolving **customer preferences,** and align better with the changing **business environment**. Payers must adapt and align their business and offerings accordingly.

Life expectancy is increasing. In 2016 global life expectancy at birth was 72 years, a 5.5-year increase over 2000, according to World Health Organization estimates.[1] People are living longer worldwide, and with ever-improving medical and healthcare facilities, life expectancy is bound to increase further. However, along with life expectancy, chronic and complex diseases, behavioral issues, and lifestyle-induced health concerns have also increased. All these factors are shifting the risk landscape and putting more pressure on the existing healthcare infrastructure and costs.

Gross global average medical trend rates are high and is expected to reach 8.0% in 2020, 4.9 percentage points more than the average inflation rate of 3.1%.[2] Healthcare expenditure as a percentage of GDP in the United States increased to 17.9% in 2017, up from 13.4% in 2000.[3] Health insurance marketplaces are commoditizing health plans, challenging payers to maintain profitability, differentiate themselves, and gain mindshare.

No wonder that improving operational efficiency and catering to evolving customer preferences are industry priorities. Technological advancements such as big data, cloud, artificial intelligence, and predictive analytics open opportunities for insurers to improve efficiency, agility, and flexibility.

Policyholders are becoming more tech-savvy and now seek products and services that are highly personalized to their requirements. They demand a convenient and holistic experience, similar to what they have come to expect from industries such as online retail. Therefore, insurers are compelled to reassess their product and service strategy.

The business environment is undergoing regulatory change, business model transformation, and the entry of new players that are seizing opportunities to fill gaps in offerings and processes across the value chain. The regulatory framework is also a critical factor that sets essential healthcare and health industry parameters. Lately, regulations have focused on raising quality and performance thresholds while introducing more systemwide transparency. This requires health insurers to delineate their unique value propositions to more deftly manage the changing industry dynamics.

---

[1] World Health Organization, Global Health Observatory (GHO) data on Life expectancy, https://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en, accessed September 2019.

[2] Aon website, "2020 Global Medical Trend Rates Report," https://healthresources.aon.com/reports-2/2020-global-medical-trend-rates-report, accessed October 2019.
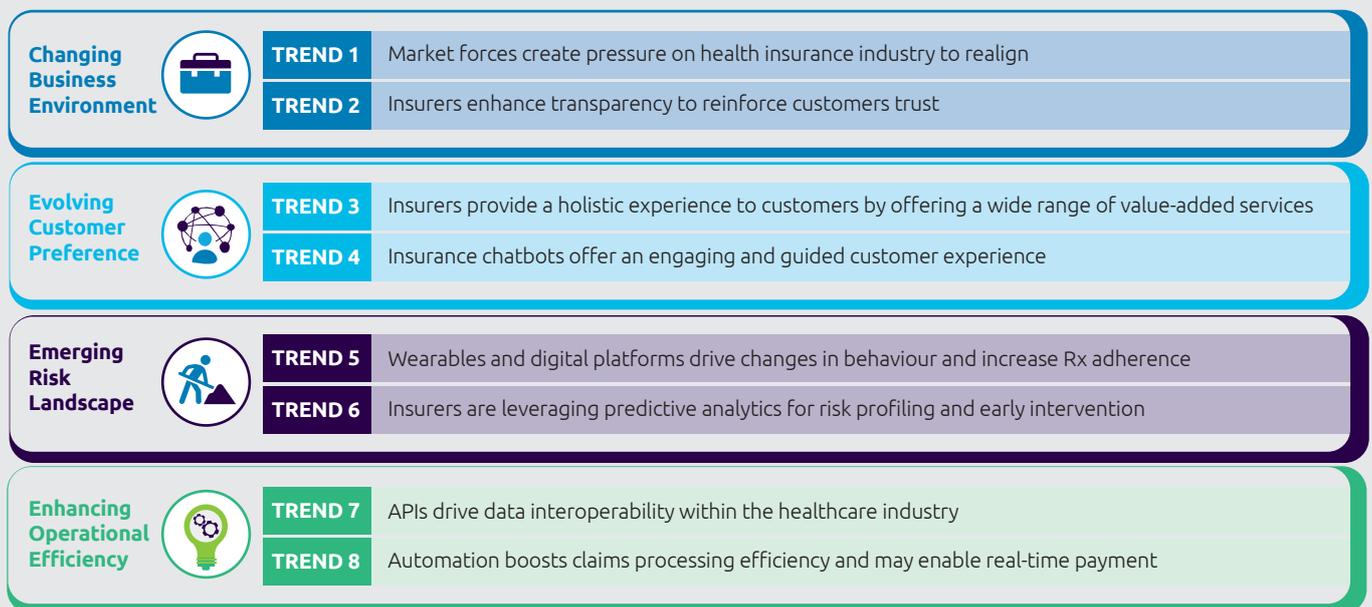
[3] Centers for Medicare & Medicaid Services, "Historical National Health Expenditure Data," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html, accessed September 2019.

## Business challenges spur a new health insurance paradigm

Health insurers are realigning across the value chain and becoming more transparent to align with the changing business environment. To meet the evolving preferences of members, health insurers are providing value-added services and using AI-driven chatbots to create a more engaging experience. Insurers are strategically leveraging new technologies – such as wearables and predictive analytics – to address the emerging risk landscape. They are also leveraging advancements in automation and APIs to enhance operational efficiency.

**Exhibit 1: Health insurers responding to the shifting market dynamics**

| Changing Business Environment | | |
|---|---|---|
| **TREND 1** | Market forces create pressure on health insurance industry to realign |
| **TREND 2** | Insurers enhance transparency to reinforce customers trust |

| Evolving Customer Preference | | |
|---|---|---|
| **TREND 3** | Insurers provide a holistic experience to customers by offering a wide range of value-added services |
| **TREND 4** | Insurance chatbots offer an engaging and guided customer experience |

| Emerging Risk Landscape | | |
|---|---|---|
| **TREND 5** | Wearables and digital platforms drive changes in behaviour and increase Rx adherence |
| **TREND 6** | Insurers are leveraging predictive analytics for risk profiling and early intervention |

| Enhancing Operational Efficiency | | |
|---|---|---|
| **TREND 7** | APIs drive data interoperability within the healthcare industry |
| **TREND 8** | Automation boosts claims processing efficiency and may enable real-time payment |

Source:     Capgemini Financial Services Analysis, 2019

*Top Trends in Health Insurance: 2020* explores the challenges shaping the health insurance industry and discusses strategies adopted by the insurers for navigating and aligning with the challenges.

