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# Redefining the Healthcare Consumer

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Consider the popular image of general practitioners (GPs) in the middle of the 20th century: They watched over pregnancies, delivered babies, made house calls when children got the measles, discreetly offered advice on everything from alcoholism to psychological problems, cared for patients as they aged, sat at their deathbeds, and consoled their survivors. Their relationship with patients was direct and unmediated by either insurance companies or the government, and thus they knew those patients—their medical histories, their approach to medical care, their financial situations. And the GPs could act directly on that knowledge in providing the best medical care that they, and the current medical technology, could provide.

It may be that the wise, avuncular GP never really existed in quite the way we picture him. Still, the image of the Marcus Welby–like family doctor of old embodied the business-to-consumer (B2C) model of healthcare at its best. Now compare that with the current state of healthcare in the United States, where any number of middlemen, including insurance companies, the federal and state governments, employers, drug companies, and hospitals stand between patients and their doctors. It is a business-to-business (B2B) model, in which payers sell insurance to employers, who then offer it, with little or no choice, to employees. The B2B model turns the employer into the consumer and creates a convoluted relationship between patient and provider that makes no one particularly happy.

This misalignment of interests in the healthcare industry is showing signs of a breakdown. Employers are increasingly unable and unwilling to bear their historical share of the costs of health insurance. It was once a given that all but the smallest companies provided healthcare coverage to their full-time employees; today, according to various sources, only about 60 percent of employers offer coverage for active employees—and that number is shrinking. Payers, the insurance companies and government programs that support the system, are also struggling with mounting costs and complexity.

It's all part of a shift from a wholesale to a retail healthcare system, in which market forces will require that patients take a more active role in determining the kind of healthcare they need and how much they should pay for it. We're already seeing that trend emerge as some employers drop healthcare coverage altogether and others move to consumer-directed healthcare plans (CDHPs)—high-deductible policies usually coupled with healthcare-oriented savings plans—or explore other ways to shift costs to employees within conventional plans. In this environment, consumers are being made to take on more of the decision making and financial responsibility for their own healthcare.

To survive in the brave new world of retail-oriented healthcare, payers and suppliers must retool their businesses to allow consumers to make their

own choices about healthcare. For this shift to be successful, payers and suppliers must develop competitively priced offerings and tailored value propositions that speak directly to their consumers' needs, preferences, and ability to pay. The one-size-fits-all wholesale model, in which employers decide which benefits they'll offer regardless of employees' age, financial status, and health, will no longer work. Payers will not only need to work with employers to tailor offerings at the individual employee level (B2B2C) but also be able to sell to a growing segment of consumers who purchase health insurance directly (B2C), and thus do a better job of meeting consumers' needs. (We refer to a B2C model below, but the lessons are equally applicable to a hybrid B2B2C model.) In the new consumer-centric world, healthcare players must all become, in effect, 21st-century Marcus Welbys.

### Three Constants of Health Consumers

In the B2B healthcare environment, payers could satisfy employers with a relatively narrow array of offerings, but in the B2C and hybrid B2B2C environment, they will have to serve consumers with a menu of products more closely tailored to their evolving needs. This approach allows payers to avoid over- or under-delivering to various segments of the market and should, in turn, improve payers' profitability as they connect pricing to product features that are most valued by different consumer segments.

Even so, our research and client work suggest that consumers in all segments are looking for the same three critical elements in their health plans. To thrive in the consumer-oriented environment, healthcare players, both suppliers and providers, will have to address those requirements to build a strong and lasting consumer base.

**Value.** Healthcare is increasingly expensive. In this evolving environment, consumers want to pay for just the features they want and nothing more. Consumers weigh many considerations, such as price, quality, and

service, when deciding what they want and how much to pay for it. Today, however, choices are presented in a sort of "black box" of benefits and options, with no easy way to sort out their relative value. Every consumer is looking for a transparent value proposition that makes sense, reduces complexity, and provides clear choices and options. To that end, payers need to price their offerings to be competitive and affordable while adding value in the form of more modular options, such as variable packages of doctor visits, hospital coverage, co-pays, and deductibles, or bundled packages of benefits that are designed for different segments.

