INTERNATIONAL FEDERATION OF HEALTH PLANS

Building a Vision for Moving from Payer to Partner

Rethinking the Contract between Health Plans and their Members

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Executive Summary

Private health insurers are experiencing a profound shift in their relationship with members. For decades, insurers have been defined by a narrow function as financial payers, providing support only when illness arises. The paper explores the need for change on the basis this approach has reached its limits in the face of myriad factors including demographic change, increasing chronic disease and the rising costs of personalised treatments. This is all further impacted by competition among insurers, growing consumer expectations and digital advancements.

It reports on how forward-thinking insurers can reimagine their role, moving beyond the traditional focus on reimbursing costs towards becoming trusted health and wellbeing partners. Members increasingly want help to extend not just their lifespan but their 'healthspan', reducing the years spent in poor health through earlier intervention, behavioural support and easier access to preventative care.

The paper highlights practical innovations that are driving this transformation. CSS's Pensionato addresses loneliness among retirees as a determinant of poor health, combining digital tools with personalised coaching. Peachy uses conversational AI to create empathetic and intuitive interactions, simplifying processes and reducing stress. Vitality's shared value model rewards healthier behaviours by integrating wearable data with behavioural science. Cimas' iGO integrates genomic testing, digital health pathways and community engagement to build a continuous relationship with members rather than episodic contact.

The paper examines how emerging technologies such as AI, data analytics and genomic profiling can be used to create highly personalised health pathways. It argues for a shift in the underlying insurance contract from a static legal document to a living framework that reflects shared value, mutual accountability and evolving health outcomes.

The report also acknowledges key barriers to this change, including regulatory constraints, internal cultural resistance and the challenge of building trust around data use. However, it concludes that insurers who embrace empathy, technology and long-term thinking can create a stronger, closer, more enduring relationship with their customers as they strive to live longer in good health, creating sustainable models that deliver better outcomes for members while reducing future system costs.

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Introduction

"The current contract is still shaped by legal, financial, and regulatory logic. It defines rights and obligations, but not relationships. If we truly want to shift toward a health partnership model, the foundation would need to evolve – not just in language, but in logic." - Patrick Wilhem, CSS

The role of private health insurers is undergoing a profound shift. Once defined almost exclusively by their function as financial payers, insurers are now confronting a landscape in which this traditional model is neither sufficient nor sustainable. Demographic trends, the rising burden of chronic diseases and the increasing costs of personalised medicine are reshaping health systems worldwide.

People may be living substantially longer lives than previous generations, but many spend a significant proportion of these later years in poor health. The result is an expanding gap between lifespan and 'healthspan'. Chronic conditions such as cardiovascular disease, type 2 diabetes and certain cancers account for the majority of deaths and consume a disproportionate share of health budgets. Yet much of this burden is preventable through earlier intervention, lifestyle change and better access to targeted support.

The Limits of the Old Model

This reality is pushing the limits of the current insurance model. As Nick Astwick, CEO of Southern Cross, comments in iFHP's white paper on Systems Thinking (1):

"The problem with private health insurance is that we've got to a point where the old model of health insurance, which involves being a good bill payer at the end of our customer's journey, is unsustainable."

Simply paying claims no longer serves the needs of members or the long-term viability of insurers.

For decades, health plans have engaged with members mainly during episodes of illness, often through complex processes while they are dealing with a condition that is often confusing and distressing. Where the insurer has had infrequent contact with the member previously, such experiences can form the basis for the relationship with the member; where there is no history of deeper interactions to characterise it. In this scenario, at the point at which people are in pain, anxious or uncertain, the interaction with their insurer can become transactional rather than supportive. This dynamic erodes trust and reinforces the perception of insurers as gatekeepers rather than as partners in health.

The Member Experience: Complexity and Frustration

The extent of this frustration is reflected in the 2024 UserTesting Survey, conducted among 2,000 U.S. adults (2). It revealed that:

- **58%** of respondents would rather endure "various everyday annoyances" than face the stress of understanding and enrolling in insurance policies,
- **27%** reported that they lacked clarity on their coverage details,
- **36%** turned to artificial intelligence tools for help navigating complex insurance information.

Further surveys in recent years (e.g. Switzerland Health Insurance Literacy Study 2023 and Australian Healthcare Index Report 2023) (3) have highlighted a significant lack of understanding and frustration

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among consumers regarding the terms and details of their health insurance policies; this appears to be a challenge in many markets around the globe.

Such findings highlight the emotional toll of navigating the current system and reinforce the urgent need for insurers to simplify, clarify and humanise their engagement with members. At the 2024 iFHP Customer Experience Study Tour, Headspace described the healthcare journey as an *emotional rollercoaster*, asking a crucial question for the future of insurance:

"How can we make the interaction with insurance coverage more empathetic? How can we offer more comfort, reassurance, hope and wisdom to people in moments of crisis and beyond?"

This challenge lies at the heart of redefining the relationship between health plans and their members. Insurers are in the process of reconsidering the perceived limits of their role in financial reimbursement; and recognising and responding to the human experience of illness, fear and uncertainty in innovative ways.

A New Opportunity for Partnership

The same pressures that make the old payer model unsustainable also create an opportunity to transform this relationship. Members increasingly want help to stay healthy, not just financial cover for when they fall ill. They are seeking guidance to prevent avoidable diseases, improve quality of life and extend their healthspan.

This notion is not new – on the contrary. However, emerging technologies and behavioural insights are unlocking ways to offer tailored, proactive support at scale. Digital tools, data analytics and personalised pathways enable insurers to interact with members more frequently and meaningfully, turning sporadic claims-based contact into an ongoing dialogue about wellbeing.

