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As reform legislation makes the U.S. healthcare industry more consumer-centric, companies will need to change their business models and add new capabilities.

by Ashish Kaura, David S. Levy, and Minoo Javanmardian

The historic healthcare reform enacted by the Obama administration and the U.S. Congress in March 2010 will fundamentally alter how health insurance is bought and sold in the U.S., and will have a major impact on the companies that provide or manage coverage for nearly 250 million people. The retail market for individuals and small businesses will become much larger and more transparent. Coverage parameters will be defined by government rather than by companies, and medical underwriting will be eliminated. Consumers will be asked to make purchase decisions on their own, often through online healthcare exchanges. Price and brand will become a more influential factor in consumer buying decisions and health plan strategies.

In this new retail era, the individual consumer will play a far more central role in the healthcare market. Already, we have seen increased cost sharing by consumers (often in the form of high deductibles and user fees, such as co-pays and coinsurance), online price comparison tools for easier shopping, and a rising awareness of consumer needs on the part of insurers. Soon, more and more consumers will make health insurance purchase decisions directly. Small employers, for example, may not participate in the selection of health plans at all, choosing instead to simply pay all or a portion of their employees' health insurance premiums. With lower barriers to switching, consumers will increasingly vote with their feet when they are not satisfied.

By 2016, as coverage is extended to the previously uninsured, the retail segment of the health insurance market, which includes small group, commercial individual, and government individual products, will expand dramatically to about 55 percent of the overall market. According to Booz & Company estimates, most of this growth will occur in the commercial individual segment, which will swell to 27 million people — far more than the 16 million buyers who would have made up the segment if the reform bill hadn't passed.

State-run healthcare exchanges, similar to the Massachusetts Commonwealth Health Insurance Connector and the Utah Health Exchange, will be a major distribution channel in this market. The exchange-based market will be highly regulated and far less opaque to consumers than it is today. The ability of health plans to manage risk — at least on the traditional basis of medical underwriting — will be severely restricted. The Patient Protection and Affordable Care Act requires the elimination of lifetime spending caps and preexisting condition restrictions, and limits waiting periods for coverage. It also requires the introduction of products that conform to government-imposed benefit tiers and that are priced according to modified age and gender bands.

The retail market that emerges from these changes will ultimately be more buyer-friendly. But reform will also significantly challenge the

Illustration by Lars Leetaru

traditional means by which health plans manage the three fundamental drivers of their business models — revenue, cost, and risk.

Demographic trends in the U.S. will further exacerbate the challenges facing health plans. Cost pressures will intensify as consumers age and need more care. Chronic diseases, which already account for approximately 75 percent of total healthcare costs in the U.S., will rise at an alarming rate, according to the Centers for Disease Control and Prevention (CDC). The CDC estimates that the number of people who are contracting or at risk of contracting chronic diseases in the U.S. is growing at five times the population growth rate and that by 2016, almost half of Americans will suffer from these diseases.

Redesigning for Retail

Health plans that choose to compete in the retail market will have to learn to operate profitably in a regulated environment in which quasi-governmental agencies set standards for participation and require benefit tiers for products. They will need to cope with the downward pressure on premiums that will result from greater consumer choice and market transparency, as well as the emergence of new competitors, including government-sponsored and consumer-organized plans.

The current go-to-market models of health plans are not well designed for this new retail era. The prominence of employer-sponsored plans is diminishing, but health insurers still have a decidedly business-to-business perspective. Their revenue assumptions are transaction based and group focused. Products tend to be "one size fits all," and product portfolios are limited to medical insurance. Today's models assume relatively little direct contact with consumers: They depend on brokers to sell products and navigate the complex, cumbersome application and renewal processes, and on care providers to submit and manage claims.

The current prevailing risk management model, which will soon be prohibited, is focused on the point of selection. Insurers use medical underwriting to select applicants who are healthy risks and either reject those who are high risk or price their policies accordingly.

Cost management models are focused on negotiating the lowest cost from providers on a fee-for-service basis. The cost structures of health plans are also burdened by high legacy costs, such as complex claims processing systems, and are designed to serve the group market, which is less price-sensitive and generates higher revenues and margins.

In the coming years, these models will not serve health plans as well as they have in the past. As the retail marketplace for medical insurance expands, health plans will need new models that are based on the changing drivers of revenue, risk, and cost. The way these models are built will depend on the answers to a number of key questions.

- How will consumers make purchase decisions in a more transparent, less restrictive market, especially one mediated by online exchanges? Which consumer segments will be most attractive, and what will it take to identify, activate, and retain them?
- How can risk be managed in the absence of medical underwriting? How should investments be staged to preserve scarce capital? What levels of capital are needed to cope with the volatility created by the regulations that limit medical underwriting?
- What capabilities will be needed to attract individual consumers? What cost structures will be needed to offset the downward pressure on margins and capital?

