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The future of the healthcare payer—Partner for life, half the cost, twice the service

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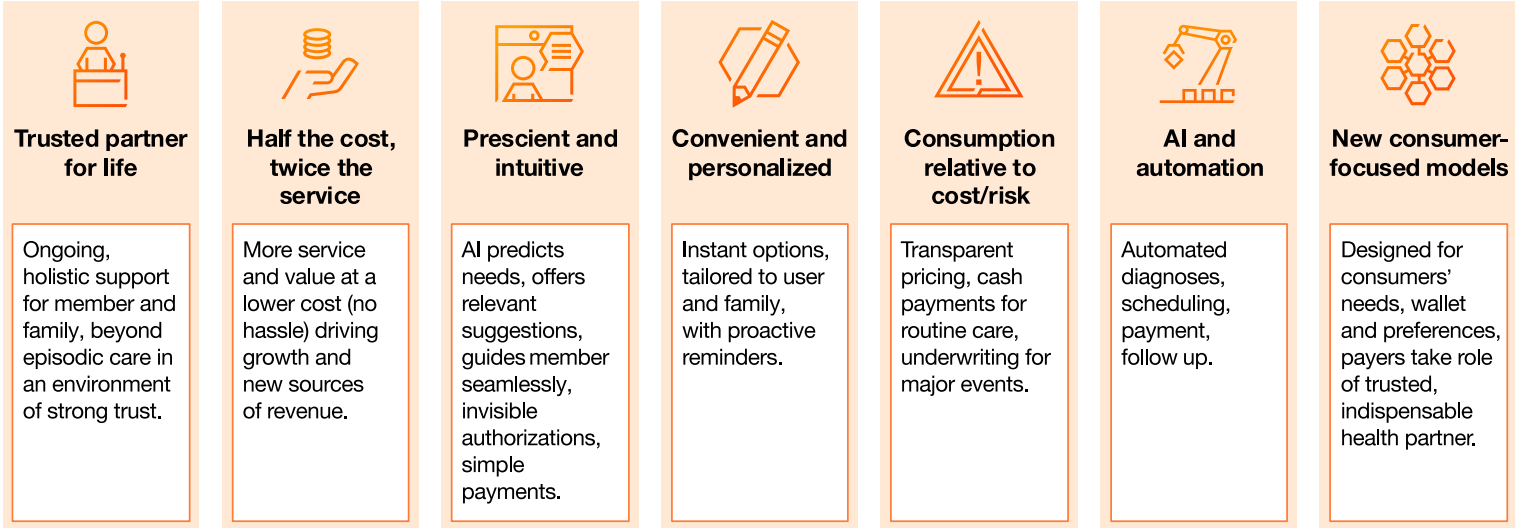
The future of the healthcare payer—Partner for life, half the cost, twice the service

A vision for 2035

The payers of 2035 can become trusted partners for life, orchestrators of holistic support for members and families in an increasingly complex healthcare ecosystem. They can help deliver twice the service at half the cost by providing greater value to members, stakeholders, and communities through innovative business models designed for growth and new revenue streams.

Drawing on broad, deep data sources, payers of the future can use AI and advanced technologies to anticipate needs and guide members seamlessly. Transactions should be transparent and nearly instantaneous, offering consumers cost transparency and predictability. Automation helps personalize diagnoses, scheduling, payment, and follow up. At the center of the health ecosystem, payers can serve as the connection point, helping members achieve their goals and offering indispensable insights to industry collaborators. The future payers who embrace innovation can collaborate and continuously evolve to meet rising expectations, enabling long-term resilience and a central role in shaping the future of healthcare.



Reasons to believe—The four forces driving a new future

Economic pressure, technological innovation, medical advances, and consumerism are reshaping the payer landscape. Confronted with these powerful catalysts of change, payers should deliver greater value with fewer resources—and do so at an unprecedented pace. To succeed, they should also rapidly invest in advanced AI and digital capabilities by automating processes, personalizing member experiences, and building adaptable networks. These efforts can help free capacity and equip workers with the technology to address complex member needs with empathy and insight. Payers that embrace innovation and collaboration can secure long-term viability and become indispensable, lifelong partners to their members.