To achieve this shift, insurers are starting to go beyond adding wellness services as optional extras. They are starting to build a new vision based on greater levels of underlying, foundational trust with their members. A vision achieved through clarity, empathy, transparency and reshaping their role from a payer of bills to a partner in health. A natural progression to this is enshrining the new vision in the underlying contract between insurer and member, one based on a greater sense of shared responsibility for maintaining good health. When members are supported to make informed choices and are motivated to take positive actions, they benefit from improved quality of life, while insurers reduce long-term costs and strengthen their value and importance in an evolving health ecosystem.

Looking Ahead: From Theory to Practice

This paper explores why this shift is both urgent and inevitable. It examines how forward-thinking insurers are already rethinking their relationships with members using personalisation, prevention and partnership to move beyond the limits of a traditional insurance model. By fostering deeper engagement and aligning their goals with those of the people they serve, insurers are beginning to close the gap between lifespan and healthspan while creating a more resilient and sustainable future for healthcare.

In the following section, we will explore a vision for redefining insurers' relationship with their members; from digital-first models that prioritise empathy and trust, to shared-value frameworks that align healthier behaviours with better outcomes for both insurer and insured. The intention is to offer practical insights into how the health and wellness partnership model can be realised in practice. Moving from just offering insurance against future ill health to empowering members to take far more control of their own health.

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The Vision for Health and Wellness Partnership

"How can we make the interaction with insurance coverage more empathetic? How can we offer more comfort, reassurance, hope, and wisdom to people in moments of crisis and beyond?" - Headspace, at the 2024 iFHP Customer Experience Study Tour

Redefining the relationship between insurer and insured echoes a broader shift towards patient-centred care, where the patient (or member) is an active participant in their healthcare. In the context of insurance, this opens a possibility of sharing the value created by better health outcomes and lower healthcare costs. It also opens up new ways to share the health risks of a member's lifestyle choices, where members take on more responsibility for the impacts of their behaviours on their health.

There are at least two interdependent pathways for enabling this. Firstly, supporting members to create healthier lifestyles that reduce and delay the "moments of crisis". Secondly, building a stronger relationship with members, one that acknowledges their health challenges and hopes and makes these moments more manageable by using empathy to build trust and create a partnership relationship where previously it has been mostly transactional.

This section of the paper will explore the vision for health and wellness partnerships and where health insurers can aim to take it. It will aid insurers in understanding the most fruitful opportunities for their cohorts and their markets. It will also aid in identifying barriers and challenges early, offering the opportunity to navigate them more successfully.

From financial transactions to lasting partnerships

"We envision a future where ... [our platform becomes a] central point of member interaction, not only in illness, but in every life stage, from adolescence to active aging." - Vulindlela Ndlovu, CEO, Cimas Health Group

An obvious shift, already apparent in conversations with iFHP members, is increasing the number of interactions or touchpoints. In a traditional insurance relationship, health plan members buy cover and subsequently have little or no interaction with their health insurer until they need to make a claim. The relationship is characterised by fewer interactions, many of which are high cost (not only in terms of funding for the healthcare episode, but in terms of time and effort to manage by the insurer).

Insurers are developing cost-effective ways to communicate with members before they become sick through the use of digital apps and platforms. By creating many small interactions that offer value, the number of touchpoints are increased and there's an opportunity to build a stronger relationship.

Vitality's highly successful reward system provides weekly and monthly benefits for users who meet their activity goals, ensuring a regular flow of positive interactions between member and insurers while also incentivising healthier behaviours. The iGO Wellness Department is shifting iFHP member Cimas' interactions with members away from episodic care, where conversations with the insurer happen only when a member seeks healthcare. Instead, by creating more touchpoints with members, iGO Wellness aims to build a relationship of continuous engagement with a member's wellbeing through their whole life. CEO of Cimas, Vulindlela Ndlovu, describes how the iGO Wellness hub includes digital health platforms that provide "virtual consultations, chronic disease management apps, lifestyle dashboards and risk

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assessments... enabling members to take ownership of their health journey through data-driven guidance." Cimas also organises community sporting events, such as its annual iGO marathon and pedal to wellness cycling events. This provides an alternative touchpoint with the member and takes the health partnership into yet another part of members' lives by emphasising a community aspect of health. People are more likely to engage in healthy activities when they're supported by social groups and communities and it will be instructive to see how insurers could have more positive influence at the community or population health level.

One vision for the member relationship is for the health insurer to be a health guide, not only offering assessments and advice but also facilitating access to appropriate care, to more health-conscious communities and increasing motivation to make healthier choices. Members are supported and empowered to adopt the most impactful healthier behaviours for mitigating their individual health risks. The value offered to members through this new relationship comes with a reciprocal request. When insurers help members become more aware of what they need to stay healthy and live more years in good health, it is then the member's responsibility to make the appropriate lifestyle changes.

Building this relationship (and the investment needed to do so) is a key part of encouraging members to take more ownership and change their behaviours to improve their own health.

Incentivising long term behaviour change

"The reality is behavioural science has shown that we are overly optimistic about our own health. However, we can use healthy behaviours to our advantage" - Kiashen Moodley, Vitality

Encouraging long term shifts in behaviour to improve health has been the goal of many population health programmes, with varying levels of success. Contributors to iFHP's White Paper on Systems Thinking affirmed that large scale behaviour change directed towards specific outcomes is complex, slow work **(1)**.