**Simplicity.** Everyone knows how hard it is to understand and make use of health plan benefits. Complexity pervades the healthcare system, from applying for insurance, to filing claims, to managing the mountains of "benefits received" paperwork. Our surveys show that, after value, simplicity is the most highly prized feature in healthcare and consumers will require it. For instance, does the payer offer easily accessible information about products, coverage, and costs that is consistent and accurate? Are coverage amounts and the claims process transparent? Can most issues be resolved with a single phone call? Does the payer have an easily navigated, informative Web site? Any company that can reduce the complexity of healthcare and health insurance will have a clear market edge over competitors.

**Trust.** One's health is an anxiety-provoking issue, even at the best of times. A primary goal of health insurance, of course, is to help relieve some of that anxiety, by helping consumers through the financial and medical perils of health problems. That's why our research found that trust is a significant matter to healthcare consumers. Yet we also found that trust is rarely associated with health payers and suppliers. Why should consumers trust their insurance company to give them good medical advice if, for instance, it can't even process their claims promptly and coherently? Trust is the product of a variety of

factors. Claims must be paid in a timely fashion, as promised. Customer service representatives must demonstrate empathy and dedication in their dealings with customers; they must provide consistent, reliable information and helpful advice as the customer's needs change due to aging or other life events. Such qualities can help burnish a payer's brand; without that reputation, consumer loyalty will be virtually impossible to maintain. The challenge, obviously, is how to build that trust.

These three constants are simply the baseline. Insurance companies, other suppliers, and providers will need to know a great deal more about the consumers they are trying to serve: Who are they? What kind of healthcare do they want and need, and how does that change over time? What do they value in a health plan? How do they want it delivered? How much can they pay? And how do they want to get information about their healthcare choices? This level of consumer segmentation may be a mainstay of market analysis in such industries as financial services and consumer products, but it is coming late to healthcare. Yet the ability of the payers, suppliers, and intermediaries in the healthcare sector to survive and thrive in an increasingly competitive market will depend in great part on their getting complete and accurate answers to these questions. Moreover, payers and suppliers must use market intelligence to anticipate and provide the products and services that best fit the wants and needs of their consumers. And it's vital that they tailor their value propositions accordingly: Beyond the product or service itself, the value proposition also includes price, distribution channel, service, and promotion. These are the keys to nurturing a relationship with consumers that transcends age and circumstance and creates "customers for life."

### **Segmenting the Consumer**

We have worked with a number of major payers to develop segmentation frameworks that are both empirically grounded and easy to act on. For one health plan, we worked with Harris Interactive to

conduct 17 focus groups and more than 3,000 telephone interviews to get an in-depth, refined view of how health needs differ by life stage. We talked directly to individual buyers of health insurance to understand what drives their purchases, what benefits they require, how best to communicate with them, and how to cement their loyalty.

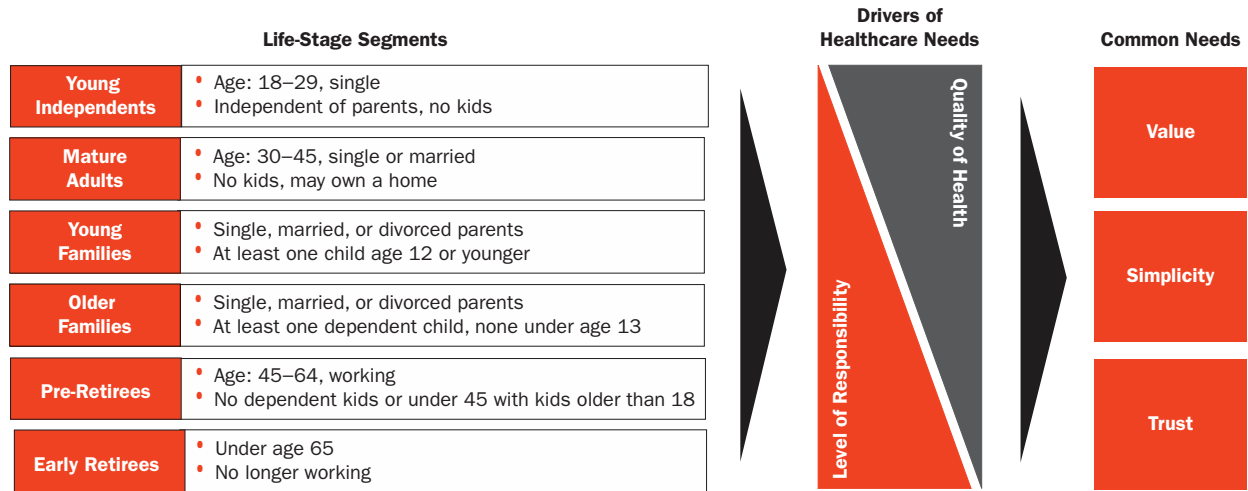
In our research, we identified six life-stage segments based on age, financial status, and level of family responsibility. Significant life events, such as marriage, having kids, changing or losing jobs, and changes in health status, correlate strongly with changes in the need for healthcare services. For example, a healthy young single adult just starting his or her career has both different insurance needs and different financial resources than an aging, married empty-nester in his or her 50s. Understanding what each of these consumer segments is looking for and how they differ from one another is indispensable to tailoring value propositions that will hit home in the retail healthcare market and address each consumer's needs as he or she moves through life (see Exhibit 1, page 4).

