



Lloyd Miller

The retail revolution in health insurance

More and more, payers are dealing with individual consumers, not companies. They will have to change their products, their mind-sets, and their competencies.

Article at a glance

US health insurers, long accustomed to working with companies, are entering a retail world. But many are ignoring the transformation—at their peril.

These payers have grown up as wholesale enterprises. Their competencies, organizational structures, and mind-sets have been—and largely remain—directed at serving groups, not individual consumers.

As a payer increasingly deals directly with consumers, it must not only develop much better insights about them but also improve its product management, retail distribution, customer service, risk management, and consumer-oriented medical management.

The transition will be difficult, since health insurers must develop these retail capabilities while managing the traditional wholesale business.

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The retail revolution in health insurance

Tom Latkovic and Shubham Singhal

Health insurers are entering a new world where individuals, not groups, are the decision makers. In essence, US health care is going retail, from the growing interest in health savings accounts (HSAs) to the proliferation of minute clinics and other convenient settings for delivering care. Yet many insurers are ignoring the transformation of their industry and the opportunities and challenges it presents.

The change is manifesting itself in several ways. Traditionally, employers selected health care products for their workers and paid for most of the services and other costs. Increasingly, however, those costs are being passed on to individuals, who now decide what products to buy, as well as where, when, and how to buy them. Individual consumers are also demanding first-rate service from their payers—service in line with what they expect from other consumer industries, such as banking or retailing—along with nearly 100 percent accuracy and the convenience of interacting at any time through a number of channels. And given the complexity of health insurance products and of the health care system, consumers want more advice and support than ever.

But health insurers, or payers, have grown up as wholesale enterprises, and their competencies, organizational structures, and mind-sets are largely directed at serving groups, not individuals. As that dynamic changes, payers will need much sharper insights about consumers, along with better product management, retail distribution, customer service, risk management, and consumer-oriented medical management.

What's more, as the industry becomes more retail oriented, payers face severe competitive threats. Analogous changes in other industries have reshaped the landscape, putting incumbents on the

defensive and rewarding entrants. The same thing could happen in health insurance. The transition will be difficult, for payers will have to develop retail capabilities while managing the traditional wholesale business.

Change is coming

When we define the retail and wholesale aspects of the health benefits industry, we look at the level of decision-making authority and financial responsibility of individual consumers, on the one hand, and of intermediaries acting for them, on the other. Exhibit 1 illustrates the landscape of health and health-related benefits. The most retail-like products, such as individual insurance policies and health-related financial services, are plotted in the upper right. We expect these products to grow rapidly over the next five years as fewer consumers receive generous employer-sponsored insurance.

Indeed, the US health care system is already more retail-oriented than many payers realize. Like employers, individuals bear 25 percent of the cost of the \$1.9 trillion a year spent on health care.¹ The more than 6 million people who have moved to consumer-directed health plans, such as high-deductible policies associated with HSAs, have attracted a lot of attention. But many other consumers make decisions about health care purchases—the 19 million people with individual insurance, employees who can choose among products from a number of carriers at work, spouses who have options from different employers, retired people with Medicare options,² and the 46 million uninsured,³ who purchase health care with their own money. Viewed through this lens, 40 to 45 percent of the people in the United States already choose their primary health insurance from among a variety of possible carriers. Consider also the large and growing ranks of people who purchase voluntary health products relating to long-term care, critical illness, and long-term disability.

¹ The sums individuals spend include all insurance premiums paid by consumers and out-of-pocket expenses for elective and nonelective medical products, as well as services not paid for by third parties.