Starting from the premise that healthy behaviours can manage health (and therefore health insurance) risk., shared value models in health insurance, as demonstrated by Vitality, have already made promising progress on designing incentives to successfully drive short-term behaviour change. Vitality's model encourages healthier behaviour by sharing the benefits of improved health with members. South African insurer Cimas is following a similar model and is currently building its own value partnership ecosystem. Cimas iGO has over 36 value partners spread across the country, offering discounts and easier access for members to facilities such as gyms, spas and fruit and vegetable stores. The value partners complement the eight dimensions of wellness that iGO seeks to address: Physical, Spiritual, Emotional, Social, Financial, Intellectual, Occupational and Environmental.

Vitality's model builds on this further by gamifying its rewards, incentivising users to move beyond a weekly view of their activity into a monthly or longer term experience of feeling positive about maintaining healthy activities. This provides a positive, trusting foundation from which to offer more specialised health advice, which may require bigger, more challenging lifestyle changes from the member.

In addition to introducing appropriate incentives, insurers and their members (and other stakeholders, as in any systems approach) must be aligned with the health outcomes they're working towards. Members need to be aware of their current state of health, understand what good health means for them and have an easy way to judge if they're getting closer or further away from their desired health outcomes.

Cimas puts value-based healthcare at the centre of its iGO Wellness Hub, emphasising the need to define shared health outcomes with members. An overarching shared outcome would be to live longer in good

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health (or increasing an individual's healthspan). Cimas is developing chronic illness dashboards to assist members in managing their wellbeing. When the member feels they have more control over these outcomes, anxiety in turn is reduced.

The Vitality Age measure gives members an intuitive way to understand their health and the impact their choices have on it. Strategy Lead at Vitality Kiashen Moodley gives us a glimpse into the future the company envisages with intuitive health scores for a range of chronic illnesses, allowing members granular awareness of their health and risk factors: "Our true north remains the creation of shared value and the achievement of this continues to evolve." Cimas also sees the capturing of clear shared value as key to future innovation, that value being born out of outcomes that matter to members, with a focus on functionality, mental wellbeing and life participation; not just survival or service use.

Adding value by turning data into personalisation

"We envision a future where every policyholder receives personalised health coaching, digital risk profiling, and genomic-based prevention strategies."
Vulindlela Ndlovu, CEO, Cimas Health Group

New technology is bringing highly personalised medical care within reach (4). Personalised medicines are currently expensive, but affordable genomic profiling, aided by AI and automation, offers the promise of predicting risk factors long before other markers or symptoms would be picked up. Big data and AI tools allow personalised guidance to be delivered at scale through AI-powered health coaching, preventative pathways and genomic profiling.

AI-powered health coaching

In the roadmap for developing its iGO Wellness Hub, Cimas shares its plans to use AI-supported health coaching to scale the delivery of personalised coaching to every member, both for individual members and individuals covered by a corporate health plan.

AI supported health coaching is already available through services like HealthifyMe's AI-powered Ria, the world's first AI-powered nutritionist, which was launched in 2017 (5). In 2024, the service had over 40 million users in India, although the service has faced challenges in localisation to reach new markets. Other AI-based health coaching services include Thrive AI, for mental health, and Numan for weight management.

Use of AI offers the capacity to scale a highly personalised approach to sharing insights, recommendations and supporting long-lasting behaviour change.

Preventative pathways

Bupa has developed an AI engine for providing highly personalised health insights. Blua, the insurer's digital health eco-system, supports health plan members to access digital healthcare.

One example of the value this provides for members is the Skin Analytics AI-tool, which showed 98.7% accuracy in diagnosing skin cancers based on photographs taken by members using a smart phone (4). This starts to make the case for why members would use the app and share their data, because they can access quick, convenient and potentially life-saving care.

The value created for insurers is in their capacity to generate rich insights from the many digital touchpoints they are creating with members.

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Vitality is also working towards a future where preventative health pathways are increasingly personalised. Kiashan Moodley observes that greater power will come from creating clear pathways based on personalised risk assessments, delivered in intuitive ways. For example, instead of advising a member to exercise more, a more powerful intervention would be to detail the exact gradient they should follow to build up from their current level of physical activity. Combining this with other personalised pathways (based on that member's health and activity data) will be incredibly powerful.

Genomic profiling

With My Genomic Health, Bupa is making significant progress toward a vision of genomic profiling as a preventative tool. In 2024, the insurer announced a whole genome sequencing pilot for up to 3,500 UK customers, and this has since been extended to include a more global cohort. This two year pilot will identify the risk of 36 diseases, including 10 cancers, before symptoms develop and give individuals access to personalised recommendations to promote health (6).

Other insurers, including Vitality and Cimas have also set out visions that include the use of genomic profiling to allow highly personalised preventative care. The vision is for targeted health guidance and interventions to be delivered to those individuals who are likely to really benefit, based on a combination of their genomic profile and their longitudinal health data. This means members are given only relevant advice, meaning compliance is likely to be higher, increasing effectiveness. It also allows for cost savings resulting from targeted chronic disease prevention programmes, so only those at higher risk are enrolled, and highly targeted screening programmes, so only those at higher risk are tested.

A combination of digital tools, genomics and scalable wellness services will enable a shift in the relationship between insurers and members, where members are empowered by their insurer with access to highly personalised health advice that aims to help them not only live longer, but to do so in significantly improved health compared to previous generations.