# Trend 01: Market forces create pressure on health insurance industry to realign

*The health insurance industry is witnessing instances of collaboration and integration across the value chain to address emerging risks and provide quality care to members.*
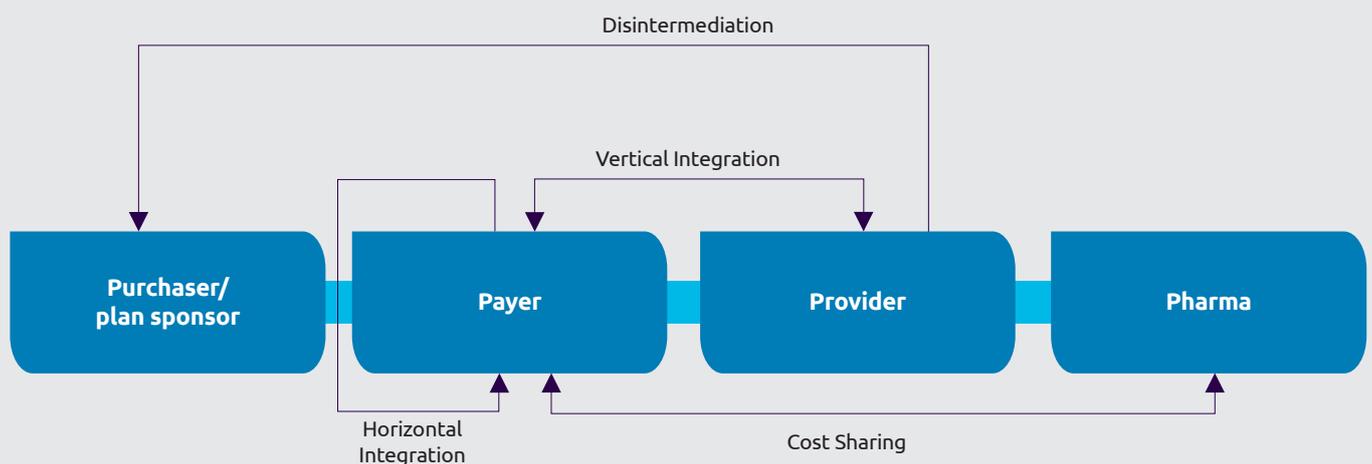
## Background

- Market forces such as new technologies, rising healthcare costs, new emerging health concerns, increased customer expectations, and entry of new players are creating pressure for realignment across the value chain.
- In response, health insurers are forming new relationships to protect their markets or attack new ones. Changes include risk-shifting between insurer and pharma companies, horizontal integration among payers, and vertical integration between insurers and care providers.

## Key Drivers

- Greater collaboration is needed across the value chain to help players tackle new emerging health care risks and concerns.
- Rising healthcare costs are driving insurers to move to a value-based care model.
- Customers are increasingly looking for quality treatment and experience.
- The entry of new players is forcing insurers to adopt new business models.

**Exhibit 2: Health insurers industry realignment**



Source:    Capgemini Financial Services Analysis, 2019

## Trend Overview

- The health insurance industry is undergoing horizontal integration to diversify product offerings, gain access to new markets, and scale up operations.
  - The acquisition of health insurer Aetna by healthcare company CVS is helping CVS introduce new programs and services to manage chronic conditions more efficiently.[4]
  - To expand government-sponsored healthcare program offerings, US-based health insurer Centene is acquiring healthcare company WellCare Health Plans.[5]
- Many players are directly providing healthcare plans, which cuts out the middlemen. This is forcing vertical integration where insurers are purchasing or building partnerships with care providers.
  - Humana acquired long-term care operator Kindred at Home and hospice provider Curo Health Services. It also partnered with Walgreens to launch a clinic in Kansas City for senior citizens.[6]
  - Cigna is focusing on affordable, quality care for cancer patients through its Collaborative Care Initiative. It has partnered with Florida Cancer Specialists and Research Institute (FCS) and Memorial Sloan Kettering (MSK) Cancer Center.[7, 8]
- Health insurers and pharma companies are coming together through contractual reimbursement models for effective risk sharing.
  - UPMC Health Plan, a US-based health insurer, and AstraZeneca, an English-Swedish pharmaceutical company, partnered through a value-based contract in early 2019. Reimbursement for prescriptions of BRILINTA, a drug intended to help heart attack patients mitigate the impact of subsequent events, will be connected to cardiovascular outcomes for targeted populations.[9]

## Implications

- Vertical integration would give insurers greater control over service quality. It would enable a more coordinated and smoother healthcare experience for customers. It would help insurers manage rising claim payouts.
- Horizontal integration through mergers and acquisitions will help insurers to scale up their operations, diversify their portfolio, and enter new markets. It would help insurers open new revenue streams and secure increased operational efficiency.
- Collaboration with pharma companies will help insurers to mitigate high costs for specialized treatments and will help players share the risk.

4  Pharmacy Times, "CVS Finalizes Acquisition of Aetna and Looks to the Future," Jennifer Barrett, November 28, 2018, https://www.pharmacytimes.com/news/cvs-finalizes-acquisition-of-aetna-and-looks-to-the-future.

5  USA Today, "Centene to buy smaller rival WellCare Health Plans in deal worth $17.3 billion," Ben Tobin, March 27, 2018, https://www.usatoday.com/story/money/2019/03/27/centene-acquire-wellcare-health-plans-17-3-billion-deal/3285726002/.

6  FierceHealthcare, "Humana emphasizes commitment to clinical programs in Q2 earnings," Rose Meltzer, August 2, 2018, https://www.fiercehealthcare.com/payer/humana-q2-earnings-call-reflects-commitments-to-clinical-programs-quality-outcomes.

7  Targeted Oncology, "FCS and Cigna Create New Initiative Focused on Better Patient Experience," Dylann Cohn-Emery, August 23, 2019, https://www.targetedonc.com/news/fcs-and-cigna-create-new-initiative-focused-on-better-patient-experience.

8  Health Payer Intelligence, "Cigna and MSK Start Value-Based, Coordinated Cancer Care Program," Kelsey Waddill, August 5, 2019, https://healthpayerintelligence.com/news/cigna-and-msk-start-value-based-coordinated-cancer-care-program.

9  Healthpayer Intelligence, "UPMC, AstraZeneca Enter Value-Based Pharmaceutical Contract," Jennifer Bresnick, January 30, 2019, https://healthpayerintelligence.com/news/upmc-astrazeneca-enter-value-based-pharmaceutical-contract.