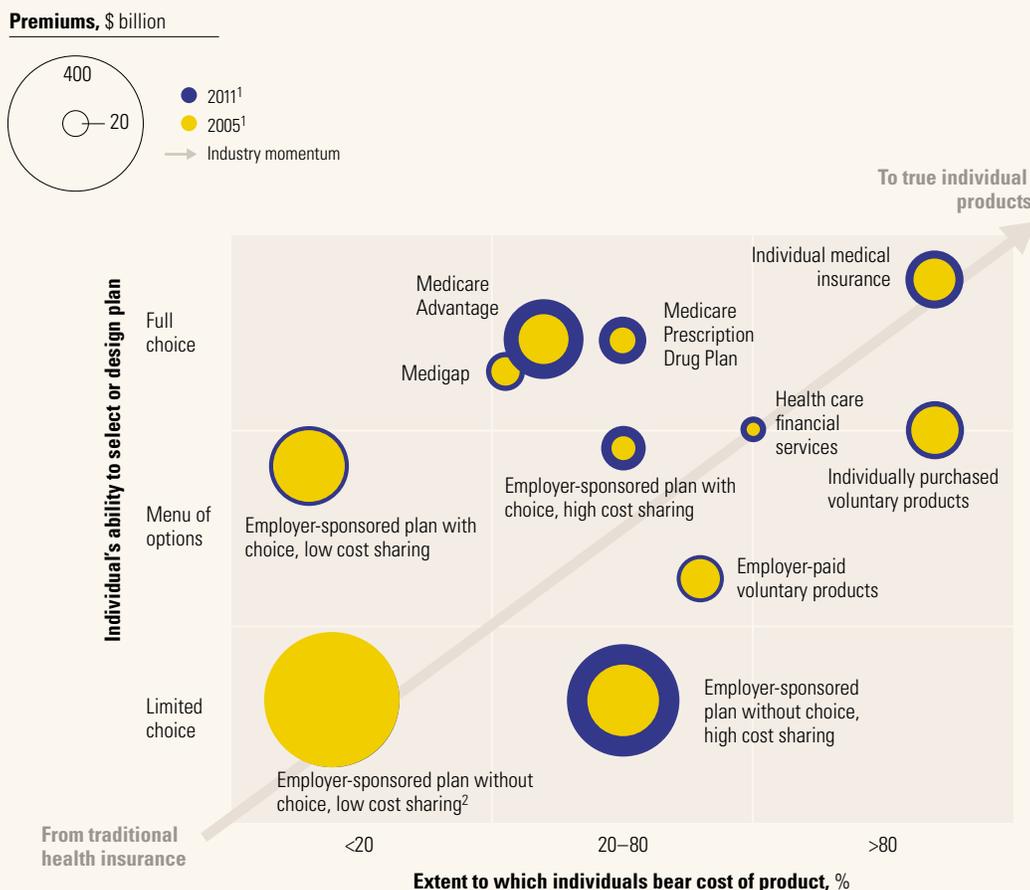
² Such as Part D plans, a voluntary prescription drug plan for those eligible for Medicare, and Medicare Advantage—all privately managed insurance plans that are subsidized by the federal government and augment traditional Medicare retiree coverage.

³ Figures are from the Kaiser Family Foundation.

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Exhibit 1

The opportunity in retail health care



¹2011 data projected; 2005 estimated from latest available data.

²Data for 2005 = \$386 billion; for 2011 = \$375 billion.

Source: Kaiser Family Foundation; Statehealthfacts.org; US Census; McKinsey analysis

We expect the industry to become even more retail oriented. By 2011 the fate of \$550 billion to \$600 billion of premiums⁴ will be in the hands of individual decision makers, not employers or the government. The underlying force propelling this movement is medical inflation, which is rising two to three times faster than general inflation, so companies are increasingly reluctant to bear the full cost of health care. State- and federal-government measures are likely to accelerate the migration of employees and retirees from

the employer-sponsored model to a retail one by encouraging consumers to assume financial responsibility for their health care, as well as by promoting competition among health plans, greater transparency in prices and quality, and more portable benefits. Employers are rapidly shifting the responsibilities and costs to workers by dropping health benefits, sharing more and more of the cost with employees, or moving to defined-contribution systems.