Reimagining empathy with frictionless access to healthcare

"We didn't see this as a service problem, we saw it as a failure of imagination… [Customers] benchmark us against Monzo, Spotify and Amazon. Empathy, simplicity and clarity are no longer nice-to-haves - they're basic expectations." - Amit Patel, Peachy

Building trust has been a key theme in discussions with iFHP's membership about the future. Demonstrating empathy is key to further humanising the relationship, shifting the perception of insurers as gatekeepers concerned only with saving cost, to a trusted health partner that is committed to the shared goal of healthier lives and better value care.

Many members are already building their own health eco-systems using digital apps, consumer devices and even owned infrastructure in the form of clinics and other care hubs. Instead of trying to compete, a more impactful role for insurers may be building on that awareness by facilitating member access to preventative clinical pathways.

Peter Salmon, a consultant with extensive experience in the health insurance sector, gives an example of the first FDA approved at-home cervical cancer screening test (7) to female members who are at higher risk (however that is evaluated) of cervical cancer. This offers a service:

- that is offered on the basis of evidenced risk (using health data to generate insights)
- it is a new diagnostic tool, not available through consumer channels (adding value for members)

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- that gives either an earlier diagnosis or allaying any that specific health concern (meeting member health needs).

Amit Patel, CEO & Founder of Peachy, describes the opportunity to build infrastructure that enables the intuitive, frictionless and data-smart experiences that customers now expect. This is more than using AI to demonstrate technical capability, it is using tech to meet the customer where they are instead of expecting them to navigate opaque, disjointed health systems during a period of high potential for anxiety concerning their health. Peachy's approach to becoming a health and wellness partner has been to reimagine health insurance as a consumer product. Amit describes it as a move from "What are you covered for?" to "How can we help you feel better today?" and further, to "How can we earn our place in your life?"

Greater responsiveness from an insurer, in the form of intuitive and convenient interactions will help to ease a member's anxiety or at least avoid adding to it. Building empathy into the service is about more than this, however. A truly empathic approach involves deeply understanding what members need and the barriers to meeting those needs, then designing appropriate solutions.

Peachy envisions a future where insurers play a critical role in shaping the member healthcare pathway, building digital systems that seamlessly guide them to the right care at the right time (8). AI and digital tools can be used to scale-up the activities of triage, diagnosis, cost optimisation, monitoring and prevention. An appropriate blend of human clinicians and AI agents can direct human judgement to where it has the most impact and adds the most value, creating capacity to offer a timely and highly personalised service at scale.

Navigating members efficiently to a credible, evidence-based pathway not only helps ease the anxiety of the claims process but will also manage the risks of members either experiencing delays in receiving primary care or going straight to costly specialists. Mitigating both ends of this spectrum has the potential to concurrently improve health outcomes and manage costs.

It also allows both members and clinicians to each retain their autonomy in the process, while the insurer adds value by creating the systems that facilitate timely, accurate navigation. This will include building sufficient trust in member relationships to gather the necessary data and for members to trust they'll be guided to the best health outcomes.

Impacting broader risk factors in health

> *"There's an opportunity for health insurers to combine their actuarial capabilities with warmth and care for members: imagining the health risks that will become serious in 20-30 years and acting now to mitigate those risks." – Nick Reed, CEO, Ninety Innovation*

Offering valuable preventative healthcare is complex, not least because it requires a long term view. Nick Reed, Managing Director at Ninety Innovation gives an example of the current diabetes epidemic. Increasing incidence of diabetes was indicated 30 (or more) years ago with increasing consumption of fast food and increasingly sedentary lives of those in the wealthier parts of the world. If we were seeing those early signs now, what could be put in place to mitigate the risks?

By looking at what early clinical and social indicators are telling us now, insurers can identify the likely health risks for specific audience segments and the concept of engaging with members at different stages of their lives by deeply understanding their specific needs at these times holds a lot of promise.

Patrick Wilhelm, Head of Innovation at Insurer CSS, explains that the development of its 'Pensionato' initiative as part of the insurer's strategy to shift its relationship with members. In developing the pilot, CSS

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identified the emerging recognition of the impact of loneliness in terms of the risks it poses to the health of retirees. Loneliness has a clear impact on health, especially for older people. In 2025 the WHO has reported that loneliness or social isolation is associated with a 29% increase in the risk of cardiovascular disease, taken from research carried out in mostly high income countries (9). This Pensionato pilot isn't aiming to address loneliness for all ages, but to develop products and services for an age group whose health is at risk over the next 10-30 years. CSS worked in partnership with UZH Healthy Longevity Center to identify the most impactful social and lifestyle-related drivers of better mental and physical health among CSS's audience in this age group. It has also chosen a co-creation with retirees to develop platform and health interventions that are most relevant and engaging for this age group. Pensionato draws on the motivational analysis questionnaires and qualitative insights from one-to-one conversations between members and Pensionato health coaches. Individual advice and coaching, delivered online for convenience.

Increasing touchpoints with members is important here too, both in terms of volume and in different parts of their lives. Pensionato, as well as offering health coaching and advice, aims to positively influence the social lives of participants. This kind of approach takes an insurer far beyond protection and potentially into influencing a social determinant of health, creating opportunities for bigger positive influence on the lifestyle choices of their members (and populations as a whole).

Another example of how an insurer is moving towards the social domain of health is Achmea's lifespan-proof housing, which is an initiative aimed at addressing both loneliness and increasing frailty of the oldest segments of the population. More details can be found in iFHP's 'Managing the Global Aging Challenge' White Paper (10).

