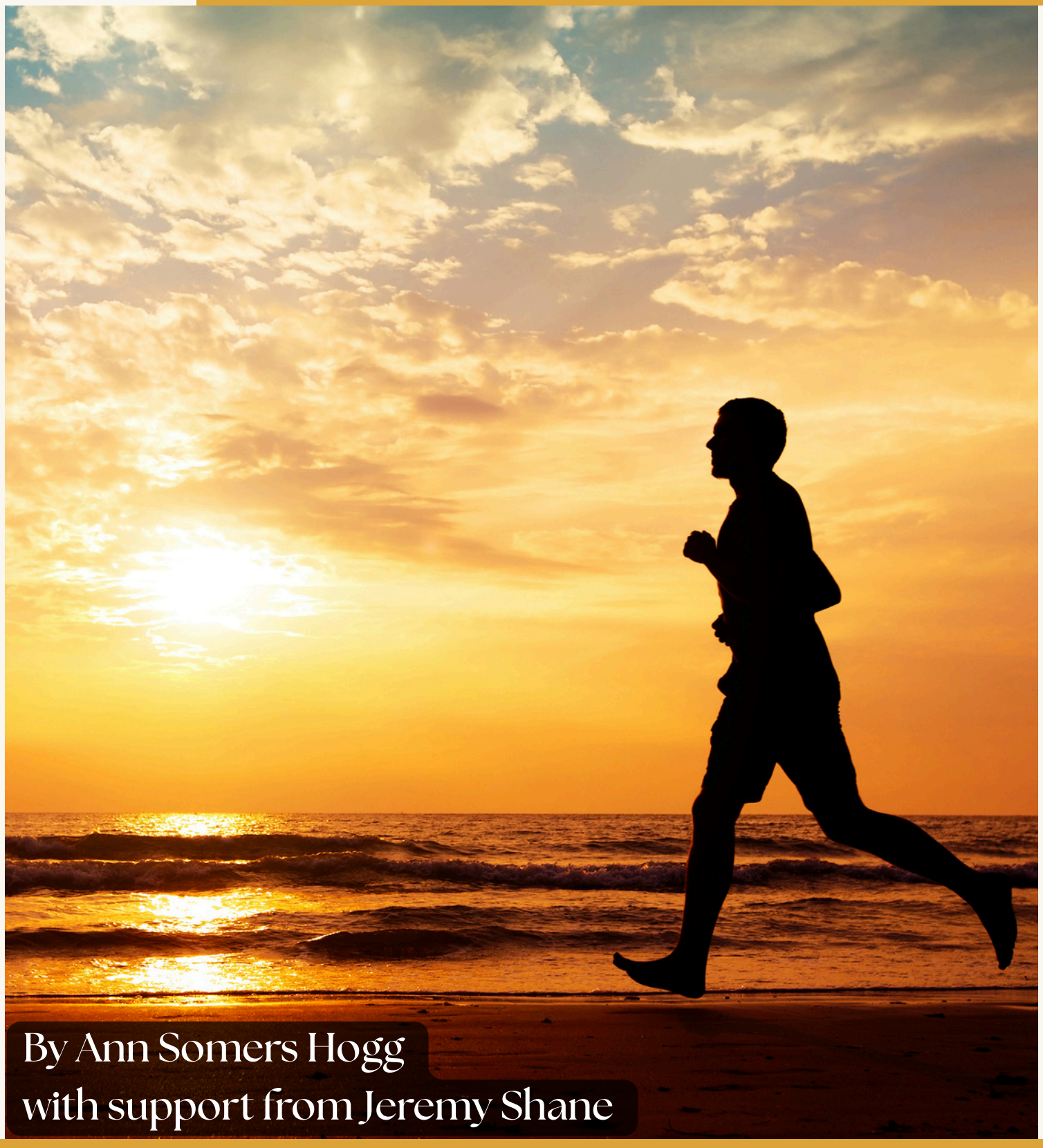
Christensen Institute

Life for Health:

How a two-insurance system might be the paradigm shift health care needs



By Ann Somers Hogg
with support from Jeremy Shane

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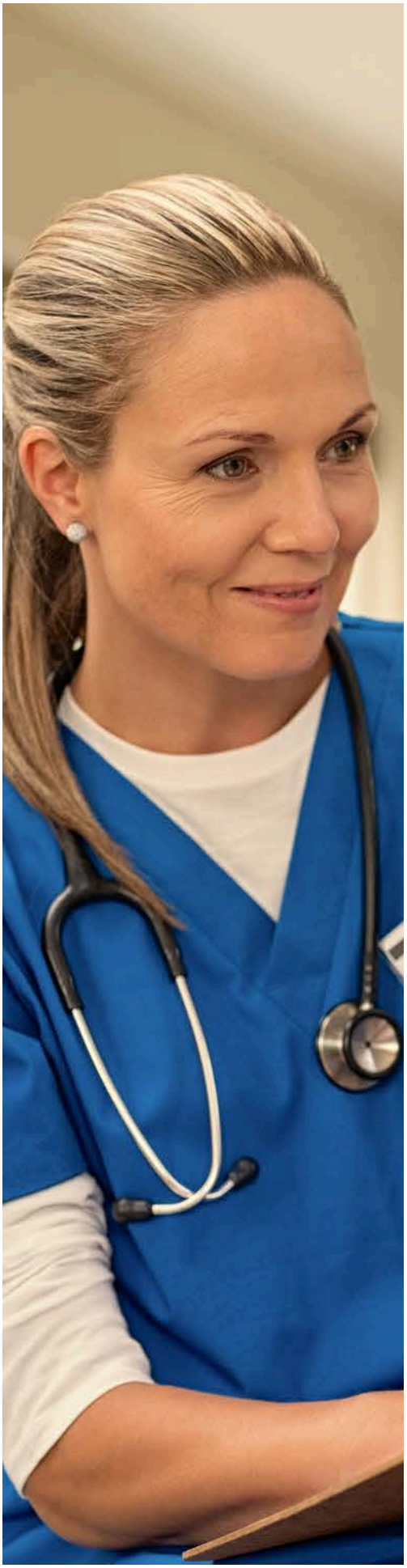


INTRODUCTION

Just over a year ago, I released my report on health insurance innovation, "Zero-inflation health care: A national strategy for unlocking and scaling insurance innovation." The report diagnoses the root cause of runaway health care cost inflation: the economic system that created it. The report also provides a roadmap for innovators and governments seeking to create a healthier and more solvent future for the nation. It spells out how they can leverage Optimal Care business models to unseat incumbent health insurers, transform the industry, and solve the problem of systemic health care cost inflation.

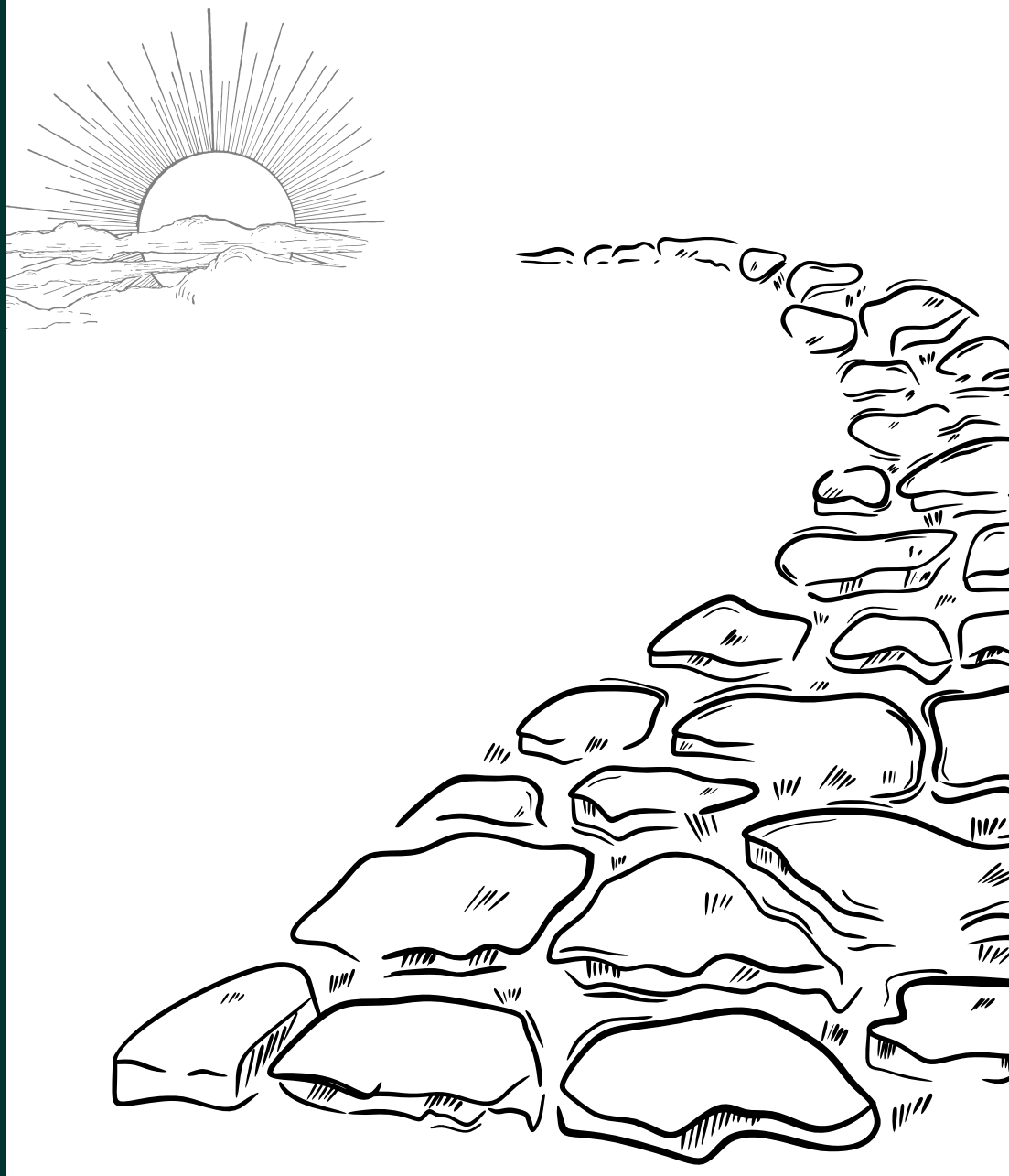
Specifically, we called for innovators to build transformative solutions that achieved three key criteria based on Clayton Christensen's business model theory:

1. Focus on a value proposition that large employers and government sponsors desire
2. Establish a new business model with new capabilities to support the value proposition
3. Create a new value network with immediate scale to support the business model

The process for transformation is summarized in the visual below:

We also noted that the pathway we laid out is not the only feasible option. Since the report's release, I've had a number of exciting conversations with industry innovators, entrepreneurs, and leaders about the best path to reduce unsustainable health care cost inflation. Now, I want to share one of those with you. The idea is called "Life for Health," which is also the title of Jeremy Shane's recently released book.

Here, I'll dive into how this idea aligns with what business model theory predicts is required for true health care transformation, because we all desire sustainably lower costs and better health outcomes.



IS THE LIFE FOR HEALTH MODEL A VIABLE PATHWAY TO ACHIEVE ZERO-INFLATION HEALTH CARE?

To answer this question, let's start with an overview of what Life for Health (LfH) is. LfH is a new system for addressing chronic disease through life insurance. Initially focusing on metabolic issues like obesity and diabetes, it can create long-term alignment between insurers and individuals to reverse disease, maintain better health, and prevent disease onset or recurrence. Everyone, over time, benefits from *fewer diseases*.

Health care and health insurance were designed to solve short-term, acute issues. But chronic disease poses fundamentally different scientific, practical, and financial issues, unfolding over decades, progressing from one organ or biological system to another, and often requiring multiple specialists to manage them. Inevitably, the mismatch between a long-term challenge and a system built for short-term episodes leads to massive overspending to manage increasingly complex symptoms. Far more value could be created—for insurers and individuals—by investing earlier and over time to reverse and prevent disease.

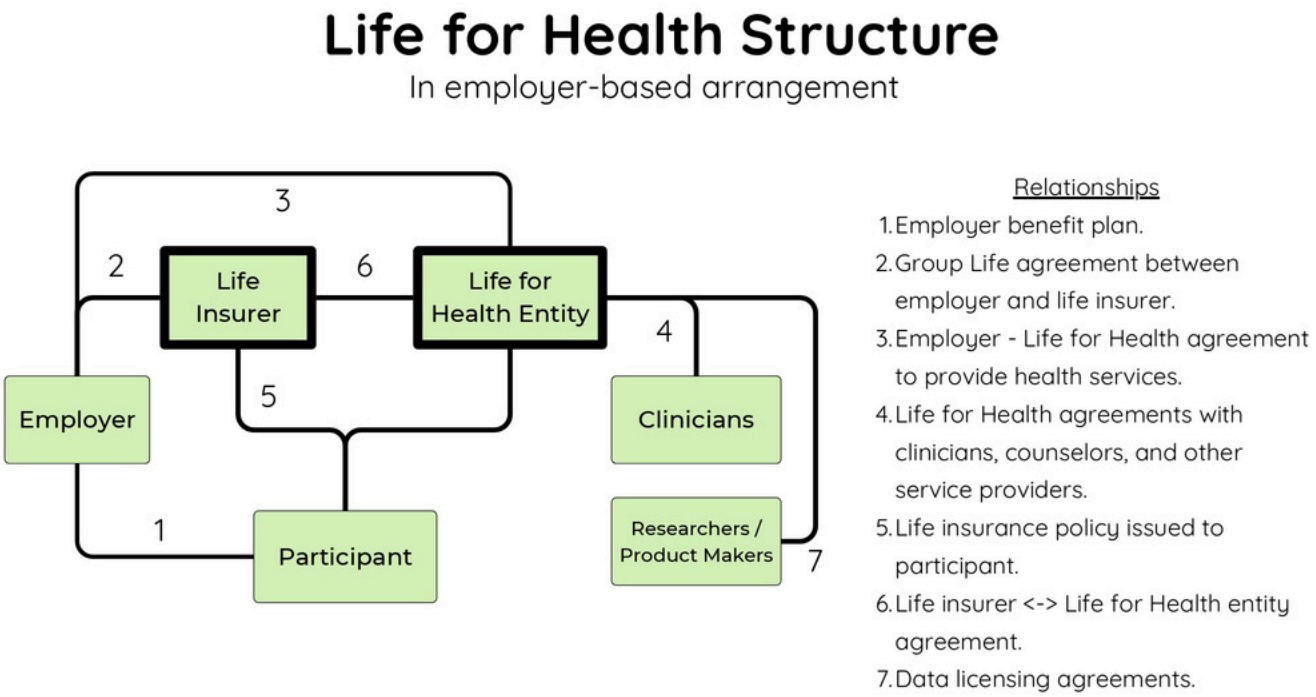
So, Shane argues that we need two systems rather than one: **Health insurance for routine, emergency, and elective issues, covering most health interactions but a minority of health spending; and life insurance for chronic and complex issues, covering fewer but much higher stakes, and costlier health decisions.**