⁴Includes individual insurance, employer plans selected by individuals with a choice of plans from multiple carriers, Medicare Advantage, stand-alone Part D plans, MediGap policies, and individually purchased ancillary products.

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It is highly unlikely that the health care system will ever return to a more wholesale environment. Regardless of which party controls the Congress or the presidency, the biggest impediment is the underfunded Medicare liability of \$30 trillion—more than 2.5 times the US gross domestic product. In fact, this liability dwarfs the \$8 trillion shortfall of Social Security and makes it extremely difficult for any government to assume responsibility for rising health care costs.

Even if change comes slowly, the impact on the industry could be huge. A similar shift in the retirement savings market—from employer-sponsored defined-benefit pension plans to defined-contribution plans—has drastically altered asset management, even though the change played out over 20 years as incumbent banks and life insurers ceded share to mutual-fund players such as Fidelity Investments (Exhibit 2). The winners took a long-term view and made their investments early. The pace of change is likely to be faster in health care: the number of HSAs has increased much more quickly than the number of 401(k) accounts did in the early days.

Winning competencies in a retail world

To succeed in a retail world, payers need new capabilities and competencies. Crucial among them are product innovation, retail distribution, customer service, and risk management, as well as consumer-oriented medical management to help people make informed decisions about managing health and medical costs. Each of these capabilities and competencies stands on a foundation of deep consumer insight and an IT-enabled administrative platform. Much of what must be done is unfamiliar to payers but well established in the world's leading consumer retailing organizations. Here we look at four: product innovation, retail distribution, customer service, and risk management.

Product innovation

Big payers often underemphasize product innovation as a source of competitive advantage, tending instead to follow the wishes of employers and their benefits consultants—an approach generating products that are hard for consumers to understand and hard to administer. These difficulties are responsible for errors and complaints, and the products themselves often

Exhibit 2

A revolution in the retirement industry

Share of defined-contribution private retirement assets, %



¹Figures do not sum to 100%, because of rounding; 2005 is latest available data.

Source: CIBC World Markets analyst reports; *Pensions & Investments*; US Federal Reserve Board; McKinsey analysis

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ignore the consumers' needs and preferences. Because employers tend to treat all employees similarly, payers have had very little chance to glean insights into the consumers' attitudes, preferences, or life stages and to turn those insights into innovative products tailored to individual segments.

Furthermore, the payers' product-development and administration infrastructure is designed to launch and refine products over long periods, reflecting the annual buying process of the employers and the even less frequent reviews of employee benefit programs. Also, employers are sophisticated buyers that seek unbundled products—networks, benefit designs, advice, tools, clinical programs, and other ancillary benefits. As a result, payers lack experience at assembling these elements seamlessly.

In a retail-oriented world, payers will need straightforward, segment-tailored, quick-to-market

products. Consumer industries gain only a fleeting advantage from any innovative offering, but distinctive product-development skills can still deliver a substantial edge. Remember, for example, that in the 1980s only a handful of credit card products were available. Today thousands of cards are aimed at consumer microsegments that vary by credit, payment, rewards, branding, service, and advice. To achieve leadership, payers must focus on several things.

An expanded product portfolio . . . One priority for payers is innovative health insurance policies and an array of ancillary products and services. Breadth is important to realize economies of scope (for example, in distribution) and because sales of many nongroup products are growing much faster than core insurance plans are. New categories of products combining five pillars of successful innovation—risk mitigation, health costs, financing mechanisms, elements of managed care, and advice—will probably emerge (Exhibit 3).

