Creating the consumer-capable health plan

Payors must develop capabilities in four new areas
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This report was originally published by Booz & Company in 2013.
The turning point has arrived for U.S. health insurers. While insurance has been primarily a B2B business — with insurers selling to employers — it will change into a de facto B2C business over the next three years, with consumers having a much bigger say in their choice of payors. As a result, payors must become far more consumer-centric, a requirement that entails transforming their operations and making sizable investments to build new capabilities that have not been priorities in the past.

We believe there are four key priorities. The first is (1) consumer analytics and marketing, which will give payors the market insights and intelligence they need to understand their customers’ evolving needs and preferences. Once that capability is in place, it can fuel the development of the three remaining capabilities we consider essential: (2) product development, or the creation of new services that are tailored to consumer segments and based on new consumer insights; (3) consumer engagement, helping members deal with health issues more proactively to keep treatment costs down; and (4) an end-to-end consumer experience, which emphasizes responsiveness and convenience as mechanisms for earning members’ trust.

In developing these capabilities, payors must emphasize strategic focus and prioritization, in some cases reallocating resources away from other areas to fund needed investments and make themselves consumer-centric. In addition, payors must build this transformation around technology. The right digital approach will be critical in creating services that consumers like and will use. However, technology is also important in fending off asymmetrical threats from external competitors, some of which may not have a history in health insurance, yet could capitalize on their strengths in digitally enabled, direct-to-consumer models to disrupt this fast-evolving field.
The turning point arrives

In the wake of the Supreme Court’s 2012 ruling on the Affordable Care Act, there is less doubt about where health insurance is headed: Source of new PQ. Healthcare in the United States has historically operated as a B2B model, yet it is evolving into a B2C, B2B2C (business-to-business-to-consumer), and B2P2C (business-to-provider-to-consumer) industry. Consumers already have a much bigger say about which insurers get their business, and this evolution will gain momentum in the coming years. Now the question is what to do about the more consumer-centric environment, and how to thrive in it.

We believe payors need to develop new capabilities in four areas. The first — consumer analytics and marketing — will be a central part of every successful health plan in the future. Payors will need analytics-driven insights to better understand the evolving needs of current and potential new members, and to guide the evolution of their strategy and operations.

The other new capabilities we believe will be critical are product development and integrated distribution; engaging the consumer in care delivery; and providing an end-to-end consumer experience. These three will all be necessary, but will vary in importance depending on the payor’s market strategy. Some of the capabilities will be table stakes for certain payors; they are things they must do simply to stay in the game. Other capabilities will be the means by which payors differentiate themselves. In those cases, the capability investments must be significant and sustained, whether the payor is trying to position itself as a low-cost producer and needs to excel in consumer engagement, or as a benefits leader and needs to excel in developing tailored and innovative products.

Payors often ask what they should expect to invest in order to become more consumer-capable. Our experience suggests that building the needed capabilities typically requires a one-time investment of US$20 to $200 per member, which is highly dependent on scale (that is, the number will be higher for payors with fewer members). Given the scope of this investment, a central question is how to find the capital needed.
Two changes may help payors in this regard. The first is doing away with activities that have ceased to have value, and reinvesting the savings in new capabilities. For example, a payor may stop offering wellness and disease management programs that have a low or negative ROI, and invest the freed-up cash into consumer research and market analytics. Many weight management programs, though well intended, aren’t effective in changing member behavior and don’t justify their cost, making them candidates to be eliminated.

The second change is making capability investments self-funding. Many of the new ideas about engaging consumers in care delivery fit into this realm. For instance, deploying an easy-to-use online tool that consistently helps consumers pick a lower-cost provider will likely become self-funding. And a tool that helps consumers see the difference in their out-of-pocket costs between a branded prescription drug and a generic equivalent has the same type of potential.
It’s hard to overstate the transformation that payors need to go through, requiring major changes in people, roles, processes, and technology. Here’s a closer look at the four new capabilities that every payor needs to be developing at this inflection point for the industry (see Exhibit 1, page 7).

1. Consumer analytics and marketing: Consumer products companies use a number of analytical approaches to understand the needs and potential profitability of different customer segments, to develop segment-specific products, and to understand the prices that consumers are willing to pay. Health insurance companies must start to gather the same kinds of market insights to assess what consumers are looking for in a health plan.

Analytical tools give payors intelligence that they can apply to everything they do, from the strategic to the tactical level. This is what makes an analytics-driven consumer insights capability so central. On a macro level, strong analytics helps payors understand the premiums and costs associated with different market segments, the lifetime value of each customer segment, the most efficient acquisition strategies, and the optimal time to launch retention efforts. Strong analytics also helps payors optimize the pool of risk among their members for financial sustainability.

