Winning with consumers: What payors can learn from ‘consumer’ companies

Top consumer companies use a similar set of five strategies to engage consumers. They perform well in all five areas but chose to be distinctive in only one or two. Payors should follow a similar approach to win with consumers.

If payors are to win in today’s healthcare world, they must become more consumer-centric. But how can they best make this transition, given that they have not had to focus on consumers in the past? To help answer this question, we investigated more than 75 leading consumer companies to identify the methods they use to engage consumers effectively. We then reviewed McKinsey’s extensive research into how consumers’ healthcare-related behaviors are changing to determine whether those methods might help payors address the challenges ahead.¹

We found that the top consumer companies use a similar set of approaches to engage consumers. The approaches focus on five areas: customer experience/branding, channel excellence (acquisition), consumer value management, risk management, and product design/innovation. However, none of the consumer companies attempt to excel in all five. Rather, each makes sure it can perform reasonably well in all areas and chooses to be distinctive in only one or two. We believe payors should follow a similar approach to win with consumers.

Customer experience/branding

Companies focusing on consumer experience establish a brand image carefully tailored to the customer segments they want to serve. They know that customer satisfaction depends on how closely actual experience meets expectations—and expectations are largely determined by brand promises. Thus, corporate culture, investment decisions, and the metrics used to gauge performance are centered on the brand.

Companies at all price points—even value players—can succeed with this approach as long as they deliver on their brand promises. For example, both Ritz Carlton and Hampton Inn have extremely high customer satisfaction ratings. The two chains focus on very different market segments, yet both have above-average occupancy rates and performance. Ritz Carlton claims that it is “the gold standard in hospitality.” To ensure that its guests receive the premium services they expect, the company gives its frontline staff considerable autonomy. Even its housekeepers are authorized to comp guests to a new room (up to $2,000 in value) if a problem arises. In contrast, Hampton Inn promises to deliver “a great stay … a great value.” It offers rooms that are clean, comfortable, and inexpensive, and makes sure that its check-in and check-out procedures are as efficient as possible.

Customer satisfaction is becoming increasingly important for payors. For example, when we surveyed consumers with individual coverage, we found that those in the top quartile of satisfaction with their health insurer were about 60

¹More details about all of the research discussed in this article can be found in the appendix, which begins on p. 11.
should then develop detailed insights into each segment’s needs and attitudes, which can differ significantly. In our consumer research, for example, about 70 percent of respondents likened health insurance to auto insurance (“just there if I get into an accident”), but 30 percent compared health insurance to cell phone minutes (“I paid for them and should use them”).

Next, payors should identify the factors most likely to drive desired business outcomes in the chosen segments and shift investments to the most important areas. Strong brand affinity, for example, often translates into willingness to pay more for products. (In our public exchange simulations, a leading brand’s product received the highest market share in 41% of simulations, even when it was not the lowest-price product.) Thus, it may make more sense to spend on getting communications right than on lowering call-center answering speed.

percent more likely to recommend their insurer to others than were those with an average level of satisfaction, and they were 40 percent more likely to purchase additional products from the company.

However, most payors do not currently have brand messaging geared to members’ expectations. Our research shows that most consumers use financially oriented terms (e.g., coverage and benefits, financial value, claims and billing experience) to describe what they want from payors (Exhibit 1). Yet in their mission statements, most payors position themselves as partners in care (Exhibit 2). This disconnect may help explain why payors scored poorly in our consumer satisfaction survey (Exhibit 3).

Payors that want to focus on customer experience/branding should begin by identifying which consumer segments they wish to target. They should then develop detailed insights into each segment’s needs and attitudes, which can differ significantly. In our consumer research, for example, about 70 percent of respondents likened health insurance to auto insurance (“just there if I get into an accident”), but 30 percent compared health insurance to cell phone minutes (“I paid for them and should use them”).

Derived importance is a standard analytical technique that predicts the importance of each driver on a consumer’s overall satisfaction (for example, if they rated peace of mind as 3 out of 10 and their overall satisfaction was 9 out of 10, then peace of mind is probably not very important).

Customer health empowerment includes satisfaction from being able to stay healthy and have the most control over health.


EXHIBIT 1 Consumers are looking for payors to be their financial partners for health-related expenses

Derived importance of drivers of satisfaction for health insurers

<table>
<thead>
<tr>
<th>Purchase and renewal</th>
<th>Peace of mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health management and wellness</td>
<td>INSURER BRAND</td>
</tr>
<tr>
<td>Financial value</td>
<td>COVERAGE AND BENEFITS</td>
</tr>
<tr>
<td>Claims and billing experience</td>
<td></td>
</tr>
</tbody>
</table>

1Derived importance is a standard analytical technique that predicts the importance of each driver on a consumer’s overall satisfaction (for example, if they rated peace of mind as 3 out of 10 and their overall satisfaction was 9 out of 10, then peace of mind is probably not very important).

2Customer health empowerment includes satisfaction from being able to stay healthy and have the most control over health.
Although payors should seek to minimize factors that could lead to customer dissatisfaction, they should focus their investments in a few areas that will delight customers and strengthen brand loyalty (for example, giving people the sense that they are empowered to manage their own health). The areas to focus on will depend on the brand and chosen customer segments. For example, access guarantees are likely to be much more important when a brand promises peace of mind than when a brand focuses on financial value.