Health plans will begin to emulate successful consumer companies in other sectors, such as Capital One.

Driving revenue. As health plans respond to the changing retail market, they will need to create go-to-market models that are specifically designed for a business-to-consumer environment in which exchanges will often play an intermediary role. In many ways, they will begin to emulate successful consumer companies in other sectors, such as Capital One, Harrah's Entertainment, United Services Automobile Association (USAA), and Progressive Insurance.

Like these companies, health plans will need to decide which consumer segments to serve. They will also need a tailored value proposition for each segment, addressing consumer needs across various health insurance products and services (such as dental and vision) and aligning the price, brand, and channels through which they are offered. They will need a more gran-

ular approach to marketing, one that uses behavior-based data and analytics to better identify consumer needs and further customize their value propositions. Think of Capital One's micro-segmentation approach to designing its credit card offers, which depends on copious data and an intimate understanding of consumer behavior.

To retain the best customers in a competitive marketplace with fewer barriers to switching plans, health plans must intensify their focus on managing the customer life cycle — calculating the acquisition, retention, and lifetime value of customers by target segment. They will also have to simplify customer touch points. Consumers have been "trained" by other service industries to expect a transparent, no-hassle experience. A recent Booz & Company study of the Massachusetts Connector, an exchange established by the state's 2006 healthcare reform act that is very similar in design and intent to the exchanges mandated by the national reform act, suggests that consumers will demand the same ease from their health insurers. Benefits will have to be transparent and comparable. Interactions with the health plan, such as enrollment, renewal, and adjudication, will have to be fast, straightforward, and user-friendly.

Health plans must learn to build customer trust and loyalty — an area that represents heretofore ignored opportunities for many insurers. In much the same way that Harrah's creates loyal relationships by using customer insights to offer carefully designed, added-value perks, health plans can link consumer insights with medical data to drive engagement and influence behavior. The most successful plans in the new retail era may be those that cement consumer relationships by serving as a valued partner — helping their customers access health and wellness services, make more informed decisions, and manage out-of-pocket healthcare expenditures.

Within the context of a retail market, health plans have to make important decisions about their brand, such as what brand equities and positioning they should adopt, and whether they should differ by the consumer segments that they are serving. Consumers will be paying attention to brands. In the Massachusetts Connector, for example, shoppers are using their awareness of health plan brands and brand reputations to quickly screen their options and simplify their choices.

Many plans should also consider how to diversify their revenue bases. There may be no other way to preserve margins in response to the ongoing price pressure on medical coverage from governments, consumers, and competitors. New sources of revenue can come from ancillary products, financial services, or other ventures, and from up-selling and cross-selling customers a suite of products designed to enhance profitability and retention. Our study of the Massachusetts Connector indicates that exchange customers will be very open to offers from health plans.

The relevance of these offers is essential, of course, and insurers will have to maintain a holistic view of their customers' needs to craft "sticky" offers. USAA is a notable example in this regard. Founded in 1922 by 25 U.S. Army officers to insure their personal vehicles, USAA now offers a full spectrum of financial services from insurance to investment products and banking. This broad portfolio allows the company to tailor its offerings to the needs of its customers throughout their lives and gain high levels of cross-selling, up-selling, satisfaction, and retention.

Ultimately, health plans that choose to compete in retail markets in the U.S. and elsewhere may borrow a page from Aflac Inc.'s playbook in Japan. Aflac designed a portfolio of products for the Japanese market, which is characterized by a rapidly aging population and a government that is reluctant to pick up the tab for its citizens' medical care. Aflac created a broad retail distribution network that includes Japan Post Network Company's 24,000 offices, 354 banks, and 544 Aflac Service Shops. The company also built an extremely strong brand in Japan: In 2009, its ad featuring the Aflac duck and the *maneki neko* (a white cat thought to bring good luck in Asia) became the top-rated TV ad and the most popular cell

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Mitigating risk. In its quest for near-universal health coverage, the health reform act purposefully upended the traditional risk management model used by health plans. No longer able to underwrite risk, insurers will need a new approach.

This new model will have to enable them to identify, attract, and retain new customers by appropriately tailoring and pricing health plan services to account for inherent risk, as well as aggressively managing the health and wellness of higher-risk customers.

For this model to work effectively, health plans must be able to identify the risk levels of consumers prior to purchase and set prices to attract these customers without surrendering the margins needed to support the customer pool. As Progressive has demonstrated in the auto insurance sector, this will require a deep understanding of consumer behavior and its outcomes, a superior risk model that utilizes multiple inputs, and a test-and-learn approach to continually lower risk and improve results. For example, Progressive discovered it could profitably supply motorcycle insurance to riders provided they were older than 30 and had no previous accidents, were college-educated, and had a credit score above 720. Health plans can follow this lead by using consumer marketing data and their deep knowledge of care outcomes to inform and improve their own risk models.