Structurally, the LfH system combines access to a holistic set of clinical and counseling services through a Life for Health entity with a universal life insurance policy. The life insurer underwrites the policy and manages policy savings. The Life for Health entity is responsible for helping participants regain and maintain long-term metabolic health, including arranging for clinical services and ensuring participants have access to all diagnostics and treatments, as needed over time, to achieve health goals.

This structure accommodates regulatory and practical realities. The combined offering ensures that participants and insurers are aligned to achieve and maintain better health over many years. However, separating the entities that provide health services and insurance coverage keeps life insurers from getting involved in the practical and regulatory complexities of delivering care, while the Life for Health entity can focus on participant outcomes and clinical excellence without becoming a life insurer.

LfH can be offered through employers or directly to individuals. In an employer-sponsored arrangement, insurance coverage is provided as a group life benefit along with enrollment in Life for Health. See the graphic below for a visualization of how this would work in an employer-based agreement.

Figure 1: Life for Health structure in an employer-based arrangement.



Source: Jeremy Shane, Life for Health, 2025.

Next, we need to see how LfH aligns with the three criteria our insurance research and business model theory predict are required for industry transformation.

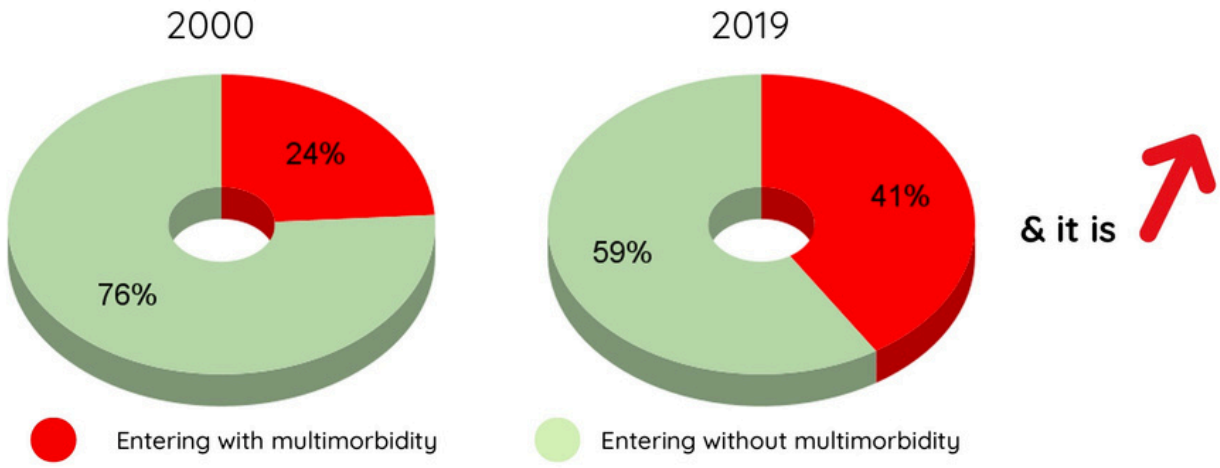
HOW LIFE FOR HEALTH ALIGNS WITH THE CRITERIA REQUIRED FOR INDUSTRY TRANSFORMATION

Value proposition that large employers and government sponsors desire

LfH's core value proposition is to align everyone in the system to reverse and reduce disease prevalence and severity. This is the opposite of health insurance as it relates to chronic disease, which profits by treating escalating illness. LfH instead values the absence of disease and shares savings among participants (in the form of retirement health savings), insurers, employers, and clinicians.

Clearly, reducing health care costs is of interest to all parties, and employers would also benefit from healthier employees, which would translate into higher productivity and lower absenteeism. Medicare would be the ultimate third-party beneficiary as more people would enter Medicare in better health, reducing health care costs. See the graph below regarding the trajectory of multimorbidity in Medicare.

Figure 2: The percentage of Americans in Medicare with multimorbidity (4+ chronic conditions) has jumped by two-thirds in 20 years.



Source: Jeremy Shane, Life for Health, 2025. Data sources: CMS Chartbooks on Chronic Conditions among Medicare Beneficiaries; Wolff, Jennifer L., Barbara Starfield, and Gerard Anderson. "Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly." Archives of Internal Medicine 162, no. 20 (November 11, 2002): 2269.