# Trend 02: Insurers enhance transparency to reinforce customers trust

*Insurers can bolster customer relationships by enhancing transparency and empowering members with more coverage and cost information.*
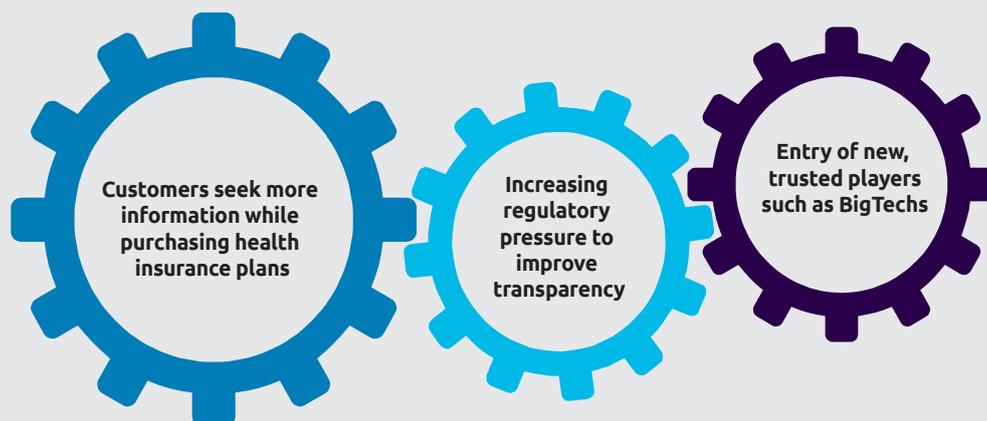
## Background

- For any organization, transparency is critical to building customer trust. Traditionally, the healthcare industry lacked transparency, which has resulted in weak brand loyalty.
- Consumers struggle to obtain detailed price information about healthcare services or whether their plan covers a prescribed drug or test that can affect out-of-pocket expenses.

## Key Drivers

- The rise in healthcare costs and emerging new health risks are driving customers to scrutinize healthcare plans actively before making a purchase.
- More stringent regulations – such as an executive order in the United States to improve price and quality transparency – are putting pressure on the healthcare industry to become more transparent.[10]
- The entry of new players such as BigTechs, which enjoy widespread name recognition and trust, is forcing insurers to beef up their relationships with customers by improving transparency.

**Exhibit 3: Why health insurance is becoming more transparent**



Customers seek more information while purchasing health insurance plans

Increasing regulatory pressure to improve transparency

Entry of new, trusted players such as BigTechs

Source:    Capgemini Financial Services Analysis, 2019

---

[10] The White House, "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First," June 24, 2019, https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first.

## Trend Overview

- Insurers are increasingly providing detailed information regarding services covered under a health plan, claims processing, and payments.
  - UnitedHealthcare provides personalized claims videos that detail how the claim was processed. The videos explain plan coverage as well as outstanding treatment fees. The program increased customer satisfaction, and reduced follow-up question calls by nearly 30%.[11]
  - Sidecar Health, a US-based health InsurTech, offers customers transparency by publishing the amount plans cover for various healthcare services. Members can make upfront payments for care using a payment card provided by Sidecar Health.[12]
- Insurers are helping members make more informed decisions before they use a health care service by providing digital tools to minimize out-of-pocket expenses.
  - Australia-based not-for-profit health fund, HCF, launched an out-of-pocket costs tool that provides information on expenses that are not covered during common procedures performed by different specialists.[13]

## Implications

- Highly informed consumers will feel empowered while choosing a healthcare provider leading to greater satisfaction and better affiliation with the insurer.
- Trusted relationships would help insurers to improve customer retention.
- Increased transparency about claims processing would heighten customer satisfaction.
- Effort and costs related to follow-up claims queries would be reduced.

---

[11] United Health Group, "UnitedHealthcare's New and Enhanced Digital Health Resources Help Empower People to More Effectively Use Their Benefits and Curb Health Care Costs," October 31, 2018, https://www.unitedhealthgroup.com/newsroom/2018/2018-10-31-new-digital-health-resources.html.

[12] Verdict, "Sidecar Health secures $18m in funding; forays into Texas market," August 7, 2019, https://www.verdict.co.uk/life-insurance-international/news/sidecar-health-secures-18m-in-funding-forays-into-texas-market/.

[13] Verdict, "HCF ahead of the pack on transparency," June 13, 2019, https://www.hcf.com.au/about-us/media-centre/media-releases/2019/HCF-ahead-of-the-pack-on-tranparency.

# Trend 03: Insurers provide a holistic experience to customers by offering a wide range of value-added services

*Insurers are providing value-added services to address evolving customer preferences, to differentiate their offerings in a commoditized market, and to improve customer engagement.*

## Background

- Health exchanges have commoditized health plans. Since the price point of core offerings are very similar, insurers are exploring ways to differentiate themselves from competitors.
- Customers' experience with other industries is driving their expectations for similar holistic services from insurers.

## Key Drivers

- Many customers concerned about their health and fitness are looking for innovative products and services to better manage their lifestyle.
- Customers seek a convenient one-stop platform to address all their health needs.
- The rise in smartphone penetration and the app ecosystem have positioned mobile as a critical service delivery channel.
- Increasing adoption of APIs enables insurers to collaborate more effectively with different players to offer a variety of value-added services.

**Exhibit 4: Factors driving insurers to provide value-added services**

Need for differentiation in highly commoditized insurance market

Rise in smartphones usage and strong app-ecosystem

**Value-added services**

Ease in collaboration due to increase in adoption of APIs

Consumers looking for convenient access to innovative health products and services

Source:    Capgemini Financial Services Analysis, 2019

## Trend Overview

- Health insurance providers are collaborating with different players to offer an array of services ranging from booking video consultations, wellness coaching, and ride-hailing to easy access to health products and healthy foods.
  - Prudential is working with tech startups Babylon Health, DocDoc, WellteQ, and MyFiziq to develop an AI-powered health and wellness ecosystem – a one-stop-shop for policyholders in Singapore. The platform offers AI-based symptom checking and health risk assessment, finds doctors, and offers virtual consultations, wellness coaching, and activity tracking.[14]
  - Anthem Blue Cross and Blue Shield in Ohio partnered with Walmart to give Medicare Advantage plan members improved access to health products. Through Walmart's in-store and online shopping options, customers buy over the counter meds and health-related products covered under their plans.[15]
  - San Francisco-based Collective Health piloted the integration of Uber Health's services into its platform through which members can book Uber rides. It provided reliable transportation to customers seeking healthcare services.[16]
  - Buffalo, NY-based Independent Health partnered with Zipongo, a digital food marketplace, to help its customers select, purchase, and prepare healthy foods personalized to their tastes, dietary preferences, restrictions, and medical needs.[17]

## Implications

- Insurers would be able to provide customers a convenient, personalized, and holistic experience.
- Insurers could boost their top line by generating new revenue from value-added services.
- Additional access to customer data would help insurers better evaluate member needs and build a core set of offerings, along with personalized and targeted value-added services.
- Higher customer engagement will increase brand stickiness and improve customer retention.