Nick Reed offers a further insight on audience segmentation. Private health insurers traditionally segment audiences by demographic, however this isn't necessarily how people think about themselves and their lives. Nick notes the rise of communities formed around a common interest who agree to pool their risk. Property insurance against a catastrophic climate event, like flooding or wildfires, provides an example. Munich Re offers solutions allowing communities from different geographic areas to pool their risk and close the coverage gap that one individual or geographic area alone would face (11). By paying attention to how their potential audiences organise themselves, insurers may unlock opportunities to provide innovative solutions for underserved groups.

In summary, looking into the future suggests a role for insurers in influencing the evolution of broader, population health risks, making the task manageable by exploring how the risks they pose to well-defined sub-populations can be mitigated.

Key takeaways:

- A vision that addresses the significant challenges faced by private health insurers (and the health systems of which they are part) involves moving beyond claims processing and developing a lasting partnership with members.
- Increased touchpoints are a pathway to building trust and can be activated at scale with digital tools.
- Behaviour change is a key lever and incentive models demonstrate that well-designed rewards can create short-term behaviour change that leads to longer term healthier lifestyles.
- AI, big data and genomic profiling can be used to create highly personalised health interventions, which increases their relevance and effectiveness.
- Members now expect seamless, intuitive and emotionally intelligent experiences: deeper empathy and intuitiveness in interactions and service design can enable the behaviour change needed to create ambitious impact.

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- Insurers are beginning to address broader determinants of health, including loneliness and ageing, by designing targeted interventions for specific sub-populations.

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Challenges in Realising the Vision and How to Overcome Them

Moving the relationship with members into a deeper health and wellness partnership represents a significant challenge in terms of steering health plan members away from the traditional perception of the role of health insurers.

This paper has aimed to extrapolate the key elements of a vision for how disrupting expectations around insurer/member interactions can, ultimately, create the impact needed to address the scale of the challenge our private health systems are facing.

The sector is in the early stages of this shift and, as with any system-wide shift, there will be numerous barriers to navigate. This section of the paper will review the main barriers to progression and indicate where insurers can focus attention and resource to move more swiftly towards maximal impact.

Technology in service of empathy: investing in impactful solutions

The Barriers

An obvious barrier to building digital tools that deliver preventative healthcare and the data architecture supporting them is the up-front costs they incur. Realising a vision of a robust AI engine enabling proactive and highly personalised outreach to members by drawing from a rich history of members' interactions, for example, will require a significant resource investment. To fund the investment required, insurers may need to review payment models.

Solutions

Peter Salmon, shares that some insurers are developing subscription based models to fund preventative services like regular health screenings, which could be triggered either by a general risk profile (like age) or a more personalised risk profile. Peter imagines a future where this becomes the main product, with traditional health insurance as an additional chargeable service. A comprehensive review of payment models is beyond the scope of this paper, however a 2025 review of subscription models in the US that can be applied to digital health services provides a starting point (12).

Avoiding the wastage of investing in new technology is as critical as identifying appropriate revenue streams. This can be avoided by developing a clear strategy that outlines how the use of technology will power specific products and solutions that improve member satisfaction and give competitive advantage.

Nick Reed, Managing Director at Ninety Innovation, reminds insurers that investing in technology alone isn't going to give a competitive edge. He observes that insurtech companies currently leading in the market are those working on increasing warmth and humanity in their interactions with members.

Useful questions would be "how can technology support us to help our members manage their health and reassure them they're getting the best level of care?" or "how can we harness technology to support a relationship that incentivises healthier behaviours and manages health risk?"

Trying to solve too many health challenges with one product or trying to serve too big or too disparate an audience group with an individual product will also create barriers to managing the investment required and evaluating impact. Instead, identifying a specific health problem that can be solved for a specific audience segment will also give a strategic direction for testing, allowing insurers to build capability and demonstrate results.

For CSS, its Pensionato pilot has been directed towards the specific health challenges of loneliness, for the underserved audience segment of retirees. An analysis of health trends for its market, with its cohort data and an empathic approach to its members concerns around healthcare will allow a health insurer to identify

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four or five health challenges, each of which will be directed towards specific audience segments. This gives a starting point for development, directing resources towards pilot projects that will provide a point of differentiation from competitors, while keeping evaluation and measurement more manageable.

Actions to address the barriers

- Review payment models, with a view to how a subscription-type model could be implemented.
- Review cohort data, market data and health trend data to scan for future health risks.
- Use the review to identify an audience segment and health challenge to design for.

Precision for a personalised approach: The case for data sharing

The Barriers

To realise the vision for health partnership, insurers will be aiming to build far more precise (and therefore more personalised) preventative health pathways. This involves gathering and analysing relevant data about a member's lifestyle, activity levels and, potentially, genomic profile.

This highlights another barrier: to harness the predictive power of genomics for preventative healthcare, members must consent to sharing their genomic data with their insurer. The principle also applies more broadly, including activity data from wearables, outputs of motivational analyses or outputs from health coaching sessions.

In an industry where members are used to viewing their insurer as the payer of bills once they require medical support, trust must be built through transparency on what health guidance insurers will provide and in what ways this may interact with and potentially impact their insurance coverage.

Vitality announced in February 2025 its offer of weight-loss medications to members as conditional to signing up to a holistic pathway including one-to-one coaching, lifestyle support and its successful incentives model for building healthier lifestyles; representing a significant step forward in helping more members manage weight-related health risks. The medications are offered based on criteria such as BMI and weight-related conditions (13).

Solutions

As healthcare pathways move further into prevention and our analytics capability allows more predictive healthcare, the selection criteria will become more complex and may become more contingent on member lifestyle choices and behaviours. If there is insufficient trust and member expectations aren't managed carefully, this could lead to greater dissatisfaction later on, where more personalised coverage rules are seen as punitive rather than supportive.