This decrease in multimorbidity translates into improved healthspan and reduced expenditures, which adds not only to employer and governmental benefits but also to an increase in societal wealth.

Figure 3: Increasing Healthspan Creates Additional Societal Wealth of ~$15 trillion.

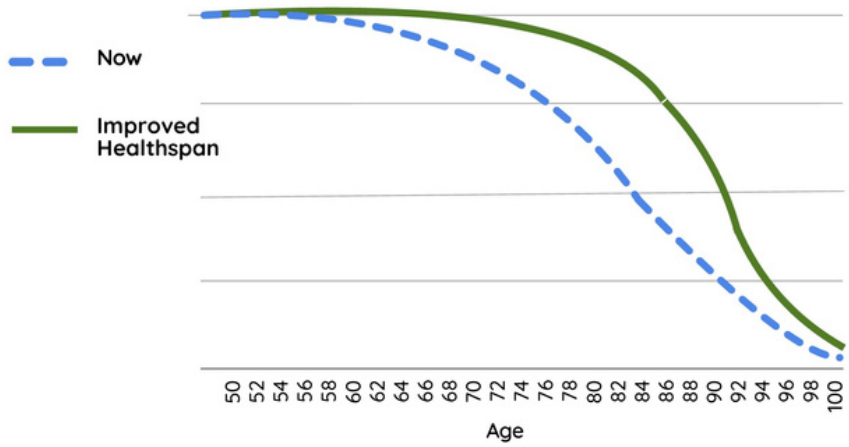
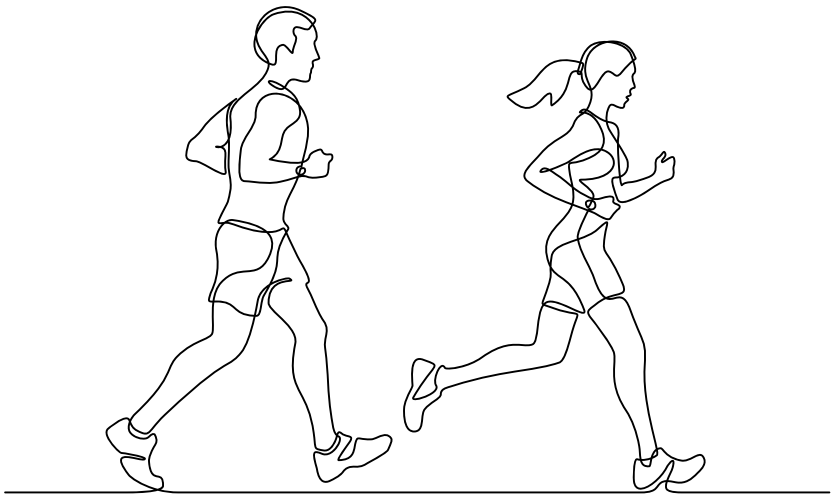


Image source: Jeremy Shane, Life for Health, 2025. *Data sources: Scott, A.J., Ellison, M. & Sinclair, D.A. The economic value of targeting aging.* Nat Aging *1, 616–623 (2021); Goldman, Cutler, Rowe et. al.*, Health Affairs, *Returns From Delayed Aging May Warrant A New Focus For Medical Research*.

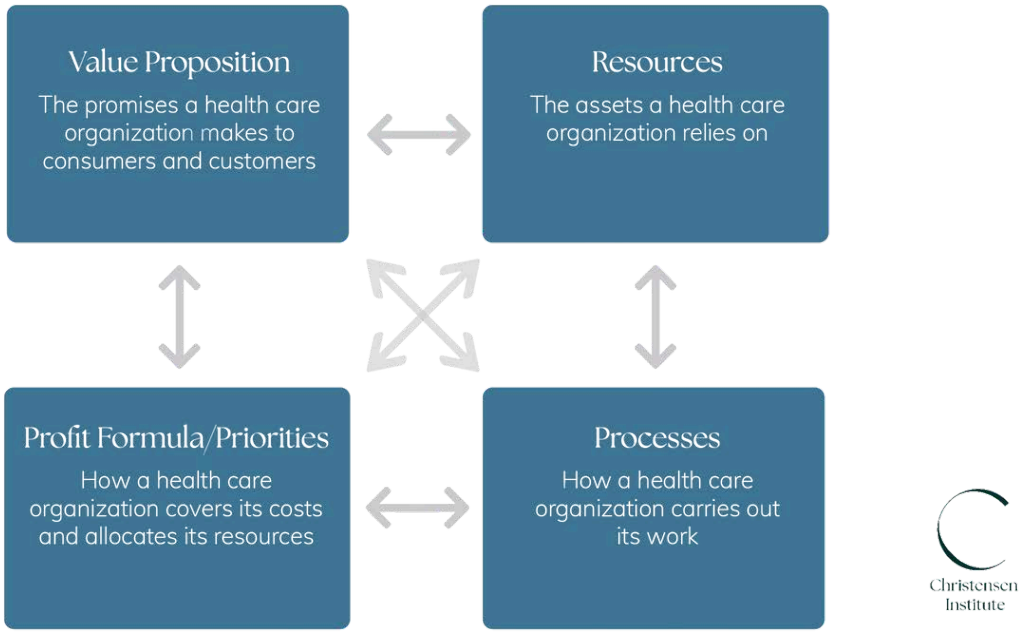
As explained here, the idea of Life for Health checks the first requirement my report outlined for transforming the health care industry and driving towards zero-inflation health care.