**Young Independents.** These individuals are typically between 18 and 29 years old, have moved out of their parents' house, and are no longer covered by their parents' health insurance policies. They've graduated from college and bought their first car, and they're starting their first full-time job. Retirement—and saving for that distant event—is too far away to contemplate seriously. They haven't gotten married yet, and they're generally very healthy. Also dubbed "young immortals" in the industry, they often regard health insurance as an option rather than a necessity, despite their active, even risky, lifestyles. Still, as a group, they are the most likely to purchase individual healthcare policies; 24 percent of Young Independents do so, compared with just 8 percent of the overall population.

When Young Independents do look for health insurance, they want policies that fit their lifestyles and cover their typical concerns—maintaining their good health and their appearance. Price matters greatly to

**Exhibit 1**

## Life Stages of Healthcare Consumers



Source: Booz Allen Hamilton

them, naturally, given their typically lower incomes, and so does flexibility: They are selective about policy features and are unlikely to purchase comprehensive coverage. They're most likely to choose high-deductible major-medical policies that cover catastrophic health problems, as well as certain preventive care and wellness programs, birth control, a reasonable number of doctor visits, and dental care. They want large networks that allow them to access care whenever and wherever they find themselves in their busy lives. And they can't be bothered with complicated policies and claims systems.

The challenge for payers is to get Young Independents to recognize the need for healthcare products and services. They tend to be impervious to messages about healthcare, so reaching them is not easy. High-impact messages might include such information as the cost of a burst appendix or a sports injury—messages that won't seem irrelevant to Young Independents or scare them off. Payers must also find high-impact venues for delivering their messages: outdoor billboards, for example, or via parents.

Attitudes toward health insurance among Young Independents can change quickly if they or someone close to them gets sick or suffers an accident. But the

most important trigger in changing their view of health insurance is getting married.

**Mature Adults.** An increasing sense of responsibility is the primary attribute of the Mature Adult, who typically falls between the ages of 30 and 45. Thus the importance of marriage as a triggering event—now they're no longer quite so independent. In addition to tying the knot, Mature Adults are typically more comfortably established in their careers, they're making more money, and they may have bought a house with an eye to having children. But many of their health concerns remain the same: maintaining their overall high level of health, keeping up their appearance, and avoiding accidents and problems related to their active lifestyles.

In many ways, Mature Adults may be the most financially secure of all the life-stage segments. Their income levels are higher and they have relatively few long-term financial commitments. Thus, Mature Adults are somewhat less sensitive to price when shopping for health insurance. Unlike most Young Independents, they have assets to protect, so they want a sensible plan that offers reasonable out-of-pocket costs. But given the likelihood of greater use, they are willing to pay higher monthly premiums to get more coverage.

They're also open to lower-cost care options, such as consulting a nurse instead of a doctor in certain situations. And they're still looking for coverage of such items as birth control and dental care, and prescription coverage is beginning to matter more.