[14] The Business Times, "Prudential powers ahead in tech with AI health platform," Lynette Tan, November 12, 2018, https://www.businesstimes.com.sg/hub-projects/singapore-fintech-festival-2018/prudential-powers-ahead-in-tech-with-ai-health-platform.

[15] Business Wire, "Anthem Blue Cross and Blue Shield and Walmart Collaborate to Give Consumers Increased Access to Everyday Health-Related Products," November 13, 2018, https://www.businesswire.com/news/home/20181113005094/en/Anthem-Blue-Cross-Blue-Shield-Walmart-Collaborate.

[16] Collective Health, "Collective Health and Uber Health Working to Give Select Members Easy Access To Transportation Services," March 1, 2018, https://collectivehealth.com/announcements/collective-health-joins-uber-health-program.

[17] Independent Health, "Independent Health partnering with Zipongo to make it easier for members to eat well," July 23, 2018, https://www.independenthealth.com/AboutIndependentHealth/Newsroom/PressReleases/2018PressReleases/IndependentHealthpartnerswithZipongo.

# Trend 04: Insurance chatbots offer an engaging and guided customer experience

*AI-driven chatbots help insurers interact meaningfully with customers – in a cost-efficient way.*

### Background

- Traditionally, companies have viewed chatbots as another channel to impersonally market products.
- However, evolving social and demographic patterns indicate that more and more customers seek experiences that are personalized, secure, and easily accessible.

### Key Drivers

- A proliferation of app ecosystems and the popularity of messaging apps are facilitating chatbot deployment on these platforms.
- Advancements in artificial intelligence are helping insurers build sophisticated chatbots.
- Rising healthcare costs are forcing insurers to reduce expenses associated with customer support services.

### Trend Overview

- Insurers are using chatbots for guiding customers to a care provider according to their needs and symptoms.
  - Cigna is leveraging the WhatsApp Business API to answer customer questions in Hong Kong. The chatbot sources information directly from Cigna's database and helps customers find a doctor.[18]
  - US insurer Anthem partnered with primary care startup K Health to build a co-branded triage and symptom-checker app. The app uses a combination of licensed data resources and a chatbot-driven patient interview about demographics, medical history, and symptoms to determine likely conditions based on other similar patient cases and then recommends potential routes to care.[19]
- Insurers are using chatbots to drive pre-purchase and purchase processes while addressing policy and claims-related questions.
  - US-based health insurer Premera launched chatbot Scout on Facebook Messenger. The chatbot informs customers about how to get details on claims, benefits, and other services.[20]
  - Australia's fourth-largest insurer, nib (formerly Newcastle Industrial Benefits), uses chatbot *Nibby* to sort customer calls and respond with information relevant to the member's query – and then connects them quickly to a live consultant. Nibby also guides site visitors to information about coverage options and the sign-up process.[21]
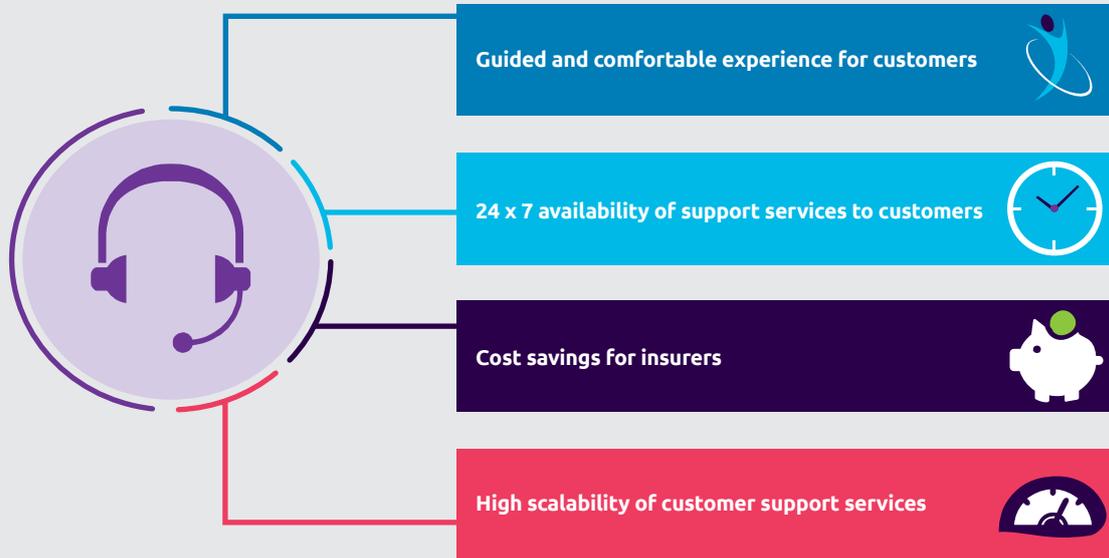
---

[18] DigFin Group, "Cigna reboots with WhatsApp/chatbot mashup," July 23, 2018, https://www.digfingroup.com/whatsapp-chatbot.

[19] BMedCity News, "Anthem partners with startup K Health on symptom checker and telehealth app," Kevin Truong, July 22, 2018, https://medcitynews.com/2019/07/anthem-partners-with-startup-k-health-on-symptom-checker-and-telehealth-app/.

[20] Microsoft, "Skip the hold music and meet Premera Scout, a chatbot that helps you with health care," Vanessa Ho, October 1, 2018, https://news.microsoft.com/transform/premera-scout-chatbot-helps-with-health-care/.

[21] CMO, "First private health insurance chatbot has 70% success rate," Vanessa Mitchell, November 28, 2018, https://www.cmo.com.au/article/650119/first-private-health-insurance-chatbot-has-70-success-rate/.

**Exhibit 5: Benefits of health insurance chatbots**



Guided and comfortable experience for customers

24 x 7 availability of support services to customers

Cost savings for insurers

High scalability of customer support services

Source:    Capgemini Financial Services Analysis, 2019

## Implications

- Insurers would be able Insurers can quickly scale their customer service operations by deploying chatbots.
- Chatbots can provide convenient, around-the-clock customer support services.
- Chatbots increase operational efficiency, leading to significant cost savings.
- Insurers would have more touchpoints for interaction to boost customer engagement.