New business model with new capabilities to support the value proposition

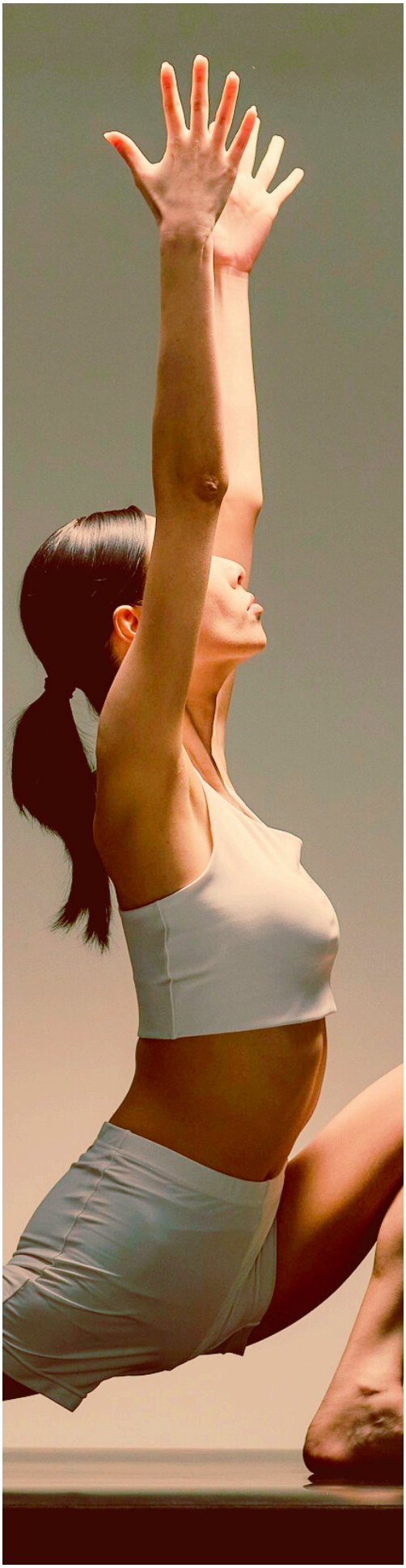
To deliver on this value proposition of lower disease prevalence, severity, and associated cost savings, new capabilities and profit formulas (i.e., the rest of the business model) are required. For a quick reminder on the four components of the business model, see below.

Figure 4: The business model diagram.



Capabilities: The most critical new capabilities (i.e., resources and processes) in the Life for Health entity are as follows. Importantly, these capabilities address clinical and data fragmentation, as well as disjointed accountability, in the current health care system.

- Resources
  - *The clinician in charge*: A physician who approves participants' intervention plans and outcome goals, and ensures coordinated treatment across the clinician/counselor team.
  - *Multidisciplinary approach and team:* Diagnostic, medical, and nutritional/behavioral/lifestyle services provided to reverse disease and improve metabolic health, including ongoing progress and risk assessments; RD, nurses, counselors, etc. are required to support delivery of services.
  - *Risk assessment tools:* Life for Health eligibility is initially limited to individuals with metabolic disease, so validated assessment tools are required to determine eligibility.
- Processes
  - *Participant empowerment:* Outcome goals are aligned with participant preferences, shared expectations with the clinical team, and the participant's level of effort.
  - *Ongoing health goal-setting and assessment:* Interventions are based on clinician-participant set outcome goals, with progress assessed periodically and longitudinally. This enables clinicians to refine clinical and behavioral interventions.
  - *Genomic risk assessment:* Whole genome sequencing in initial health assessment, counseling (if appropriate), plus access to treatment if disallowed by health insurance (i.e., surgery for BRCA mutations).
  - *Transparent data sharing:* Everyone who works with the participant will be able to see the intervention plan, desired outcomes, and current progress.



Profit formula/priorities: To understand the profit formula for LfH, let's take a quick look at today's health insurance financial model. It's actually two products in one. First, it provides protection against the extraordinary costs of catastrophic health events, but this accounts for only a small portion of the premiums paid by employers, the government, and beneficiaries. However, 90% of expenditures are for chronic and mental health conditions. This 90% is effectively sick care: the portion of health spending that increases exponentially as chronic disease prevalence and severity affect an ever-larger percent of an ever-aging population.

