The health insurer of the future
A bold opportunity

The health insurance industry is being disrupted by a once-in-a-lifetime confluence of trends. These forces – which range from growing pressures within the insurance sector to megatrends reshaping all of health care – mean that the health insurer of the future will need to operate in very different ways.

These developments therefore present a unique opportunity. For any company that has traditionally not been in the health insurance business or an existing player that is more open to innovation, there is the potential to leapfrog over the competition and re-define health insurance with a fundamentally different proposition – one that is more strategically aligned with the future of health care than anything else in the market today.

In this document, we present one such vision. In this model, the insurance contract changes from a short-term transaction to a longer-term partnership in which the insurer and the insured collaborate to improve behaviors and health outcomes. The role of the insurance company changes: from being just in the business of quantifying and pricing risk, the insurer expands into the business of influencing and lowering risk. The amount of information available to the insurer increases exponentially in this new data-centric, technology-enabled model – giving the company a much deeper understanding of the customer than has been possible so far.

Since the power of this model comes from how well-aligned it is with the future of health care and health insurance, let’s start by exploring some of the biggest trends disrupting these sectors.
Disruptive trends

1. The chronic disease crisis

We are on the cusp of a looming chronic disease epidemic. Already, so-called “non-communicable diseases” such as heart disease, type two diabetes and hypertension are the biggest drivers of global health care spending, accounting for about 75% of costs. markets — will only be exacerbated over time.

These chronic diseases share two characteristics that have significant implications for the payment and delivery of health care. First, they have a strong behavioral component. While genetics and environmental factors play a role in the incidence of such ailments, behaviors – diet, exercise, smoking, stress levels and even sleep patterns – are the most significant component. Second, as the name suggests, chronic diseases play out over the long term – they are caused by the cumulative effect of years of behavioral patterns and, once diagnosed, patients have to live with these conditions for the rest of their lives.

The greatest need, therefore, is a focus on changing long-term behaviors and managing chronic diseases over the long run in more efficient ways. Yet, nobody in today’s health care systems has the incentive to focus on the long-term needs of patients.

In the fee-for-service model that has so far been dominant, providers are reimbursed for procedures conducted rather than results delivered – creating little or no incentive for preventive interventions. While this is changing, the move away from fee-for-service (discussed in the next section) is happening slowly, often in the form of small-scale experiments, and even these new incentive structures don’t always align interests with long-term outcomes. Meanwhile, insurance companies and employers (who subsidize insurance in many markets) aren’t very incentivized to focus on truly long-term behaviors and costs – doing so might end up lowering costs for the competition, thanks to employee and customer turnover. Even governments in single-payer systems – which ultimately have the most to lose from the ticking time bomb of chronic disease – have misaligned incentives, since the elected representatives who control budgets are more focused on near-term election cycles than the longer-term costs of chronic disease.

Disruptive idea: what if you could develop an offering that, for the first time, truly aligned incentives around long-term behavioral change?
2. The move to outcomes and value

As health care costs escalate — in large measure, thanks to the growing chronic disease burden — public and private payers are restructuring financial incentives to better align them with health outcomes and economic value. New models are emerging based on various forms of outcomes-based payments (e.g., rewarding or penalizing providers for their success or failure delivering certain agreed-upon health outcomes) or capitation (e.g., paying providers a fixed amount per patient or episode of care). Many health systems are looking for ways to reduce variation in care, examining the comparative effectiveness of drugs and other treatments.

While these are all positive developments, they are making only limited headway in aligning incentives with the drivers of long-term costs. In many cases, payers are moving slowly, starting with relatively limited experiments and pilots.

Disruptive idea: Could you design an approach that embraces pay-for-performance not as a limited experiment, but as the basis for its entire health insurance offering?