On a more tactical level, analytics can help payors quickly understand the impact of competitors’ moves and respond to them. It’s analogous to Procter & Gamble being able to assess how a competitor’s new packaging might affect the sales of one of its products. If P&G’s analysis suggests that the rival’s innovation will appeal to a highly profitable customer segment, it can take steps to neutralize that
rival’s advantage. Likewise, a payor battling for share in a newly launched health insurance exchange can look to develop specific intelligence about the market.

One national payor did just this, developing a proprietary analytics engine to help it assess consumer preferences for products being offered on state-level insurance exchanges. That payor was able to simulate consumer choice and ultimately estimate the impact that different product configurations would have on its market share across different member segments.
A well-functioning analytics group can be put together in six to 12 months, and can be executed as a simple add-on without requiring massive system changes or data integration. In most cases, the required investment will be a few million dollars or less. This will cover the cost of hiring data analysts, setting up a direct marketing database, and doing initial segmentation analysis. Indeed, the bigger challenge involves weaving consumer analytics into everything else the enterprise does, requiring changes in processes and behaviors, along with sustained involvement from leadership.

2. Product development and integrated distribution: Once payors have a better consumer analytics capability in place, they can generate more granular insights about evolving consumer preferences — and then tailor their benefits to meet those preferences. The same is true of provider networks. For instance, if research shows that some members want access to a region’s top-rated hospitals and are willing to pay more for it, a payor can put together a premium offering that includes those hospitals.

The product design imperative also means being willing to try different marketing approaches. Potential options include co-branding with hospitals and partnerships with retail companies for discounts on consumer products. In terms of distribution, payors need to have a strong, consistent presence everywhere — online, in call centers, and, in some cases, in retail-like insurance “storefronts.”

Technology will figure heavily in these new products and customer touch points. Investments will be needed in areas such as mobile applications, data capture and management, and decision support tools across different platforms (including both public and private exchanges). Indeed, the emergence of exchanges gives payors a chance to grow while making needed investments in connectivity. One big benefit of technology is that as more transactions shift into the digital realm and no longer need to be processed manually, payors’ operating costs should drop substantially.

3. Consumer engagement in care delivery: These strategic adaptations will require levels of investment that payors can sustain only by transforming their cost structures — in particular, the impact of
medical costs. The most effective way to do this is to get consumers to change their behaviors. By our calculation, some $500 billion of the $2.6 trillion in U.S. healthcare costs is driven by individual behavior choices (as opposed to genetics, geography, or other factors) and is thus avoidable. This number does not include the potential additional savings if consumers more consistently took economics into account in deciding where to go for care.

One innovation that is already generating interest is the idea of “bundled” healthcare services. In a healthcare bundle, common procedures such as Lasik surgery have a single, all-in price. This is a departure from the current approach in which different parts of a medical procedure are billed separately (with one bill from the surgeon, one from the anesthesiologist, one from the facility, and so on). The predictability of bundles and the promise they have to deliver savings suggest that payors might want to look closely at this idea. Some already have. For instance, Florida Blue has begun collaborating with the Mayo Clinic on a knee replacement bundle.

Payors have put more effort into influencing consumer behaviors in recent years — for example, through accountable care organizations and patient-centered medical homes. Some have sought to employ behavior-changing initiatives analogous to those that have worked in other industries, including offering rewards programs with incentives for healthy behavior.

These initiatives have had some success, but haven’t proved transformative to cost structures thus far — possibly because of capability gaps within the payors themselves. For instance, most health insurance companies do not have a deep understanding of how to measure the ROI of consumer programs. Many haven’t figured out which programs would work best for their different customer segments. Lacking this knowledge, many payors have chosen to accept a certain level of inefficiency, and have offered multiple programs aimed at similar health and wellness outcomes. It may be time to move away from the idea of health engagement “programs” and toward holistic health engagement models that use analytics to prompt specific populations to change their behaviors.
In Indiana, for instance, Anthem has partnered with Castlight, a company that specializes in healthcare transparency, to develop a searchable database that shows cost estimates and quality ratings for doctors and procedures. This information allows state employees and the employees of self-insured employers to pick more affordable healthcare options without jeopardizing the quality of care they receive.

Another step on the consumer engagement continuum is “reference pricing,” in which a payor sets a fixed price for a given procedure and allows the patient to choose whichever provider he or she wants within the network; if that provider charges less than the fixed price, the patient can keep the difference. (Conversely, a patient who opts for a procedure that costs more than the reference price must pay the difference.)

Consumer engagement is another area where technology is critical. In addition to enabling transparency, the convergence of “big data” and mobile technology can add value in ways not yet fully explored. For instance, cloud-based services have the potential to reduce medical costs. As one example, when an insured consumer has a need for urgent care, location intelligence could recommend cheaper and faster alternatives to a hospital emergency room.

4. End-to-end consumer experience: Before long, one of the truisms of online retail — that one’s competitors are only a mouse click away — will be true of health insurance. Consumers will have alternatives in their choice of provider, and the options will be only one downloaded app away.