Shifting sick care spending for metabolic conditions out of the status quo health insurance model covers the clinical costs in the LfH model. However, it's not a 1:1 shift as LfH's goal is to save trillions of dollars over time by reversing and preventing disease (see above). The Life for Health entity agrees to beat a long-term forecast of an individual's expected health costs based on their health situation and risk factors upon joining the program. This is essentially what life insurers do for mortality, extrapolated to chronic disease.

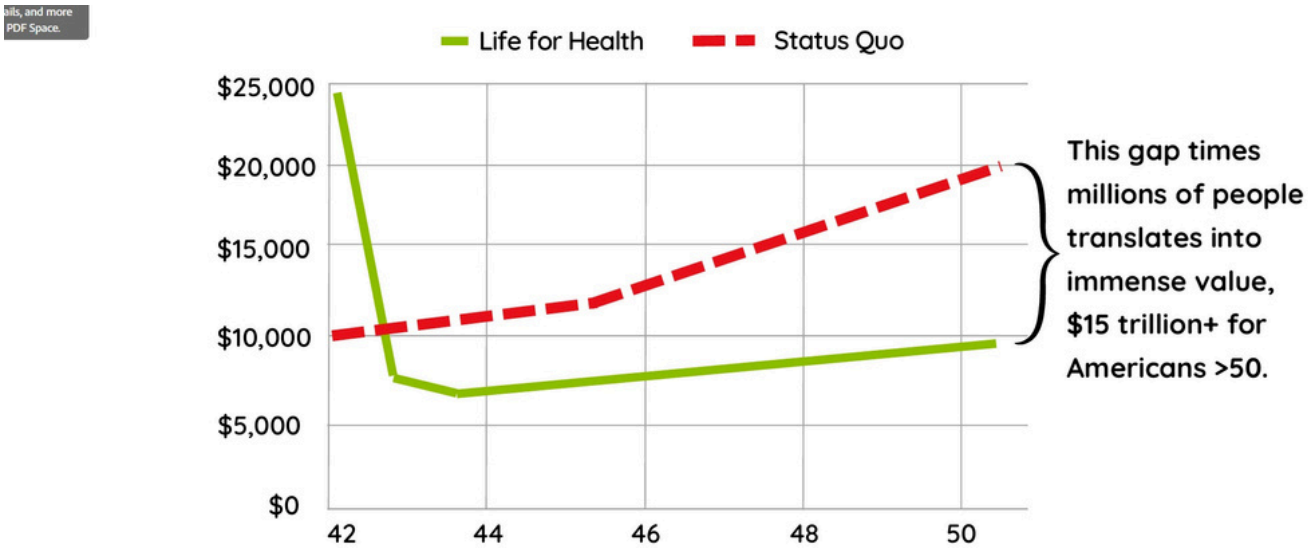
Participants set health outcome goals with clinicians, and when they achieve and maintain them, they can earn sizable payments. These payments go into the insurance policy's cash value, allowing them to grow on a tax-deferred basis, providing a growing nest egg for future health or retirement costs. Additionally, a portion of clinical compensation is tied to long-term results, balancing their near-term and multi-year track record.

In this system, everyone benefits to the degree that health outlays beat the long-term cost projection, with participants, insurers, employers, clinicians, and Medicare sharing in the value of a better health trajectory.

"In this [Life for Health] system, everyone benefits to the degree that health outlays beat the long-term cost projection, with participants, insurers, employers, clinicians, and Medicare sharing in the value of a better health trajectory."

The following graph highlights the savings that could be achieved by investing in reducing multimorbidity over time.

Figure 5: Investments to reverse and prevent disease multiply over time, leading to better health and lower costs.



Note: The green line - Life for Health's cost - is higher in the first year than Status Quo spending, reflecting the potential size of initial investments to restore metabolic health. This line is a "worst case" upfront investment involving weight loss surgery.

Image source: Jeremy Shane, Life for Health, 2025. Data sources: American Society for Metabolic and Bariatric Surgery; Meyers, Juliana, et al. "The health care resource utilization and costs among patients with type 2 diabetes and either cardiovascular disease or cardiovascular risk factors: an analysis of a US health insurance database." Clinical Therapeutics 43.11 (2021): 1827-1842. https://doi.org/10.1016/j.clinthera.2021.09.003; Pearson-Stuttard, J., Banerji, T., Capucci, S. et al. Real-world costs of obesity-related complications over eight years: a US retrospective cohort study in 28,500 individuals. Int J Obes 47, 1239–1246 (2023). https://doi.org/10.1038/s41366-023-01376-4; Thorpe KE, Joski PJ. Estimated reduction in health care spending associated with weight loss among adults. JAMA Netw Open. 2024;7(12):e2449200; Cawley J, Meyerhoefer C, Biener A, Hammer M, Wintfeld N. Savings in Medical Expenditures Associated with Reductions in Body Mass Index Among US Adults with Obesity, by Diabetes Status. Pharmacoeconomics. 2015 Jul;33(7):707-22. doi: 10.1007/s40273-014-0230-2