# Trend 05: Wearables and digital platforms drive changes in behavior and increase Rx adherence

*Customers who adopt healthy habits and adhere to prescribed medication maintain better health and experience more positive health outcomes.*
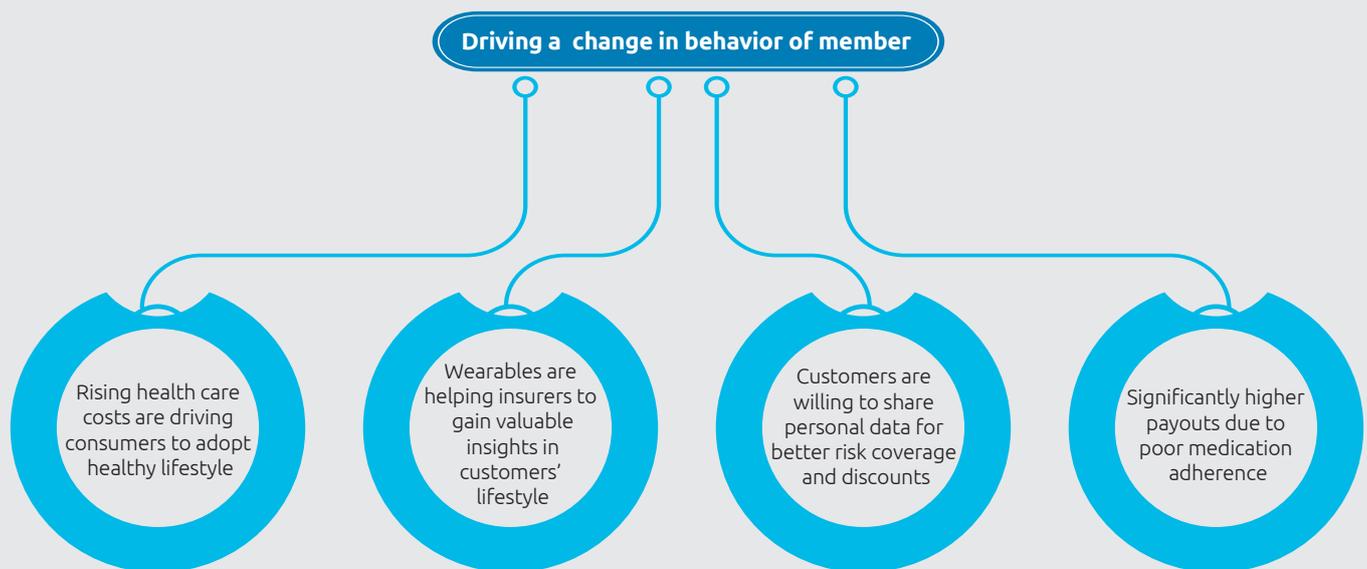
### Background

- Chronic and complex conditions such as high blood pressure, asthma, diabetes, mental illness, etc., are on the rise.
- Patient adherence to prescribed medication significantly affects healthcare costs. Medication non-adherence in the United States has been reported to cost $300 billion annually.[22]

### Key Drivers

- Rising health care costs are driving consumers to adopt a healthy lifestyle.
- A rise in the sales of activity trackers like health bands, smartwatches, etc. enables insurers to capture data to understand policyholders at a granular level.
- Customers are more willing to share personal data in exchange for benefits such as lower premiums and rewards.
- Member health often declines because of medication non-adherence, leading to significantly higher payouts.

**Exhibit 6: Why insurers are working to change member behavior**



Driving a change in behavior of member

- Rising health care costs are driving consumers to adopt healthy lifestyle
- Wearables are helping insurers to gain valuable insights in customers' lifestyle
- Customers are willing to share personal data for better risk coverage and discounts
- Significantly higher payouts due to poor medication adherence

Source:     Capgemini Financial Services Analysis, 2019

[22] HealthCare Finance, "Patients who skip medications cost healthcare $300 billion annually," Jeff Lagasse, May 14, 2018, https://www.healthcarefinancenews.com/news/patients-who-skip-medications-cost-healthcare-300-billion-annually.

## Trend Overview

- Insurers are promoting the use of wearables to encourage policyholders to adopt a healthy lifestyle.
  - UnitedHealthcare provides members an Apple Watch, free of cost, by meeting some walking goals.[23]
  - Aetna has collaborated with Apple to launch *Attain*, an app that tracks the daily activities of Aetna members, helps them to reach their personalized goals, and offers rewards for goal achievement.[24]
- Insurers aim to increase medication adherence by leveraging various digital channels.
  - Groove Health, a medication adherence software firm, collaborated with US-based insurer CNA, to provide CNA's long-term care policyholders an AI-based mobile app with features such as personalized adherence interventions, medication reminders, drug-to-drug interaction alerts, and progress sharing with caregivers and physicians.[25]

## Implications

- In the long term, an active and healthy member base would help insurers boost overall profitability.
- Medication adherence would reduce readmissions and payouts.
- Digital platforms would help insurers create more customer touchpoints, thereby increasing customer engagement.

---

[23] FierceHealthcare, "UnitedHealthcare adds Apple Watch to Motion program with option to 'walk it off'," Evan Sweeney, November 14, 2018, https://www.fiercehealthcare.com/payer/unitedhealth-apple-watch-motion-wellness-wearables-data-devices-incentives.

[24] CVSHealth, "Aetna Announces Attain, a Personalized Well-being Experience Combining Health History with the Apple Watch," January 29, 2019, https://cvshealth.com/newsroom/press-releases/aetna-announces-attain-a-personalized-well-being-experience-that-combines-health-history-with-apple-watch-information-to-empower-better-health.

[25] PRNewswire, "CNA Insurance To Bring AI-Powered Medication Adherence Platform To Policyholders To Support Healthier, Independent Lives," August 21, 2019, https://www.prnewswire.com/news-releases/groove-health-collaborates-with-cna-insurance-to-bring-ai-powered-medication-adherence-platform-to-policyholders-to-support-healthier-independent-lives-300904870.html.

# Trend 06: Insurers are leveraging predictive analytics for risk profiling and early intervention

*Predictive analytics offer insurers an insightful assessment of potentially high-risk customers to mitigate loss, boost profitability.*

## Background

- Health insurers have extensive experience in underwriting and pricing health-related risks. Traditionally, however, coverage decisions were based on relatively little personal information about the customer.
- With advancements in technologies such as big data and connected devices, insurers now have access to vast customer data, which can be used to generate actionable insights.