3. M-health technologies

Health is being democratized by a proliferation of m-health technologies that are empowering individuals as never before. Social media platforms are allowing patients and physicians to share information with each other, enabling them to learn in new ways and in real time. Mobile apps are blurring the lines between smartphones and medical devices, and allowing individuals to conveniently and continuously track everything from blood sugar to sleep patterns. Implantable and wearable sensors — ever cheaper and increasingly ubiquitous — are bringing the “internet of things” to health care and transforming everyday objects, from weighing scales to running shoes, into medical technologies that can help individuals monitor and manage their care.

These technologies may seem like novelties with niche appeal, particularly in these early days, but their potential for managing chronic diseases is nothing short of revolutionary. An inexpensive sensor or app that allows a patient to monitor key biometrics such as blood pressure or glucose levels is far more cost-effective than the alternative of in-person consultation at a clinic. Moreover, these technologies can monitor patients continuously as they go about their everyday lives, allowing for timely intervention only when needed. Deploying them with at-risk patients could supercharge prevention at a fraction of the cost.

Unfortunately, while these technologies are far more cost-effective at managing and preventing chronic diseases, payers have been slow to adopt them. In legacy fee-for-service systems, there is often no way to get reimbursed for using m-health technologies — which creates uncertainty in the minds of providers and patients, and leads to spotty adoption. And while payers are moving from fee-for-service to pay-for-performance models, they are often doing so through limited experiments in which they transfer risk to providers. It is up to providers to then decide whether or not to adopt technologies, which may or may not happen. But payers themselves are not embracing m-health technologies or promoting them in a big way.

Disruptive idea: Could your new approach be powered by m-health technologies — allowing much greater insight and influence over patients’ behaviors and driving down costs through widespread adoption?
The health insurer of the future

4. The big data revolution

The term “big data” seems to have gone from obscurity to buzzword almost overnight. Big data – which refers to a quantum increase in the volume, variety and velocity of information being generated – is rapidly being generated in the form of electronic health records, payer claims, pharmacy data, laboratory test results, patient registries, and the slew of m-health technologies discussed above.

In health care, however, much of this data remains siloed. These various data sources, being collected by different entities, are not being combined because of numerous factors – organizational boundaries, privacy and security issues. This is a significant issue because the real power of big data emerges from connecting dots across these streams of information – without which this information isn’t really big data as much as a big assortment of little data.

As a result of this data fragmentation, nobody in health care has the “full picture.” Different entities – payers, providers, pharmacies, device manufacturers and others – have individual pieces of information about the patient. And while companies have emerged to combine many pieces of the puzzle (e.g., Symphony Health Solutions and GNS Healthcare), nobody is yet consistently accessing and integrating data from the growing pool of m-health technologies that are generating real-time information about patients’ behaviors.

For insurance companies, this compounds the problem of information asymmetry. While health insurers have extensive experience in underwriting and pricing health-related risks, the unfortunate reality is that these functions are based on relatively little information about the patient. Insurers don’t know much about their customers (typically, their information consists of demographic characteristics and the insured’s health and family history) and may be precluded by regulations from using some information (e.g., gender) in their pricing decisions. Emerging technologies, such as personal genome sequencing, are likely to increase this imbalance in information since insurers may be prohibited from using genomic information in their underwriting decisions.

The bottom line: while health care is entering the era of big data, and patients are increasingly empowered with information about their behaviors, risks and outcomes, insurance companies remain in the dark.

Health insurers have also traditionally not been very adept at using the data they already have. While insurers possess considerable amounts of customer data, this information is typically fragmented thanks to legacy systems and internal silos. Data is often not shared across different product lines, or financial, management, IT systems.

**Disruptive idea:** What if you could make data a central component of a new insurance offering – creating the complete picture that has so far been missing to better understand and influence risk?
5. Customer centricity in insurance

At a time when customers are being enabled with more transparent information and more freedom of choice, companies in many industries are looking for ways to become increasingly customer-centric. The same trend is playing out across health care, as patients are gaining access to information and taking control of their health care decisions. With health systems becoming more focused on patient outcomes and behavioral change emerging as the paramount challenge, companies involved in health care are increasingly focused on getting closer to the ultimate customer.