Force #1: 'The big squeeze'

Health plan margins are at their lowest in two decades, and 2025 is expected to be a break-even year overall. [i] (See slide) The outlook remains challenging. Commercial markets face shrinking group margins as enrollment declines, and employers seek cost-saving solutions and alternative products. Medicaid growth is likely to slow as federal policy tightens. The ACA individual market remains volatile.[ii] Medicare Advantage margins are under pressure.[iii] Across the sector, rising medical costs are a major concern. PwC projects the medical cost trend for 2026 will be 8.5% for group plans and 7.5% for individual plans, consistent with recent years.[iv] Without innovation, cost control, and adaptation to new regulations, ongoing margin compression can threaten payer viability.

These financial pressures are reflected in some risk-based capital projections, posing potential challenges for payers lacking sufficient reserves to weather ongoing uncertainty. As margins shrink—driven by decreases in membership volume and revenue—payers should scrutinize fixed-cost investments that, due to reduced scale, may no longer be justified.

Health plan margins are at their lowest point in two decades, with 2025 projected to be a break-even year overall

Gross margin ratio by line of business

	2022	2023	2024	2025
Individual	2.1%	4.5%	3.7%	**-1.1%**
Group	1.8%	2.1%	0.8%	**-0.6%**
Medicare	3.1%	1.9%	**-0.1%**	0.0%
Medicaid	3.2%	2.7%	**-0.4%**	**-0.9%**

Source: Statutory Financials with Q2 health filers through 08/25, PwC Analysis.

Force #2: Technological innovation

Payers are adopting tech tools to render operations more efficient; create more personalized, streamlined member experiences; and harden cybersecurity. But the pace of the subsector's adoption of advanced technologies such as AI lags health systems and other parts of the industry. [v]

Years of deferred maintenance and accumulated technology debt continue to burden many payers. Modernization is typically urgent and costly. Payers should use new technologies—whether by upgrading legacy systems or starting fresh—to help deliver high quality services at a lower unit cost per member, shifting the focus from traditional business metrics.

Generative AI (GenAI) is automating workflows, reducing costs, and enhancing productivity. Intelligent prior-authorization and claims automation, enabled by Fast Healthcare Interoperability Resources (FHIR) APIs and AI-driven tools, are streamlining decision-making and lowering administrative expenses. GenAI "digital front doors" and virtual care models are making healthcare access faster and more personalized. Strong cybersecurity and "zero-trust modernization" (continuously confirming and authenticating) are essential, as recent attacks underscore the need for high-level protection of personal health information.

Payers already are using technological advances to improve operational efficiency, member experience, and cybersecurity.

Operational Efficiency

Type	Description
Enterprise-wide AI & Gen AI modernization	• Direct consumer experience gains (faster answers, smoother handoffs) and structural efficiency (shorter cyclet imes, higher first-pass accuracy, lower admin cost). • Scaling requires strong governance, risk controls, and workforce upskilling to deploy hundreds of use cases safely across the enterprise.
Intelligent prior-authorization & claims automation (end-to-end automation hat combines FHIR APIs—CRD/DTR/PAS—with AI/IDP and workflow tools)	• Near-real-time decisions, lower admin cost, and fewer delays/denials. • Compliance with CMS-0057-F (PA API, faster turnaround, metric reporting). • Better provider experience via in-workflow automation and standardization.
Interoperabi-lity & FHIR APIs (Patient Access, Payer-to-Payer, Provider Access; prior-auth (APIs)	• Regulatory compliance (CMS interoperability and prior authorization rules). • Data fluidity across plans and care settings → better coordination, faster PA/claims, fewer manual faxes. • Foundation for ecosystem apps and digital front doors.

Member Experience

Type	Description
Generative-AI "digital front doors" (member assistants, personalized guidance in apps)	Faster answers about coverage/claims, simpler next-best-step navigation, fewer calls, and more personalized care choices across channels.
Virtual-first and asynchronous access (chat-based/online e-visits, $0 virtual urgent care, enterprise telehealth).	On-demand, low-friction access to urgent and routine care; shorter wait times; improved convenience—especially after hours—without sacrificing continuity.
Prior-authorization simplification and digitization (streamlined rules, electronic PA, faster turnarounds).	Fewer delays and denials; clearer status; faster starts for treatment—especially for chronic and cancer care—via standardized electronic workflows.