## Key Drivers

- Rising health care costs are forcing insurers to identify high-risk customers and provide early intervention services.
- New medical and health concerns (increasing chronic diseases, lifestyle-induced risks, etc.) must now be factored into underwriting decisions.
- Increasingly, customers appear willing to share data, which gives insurers access to previously unavailable data points to better understand members.

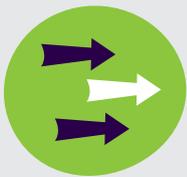**Exhibit 7: Key drivers of predictive analytics in health insurance**



Need for early interventions

Need for more accurate risk profiling

**Predictive Analytics**

Greater availability of data

Rise in customer willingness to share data

Source:     Capgemini Financial Services Analysis, 2019

## Trend overview

- Insurers are leveraging predictive analytics for better risk profiling in the underwriting process.
  - Bermuda-based reinsurer PartnerRe leveraged the mobile-first digital health engagement platform of Zurich-based dacadoo, to roll out a wearable technology and wellness pilot project. The initiative will enable PartnerRe to provide health insurers with actionable insights for leveraging wearables to underwrite risks more accurately and improve customer engagement.[26]
- Insurers are using predictive analysis to identify and monitor high-risk individuals to intervene early and prevent further complications.
  - Late-stage startup Prognos uses an AI-based system on a lab registry of 18 billion clinical records to help health insurers determine which new beneficiaries need the most care and will drive the highest cost. This helps insurers in better disease management of members.[27]
  - Long-term care insurer CNA collaborated with HealthTech firm GreatCall to offer members in-home passive remote monitoring solutions that use sensors to measure daily activities such as eating, sleeping, and movement. It will identify patterns through predictive analysis and help monitor customers' health for any anomalies and provide timely interventions.[28]

## Implications

- Predictive analysis can help insurers more accurately profile customer risk and bolster underwriting profitability.
- Early intervention for high-risk individuals could help payers reduce claims.
- Personalized offerings based on predictive analysis would drive higher customer satisfaction and brand loyalty.

---

[26] PartnerRe, "PartnerRe Launches Wearables Pilot with Digital Health Platform, dacadoo," May 16, 2019, https://partnerre.com/news/partnerre-launches-wearables-pilot-with-digital-health-platform-dacadoo/, accessed September 2019.

[27] Global Newswire, "How health insurance companies use AI to make consumers healthier," Susan Morse, November 9, 2018, https://www.healthcarefinancenews.com/news/how-health-insurance-companies-use-ai-make-consumers-healthier.

[28] MedCity News, "Through new partnership, GreatCall brings its technology to CNA policyholders," Erin Dietsche, January 28, 2019, https://medcitynews.com/2019/01/greatcall-cna-policyholders.

# Trend 07: APIs drive data interoperability within the healthcare industry

*Interoperability will enable insurers to streamline data sharing and empower patients with health data knowledge and control.*
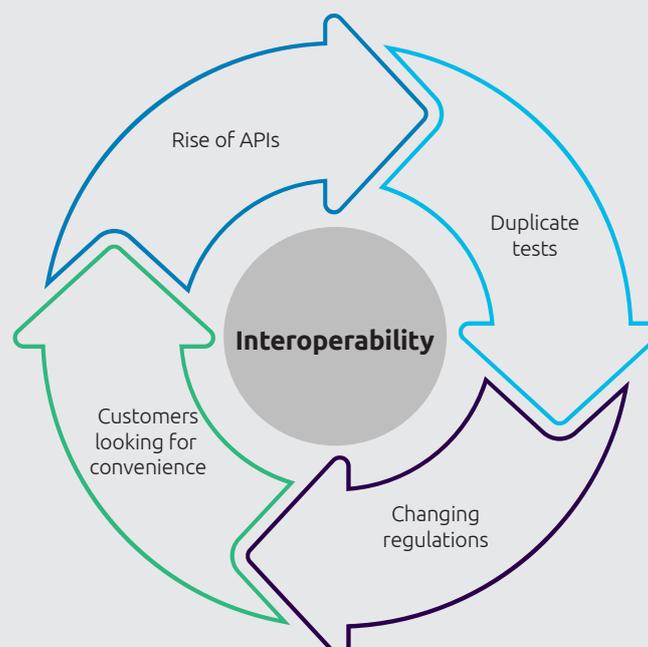
### Background

- Traditionally, it has been difficult for healthcare industry stakeholders (insurers, clinical health labs, care providers, and patients) to share data seamlessly among each other because manual effort was required to gather all relevant information from data storage silos.
- Fragmented medical records hinder seamless healthcare services for patients.

### Key drivers

- API technology can enable the seamless and secure exchange of information such as pharmacy data, clinical lab results, and health claims.
- Without a patient's medical history, duplicate tests or other avoidable expenses can result.
- Today's consumers seek convenience while using health services.
  - Regulatory authorities, such as the US Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS), support an ecosystem in which patients and care providers can access health information easily.[29]

**Exhibit 8: Drivers of interoperability in health insurance**



Source:     Capgemini Financial Services Analysis, 2019

[29] American Nursing Informatics Association, "HHS Proposes New Rules to Improve Interoperability of Health Information: Public Comment Period Extended to June 3," https://www.ania.org/article/hhs-new-rules-health-information, accessed September 2019.

## Trend overview

- Insurers are increasingly pushing for interoperability of healthcare and the use of Electronic Health Record (EHR) services for customers.
  - UnitedHealth was expected to launch an EHR tool by the end of 2019 for its customers leveraging its mobile wellness platform Rally. It would be fully integrated and portable, thus providing customers easy access to health records and details about previous care.[30]
  - Humana partnered with the cloud-based EHR platform Epic to provide real-time drug-pricing information to customers based on their healthcare plan. Epic enables both providers and insurers to make informed decisions while keeping costs in mind at the point of care itself.[31]
  - The CARIN Alliance, a collaboration of US health insurers, care providers, health IT companies, and technology players such as Apple and Google, has developed a data model to standardize the sharing of claims data. The organization is testing an API that would enable patients to access their claims data and authorize its use by third parties.[32]

## Implications

- Clinicians could provide quality care – with lower payouts – if they had a 360-degree view of patients' health history.
- Electronic Health Records offer customers ownership and easy access to their health data, which sets the stage for convenient health services experience.
- Standardized health data would open new opportunities for insurers to extract meaningful information from member health data and positively influence their health.
- Insurers must be vigilant while sharing data and fortify their cybersecurity measures since there are massive regulatory fines against a breach that exposes customer's personal data.

[30] MedCityNews, "UnitedHealth Group launching portable EHR for members by the end of 2019," Kevin Truong, October 22, 2018, https://medcitynews.com/2018/10/unitedhealth-group-launching-portable-ehr-for-members-by-the-end-of-2019/.