For health insurance companies, this is particularly challenging. Historically, insurers have not been very customer-centric. Many insurance companies adopted the independent agent model – a more cost-effective alternative to full-time employees, but one that invariably created a buffer between insurers and the insured individuals they ultimately serve. Agents – who are naturally interested in protecting their role as intermediaries and shielding themselves from being disintermediated – have an incentive to control information about customers rather than share it. Insurers – cut off from the individuals they serve – often think of the agent, and not the insured, as their customer.

**Disruptive idea:** could you develop a proposition which places the customer squarely in the center – using deep data about customers to understand their needs and deploying m-health technologies to build relationships and guide customers’ behavior?

6. Pressures on underwriting

The core underwriting business has come under increased pressure in recent years, thanks to a number of developments. Investment income has declined, increasing the demands on profits from the core insurance business. Regulatory constraints are putting even more pressure on underwriting performance. Micro-segmentation in some non-health lines of business (e.g., automotive) is allowing some competitors to take the best risks, which then leads to deteriorating claims experience for other firms.

**Disruptive idea:** could your health insurance offering find new sources of revenue to supplement earnings from the core underwriting business?
Bringing it together: a new model for health insurance

The trends discussed will disrupt the health insurance business as we know it. To remain relevant, health insurers will need to reinvent their business models in fundamental ways: to get closer to customers, better understand their behaviors and risks, and use data and technologies in new ways.

There is no one “correct” response to these demands, and companies could conceivably develop a number of innovative new models. In this paper, we present one possible new model that EY has developed to respond to these changes. After discussing this core new model, we also present several variants that take into account regulatory constraints in the largest potential market: the US.

This business model is a fundamentally new approach to health insurance. It transforms insurance from a short-term contractual relationship to a longer-term collaborative one by laying the foundation for ongoing engagement with customers. The model is powered by m-health technologies (which help influence customer behavior and also generate reams of valuable data). It is delivered by a consortium of health care-related entities, which collaborate to improve outcomes and share success. The model allows the insurer and its collaborators to create best-in-class health data — an extremely valuable asset in increasingly outcomes-focused health care systems that provides a lucrative revenue stream.

Most importantly, the model changes the very business that health insurers are in. So far, insurers have been in the business of pricing and underwriting risk — risk has been static and unfortunately, quantified using relatively little information. With this new approach, the insurer would leapfrog over the competition and enter a very different business — not just pricing and underwriting risk, but influencing and reducing risk as well, and doing so with a much better understanding of customers’ behaviors and risk factors.

Option 1: The core model (non-US private insurance markets)

The core model (which, due to regulatory constraints in the US, would largely be sold in non-US markets that have private insurance) would enter the market with a very different value proposition. Instead of positioning insurance as a traditional one-year contractual relationship, the new offering would seek to build a long-term collaborative relationship with customers. The basic value proposition would be something along these lines:

“Sign up with us and we will work with you to keep you healthy for the rest of your life — or as long as you choose to stay with us. You’ll get the latest apps and technologies to help you manage your health — your diet, activity, biometrics, sleep biometrics and sleep. Over time, you can expect that your premiums will increase more slowly than they would if you had signed up with another insurer — and you’ll even earn additional rewards for proactively managing your health.”

Customers would have economic incentives to stay with the program for multiple years. These could be in the form of a carrot (e.g., rebate checks) or a stick (e.g., a multi-year contract with an early-termination penalty), depending on regulatory restrictions in different markets. Since a key component of the model would be to keep this customer group healthier than the underlying population, it is also highly likely that premiums would increase at a slower-than-average rate: an additional economic incentive for customers to remain in the program for the long haul.