Cybersecurity

Type	Description
Cybersecurity and zero-trust modernization.	• Protect PHI and keep core processes (pharmacy/claims) resilient; avoid billion-dollar outages and reputational harm. • Zero-trust network access, MFA, segmentation, and vendor hardening are now table stakes.

Force #3: Medical advances

Medical advances hold tremendous promise. At the same time, they also can introduce significant costs, compelling payers to rethink how they finance and manage access to breakthrough therapies. Innovative treatments such as gene and CAR-T cell therapies have led payers to pursue outcome-based agreements with pharmaceutical manufacturers, linking payments to real-world patient results. The CMS's Cell and Gene Therapy Access Model further supports outcome-based contracts, improving Medicaid patient access, and reflecting a broader shift toward value-based care and financial innovation.

The growing use of GLP-1s (and their expanding indications) are driving up near-term costs. Payers are responding by negotiating directly with manufacturers, launching new PBM models, capping member copays, and reconsidering coverage for certain conditions. As patents expire and generics enter the market, payers should continually reassess formulary strategies. Payers also have to consider the impacts of new antibody-drug conjugates and radiopharmaceuticals, including complex logistics and new reimbursement models. Payers should possess agility, data-driven decision-making, and collaboration so they can manage patient access and costs.

Therapies are being marketed that offer precision and efficacy; they also come with relatively high price tags owing the complexity of their manufacture, logistics and delivery

Gene therapies	CAR-T cell therapy	Anti-obesity drugs (GLP-1s and next-gen incretins)	Antibody-drug conjugates (ADCs)	Radiopharmaceuti-cal / radioligand therapies (RLTs)
Treat monogenic diseases	Treat patients who failed conventional treatments for some cancers	Eligible population is large, contributing to high cost burden for payers	Combines targeting antibody with potent chemotherapy payload	Targeted cancer treatment combining ligand and a radio-active particular to deliver radioactivity to tumor cells directly
High upfront costs	Expensive, specialized product infrastructure, including work with providers	Labels expanding into other areas, such as cardiovas-cular risk reduction, sleep apnea, and liver disease	Improve precision, reducing side effects for patients	Costly, may require specialized infrastructure for manufacturing and logistics with rapid delivery necessary
Payers striking out-come-based agree-ments with pharmas		Payers negotiating with pharmas; USG is embarking on Medicare price negotiation for one popular GLP-1	Costly, fast-growing market	

Force #4: Consumerism

Consumerism is reshaping the American healthcare landscape. While 44% of American consumers say the system will improve by 2035, more than half are critical of the healthcare system as it is today.[vi] Fifty-one percent describe the system as "fundamentally broken."[vii] Financial worries are central, with 75% of consumers concerned about costs not covered by insurance, 71% about out-of-pocket expenses, and 70% about high premiums. These anxieties are even more pronounced among caregivers. Nearly half (44%) say they cannot afford their own healthcare needs, and 43% cannot afford mental health care, both significantly higher than non-caregivers.[viii]

Consumers are more proactive and informed, often conducting their own research. Health technology adoption is widespread, with 80% of millennials and Gen Z, and 75% of affluent consumers, reporting that they use some kind of health tech monthly. Many are comfortable with AI-enabled services such as scheduling appointments or refilling prescriptions, and 20% would pay more for streamlined, AI-enabled healthcare. Ultimately, many consumers say they want a one-stop, integrated platform that simplifies their healthcare experience (payments included) and helps them make informed choices.[ix] To succeed, consumer-centric payers should outpace rising consumer expectations with rapid innovation—a challenging but essential task for the years ahead.

Consumers are looking for a complete solution; a one-stop shop for healthcare. And one in five are willing to pay more for it.