To fully enter into partnership, insurer and insured must have a common understanding of needs and risks from as early as possible, from which to align on meaningful health outcomes and how data is essential in achieving them.

To be the basis of meaningful activity, and for the protection of both health insurers and their members, this must also be accurately captured in the contract between the two parties.

Actions to address the barriers

- Earn members' trust so they are confident about sharing sensitive health data.
- Educate members on the benefits of the data required for personalised health pathways, while also being transparent about how that may interact with their coverage.

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- Clearly communicate data requirements in the context of a wider, long term vision for supporting members' health and wellbeing.

Scaling a personalised approach: the case for relationships

The Barriers

The inability of regulators to keep pace with rapid developments in technologies like AI and genomic profiling, which are key tools for further scaling a personalised approach to member interactions, presents another challenge for insurers. This can slow or stop the development of new approaches in an already risk-averse industry.

Another potential challenge to a highly personalised approach is member loyalty. A preventative approach (and even more so a predictive approach) requires a significant investment of time and resources. If member turnover is high, the value created by keeping them in good health is lost to the insurer. Deeper and more frequent interactions with health plan members as well as clearly communicating a vision and personalised strategy for achieving their longer term health goals can help engender greater brand loyalty. However, if insurers lose member trust around the eventual process of making a claim, that carefully nurtured relationship may break down.

Peachy's model of personalising interactions, using its 24/7 app and conversational AI interface, has allowed the insurer to provide an empathic response at scale. Interactions with members are built on the trust that Peachy will provide a member-first experience that eases anxieties about health and treatment quickly, with referral to a human when needed. Amit Patel describes Peachy's vision as: "we earn our place in your life", and its brand is built on minimising anxiety and uncertainty about claims. This foundation of trust could go a long way to reassuring member anxieties about data sharing, as discussed earlier in this paper.

Current challenges, however, involve scaling Peachy's model even further. As Amit observes, trust doesn't necessarily scale linearly. To scale for much bigger audiences, spanning more age groups and more complex health needs requires a tweak in approach. In answer, Peachy is developing its machine learning models, continually training them, while exploring the optimal combination of AI and human intelligence.

Solutions

Based on Peachy's experiences of navigating this landscape in the development of its conversational, AI powered claims process, Amit Patel advises building relationships with regulators and working with them to explore and understand the new landscape.

It is crucial to strike the right balance between protection for the customer and room for innovation. Members are looking for solutions that are as seamless as the digital apps they're using in the rest of their lives and yet, as already discussed, a robust foundation of trust must also be in place. Members will want to be reassured their insurer is acting in their best interests for the relationship to endure.

Actions to address the barriers

- Build relationships with relevant regulators and work with them.
- Direct AI and digital tool development towards complementing and extending human capacity for nuanced clinical judgement, cost-data analysis and empathic responses, not as replacements.

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Member agency and accountability: offering intuitive measurement

In the partnership relationship, a member's accountability for making choices that affect their health is highlighted. Giving members the ability to measure their own progress is therefore increasingly important, not just for motivation, but also for accountability.

The Barriers

As explored in iFHP's White Paper (1) robust evaluation is critical to support accountability in behavioural interventions and, in general, not enough resource is given to planning measurement and evaluation that is relevant and credible (see the paper for a fuller discussion).

If members aren't engaged in the measurement of their progress, this will be a barrier to success. Measures must be both intuitive, to cut through the many apps and sources of data in our already busy lives, and credible, so they are trusted.

Solutions

Alongside increasingly precise health pathways, indicators that are more granular than a 'true age' type measure will be needed. Peter Salmon asks: "What would be possible if we could predict the progress of diabetes or other metabolic diseases in an individual, long before the obvious symptoms appear?"

Peter believes there is a need for more of a real time predictive health or lead indicator that can direct and support members into pathways of care. This would also raise members' awareness of their health risks, giving them feedback on their lifestyle choices and progress towards relevant health outcomes. As such we would see a move beyond general preventative health and into predictive maintenance, where insurers can identify personalised behaviour or lifestyle risks, enabling insurers to navigate a member into a highly personalised care pathway and to monitor its effectiveness in real-time. Such measures will also raise members' awareness of their health risks, giving them feedback on their lifestyle choices and progress towards relevant health outcomes.

The concept of shared value also encompasses shared risk, where if a member stops following an evidence-based healthcare pathway designed to manage their health risk, they may lose discounts and the insurer must fall back on other means of risk reduction. As we move into a future of predictive healthcare, designing wellness indicators and providing short-term rewards for taking healthier actions will become even more important. Evaluating progress of future conditions will be less and less dependent on obvious physical symptoms and members will be more reliant on data-driven tools from their insurer (or other knowledgeable innovators).

Another step forward might be using intuitive, meaningful indicators for the current likelihood of developing specific chronic diseases. These would enable both insurer and member to evaluate progress in mitigating the risk of developing the condition. The goal would be for members to have no (or few) unpleasant surprises about their health. Rather than awaiting the results of annual screenings or check-ups, in-app dashboards will show their current health status for all relevant and manageable conditions. The only exception would be conditions where there is no preventative pathway and where awareness of the risk would confer no benefit to the individual.

Actions to address the barriers

- Endorse sufficient time and resources for credible, robust evaluation as part of the product development phase.
- Develop robust indicators of health that reflect the impact of following preventative health guidance and increase member's view into the future of their health.

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- Ensure members can easily access their health indicators so they have full agency, especially as predictive health pathways are rolled out.