Exhibit 3

A solid platform

5 pillars for successful product innovation

Risks	Costs	Financing mechanisms	Managed-care elements	Advice
<ul style="list-style-type: none"> • Health events • Low-intensity event • Disease, illness • Condition that is not time sensitive¹ • High-intensity event • Accident • Mental illness • Disability • Impairment • Other risks • Medical inflation • Longevity • Death • Caregiver risk • Uninsurability 	<ul style="list-style-type: none"> • Preventative care • Basic care • Treatment of serious condition • Dental treatment • Outpatient care • Discretionary treatment • Nontraditional treatment • Inpatient care • Pharmaceuticals • Behavioral treatment • Institutional care • End-of-life care • Nonmedical costs² 	<ul style="list-style-type: none"> • Discount, value cards • Savings • Investments • Annuitization • Insurance • Financing, credit cards • Sale of illiquid asset • Structured financial products 	<ul style="list-style-type: none"> • Network access • Discount programs • Disease management • Case management • Wellness • Medical policy, technology evaluation • Provider assessment 	<ul style="list-style-type: none"> • Health-related financial advice • Preventive health advice • Treatment advice • Concierge services

¹For example, hip replacement.

²For example, making one's house wheelchair accessible.

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... that is integrated and flexible. Rather than build each new product in a silo, payers must integrate across their portfolios. Sophisticated bundling approaches will be needed to combine product distribution, consumer preferences, and ease of communication. (One such approach is an insurer's attempt to bundle individual health, dental, and life insurance.) Many operational features, including billing and customer service, must also be integrated so that consumers have just one Web site, one bill, and one customer service phone number no matter how many products they select.

Effective product management. Payers tend to have weak product-management skills focused mostly on coverage levels and the design of benefits. They exert little influence over a product's other elements, including the service experience, the network, and clinical programs—and that will have to change. Payers must design, launch, and manage products quickly, from concept through commercialization, in a way that satisfies the needs of all constituents. A much stronger connection between efforts to gain market insights and the product-development process will be needed.

Retail distribution

As the employer-sponsored insurance market shrinks, payers must generate sales by dealing directly with the consumer. To do so, they must build expertise in managing retail channels and bolster their approach to distribution by improving their branding and marketing. Whether payers distribute directly to consumers or through intermediaries, they will also need distinctive brands and an overall brand communication strategy that gains the consumer's trust, for a strong consumer brand can deliver significant value by way of price premiums, by attracting more healthy people (thereby reducing medical losses), and through lower distribution costs. Payers will also have to manage their marketing dollars more effectively because distribution approaches will become more and more complex, and the nominal dollars in play are likely to grow rapidly.

Building retail channels. Reaching individuals, unlike groups, requires a host of channels and sales approaches. Five types are emerging:

1. *Direct-response channels.* These include a captive sales force, call centers, the Internet, direct mail, and television commercials. One provider, for example, primarily uses the Internet to sell a product aimed at consumers aged 18 to 29 ("young invincibles") who think they need no health insurance. Humana and Blue Cross Blue Shield of Michigan use a traveling consumer sales force in recreational vehicles to promote products for retirees and to build brands.
2. *Retail channels.* Payers are offering health benefits products through Costco and Wal-Mart Stores, pharmacies such as Walgreens, and online portals such as ehealthinsurance.com.
3. *Affinity-marketing relationships.* Payers that have used such relationships successfully include Humana, with Virgin, and United Healthcare, with the American Association of Retired Persons (AARP).
4. *Partnerships with financial institutions.* As consumers pay more for health care and for health-oriented financial products (such as HSAs and health-focused credit cards), these two areas will naturally converge. Assurant, for instance, has employed partnerships with, among others, AXA, Lincoln Financial, MetLife, and State Farm. There will be further opportunities to use the branch networks of retail banks as HSAs grow in popularity.
5. *Work sites.* Given the payers' strong relationships with employers, this channel is perhaps the most natural and important one. As the employers' role evolves from sponsorship to facilitation, payers should make good use of the benefits they can gain from this channel: distribution access, payroll deductions, and opportunities to implement wellness programs. Work site marketing will continue to be a major purchase

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criterion for large employers that want to migrate toward consumer-directed health plans.

Choosing channels. The breadth and scope of the retail channels may seem overwhelming, but it doesn't have to be. Although no one channel will dominate, payers will find that some align better than others with their retail strategy.