With that foundation, let's look at the benefits to each stakeholder group:

- **Participants** gain a decade-plus of healthspan and increased retirement health savings, which could be as much as $50k-$100k depending on their age and health situation upon joining.
- **Life insurers** gain millions of valuable consumers who are currently limited in their ability to buy coverage, as income to health insurers continues to rise. They gain a portion of these funds, plus fees, over time to manage participants' savings and to offer an opportunity to upsell annuity or other products. Fundamentally, they also regain control over efforts to improve the long-term morbidity/mortality profile of middle-aged populations, a critical goal given declining birth rates.
- **Employers** are big winners (whether or not they continue to finance health costs directly), gaining healthier workforces and lower health and disability costs.
- **Clinicians** are liberated from insurer micromanagement, with a portion of all service payments tied to participants' outcomes over time. Procedure-specific coding arbitrage becomes irrelevant, as does prior authorization.
- **Researchers and innovators** can tap into longitudinal data and participant relationships to reduce the time and cost of clinical development phases, while also gaining real-time, real-world evidence on how well their products work. Life for Health also accelerates work to develop outcomes-based pricing for one-time curative therapies or breakthrough drug classes like GLP-1s and CAR-Ts. Upfront pricing can come down, increasing access, with additional payments over time based on recipient outcomes.
- Most of all, Life for Health can ensure the fiscal solvency of **Medicare and Social Security**, which currently absorb (and socialize) most of the later-in-life costs of multimorbidity, greater cancer risk, and dementia. Life for Health does not end these threats, but helps postpone the onset and severity.

Based on this assessment, it seems Life for Health aligns with the requirement of a new business model with supporting capabilities to deliver on the new value proposition, which is aligned with employer and government interests.

New value network to support the business model

Let's start by defining a value network. It's an ecosystem of individuals, other organizations, institutions, and regulations that a company interfaces with to establish and maintain its model. Business models don't exist in isolation. They function *within* a supportive value network that determines the resources an organization has access to, the rules it must follow, and the permissions it needs to operate. The value network also includes external entities with varying degrees of power to shape the organization's priorities through resource dependence, regulation, and democratic governance.

This requirement is where the rubber meets the road. There have been many attempts to disrupt health insurance in the past (see here for examples), yet none have succeeded at scale. For new business models to create industry transformation, the value network must be an enabling force. That means regulation must support the new business model and provide a path to immediate scale. Scale is required because insurance doesn't work without scale.

One benefit to using a life insurance model to manage and improve metabolic health is that the Life for Health entity wouldn't be subject to medical loss ratio (MLR) requirements. For more on why MLR inhibits innovation, see here.

What is the value network that could enable Life for Health? To prove that LfH can seed industry transformation, the following requirements must be met:

- **Scale**: Life for Health must target very large corporate and/or government sponsors for a pilot, and bring the solution to market in partnership with a scaled entity. It will also need to attract outcomes-focused providers willing to tie a portion of compensation to longer-term participant outcomes.
- **Growth:** After proving the desirability, viability, and feasibility of the model, Life for Health should target additional customers (i.e., self-insured employers and government sponsors) to grow market share, scale, and pull more stakeholders out of the incumbent health insurance value network, and into the Life for Health value network.

THE PATH FORWARD

As we outline in the process for transformation at the start of this piece, Life for Health must achieve three goals to transform the industry:

1. Focus on a value proposition that large employers and government sponsors desire
2. Establish a new business model with new capabilities to support the value proposition
3. Create a new value network with immediate scale to support the business model

This analysis highlights how the concept meets the first two criteria and may meet the third, with the right pilot and scale partners. Like with all innovations, the proof is in the testing process. Whether Life for Health can succeed in transforming the health insurance industry into one no longer characterized by worsening health outcomes and runaway cost inflation has yet to be tested. But on paper, it clearly checks at least two of the three boxes we outlined as requirements for success.

I'd love to know what you think. What are the key assumptions you think need to be tested in this model? Which employers or states would be interested in piloting this model? What's missing from the approach?

Let us know your thoughts by sending me an email.

About the Institute

The Clayton Christensen Institute for Disruptive Innovation is a nonprofit, nonpartisan think tank dedicated to improving the world through Disruptive Innovation. Founded on the theories of Harvard professor Clayton M. Christensen, the Institute offers a unique framework for understanding many of society's most pressing problems. Its mission is ambitious but clear: work to shape and elevate the conversation surrounding these issues through rigorous research and public outreach.

About the Author

Ann Somers Hogg is the director of health care research at the Christensen Institute. She focuses on business model innovation and disruption in health care, including how to transform a sick care system to one that values and incentivizes total health. Prior to joining the Institute, she worked for Atrium Health, where she most recently served as the AVP of Strategy and Transformation. Ann Somers holds an MSPH in Health Policy and Management from UNC-Chapel Hill.