Gaps in expertise and influence: managing systems-level change

"It takes a lot of hard yards to make even small changes in behaviour"- Kiashen Moodley, Vitality.

The changes in the role of insurers described in this paper are a form of systems change and it is clear insurers can't improve long-term health and wellbeing of their members alone.

The Barriers

This highlights a barrier around insufficient internal expertise to achieve the needed systems-level change, for example:

- Bringing in the necessary technical expertise to design secure, seamless data architecture for genomic profiling, and using this data to generate valuable insights.
- Forming closer links with primary care clinicians and relevant specialists, like chronic disease specialists or experts on aging, to create evidence-based health pathways.
- Collaborating with behavioural scientists to understand motivators and design suitable incentives, alongside partnering with brands who can offer appealing rewards.

Another barrier insurers may encounter is having insufficient influence over a member's lifestyle to support the desired health outcomes. Depending on the scope of intended health pathways, supporting a member's health journey could, conceivably, mean finding ways to be involved in all aspects of their life from diet, shopping habits, exercise, working environment, community memberships, personal relationships, political affiliations, societal influences, personal values, long held beliefs and more.

Solutions

It will be important for insurers to consider to what extent they can support incentives to influence a member's health choices.

To fill expertise gaps, insurers are beginning to explore new strategic partnerships, while keeping the investments in collaboration manageable. A sustainable approach to this will be going back to the initially defined problem space, reviewing the existing evidence-base and reviewing how potential partnerships are in service of the solution.

An example of an ambitious approach is Kaiser Permanente's Community Health Initiative, launched in 2003. Working towards the health outcome of reducing obesity (and the attendant health risks and care costs), it makes use of community-level levers (rather than solely individual-level interventions). These include collaborating with local organisations to create safe spaces for exercise and improve access to healthier foods. The choice of partners had a strong influence on the number of people reached and the scale of impact of the initiative, which was evaluated using the concept of 'Population Dose' (14).

Corporate health insurance plans may provide existing partnerships for insurers to explore, as a way to reach many individuals with a targeted intervention. Cimas uses cohort data to develop targeted, organisation-wide wellness programmes with its corporate customers. Insurers must be clear which health goals they are working towards and what scope they have (in terms of available resource and potential influence) to broaden that influence and achieve bigger health goals for larger audiences.

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Actions to address the barriers

- Identify what external expertise is needed in behavioural science, technical development and in the context of specific conditions or life-stages to develop credible solutions.
- Identify levers of influence from across a member's life that could hinder a member's ability to reach their health goals.
- Consider ways to fill identified expertise or influence gaps that are both achievable and sustainable.

Shifting the identity of insurers: internal change management

The Barriers

CSS and Peachy are keen to emphasise the importance of internal transformation. Peachy embraced the opportunity of building a new tech stack that could be designed to incorporate AI to create a more empathic member experience. CSS' Pensionato demonstrates it isn't necessary to be a start-up to innovate but some of the biggest barriers to successfully testing novel products can be the insurer's internal landscape. Barriers can be encountered among senior executives in giving colleagues the confidence and motivation to play their part in achieving a new vision.

Solutions

For Peachy innovation was a given as the company was started with the remit of innovating and disrupting health insurance. For CSS, innovation is actively included in the organisation's strategic goals and targets. To build collaboration with colleagues at the implementation level, product leaders must identify ambassadors among colleagues. Having something tangible to share, to demonstrate benefits and how it will operate is key.

Actions to address the barriers

- Set strategic goals for development of health and wellness products at board level and ensure they are on the radar of everyone in the organisation.
- Plan a programme to demonstrate new products and identify ambassadors among staff who are willing to offer support.

The existing power dynamic: congruence across all touch points

Amid all these changes, resistance is likely to arise from the long-established power dynamic between insurers and members.

The Barriers

The underlying logic of the insurance contract is still based on a low touch-point relationship, governed by claims assessments and generic coverage rules.

While this has aided scaling in the past, it is out of touch with the personalised approach insurers are moving towards in regard to empowering members to manage their own health. This incongruence runs the risk of undermining trust around sharing of data and increasing member accountability for increasing their step count, changing their diet or managing their chronic conditions.

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A simple example from earlier in the paper, of offering weight loss drugs to members based on BMI and weight-related conditions, highlights a potential area where trust could break down. The insurance contract and coverage criteria will become far more personalised and contingent upon more granular health data than ever before. Yet the problem remains that if treatment a member believes they are entitled to (or in this case, that they are supporting through engagement with a more holistic, preventative health programme) is not funded, they may blame the insurer.

Coverage and exclusions rules have always been made with reference to a member's medical history and information that indicates their lifestyle choices (so far as they are understood to affect health), therefore this is not unprecedented. The difference, however, is the level of detail and specificity of recommended activities or lifestyle changes and the granularity with which progress can be monitored. This gives members more agency over improving their wellbeing and while also giving insurers more data to evaluate whether a member is managing their risk appropriately.

More data and more detail without greater trust does not solve the original challenge. If trust is low and coverage and policy criteria are not accessible and easy to understand, a breakdown in communications can still easily occur.

Solutions

If the underlying logic of the insurance contract remains static, it will be at odds with the vision of health and wellness partnership, where member and insurer work together to improve their health outcomes.

To fully support the vision for health and wellness partnership, insurers may wish to start exploring, now, what an updated version of insurance policy and contract documents could look like and how this would be communicated to members in an accessible and intuitive way.