For one thing, payers should define which consumer segments they want to pursue. If their customer base consists of large groups, for example, they might focus their retail efforts entirely on employees leaving the group environment. These people will become crucial to payers as employers drop coverage and lay off workers or, in the biggest movement of all, employees retire. This approach would require an emphasis on work site marketing and distribution. On the other end of the spectrum, serving healthy young individuals or currently uninsured ones would require direct channels and partnerships.

Different consumer segments have different preferences and attitudes, and the payers must understand them. Some consumers, for example, want a trusted adviser who can make decisions for them, while others desire information and tools to make their own decisions. Preferences also vary by demographics; for example, most retirees value greater support. Understanding these preferences is important when companies decide whether to use direct channels or ones that provide for human intervention. Because a consumer's risk profile (that is, health status) is correlated with demographics, the choice of channels can be a significant driver of profitability.

Payers should look for opportunities to use channels and sales to build their brands. Offering a product through value-oriented retailers, for instance, may reinforce the perception that it is cost competitive, while selling it through a high-end financial adviser may support its positioning as a rich set of benefits with superior service.

Finally, payers face a strategic choice about whether to own direct relationships with consumers. In similar industries, such as asset management, players that just create products thrive thanks to superior performance and brands. Retail distributors, by contrast, gain more power because they can benefit from the relationships they build up. Distribution and direct trust-based relationships with consumers are hard to create, however. Payers that want to follow this route should think about building a stronger captive sales force; many companies that focus on health products for individuals already have one. Although a captive force can come into conflict with independent agents and is often costly, this model offers big benefits, including the alignment of incentives, superior pricing, a sales force that is knowledgeable about products, and greater brand equity. With the appropriate level of scale, a captive force can be productive and profitable.

An outstanding consumer experience

For most payers, the consumer experience means servicing consumers as efficiently as possible, largely through inbound phone calls. Customer satisfaction is the primary metric. But this approach isn't enough in the retail environment, where payers must learn to deliver a value-added experience. The goal is to develop loyal and committed consumers who recommend the payer to their friends and relatives, thus improving its reputation and winning new customers who are much less likely to shop around, even when presented with lower prices.

Although the consumer experience is the sum of both positive and negative experiences across all interactions with a company, not all interactions are equal. We separate them into two types: "moments of truth" and routine interactions.

Moments of truth. Some interactions offer an opportunity to give the consumer a feeling of being cared for—a feeling that can generate strong loyalty and commitment.⁵ On the flip side, even

⁵Marc Beaujean, Jonathan Davidson, and Stacey Madge, "The 'moment of truth' in customer service," *The McKinsey Quarterly*, 2006 Number 1, pp. 62–73.

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a mildly negative experience during moments of truth can create ill will. These interactions have a lasting impact on a consumer's perceptions of a payer and influence behavior disproportionately.

Moments of truth—for example, a major illness, retirement, a job change, or the birth of a child—often involve high emotion. Our research shows that most consumers want support and guidance from payers at precisely these times. Consumers cite three major kinds of interactions when they want to receive support, but don't:

1. Advice on the planning of health-related expenses and on selecting health insurance plans—especially at retirement, a job change, or the birth of a child. Consumers are seeking peace of mind; they want to know if they have adequate coverage. Most employees don't know, for example, if they will receive health benefits in retirement and if so, how much they have to pay and what the plan covers.
2. Support in navigating the complex health care system, especially after a major illness. Consumers find it difficult to sort out the coverage available under their health plans and quite frustrating to reconcile the explanations of benefits and the multiple bills they receive from different providers for the same episode of care.
3. Support and guidance in dealing with chronic conditions or the aftermath of an acute illness. Consumers often cite as a defining moment an exchange with empathetic nurses or case managers when a family member fell ill.