As a result, a payor’s success will hinge on the quality of the experience it delivers to its members. Create a positive customer experience, and members not only will renew but likely will become a source of referrals and incremental sales, perhaps through social media. Deliver a less positive experience, and members may drop you the first chance they get — and tell their friends to do the same.

Recognizing this, many payors are offering new tools or resources that can help members improve their health in visible ways. An example is the personal health coaches that some payors are starting to use. The role of these care consultants is to ensure that members continue to recuperate from illness and surgical procedures. Personal
health coaches have the added benefit of lowering the number of costly hospital admissions and readmissions that payors must cover. In this sense, they are also an example of a self-funding investment.

Consumer experience represents a significant new hurdle for payors. Historically, health insurers have not been known for exemplary customer service. Customers who called with claims questions often struggled to get a simple, definitive answer.

In the future, the onus will be on payors to do better in basic areas like this. Responsiveness, accessibility, and convenience will be the way payors earn their members’ trust. Without trust, consumers will not be receptive to payors’ ideas about becoming more engaged in their own healthcare — the biggest untapped opportunity to create value and address healthcare affordability.

To improve consumers’ sense of their end-to-end health insurance experience, payors are making new use of technology. For instance, Medical Mutual of Ohio has turned to Benefitfocus, a provider of cloud-based services, to help it build a private insurance exchange that walks consumers through a preenrollment selection process. This could be a self-funding investment if it increases Medical Mutual’s business, steers its members toward lower-cost selections, and reduces the number of manual transactions that employees must handle.

There are many other examples of payors focusing on the consumer experience. For instance, Cigna is using rewards programs — a staple of consumer-centric companies — to promote healthy behaviors. Cigna members who actively participate in health improvement programs receive points that they can redeem for gift cards, merchandise, or a variety of health-specific benefits, including eligibility for optional (and previously unreimbursed) medical procedures. Insurance-plan reward programs might seem expensive, but if they reduce the incidence of serious illness among a member segment, they can more than pay for themselves.
As payors make themselves more consumer-centric, there are several imperatives they should bear in mind. First, though they won’t need to be world-class in all of these new capabilities, they will need to develop all of them to at least some degree. Analytics-driven consumer insight lays the foundation for the other three capabilities, but there are linkages among all of them. The benefits of consumer engagement (including members opting for more cost-efficient medical treatment) will never be realized without an end-to-end consumer experience that fosters trust. Likewise, a capability in product development/innovation is necessary if a payor is to have something to offer the customers it is seeking to actively engage.

The second thing to keep in mind is the extent to which the future will depend on the smart use of digital technology, which has given consumers far more choice and transparency in other industries. Technology will enable many of the new insurance products that consumers will use, and enhance the consumer’s end-to-end experience (by making insurance services available whenever and wherever the consumer wants them). And technology will determine, at least in part, which payors succeed in the new, integrated, and largely online world of exchanges. Notably, technology is not all about upside. It represents a threat if existing competitors find a better way to use it, or if asymmetrical competitors enter the insurance domain (as Amazon has done in the areas of retail and media).

Finally, payors seeking a more consumer-centric approach will have to change their operating models and cultures. Organizationally, most insurance companies nowadays have a strong functional focus. They are not set up to respond to consumer preferences or to
innovate in response to consumer needs. Consumer-centricity will require them to develop a new language of business and find ways to manage new organizational assets. For example, to better serve consumers, Horizon Blue Cross Blue Shield of New Jersey decided to open a physical retail store. That required extensive training for store staffers, not only to make them conversant in all of BCBS’s products but also to enable them to provide the experience that consumers expect in high-quality retail interactions. Changes like these won’t happen overnight; they will take years. But the time to get started is now.
The changes affecting the health insurance industry are historic in scope. Payors should start by asking themselves a few fundamental questions:

- What are the areas in which we must invest in order to become more consumer-centric, and which current investment areas can we stop altogether? What’s the best way to shift between the two?

- Which investments can we make in ways that are self-funding because they reduce either administrative costs or our members’ medical expenses?

- What is our biggest technological vulnerability, and is it something a competitor could exploit? What can we do to strengthen ourselves in this area?

- What do we need to change in our operating model to become truly consumer-centric? Are there cultural strengths we can build on to accelerate our transformation?

The key is to realize just how much is at stake. Consumerization doesn’t represent an addition to the current payor model; instead, it is a new way to do business, driven by the four capabilities discussed here. What’s the cost of not developing these capabilities? Almost certainly, a loss of customers and a gradual descent into irrelevance. For any payor that thinks it can preserve the status quo, consider this: There are traditional and new rivals working right now on innovative new value propositions to entice and serve the individual consumer. The question is whether payors will respond proactively to these threats or be overtaken by them.
Endnotes


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This report was originally published by Booz & Company in 2013.