Integration is a consumer priority

For **faster** care, consumers want:
- Unified health records (46%)
- Personalized medications (37%)
- Virtual-only providers (34%)

For **more affordable** care, consumers want:
- Unified health records (41%)
- Personalized medications (37%)
- Virtual-only providers (35%)

Source: PwC consumer survey, 2025

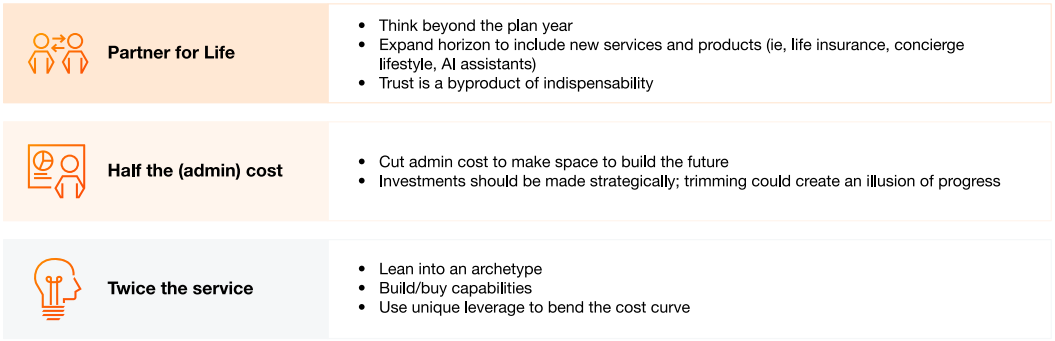
Base: All Qualified Respondents (n=4,030)
Q18: Would you be willing to trade your current healthcare experience for any of the below for faster or more affordable care? (Select all that apply)
Q26: How willing would you be to use these options, if they were accessible to you?
Q28: Would you be willing to spend more out of pocket than what you typically spend on your current healthcare experience to receive the following? (Select all that apply)

03

Building a partner for life— Half the cost, twice the service

The transformation begins with a bold first step—dramatically cutting administrative costs and reinvesting in next generation AI-led capabilities. This newfound capacity sets the stage for the second step—building the capabilities required to deliver twice the service. Only by executing both steps can payers evolve into true partners for life, ready to meet the demands of tomorrow's healthcare landscape.

The opportunity— Partner for life half the cost twice the service
Payers are uniquely positioned to deliver on this yearning for a more connected, more personalized platform for healthcare.

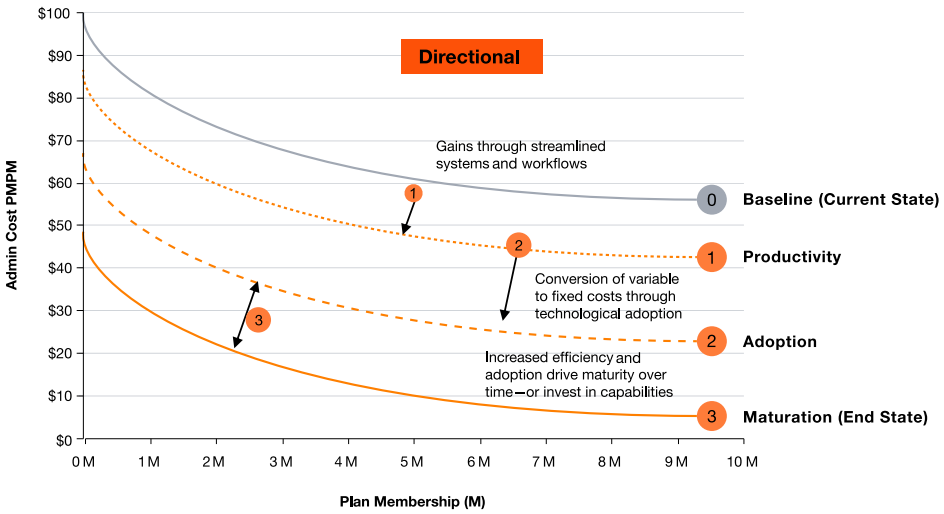


Partner for life– Half the (administrative) cost

Half the cost, in theory

AI and other tech innovations are projected to dramatically lower and flatten the administrative cost curve for health plans over time. This reduction is not possible overnight. Rather, a transformation of administrative costs is possible in four phases: baseline, productivity, adoption, and maturation.