To make the model work, insurers would need to assemble a consortium of people with complementary assets and skills. Key members of the consortium might include:

- **Insurer**: would perform traditional insurance functions (e.g., acquiring customers, underwriting and pricing, collecting premiums, paying benefits). In addition, the insurer could potentially function as the central node in the consortium as the host and founding member.
Provider network: to reach patients in health care settings, it will be critical to partner with a health care provider network with broad reach (e.g., a hospital chain). In addition to the usual function of delivering traditional medical services, the provider network would play an active role in proactively guiding behavior through prevention programs, timely intervention as well as timely intervention. A key emphasis of the consortium would be to identify individuals who are at high risk of experiencing adverse medical conditions or incurring significant expenses — and intervening proactively.

Data consolidator: since data is a central part of the business model and none of the other partners have the deep skills needed to combine and analyze data from multiple streams and in various formats, a data consolidator would be needed.

Technology provider: in addition, a technology provider would provide the physical infrastructure needed for this data-centric approach. This would include data storage and management services run in the cloud.

Government: lastly, collaborating with one or more governments would make sense. It would give governments a way to align interests around longer-term prevention and management, and any tax or other incentives provided would help make the consortium more economically viable.

In addition to these core members, the consortium would likely also include other service and product providers. Chief among these would be numerous device and app manufacturers whose technologies would be vital for monitoring patients, tracking outcomes and influencing behaviors. Gyms or fitness centers and supermarket chains might be included to provide additional incentives for customers to adopt healthy behaviors. For instance, individuals might receive heavily discounted gym memberships and coupons for healthier food options.

To structure and manage the consortium, an independent alliance management function would need to be built. This function would recruit additional resources, negotiate terms and support the consortium with additional services and tools.

The terms under which consortium members join and participate would be based on individual preferences and negotiations. It is likely that most of the supporting organizations (e.g., gyms, supermarkets) will prefer to participate on a fee-for-service basis. However, one or more of the core members (e.g., the provider network) should participate on a risk-sharing basis — contributing assets and providing services in return for a share of profits.

The members of the consortium would collaborate to influence behaviors and provide behavioral feedback to individuals. Mobile technologies could monitor behaviors (e.g., diet, exercise) and outcomes (e.g., blood sugar, blood pressure) and provide timely input to users — all in real time. The data analytics component could be used to identify patients most at-risk. Providers could provide human intervention and guidance, with a particular emphasis on these high-risk patients. The combined effect of these interventions would be to nudge individuals toward healthier behaviors, leading to slower increases in costs and premiums over time.

Combining data from all of the consortium members, as well as the m-health technologies used by patients in real time, would have the potential to create a state-of-the-art database with information and capabilities that simply do not exist in today’s health systems.

This would be a complete picture of customers’ health outcomes, behaviors, tests, genetic information, medication — and based not just on periodic measurements generated in the clinic but on continuous streams of real-time, real-world information.

Attracting other members to the consortium such as retailers and supermarket chains could create the opportunity to add even more sources of data, such as retail purchasing patterns. This data would not be a health record (information captured from procedures conducted in the clinic) as much as a “life record” (a wide-ranging set of parameters tracked over the course of customers’ everyday lives).
This integrated, comprehensive, real-time data should be very valuable for other organizations in health care. While it is tempting to dismiss m-health technologies and apps as novelties and niches, the data they are starting to generate will over time prove truly revolutionary. Today, a patient’s blood pressure may be measured once a year, during an annual physical. This is an almost meaningless exercise, since that single measurement could have been influenced by any number of factors (a stressful argument earlier in the day, a decision to walk up a few flights of stairs rather than taking the elevator etc.) While the blood pressure data produced by a wearable sensor or smartphone app may be less accurate than a measurement in the clinic, it is far more valuable because it provides a trend line. And that trend information allows one to see how a user’s blood pressure changes over the course of time and, more importantly, correlate those fluctuations with changes in medication regimes, diet, exercise and sleep patterns. Context and continuity trump differentials in precision.