[31] FierceHealthcare, "Humana to integrate real-time benefits check into Epic's EHR," Kevin Truong, Paige Minemyer, June 11, 2019, https://www.fiercehealthcare.com/payer/humana-to-integrate-its-real-time-benefits-check-into-epic-s-ehr.

[32] FierceHealthcare, "Anthem, Humana along with Apple and Google testing API for patient access to claims data," Heather Landi, August 2, 2019, https://www.fiercehealthcare.com/tech/anthem-humana-along-apple-and-google-testing-api-for-patient-access-to-claims-data.

# Trend 08: Automation boosts claims processing efficiency and may enable real-time payments

*Automation technologies enable faster and more efficient claims processing, which can improve customer satisfaction and reduce operational costs.*

### Background

- It is complicated and time-consuming to process out-of-network claims manually.
- Many human interventions are necessary, which often leads to errors, especially while adding information from the submitted documents.
- Health insurers are also aware of the importance of automation in claims processing:
    - According to the *World Insurance Report* (WIR), 2018, 48% of health insurers claim that they use robotic process automation (RPA) to streamline the claims process.[33]

### Key Drivers

- Increasing healthcare costs are putting pressure on insurers to reduce administration overheads.
- Slow or delayed claim processing directly impacts customer experience, which may result in loss of revenue if a disgruntled customer decides to make a switch.
- Regulators are pushing to reduce claim processing time.
    - The Insurance Regulatory and Development Authority of India (IRDAI), has mandated penal interest payments for claims not processed within 30 days.[34]

### Trend Overview

- More and more health insurers are adopting automation technologies such as RPA, cognitive document processing (CDP), and optical character recognition (OCR) to streamline the claims process.
    - United Healthcare is leveraging Microsystems Technology *OCR for Forms* solution to reduce turnaround time by scanning instead of microfilming documents and automating data entry with similar accuracy.[35]
    - Aetna developed an artificial intelligence-based application for parsing healthcare providers' contracts and assisting in claim settlements. It helps reduce the manual work done by employees and enables Aetna to provide members a better claims experience.[36]

---

[33] Capgemini | EFMA, World Insurance Report 2018, https://worldinsurancereport.com.

[34] India Today, "Claims turn easy," Naveen Kumar, October 1, 2018,
https://www.indiatoday.in/magazine/smart-money/story/20181001-claims-turn-easy-1344302-2018-09-22.

[35] ECM Connection, "United Healthcare Corporation Readies for the Revolution with OCR for Forms,"
https://www.ecmconnection.com/doc/united-healthcare-corporation-readies-for-the-0001, accessed September 2019.

[36] Global Big Data Conference website, "Aetna enlists AI to settle health insurance claims," July 25, 2019,
http://www.globalbigdataconference.com/news/144332/aetna-enlists-ai-to-settle-health-insurance-claims.html.

- Insurers are working to extend real-time claims adjudication to customers so invoices can be settled when a patient leaves a healthcare facility.
  - Oscar Health Claims System focuses on real-time processing by linking claims, members, plans, benefits, payments, and providers – to instantly pay providers for services.[37]
  - Anthem and several Blue Cross Blue Shield plans have invested in startup OODA Health to enable instant payments. OODA uses cloud-based solutions allowing real-time collaboration between insurers and providers to automate and speed up the claims process.[38]
  - Alipay leverages a blockchain system to process health insurance claims in real-time. Alipay's blockchain-based prescription service automates the process of getting a repeat prescription, which usually involves queuing at a hospital.[39]

**Exhibit 9: Impact of automation in claims processing**



**Faster claims processing**

**Higher operational efficiency**

**Strategic use of human resources**

**Stronger customer relationship**

Source:     Capgemini Financial Services Analysis, 2019

## Implications

- Automation would weed out various human errors leading to faster claim processing and improve overall customer experience.
- Insurers will be able to process claims with fewer resources and obtain higher operational efficiency.
- Utilization of employees in creative and strategic initiatives instead of mundane tasks which can be automated.
- Real-time claims settlement would enable insurers to foster a positive customer relationship based on trust and transparency.

[37] Medium, "Oscar Health's New Claims System," Alan Warren, May 30, 2018, https://medium.com/oscar-tech/oscar-healths-new-claims-system-123b8210acf7.
[38] FierceHealthcare, "OODA Health raises $40.5M to simplify billing, with backing from Anthem and Blues plans," Eli Richman, September 19, 2018, https://www.fiercehealthcare.com/payer/ooda-health-raises-40-5m-series-a-funding-anthem-and-bcbs-board.
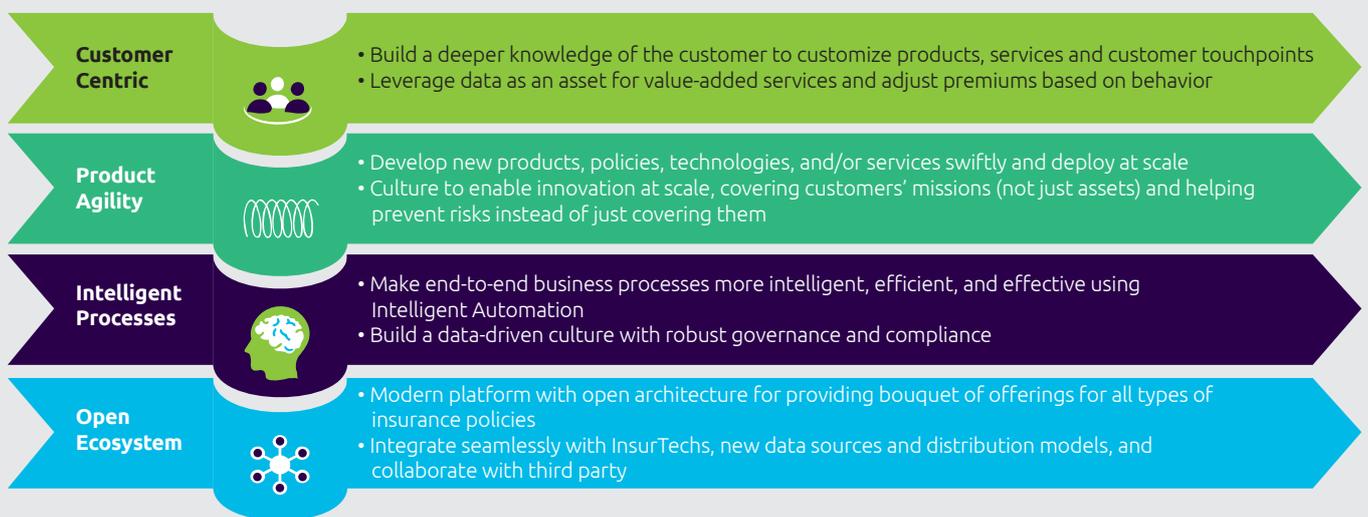[39] Ledger Insights, "Ant's Alipay uses blockchain to process health insurance claims in seconds," https://www.ledgerinsights.com/blockchain-alipay-china-health-insurance-claims, accessed September 2019.