Illustrative Cost Curve Shift
Advances in AI are projected to further push down and flatten the administrative cost curve in the future
Few payers have proven fixed costs reductions after adopting AI solutions (step 2)...in the new ecosystem step 3 will demand speed and persistence



Sources: PwC analysis, PwC Behind the Numbers 2026

- **Baseline (current state):** Health plans face high fixed and variable administrative costs. This is largely due to fragmented systems, manual processes—fax/phone utilization management decisions, outdated back-office systems—and years of accumulated or acquired technology and process debt. Large plans tend to have lower PMPM administrative costs by spreading fixed costs across a larger membership base, benefiting from economies of scale.

- **Productivity:** Streamlined systems and workflows—such as centralized enrollment and billing channels, and digital sales management—would reduce manual effort and drive down both fixed and variable costs.

- **Adoption:** The next phase involves implementing AI and modern platforms—predictive care management models, personalized agile marketing—to begin replacing manual tasks. This would shift more variable costs to fixed costs, further lowering the overall cost curve.

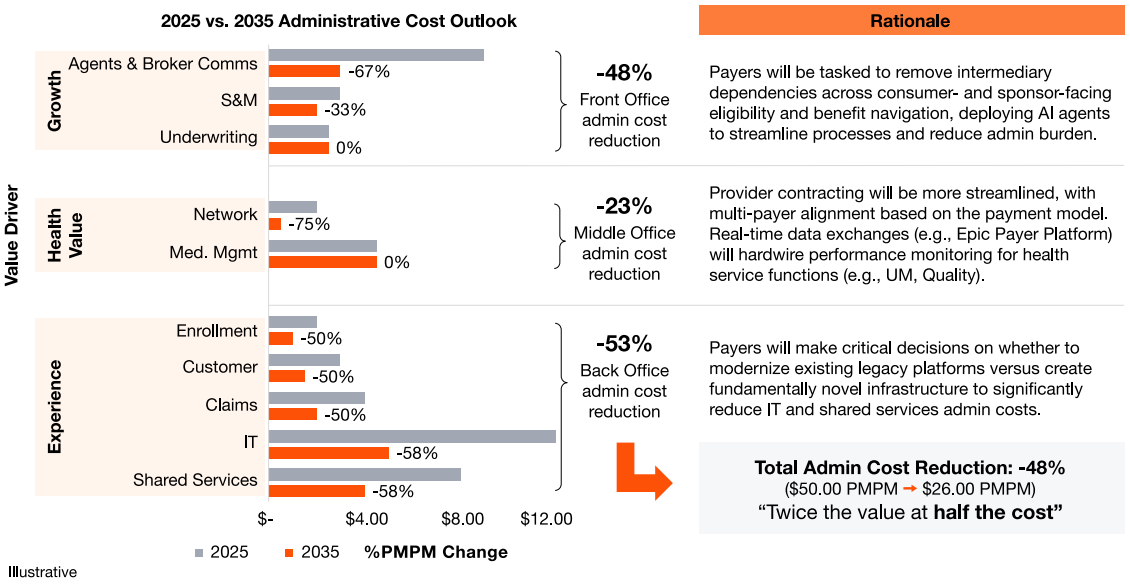
- **Maturation (end state):** As legacy systems are retired and AI-native platforms enable rapid scale, fixed costs would decrease even more. The industry would transition from labor-heavy operations to AI-enabled platforms, flattening the cost curve and making administrative costs less dependent on scale.

Payers can achieve fixed cost reductions after adopting AI solutions (the adoption phase). In the new ecosystem, maturation can demand speed and persistence to realize the full benefits. Gains can be won through streamlined systems and workflows, conversion of variables to lower fixed cost structures via technological adoption, and increased productivity and maturity over time.

Half the cost, in action

Payers can expect to cut administrative costs by half, requiring platforms and systems to deliver more effectively. One scenario modeled below illustrates the likely magnitude of the challenge and the opportunity.