Furthermore, disruptive innovation tends to follow a predictable pattern — something that has been well-documented in studies of other industries, from personal computing to mobile telephony. When a disruptive technology first emerges (e.g., the personal computer in 1980), it isn’t as robust as the traditional offering it seeks to replace (e.g., the mainframe computers that were dominant in that era). They are therefore only adopted by passionate early adopters and dismissed by mainstream businesses as novelty products with niche appeal. But the disruptive offerings improve more quickly than most people expect and quickly supplant the more traditional offerings. This same pattern has been repeated with countless other technologies — examples range from free smartphone apps that have disrupted standalone GPS and satnav systems and digital printing and desktop publishing, which has disrupted traditional offset printing. There is no reason to think health data will be any different. Quicker than many expect, accuracy will improve, the data points measured will increase, patient adoption will take off — and the database created by the insurer and its consortium partners to combine all of this contextual data with information generated in health care settings should be a very lucrative asset. We therefore combine all of this contextual data with information generated in health care settings should be a very lucrative asset. We therefore

Data monetization could provide a valuable revenue stream, but it is not the only way in which this model could be more profitable than the traditional insurance offerings produced by competitors. Overall, these differential sources of profitability include:

- **Better claims experience**: from having a healthier demographic
- **Behavioral change**: leading to better prevention and disease management
- **More efficient care delivery**: from real-time monitoring, and predictive analytics
- **Data monetization**: fees generated by providing state-of-the-art data to other health care companies

In addition to these new sources of profitability, the insurer would also have the opportunity to build *brand and reputation* through this model. The company could improve its brand by emphasizing that this new approach is:

- Investing in the biggest health challenges that are threatening to undermine the sustainability of health care systems
- Aligning interests for the long run (something that is largely absent from existing approaches)
- Innovative and collaborative

The offering would also need to be positioned carefully to address potential brand risks. These include privacy concerns and negative perceptions related to the fact that the insurer would profit from customers’ data and might be seen as “cherry picking” the youngest and healthiest customers while leaving competitors with the rest. To some extent, the variations presented in Options 2-4 below address these risks.

The need for these options stems from the fact that US regulatory changes, in particular the Patient Protection and Affordable Care Act (ACA or “Obamacare”). For instance, the risk adjustment provisions of the ACA do not allow insurers to benefit from having lower-risk customer populations. Therefore, any differential profit the insurer earns from having a younger demographic would effectively be given back to its competitors. In addition, the ACA requires that insurers spend at least 80% of premiums on medical losses (i.e., benefits paid to customers). In effect, this caps the profit that insurers can earn at 20% of premiums (this would be further reduced because of overhead). Therefore, the ability to generate additional profits from the model would be constrained.

In light of these regulatory constraints, we have developed three alternative options which adjust the core model presented above for compatibility with US market regulations.
**Option 2: US individual market**

This variant of the core model would be marketed in the US individual market—a segment poised for significant growth under the ACA, which expands access and creates new insurance exchanges for individuals to buy coverage. Because of the constraints placed by the ACA’s risk adjustment provisions, the product would be marketed broadly to all age groups. The customer base may end up trending somewhat toward younger age groups in practice, since these individuals may be more drawn to the technology-enabled, data-sharing proposition.

This would have implications for the profitability of the model. Insurers would not reap any benefits from having a lower-risk customer base. The model would also not benefit from any efforts to increase prevention. To the extent that one insurer was more successful than another at prevention, it would end up with a healthier, lower-risk population—the benefits of which would be negated by risk adjustment. However, the insurer would still benefit financially from behavioral change aimed at better disease management of existing patients and from delivering care more efficiently.

Moreover, a key source of revenue and profit—data monetization—would not be affected by the ACA medical loss ratio and risk adjustment provisions, since those only apply to income from premiums. In addition, in this model the insurer would no longer have to contend with potential brand risk from perceptions that it is cherry picking the healthiest customers. Even if it ends up with a somewhat younger demographic, it would still not benefit financially—increasing the perception that the company is doing the right thing for customers and the health care system by investing in a model even if it means giving up some of its profits to competitors.