For Mature Adults, all roads are leading to the most significant life-stage trigger of all: having children.

**Young Families.** Having children changes everything. Young Families, typically adults ages 24 to 45 with at least one child under the age of 13, have a wholly different set of priorities. Maintaining that active, carefree lifestyle is suddenly no longer as important—and who has the energy? Often both parents in Young Families are working, and the rest of their time and effort is dedicated to the children—keeping them healthy and happy and planning and saving for their education. Meanwhile, their own parents are aging, which leads to an entirely new set of healthcare and financial concerns. Suddenly their own healthcare concerns begin to pale in comparison with all these new responsibilities.

Given these trying circumstances, it's no wonder that Young Families may focus narrowly on their children when considering health insurance. But they also need to keep things simple and reduce their stress levels. So they look for plans offering comprehensive coverage and a strong and broad network of doctors that gives them easy access to specialists such as pediatricians and orthodontists. They demand the ability to get excellent medical advice and information for their children (and for their aging parents, even though they may be covered by Medicare). Because families with young children visit doctors more frequently, these consumers want low co-pays.

Young Families have much to worry about, but as the children grow older, some relief is in sight.

**Older Families.** The children of Older Families have entered their teens, and they've grown much more independent. That's good, in many ways. Their parents, typically between the ages of 34 and 45, now worry less

about childhood illness than about the teen's active lifestyle. Teenagers are learning to drive, getting their first jobs, and behaving in ways that are much riskier than when they were younger. They're also dealing with such concerns as acne, drugs, and sexual issues. All that means more stress for their parents, who also have plenty of other things to worry about: Their careers are advancing and their income is rising, but college must be paid for, retirement concerns are growing, and their own parents aren't getting any younger.

When Older Families go shopping for health insurance, they remain less sensitive to paying premium prices for their children's insurance than for their own, but comprehensive coverage for their children is no longer as important as major-medical and accident insurance. Still, these consumers typically require such specialist services as dermatology and orthodontics for their teenage children, and help for themselves with relieving the stress of being parents of teenagers. They are also getting older, which means increasing concerns about dental and vision care, and a growing interest in long-term disability insurance. Moreover, the responsibility of caring for an aging parent is a constant reminder that they need to take care of themselves and save for their own retirement.

The relief of getting their children safely through the teenage years will be reflected in their changing needs as they enter the next life stage.

**Pre-Retirees.** Compared with Older Families, Pre-Retirees—anywhere from about 45 to 64 years old—have it relatively easy. Their children are off to college or their first real jobs and are beginning to purchase their own health insurance. So the parents can now concentrate on their own needs. Financially, they are most concerned with protecting their nest eggs and preparing themselves for retirement. Will they be healthy enough to enjoy the active, retired lifestyle they've worked so hard to attain, especially given that life spans are getting longer? And will they have enough money when they come to need long-term care?

Even though their own health is now their primary concern, Pre-Retirees remain very price-sensitive—no surprise, given all their financial obligations. What matters to them is maintaining their health while limiting their out-of-pocket expenses and that requires a comprehensive plan that includes both major-medical and doctor visits and covers preexisting conditions as well as dental, vision, and long-term disability.

**Early Retirees.** Early Retirees carry over into their retired lives many of the same concerns as Pre-Retirees. Early Retirees—those under 65—want to lead active lives now that they're no longer working, so their health matters to them a great deal. But financial concerns can impinge on their freedom. They're now dependent on a fixed retirement income and concerned about how to pay for increasing medical care needs. The nest egg needs to last longer and tide them over until Medicare kicks in and even beyond that. Thus, they're usually more risk averse than Pre-Retirees.

Under these circumstances, comprehensive major-medical coverage is essential to Early Retirees, and it should cover preexisting conditions and provide decent prescription benefits. With premiums at this stage hitting US\$1,000 to \$1,500 per month, Early Retirees want to get a good grip on their overall healthcare costs, given their fixed incomes. As long as they're covered for major medical, they may be willing to forgo nonessential ancillary coverage, including preventive care, which they are typically more willing to pay out of their own pockets. At the same time, Early Retirees would also like to cap their out-of-pocket expenses through a maximum that protects them in case of severe illness or injury.