Payers can expect to cut nearly half of admin costs, requiring platforms and systems to deliver more effectively



Illustrative

- **Front office:** Through 2035, an estimated 40% to 50% reduction is expected in administrative costs, mostly due to cuts in agent and broker commissions and sales and marketing. New AI based reasoning models can help members select plans that are right for them, reducing the archaic agent-based plan selection model that is infested with biases. Underwriting spending will likely shrink modestly, even after shifting today's significant manual work flows into AI-powered processes such as automated risk scoring, reinsurance triggers, and decline decisions. Payers should remove intermediate dependencies across consumer- and sponsor-facing eligibility and navigation, with tools such as AI agents streamlining enrollment and reducing administrative burden.
- **Middle office:** A 20% to 30% reduction in administrative costs is expected through 2035, mainly through network management reductions. Medical management spend can shrink as organizations shift away from manually heavy

prior authorizations and utilization management processes and toward member analytics and behavioral change. Future middle office capabilities perform intelligent sensing, authorizations at point of service, precise patient navigation, and real-time data exchanges within the healthcare ecosystem with providers and employers, making possible real time performance monitoring. The human-led, workflow-based care management model can be replaced with a newer, more intelligent patient and physician behavior change model.

- **Back office:** A significant cut to shared services, IT, claims, customer service, and enrollment is predicted, removing more than half of back-office costs by 2035. The back office is highly invisible, somewhat antiquated, and plagued with systems that were built in the prior century. Payers can create novel infrastructure to help reduce IT and shared services costs like banking where real time verification and transactions take place, and native rich communications systems (RCS) enable customer service models.

Partner for life: Twice the service

The elements defining the business model of today are reshuffling to establish four new models for the future: the lean operator, the risk clearinghouse/marketplace for care, the value/market integrator, and the consumer health partner for life. (For web: See slide)

Partner for life: Twice the service
The elements defining the business model of today are reshuffling to establish four new models for the future: the lean operator, the risk clearinghouse/marketplace for care, the value/market integrator, and the consumer health partner for life.

	Lean Operator Delivering basic, efficient products, leveraging automation and digital platforms to reduce admin overhead and provide competitive pricing.	**Risk Clearinghouse/ Marketplace for Care** Marketplaces where members assemble customized insurance plans that emphasize quality and cost-effectiveness.	**Value / Market Integrator** Enhanced integrated delivery fusing finance with close provider alignment enabling coordinated care and shared accountability.	**Consumer Health Partner For Life** Offering hyper-personalized care holistically orchestrated in a way that aligns with members' lifelong health needs and wants.
Relationship Basis	Servicing **cost-conscious consumers** who value standardized coverage and low premiums.	For **discerning consumers** seeking personalized benefits configurations, from a litany of choices, offered with transparency and delivered affordably.	Enabling **providers** looking for ways to improve population health, manage shared risk, and ultimately optimize the patient journey.	Servicing **empowered, digitally native consumers** desiring deep, hyper-personalized insights that drive advocacy and underpin affordable care.
Archetype in Action	• **Straight-through processing** for enrollment, claims, payments, and service, with ML-backed error prevention • **Simple, transparent** EoBs and **virtual agents** resolving follow-up questions • **Automation-backed insurance** driving down unit costs and **reducing consumer abrasion** through streamlined, seamless functions hidden to the member (e.g., AI-driven chatbot support, FWA detection)	• Consumers choose plans along the spectrum from standardized one-size-fits-all plans to **configurable "benefit baskets"** assembled in real time • **Marketplace** driven by flexible product services, data-sharing consent ledgers, and standards-based catalogues for price / quality indices • Transparency in price and quality drive **confidence and convenience in shopping for care**	• Tightly coupled or owned **provider assets,** advanced **care coordination,** and **value-based payment models** across virtual, home, and facility settings • Unified care plan supported by **payer's navigator app surfacing personalized next best action** for consumers and care teams • No surprise charges, fewer avoidable admissions, and **measurable gains** in quality-of-life scores	• Real-time, **AI-tailored recommendations for preventive screenings**, integrated seamlessly with members' wearable devices, and paired with behavioral nudges through a wellness app • This vision turns the payer into a **proactive health partner—**one that leverages **longitudinal health management tools and practices** to enable better outcomes, build trust, and drive lifelong value