**Option 3: US large group market**

Option three would be marketed to large US employers that provide insurance to their workers. In this offering, the age distribution of its customer base would roughly mirror that of the employers it is serving.

Since large groups are not subject to risk adjustment, the insurer would retain the ability to focus on behavioral change to improve both disease management and prevention. The data monetization component could also still be deployed.

**Option 4: US self-insured employer market**

Option four is similar to option three, except that it is designed for large employers that are self-insured. The core insurance functions performed by the insurer under this variant would differ from those in any of the models described above. The insurer would provide reinsurance/stop-loss coverage and administration services for large employers.

Since the core insurance function is not being provided by the insurer, but rather by employers, and since employers are not regulated as insurance companies, the risk adjustment and medical loss ratio requirements would not apply. So, as in option three, the insurer could focus on behavioral change to improve both disease management and prevention. As with all of the other variants, the data monetization component could still provide a significant revenue and profit stream.
### Table 1. Summary of model options

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<thead>
<tr>
<th></th>
<th>Option 1: “Core” model</th>
<th>Option 2: US individual market</th>
<th>Option 3: US large groups</th>
<th>Option 4: US self-insured employers</th>
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<tbody>
<tr>
<td>Marketed to</td>
<td>Individual/employers</td>
<td>Individuals</td>
<td>Large employers</td>
<td>Self-insured employers</td>
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<td>Long-term relationship</td>
<td>Yes (behavioral rebates and or early penalty)</td>
<td>Yes (behavioral rebates)</td>
<td>Yes (behavioral rebates)</td>
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<td>Providing insurance (underwriting and pricing risk)</td>
<td>Providing insurance (underwriting and pricing risk)</td>
<td>Providing insurance (underwriting and pricing risk)</td>
<td>Providing reinsurance, stop loss and administration for employers</td>
</tr>
<tr>
<td>Insurer role: other</td>
<td>Guiding consortium, influencing behavior</td>
<td>Guiding consortium, influencing behavior</td>
<td>Guiding consortium, influencing behavior</td>
<td>Guiding consortium, influencing behavior</td>
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<tr>
<td>Technology enabled</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Behavioral feedback, incentives</td>
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<td>Consortium</td>
<td>Yes</td>
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<td>Data monetization</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Differential sources of profit:</td>
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<td></td>
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<tr>
<td>► Behavioral change: prevention</td>
<td>Yes</td>
<td>No (ACA risk adjustment)</td>
<td>Yes (large groups not subject to risk adjustment)</td>
<td>Yes (employers not regulated as insurance cost)</td>
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<td>► Behavioral change: disease management</td>
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<td>► More efficient care delivery (RT care, prediction etc.)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>► Data monetization</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Brand benefits:</td>
<td></td>
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<tr>
<td>► Investing in biggest health challenges</td>
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<td>Yes</td>
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<td>► Innovative and collaborative</td>
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<td>► Aligning interests for long run</td>
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<td>Brand risks:</td>
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<tr>
<td>► Privacy concerns</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>► Profiting from data</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>► “Cherry picking” customers</td>
<td>Yes</td>
<td>No</td>
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</table>

**Moving ahead**

The core model discussed above and the three variants developed for the US market represent one possible approach that an insurer could take to enter the health insurance market in a way that is better aligned with the future of health care. While we have done some high-level quantification of market potential and think that this is a feasible approach, additional due diligence would need to be conducted. The insurer would also need to identify potential partners and scope out their receptivity before moving forward.

It is also worth pointing out that this is not the only approach that an insurer could take. Significant market disruptions typically lead to multiple new business models and, therefore, other options might want to be explored. This would ideally be done via a facilitated visioning and strategy development session – an approach that our clients in other parts of health care (e.g., life sciences) have successfully used.

Regardless of which business model is ultimately chosen, we think many of the components of the approach described in this document – customer centricity, a focus on outcomes and data, collaboration – will be critical in today’s rapidly changing health care systems.
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EYG No. EG0235
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