Routine interactions. Other more ordinary interactions can generate only “value for money” varieties of customer satisfaction, with a lower impact on overall loyalty and commitment. Often, these interactions are transactional⁶ in nature, involve clearly defined needs, and recur a number of times. Although one mildly negative interaction of this kind isn't overly important, the cumulative

impact of many of them certainly is—and difficult to reverse once an opinion is formed.

Payers must realize that the consumer's expectations are created not just by health insurers but also by interactions—often superior ones—with other kinds of service providers, such as financial institutions, telecommunications providers, and retailers. The fact is that payers routinely deliver poor customer service, including confusing enrollment processes, claims errors, and inconsistent answers from customer representatives.

Delivering high-quality service across the board is essential. In the retail world, for example, 99 percent claims accuracy just isn't good enough—would any consumer accept a checking account that had errors this often? Payers have a big opportunity to improve the accuracy and timeliness of their process flows by removing unnecessary steps and automating activities in areas such as enrollment and billing. In addition, they must meet new payment and transaction needs, including real-time pricing delivered to providers and consumers at the point of service.

Risk management

Most payers have relied on simple approaches to underwriting and rating. Although the use of actuarial science and other sophisticated techniques has become more common, companies still leave value on the table by pricing both too high and too low. In some states, for instance, the loss ratio for payers can vary by 30 to 40 percent, which indicates that some insurers are maximizing prices much more than others are. To price effectively, payers must understand not only the risk profiles of individual consumers but also their true cost to serve, which often varies by segment and channel. Marrying insights about the behavior of consumers with the methods of actuarial science could create a competitive advantage. Progressive, for example, transformed the auto insurance industry by building sophisticated

⁶Bradford C. Johnson, James M. Manyika, and Lareina A. Yee, “The next revolution in interactions,” *The McKinsey Quarterly*, 2005 Number 4, pp. 20–33.

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actuarial models that allowed the company to gain share broadly and to play profitably in high-risk markets such as those for young drivers and motorcyclists.

Getting it done

The health care world is unmistakably becoming more centered on individuals. Although the journey will be long and challenging, payers must develop a retail orientation to remain relevant. Better insights about customers—an understanding of what they need and prefer and of how they behave—underpin most of the capabilities that companies will need, but so far they have made only limited investments in this crucial area. The winners will be those payers that develop a comprehensive, integrated view of the consumer, including a clear understanding of the needs of the segments they hope to serve.

Even a company with a historical orientation toward consumers will have difficulty changing its culture and operating model and building the capabilities it needs. Although each enterprise will find its own path, three areas are critical: actively shaping new mind-sets, defining a clear consumer value proposition and retail strategy, and starting to build capabilities.

Creating new mind-sets is perhaps the most nebulous—but also the most important—aspect of a payer’s transition. Obvious though this step may seem, the payer must start believing that the consumer is the customer and act appropriately. Retail payers should also look outside their own walls to learn from industries such as retailing, retail finance, consumer electronics, packaged goods, and travel and leisure. They should also

be willing to create alliances and partnerships with players both inside and outside health care.

Second, like companies starting any new business, the payers will need to define a vision and strategy—in this case, one promoting the transition to a more retail-oriented approach. This process begins with the definition of a core consumer value proposition (based on the company’s sources of competitive advantage) for key segments. Payers will also have to define the products and markets where they intend to lead, to follow, and to be absent.

Third, payers must thoughtfully build the capabilities they need by hiring strong executives—many, perhaps, from outside the industry—who have useful skills and mind-sets. Acquisitions, alliances, and joint ventures are also likely to be part of every payer’s capability-building approach; collaboration can shorten a company’s development time and mitigate strategic and financial risk.

Without a sustained program, companies often stumble; in recent history, leading ones such as AT&T, McDonald’s, and P&G all had to make a significant effort to rebuild their consumer orientation. Payers must also continue to improve their performance in the traditional business model to meet investors’ current expectations and, more important, to generate capital they can invest in the business of the future. *Q*

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