- **Lean operator (LO):** LOs offer stripped-down, ultra-efficient health plans by using automation and digital platforms to reduce administrative costs and provide competitive pricing. They target cost-conscious consumers with low-premium, standardized coverage via ICHRA-backed and ACA plans, and may partner with employers for ASO plans. LOs use straight-through processing and virtual agents for transparent service, while maintaining lower risk ownership.
- **Risk clearinghouse/marketplace for care (RCMC):** RCMCs are digital marketplaces where members can browse and select from a wide range of customized plans and services. They cater to discerning consumers armed with ICHRA funds or shopping on the ACA exchanges who seek personalized benefit configurations, broad choice, and full transparency. Members can choose between standard plans or assemble custom benefits baskets in real time. RCMCs operate with flexible product offerings, consent ledgers, and standards-based catalogs for price and quality while maintaining lower risk ownership.
- **Value/market integrator (VMI):** VMIs specialize in Medicaid managed care organizations, Dual-Eligible Special Needs Plans (D-SNPs), and Medicare Advantage (MA). They work closely with providers (and/or with VMI-owned provider assets) seeking ways to improve and manage the more complex populations through improving the patient journey. VMIs specialize in value-based care arrangements across virtual, home, and facility settings. VMIs use evidence-based medicine and stringent clinical guidelines for member care to help deliver better outcomes. VMIs risk ownership is high.
- **Consumer health partner for life (CHPL):** CHPLs take an integrated, long-term approach to member health, offering hyper-personalized products, incentives for healthy behaviors, and financial tools that support lifelong needs. Their primary relationships are with empowered, tech-savvy members seeking affordable, personalized insights—often accessed through employers or Medicare Advantage. CHPLs use real-time, AI-driven recommendations and seamless integration of care and finances to deliver healthcare financial protection throughout the consumer's life. Of all payer models, CHPLs often assume the highest risk to support member lifelong health journeys.

Delivering twice the service by building, buying (and shelving)

Future ecosystem of payer archetypes

Lean Operators (LOs)

Focused as they are on delivering basic products powered by automation, should prioritize health value capabilities such as utilization management, provider contracting design and financial and service experience capabilities in areas such as claims adjudication and pricing, member enrollment, and digital service. Growth and development capabilities such as group sales, marketing, and underwriting are less of a priority, as are capabilities in payment and service validation. By building strengths in these areas, LOs can deliver excellent service—and use narrow networks and site of service steerage to control medical cost—at a low price.

Risk Clearinghouses / Marketplaces for Care (RCMCs)

Should focus on growth and development capabilities such as vendor contracting and management, health value capabilities such as medical cost and trend management, and utilization management and risk coding. Of secondary importance are strengthening capabilities in broker strategy and management, actuarial and underwriting and provider performance management. RCMCs tackle medical cost through enhanced scrutiny of documentation and coding and bundled payments.

Value / Market Integrators (VMIs)

Focused on delivering better outcomes for wealthier populations, should throw their energies into building health value capabilities such as provider contracting design, provider enablement, and care management along with financial and service capabilities in provider services, defining clinical pathways and remote monitoring. Their primary lever for curtailing medical cost growth is managing patient outcomes through care plan adherence, drug spend optimization, effective use of care sites, including transitions to lower cost sites. In this model, payers take a financial consultation role.

Consumer Health Partners for Life (CHPLs)

Shouldering considerable risk delivering expansive products and services to empowered consumers, should invest in building health value capabilities such as population health and precision health and financial and service capabilities such as multi-channel engagement and advocacy enablement. CHPLs may also want to double down on member segmentation, product portfolio management, pharmacy, provider enablement, member enrollment, and payment and service validation. CHPLs control medical cost through provider incentives and smart use of palliative care and evaluation of support care.

Next steps— No regrets, big bets

There are key, 'no-regret moves' payers can make in the short term while they identify the archetype-defining 'big bets' required in the long term.