Actions to address the barriers

- Review all customer touchpoints (including claim submission and assessment) under the lens of the vision for a holistic health and wellness partnership.
- Create a timeline for bringing the new roles and responsibilities for both members and insurers into the contract, in a way that supports development of new products and evolution of existing insurance offers.

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Redefining the Contract: From Legal Logic to Living Partnership

"The current contract is still shaped by legal, financial, and regulatory logic. It defines rights and obligations, but not relationships. If we truly want to shift toward a health partnership model, the foundation would need to evolve – not just in language, but in logic." - Patrick Wilhem, CSS

The traditional health insurance contract has been constructed as a static document of entitlements and exclusions, framed entirely by risk management and reimbursement. It speaks to legal and financial safeguards but fails to express a relationship.

In the emerging vision, the contract must move beyond rigid definitions of coverage and claims. It must reflect a long-term partnership built on shared value, recognising that members and insurers both benefit when health is improved, risks are reduced and care is more personalised. The insurer is no longer just a payer of bills; it also becomes a trusted guide in navigating prevention, early intervention and wellbeing across a member's lifetime. To support this vision, the contract should acknowledge that health outcomes are shaped by both parties working together, supported by proactive tools, personalised guidance and transparent use of data.

This evolution requires the contract to change not only its language; to become more human-centred, and accessible; but also, its logic, moving from defined obligations towards a shared journey with mutual commitments and benefits.

Embedding a Broader Vision for Wellbeing

Central to this shift is data as an enabler of better health outcomes. In the new relationship, wearable devices, health screenings and even genomic profiling are framed within a single purpose: to anticipate health needs, prevent avoidable illness and personalise support. Members gain more precise, relevant guidance while retaining control and trust over how their data is used.

The broader wellbeing vision means members are supported not just in moments of crisis but at every stage of their health journey, from targeted prevention and lifestyle change to community engagement and ageing well. Insurers facilitate access to early diagnostics, behavioural incentives and health coaching that can empower members to make informed choices long before chronic illness occurs.

Making the Value Proposition Longer Term

The value to members is not merely short-term rewards or simplified claims processes, it is a long-term relationship with insurers that helps close the gap between lifespan and healthspan. Through regular, supportive interactions, the insurer provides a pathway that helps members sustain their health over decades, through access to personalised, continually adapting preventative tools as core to the relationship as insurance for clinical treatment.

This long-term value is reciprocal. Members who remain engaged in healthier behaviours experience fewer health crises, live better lives and reduce the burden on their insurer. The insurer, in turn, gains a more sustainable model and can reinvest savings into even more innovative health services.

In this way, the agreement between insurer and insured becomes a living framework for a shared future, not simply a set of financial guarantees.

Towards a New Contract Logic

To reflect this evolving partnership, it should:

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1. **Establish shared value as the central principle**
   Show clearly how both members and insurers gain from improved health outcomes, creating a foundation of trust and mutual benefit.

2. **Reframe data gathering as a wellbeing enabler**
   Commit to using member data to provide more personalised, preventative care, communicated with transparency and aligned with the member's long-term health goals.

3. **Communicate a longer-term vision**
   Outline how the insurer's support will evolve with members across different life stages, helping them stay healthy in youth, manage chronic risks in midlife and age with dignity and independence.

4. **Define shared accountability**
   Make members responsible for actively engaging with prevention programmes, while insurers offer fair incentives, meaningful rewards and accessible support pathways.

5. **Allow for adaptive evolution**
   Make clear that the contract will continue to evolve in step with advances in medicine, behavioural science and digital innovation, always keeping the member's goals for their wellbeing at the centre.

6. **Move from transactional to relational logic**
   Shift the tone and structure from rigid financial obligations to a collaborative relationship based on empathy, transparency and co-created health outcomes.

By redefining the relationship in this way, insurers and members co-create a sustainable, human-centred framework. It becomes not just a record of rights and obligations but an evolving agreement that sustains trust, supports healthier lives and reflects the deeper purpose of a health partnership model.

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Concluding Remarks

On the horizon for health and wellbeing partnership is the convergence of:

- innovative product design for specific audiences and health challenges,
- personalised and predictive, health guidance and pathways,
- appropriate and well-designed incentives, towards shared outcomes,

to create products and services that support members' desire for longer, healthier lives and an insurer's mandate to fund the healthcare they seek.

To improve value for their health plan members, in an environment of increasing costs and increasing economic uncertainty, private health insurers recognise the relationship needs to shift.

It is not only insurers changing their behaviours; this vision also involves health plan members changing their behaviours and re-characterising their role in the relationship.

In the vision discussed over the course of this paper, examples of shifts in member behaviour include:

- sharing personal data with their insurer;
- giving consent for genomic profiling and sharing the resulting data,
- sharing more accountability for the action they take to follow precise and personalised health pathways and how this may affect future coverage, benefits or discounts.

Moving from a transaction-based relationship to a partnership requires trust on both sides. Trust is developed in the sum total of interactions between insurer and insured and, as Amit Patel observes "trust is fragile, and it can be easily lost". The trust needed to realise the vision of partnership with members isn't built by increasing the number of interactions or bolting on an addition health and wellness service alone.

As Nick Reed emphasises, insurers who can bring more warmth into their interactions with members, with the goal of reassuring a member they are well cared for, are being supported into the most appropriate health pathway and that their insurer is active in their wellbeing will earn member trust and loyalty.

If insurers go too far in evolving their services without embedding this in the core of the business, from the contract, through to internal change management and across all touch points with prospects and members outwards, this will undermine progress against those challenges the health and wellness partnership seeks to address.

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