# Conclusion

To thrive over the long term, health insurers must understand customer expectations and market trends while maintaining the right partnerships to innovate at the speed and scale necessary to stay competitive. We call such a carrier an *Inventive Insurer*.

An Inventive Insurer is prepared to build a **customer-centric** approach, supports **product agility,** has adopted **intelligent processes,** and fosters an **open ecosystem** (Exhibit 10).

**Exhibit 10: Health insurers are acquiring Inventive Insurer competencies**



**Customer Centric**
- Build a deeper knowledge of the customer to customize products, services and customer touchpoints
- Leverage data as an asset for value-added services and adjust premiums based on behavior

**Product Agility**
- Develop new products, policies, technologies, and/or services swiftly and deploy at scale
- Culture to enable innovation at scale, covering customers' missions (not just assets) and helping prevent risks instead of just covering them

**Intelligent Processes**
- Make end-to-end business processes more intelligent, efficient, and effective using Intelligent Automation
- Build a data-driven culture with robust governance and compliance

**Open Ecosystem**
- Modern platform with open architecture for providing bouquet of offerings for all types of insurance policies
- Integrate seamlessly with InsurTechs, new data sources and distribution models, and collaborate with third party

Source:     Capgemini Financial Services Analysis, 2019

Insurers are moving closer to Inventive Insurer status as they strive to manage the evolving landscape.

They are leveraging wearables, digital platforms, and advances in predictive analytics to gain deep customer insights. With actionable insights, they can engage with members better and help them lead a healthier life by influencing their behavior, ensuring medication adherence, and providing a guided experience.

To meet evolving customer requirements, insurers are expanding their product and service offerings and extending numerous value-added services to policyholders. Automation technologies and analytics are enabling the development of intelligent capabilities, such as AI-based claims automation and predictive analytics-based risk profiling and early interventions in high-risk cases.

Health insurers are also opening their systems to enable better collaboration with ecosystem partners to streamline data sharing and introduce more transparency in the system.

# References

1.  Capgemini | EFMA, World Insurance Report 2019, https://worldinsurancereport.com/.

2.  Capgemini | EFMA, World InsurTech Report 2019, https://worldinsurtechreport.com/.

3.  Healthcare Finance, "How health insurance companies use AI to make consumers healthier," Susan Morse, November 09, 2018, https://www.healthcarefinancenews.com/news/how-health-insurance-companies-use-ai-make-consumers-healthier.

4.  HealthData Management, Beyond the Wow Factor: Getting the Most Out of Disruptive Technologies, https://www.healthdatamanagement.com/whitepaper/beyond-the-wow-factor-getting-the-most-out-of-disruptive-technologies, accessed September 2019.

5.  The Economic Times, "Claim settlement process of health insurance: TPA vs In house claim department," Navneet Dubey, May 28, 2019, https://economictimes.indiatimes.com/wealth/insure/health-insurance/claim-settlement-process-of-health-insurance-tpa-vs-in-house-claim-department/articleshow/69423425.cms.

6.  Forbes, "Top Five Digital Health Technologies in 2019," Reenita Das, February 4, 2019, https://www.forbes.com/sites/reenitadas/2019/02/04the-top-five-digital-health-technologies-in-2019/#5dc704de6c0f.

7.  Insurance Nexus, "Insurance Customers Speak Out," https://www.insurancenexus.com/customer/insurance-customers-speak-out accessed September 2019.

8.  RGA website, "The Digital Future of Health Insurance," December 5, 2018, https://rgare.com/knowledge-center/media/articles/the-digital-future-of-health-insurance accessed September 2019.

9.  Healthcare IT News, "Insurance company pushes for a 'new ecosystem of digital healthcare'," Tammy Lovell, April 9, 2019, https://www.healthcareitnews comnewsinsurance-company-pushes-new-ecosystem-digital-healthcare.

10. *Livemint,* "How health insurance companies use AI to make consumers healthier," Revati Krishna, August 3, 2019, https://www.livemint.com/money/personal-finance/from-claims-to-medical-advice-to-health-checks-insurance-gets-tech-savvy-1564487821576.html.

## Disclaimer

# About the Authors

**Saurav Swaraj** is a senior consultant with the Market Intelligence Group at Capgemini Financial Services. He has more than five years of consulting and strategic analysis experience across multiple sectors including insurance.

**Geet Aggarwal** is a manager with the Market Intelligence Group at Capgemini Financial Services. He has more than four years of experience in IT, consulting, and strategic analysis.

**Dharmendra Vishwakarma** is a consultant with the Market Intelligence Group at Capgemini Financial Services. He has worked on various thought leadership, strategic, and research projects in the insurance domain.

The authors would like to thank the SMEs listed below for their contributions to this paper:

- **Aimee Sziklai,** Vice President, Financial Services
- **Milind Shah,** Senior Director, Capgemini Invent
- **Elias Ghanem,** Vice President, Global Head of Market Intelligence Group
- **Vikash Singh,** Director, Market Intelligence Group
- **Tamara Berry,** Editor, Content Manager, Market Intelligence Group
- **Kalidas Chitambar,** Director, Creative Services
- **Suresh Kumar Chedarada,** Senior Consultant, Creative Services
- **Sourav Mokherjee,** Manager, Creative Services
- **Balaswamy Lingeshwar**, Consultant, Creative Services
- **Dinesh Dhandapani Dhesigan**, Consultant, Market Intelligence Group

## About Capgemini

A global leader in consulting, technology services and digital transformation, Capgemini is at the forefront of innovation to address the entire breadth of clients' opportunities in the evolving world of cloud, digital and platforms.

Building on its strong 50-year heritage and deep industry-specific expertise, Capgemini enables organizations to realize their business ambitions through an array of services from strategy to operations. Capgemini is driven by the conviction that the business value of technology comes from and through people. It is a multicultural company of over 200,000 team members in more than 40 countries. The Group reported 2018 global revenues of EUR 13.2 billion.

Visit us at

## www.capgemini.com

Learn more about us at:

www.capgemini.com/insurance
email: insurance@capgemini.com

## People matter, results count.