No-regret moves buy survival and big bets define identity; Payers that do both simultaneously can set the pace for 2035

All payers will reduce administrative costs, at the functional area level, to remain afloat…

No-regret Moves
table stakes; agnostic of archetypes

Simplify back office: Replace legacy cores, automate admin, and drive zero-friction operations; payers must trade off between investing in people vs. investing in deeper technologies

Modernize the core/ Scalable technology modernization: Build tech and AI into the backbone of operations to lock in structural cost advantages

Pursue deals for desired capabilities: Acquire/partner to secure digital, and other relevant assets that accelerate transformation

…while investing in key differentiating capabilities to competitively serve the stakeholders of 2035

Big Bets
are archetype-defining choices

Deliver value chain orchestration: Decide whether to vertically integrate (Value/Market Integrator) or stay lean and hands-off

Redefine the product model: Choose between offering stripped-down, ultra-low-cost coverage vs. becoming a platform for configurable, consumer-designed benefit bundles

Invest in lifetime health: Choose whether to become a Health Partner for Life with prevention, genomics, and long-term ROI models.

Cost cutting measures are no regrets

In the short term, payers should focus on foundational actions that are essential for survival in a rapidly changing healthcare landscape. These no-regret moves can include:

- Simplifying the back office by replacing legacy systems and embracing cloud-enabled platforms.
- Automating administrative tasks.
- Driving zero-friction operations.
- Modernizing core operations by building scalable technology and AI into the backbone of their business to secure structural cost advantages.
- Pursuing strategic deals to acquire or partner for digital and other relevant assets that help accelerate transformation and keep payers at pace with market demands.

Big bets are archetype-defining choices

- **Deliver value chain orchestration:** Decide whether to vertically integrate (VMI) or stay lean and hands-off.
- **Redefine the product model:** Choose between offering stripped-down, ultra-low-cost coverage or becoming a platform for configurable, consumer-designed benefit bundles.
- **Invest in lifetime health:** Choose whether to become a CHPL with prevention, genomics, and long-term ROI models. Consider new partnerships and products like life insurance or financial services.

05

The future of reimbursement—An end to the payment struggle

Payers and providers are entrenched in costly and counterproductive payment disputes, each side investing heavily in technology, personnel, and processes in an effort to gain an advantage. These adversarial dynamics foster suspicion, with both parties believing the other is manipulating the system for their own benefit. At its core, the current reimbursement approach requires payers and providers to determine the cost of care only after services have been delivered, which inevitably leads to disputes over payment. These ongoing battles transform every patient encounter into a potential conflict, ultimately failing to serve the interests of payers, providers, and consumers.

Looking ahead, the future of reimbursement holds the possibility of a truce—a collaborative shift from adversarial negotiations to a mutually beneficial prospective payment framework. By sharing access to data and evidence-based standards of care, payers and providers can near-instantaneously assess the likely course of a patient's treatment. In a global accountability model, both parties agree in advance on detailed reimbursement terms based on patient presentation and evidence-based clinical guidelines. Alternatively, a global budgeting model allows payers and providers to set per-patient payments for broad categories of care, such as an inpatient admission, using mutually agreed-upon data and standards. This would allow the more effective providers to create a margin for those that deliver better care.

In both models, the consumer wins. Survey after survey reveals that many consumers find healthcare costs confusing and unpredictable. For example, a 2023 KFF survey found that three out of ten adults struggle to understand how much they will have to pay out-of-pocket when using health insurance. By introducing AI, predictive analytics, and other advanced technologies, payers and providers can move past payment disputes, create genuine transparency and predictability for various parties, and focus resources on building capabilities that enhance consumer experience, transform business models, deliver better outcomes, and reduce administrative costs.

06

Seize the future

US payers have a chance to shape the health ecosystem—including reimbursement—through thoughtful reinvention of their business. They have the chance to use technology to deliver more service for less. They can underwrite the development of a health ecosystem that is more productive, more affordable, and more effective.

Payers should act now, accelerating personalization, building adaptable networks, deploying automation, and experimenting with new models that underwrite care, expand access, and empower consumers as active managers of their health to meet the 2035 benchmark. By seizing this moment, payers can start down the path of delivering twice the service at half the cost and setting themselves up as a partner for life for their members and for the healthcare system.

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The future of the healthcare payer— Partner for life, half the cost, twice the service

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