It should be noted that life stage is only one dimension along which consumer needs can be segmented. Research shows that there are other dimensions—many of which can be used in conjunction with life stage—that can be equally powerful. For example, income or wealth is a good index of an individual's willingness to spend on healthcare. A wealthier Young Independent may be more willing to purchase

comprehensive health insurance than a less well-to-do Pre-Retiree. Other types of segmentation are keyed to an individual's attitude toward health and wellness—frequency of gym visits, for example, or reliance on traditional versus nontraditional care providers—but measuring attitude in the healthcare context is tremendously complicated and expensive. For that reason, we believe life stage is the best foundation for healthcare segmentation.

### **Leveraging Segmentation**

Having laid out the consumer segments that payers, providers, and suppliers will have to serve, the next step is to figure out how best to serve them. What kinds of products are the members of each segment interested in? How much are they willing to pay? What's the best way to distribute those products? And what's the most effective means of promoting those products or educating consumers? The ultimate answers to these questions will vary according to payers' strategic goals—do they want to focus on one or two segments or nurture customers as they transition across life stages?

One key difference across segments is channel preference—how health insurance consumers prefer to receive information, make purchases, and submit and monitor claims. As in retail banking, most healthcare consumers typically use multiple channels—directly from the company, via the phone, over the Internet, or through agents—and they use them for different purposes. Payers' Web sites have been successful at providing information but have been less successful as sales and transaction channels. For sales, people prefer direct contact with the payer, though independent insurance agents remain popular, especially with older consumers. (Some health plans are experimenting with direct channels such as retail stores that enable one-on-one customer interactions.) For claims transactions and the like, most people prefer to speak to the payer's customer service representative. Each consumer segment is different, and marketers need to understand what each group

values (Is price more important than convenience? How important is the personal touch?) and how these attitudes will affect the buying process. These are the questions that payers, suppliers, and providers need to explore in fine-tuning their channel mix, asking themselves whether they're tapping into the most effective channels to reach each target segment.

How inventively players can put all this information together, developing the right product at the right price, and promoting and delivering it through the right channels, will determine how they succeed in the new retail healthcare environment. Tonik.com, a Web site that sells low-cost, high-deductible, individual health insurance to Young Independents, is a case in point. Owned by WellPoint Inc., the Indianapolis, Ind.-based marketer of Blue Cross Blue Shield plans, Tonik.com has been very successful, signing up hundreds of thousands of previously uninsured people at rates as low as \$67 a month, in just the past few years. Tonik's sales effort is focused on the Web, a highly cost-effective channel that its target audience is particularly comfortable with, and it uses clever marketing to reach its intended audience. Different products are marketed to different subsegments, such as Thrill-Seekers and Part-Time Daredevils, and the site likes to advertise at places like ski resorts, where its intended audience might be forced to face the need for health insurance. Such plans won't work for everyone, of course—but that's the point. WellPoint was spot-on with its value proposition, tailoring a complete package to a particular audience and executing against its plan with great effectiveness by building deep capabilities to serve that segment.

### **Customers for Life**

The single most important factor in generating sustainable revenues and profits in the B2C environment is customer retention. The longer a payer can hold onto a consumer as that consumer's healthcare needs change and ability to pay increase, the more profitable over time that consumer will be.