More important, health plans will also need to develop a new set of tools to manage the health risks of consumers after they purchase coverage. Some of these tools will help consumers better manage their own health and make better decisions about care. Some will help providers coordinate care, manage population health, and meet quality, outcome, and cost objectives, such as reducing errors and readmissions.

Health plans must build consumer trust — an area that represents heretofore ignored opportunities.

Managing costs. As the need for investment in new retail capabilities collides with the margin and capital pressure created by reform, the cost structure of health plans will require close attention. Further, insurers will likely find it more difficult to cover increases in cost by simply raising prices. For instance, on April 1 of this year, the commissioner of insurance in Massachusetts rejected 235 of 274 small-group rate increase requests, creating a standoff with health plans and, for a short time, making it impossible for new customers to buy health insurance in the state. In May, the state's largest health insurer, Blue Cross and Blue Shield of Massachusetts Inc., underscored the need to more aggressively manage costs when it announced a US$55 million provision for anticipated second-quarter losses caused by inadequate premium rates.

Health plans will need to pursue lean cost structures more aggressively than ever. One promising means of achieving this is to work with providers to change the traditional fee-for-service model to a pay-for-performance model. Indeed, a number of innovative experiments are already under way, aimed at decoupling payments from the volume of care and attaching them instead to quality and outcomes. These efforts could deliver transformational levels of savings because they represent an opportunity to reduce both administrative and medical costs. (See "A Better Model for Health Care," by Gary D. Ahlquist, Minoo Javanmardian, and Sanjay B. Saxena, *s+b,* Autumn 2009, for a description of how such savings were realized in the Healthcare of the Future experiment run in the state of Florida.)

Cost alignment will be another important component of cost control. Acquisition costs, whether through a broker or alternative distribution channels, should be aligned with the expected lifetime profitability of the customer, and service levels can be tailored to meet customer preferences to avoid under- or over-serving specific segments. For example, affluent customers may desire concierge service whereas Gen Y customers may prefer self-service via online channels.

The greatest cost management challenge for most insurers will be developing a viable B2C retail business without disrupting their profitable, group-based B2B business. The new retail market will require a low-cost model, but existing B2B organizations often carry legacies in terms of culture, structure, and process that are not consistent with a low-cost model. Running two models simultaneously has proven challenging in other industries: Witness the inability of Daimler-

Chrysler to profitably straddle the high- and low-end automotive market and the failure of low-cost ventures among the major airlines, including Continental Lite, United's Ted, and Delta's Song.

These failures can be avoided if health plans resist the temptation to stretch their current models in an effort to straddle the B2C and B2B markets. Instead, they should consider several critical strategic choices for the retail market. They all will have a major impact on cost. These include:

- Where the new B2C business should be housed — whether it should be embedded in the existing business, developed as a separate business unit, or organized as a subsidiary.
- Which functions should be considered core and which noncore, including which parts of the value chain should be retained and developed to best-in-class levels and which parts can be outsourced or offshored.
- Whether in-house capabilities should be shared or owned, including where they should reside within the organization.
- Which new retail market skill sets need to be assembled through outside hiring and which through retraining existing personnel.

Start Now

It will require a long-term, transformational change effort and an iterative approach to create the models and build the capabilities needed to capture the opportunities and mitigate the risks posed by health reform. Health plans that choose to compete in the retail market should begin the journey today.

The priorities for the coming months are clear: Health plans should define and develop their approach to the new market by undertaking five initiatives.

1. Decide where and how to participate. They should identify the attractive business and consumer segments in which they will compete and begin developing a robust understanding of consumer needs within these segments in order to define the right to win and capabilities required.

2. Audit the existing brand and start building a retail brand. They should conduct an audit to understand their current brand equity, define the brand in the new retail market, and begin creating a retail brand strategy.

3. Select a retail operating model. They should identify the capabilities needed to compete in the new market and decide how to develop them and where in the company to house them.

4. Create a risk management approach for individuals. Health plans should understand what levers are available to identify consumer risk prior to purchase, and assess medical management and network management strategies to manage risk post-purchase.

5. Begin aggressive administrative and medical cost management efforts. Plans will need to operate profitably in lower-price-point environments, while freeing up funding for investments in new capabilities.

Forward-looking insurers are already acting on these initiatives. They know that the new retail era offers valuable opportunities for companies that are prepared to get up close and personal with consumers — and great risk for those that are not. +

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