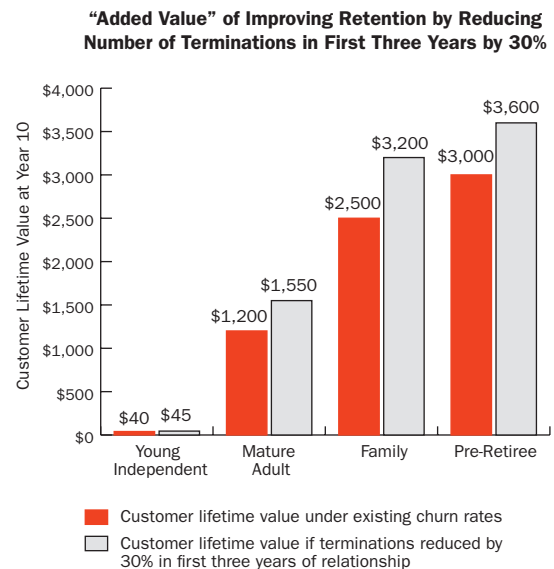
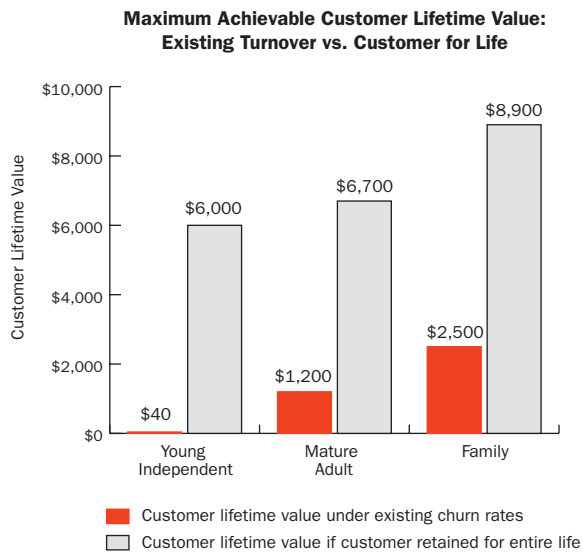
Unfortunately, according to our surveys, loyalty in the healthcare business is driven largely by price, because in the absence of other points of differentiation, such as simplicity and trust, consumers have no other way of distinguishing one plan from another. But price is a weak foundation on which to build long-term customer relationships. Individual customers of one large payer we studied stayed with the company for just two to four years, depending on the customer's age, and the youngest were jumping the soonest. In fact, only about 40 percent of customers in the Young Independents segment stayed with the company for more than two years. Yet if those same customers could be retained for longer, the added benefit to the payer would be enormous. The lifetime value of Young Independents would jump from just \$40 at current churn rates to \$6,000 if retained for life, while the value of a family would rise from \$2,500 to \$8,900 (see Exhibit 2, page 8).

How can customers be induced to stay longer? Take a cue from USAA, the San Antonio, Texas, insurance and banking firm for military personnel. It is the gold standard in understanding who its customers are and then anticipating their evolving needs and marketing to them accordingly. Thanks to competitive rates and outstanding customer service—which includes a highly trained customer service staff and an effective process for capturing customer feedback—the company commands unprecedented loyalty. As of 2004, nearly 80 percent of its 5.4 million members had been with the firm for more than five years.

USAA has created value propositions tailored to each of its customer life-stage segments—marriage, military deployment, discharge, and so forth—and it has the deep insight to anticipate its customers' changing needs as they move from one life stage to the other. USAA's customer service representatives—15 percent of whom are former military personnel—are superbly equipped to provide just the right kind of service. They know what their customers need, how they want the products delivered, and how they expect to be treated—

**Exhibit 2**

## Value of Increased Retention



Source: Booz Allen Hamilton

all important factors in customer retention. It is this insight and constant attention to the individual’s evolving needs that help USAA nurture customers for life.

Can healthcare payers and suppliers achieve similar results? Yes, but it will require the development of integrated product offerings that are tailored specifically to the needs, values, preferences, and behavior of every consumer segment. One approach might be to develop a single core product—equivalent to the financial-services industry’s checking account or financial statement—that will encourage stickiness, and then cross-sell other products such as a monthly health finance statement that will tie consumers more tightly to their payers.

Doing this sort of thing will require a major transformation of the healthcare payer business model to one that takes its lead from the market itself. That

means creating the means to act nimbly to develop new products in the face of changing technology, market conditions, and consumer expectations. It means making bets on how far the industry will move toward a retail market, and what role it wants to play in this new healthcare value chain. It means gaining a much better understanding of who the consumers are, and developing the research capabilities to do so. And it means building new sales and marketing capabilities to promote these new value propositions.

The coming retail market for healthcare will be driven by consumers with very high expectations of what their healthcare suppliers, payers, and intermediaries can do for them as individuals. Successful players must be able to meet those expectations quickly, flexibly, and cost-effectively. In such a competitive market, there will be no alternative.

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