Channel excellence (acquisition)

Some consumer companies use multiple channels (including partnerships) in sophisticated ways both to increase demand for their products and to fulfill that demand. These companies realize that in today’s world, all channels must be closely integrated. They know that consumer preferences for how to obtain information and make purchases often vary, and their channel

EXHIBIT 2 Most insurers are positioning themselves as partners in care

Mission statements of health insurers¹

¹Mission statements of top-20 health insurers by market share.
Source: Company websites, 2013
strategy takes those variations into account. At the same time, they monitor the return on investment in each channel closely.

American Express, for example, uses a range of channels to market its cards, including direct mail, email, partnerships, web widgets, and live events. It monitors the performance of each channel carefully and is particularly sophisticated in how it uses information about its members’ digital behavior to guide its digital strategy. Amex has also developed innovative programs that tie its digital and retail channels together in win-win arrangements that create value for two sets of its core customers: end-consumers and merchants. For example, it has partnered with Twitter to give cardholders immediate discounts at certain merchants when they tweet with an Amex hashtag. Similar programs are in place with Foursquare and Facebook to provide discounts and targeted offers to members. By creating value for both sides of its business, Amex is able to drive word of mouth, while simultaneously generating higher merchant processing fees.

Our consumer research indicates that, at present, there is no single path people are taking to investigate and buy health insurance—most of them consult a range of sources. The channels used most often (usually in combination) were:

• Online sources, such as insurance company websites (44%), web searches (39%), and web insurance portals (31%)
• Mailings (38%)

EXHIBIT 3

The health insurance industry lags in customer satisfaction

<table>
<thead>
<tr>
<th>2013 rank</th>
<th>Industry</th>
<th>Customer satisfaction, average score¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Brokerage</td>
<td>8.59</td>
</tr>
<tr>
<td>2</td>
<td>Auto insurance</td>
<td>8.52</td>
</tr>
<tr>
<td>3</td>
<td>Retail</td>
<td>8.41</td>
</tr>
<tr>
<td>4</td>
<td>Banking</td>
<td>8.35</td>
</tr>
<tr>
<td>5</td>
<td>Physician/specialist</td>
<td>8.33</td>
</tr>
<tr>
<td>6</td>
<td>Hotel</td>
<td>8.28</td>
</tr>
<tr>
<td>7</td>
<td>Mobile phone</td>
<td>7.89</td>
</tr>
<tr>
<td>8</td>
<td>Airline</td>
<td>7.88</td>
</tr>
<tr>
<td>9</td>
<td>Utilities</td>
<td>7.82</td>
</tr>
<tr>
<td>10</td>
<td>Phone</td>
<td>7.73</td>
</tr>
<tr>
<td>11</td>
<td>Postal</td>
<td>7.71</td>
</tr>
<tr>
<td>12</td>
<td>Health insurance</td>
<td>7.71</td>
</tr>
<tr>
<td>13</td>
<td>Internet</td>
<td>7.66</td>
</tr>
<tr>
<td>14</td>
<td>Pay TV</td>
<td>7.55</td>
</tr>
<tr>
<td>15</td>
<td>Healthcare provider (facility)</td>
<td>7.39</td>
</tr>
</tbody>
</table>

¹Customer satisfaction was measured on a scale of 1 to 10; includes up to three companies per industry per respondent.
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• Recommendations from friends, family, or colleagues (36%)
• Phone calls to either an insurance company representative (25%) or an agent/broker (27%)

Consumers have different expectations for the different channels, and those expectations often vary depending on where the consumers are in the purchase journey. For example, most consumers visit payor websites to get information, but only a minority of them (those who put a premium on ease of experience) currently buy insurance there. The number of clicks required to complete a transaction is important for website sales, but for brokers, attempts to sell too quickly can backfire. (Broker sales are driven primarily by relationships and the desire for advice.)

Differences such as these have important implications for how each channel is constructed. A payor’s website, for example, should provide a breadth of information, a quick path to purchase for consumers who know what they want to buy, and links to other resources (such as brokers and telesales reps) for consumers who prefer human contact.

As the number of channels expands, integration becomes increasingly important, because all channels should deliver a consistent message. Most consumers are likely to require multiple interactions in different channels before they purchase a health insurance plan, and payors will need to be able to track consumers across channels (and products) and follow up with them to ensure that as few sales as possible are lost.

Most payors that want to focus on channel excellence will have to increase the breadth of their channel mix. All such payors will have to measure channel performance closely and ensure that their marketing mix is driving sales to the right channels. Our research shows that most payors’ marketing mix is misaligned—for example, almost two-thirds of payors’ marketing spending is currently allocated to television, yet TV ads trigger only a minority of sales. Our experience suggests that with a broader set of channels, a more focused marketing mix, and the processes and tools needed to monitor performance, online and telesales can be increased by 15 to 35 percent.

Consumer value management

Some companies gain competitive advantage by maximizing the lifetime value (LTV) of their customers. These companies offer a suite of products designed to address specific consumer needs at different stages of life so that they can increase loyalty and the overall number of products sold. They also often offer reward programs to strengthen loyalty and use well-timed contacts with customers to further boost sales. These companies have sophisticated retention programs that reduce churn both proactively and reactively, thus increasing customer LTV.

A leading telecommunications company, for example, mines its data to improve its interactions with consumers at every touch point, from the initial sale onward. It monitors when customers make repeated service calls and uses speech analytics to flag when they mention competitors more than once on those calls, because the risk that these customers will churn is appreciably higher than average. The company also provides its telesales reps with personalized “people like you” up-sell recommendations about additional television programs to offer each customer. The company goes even further by arming the telesales reps with clips of these shows that can be emailed to customers while they are still on the phone.
For payors, the risk of churn in their individual and group books of business increases when members become eligible for Medicare. Our research indicates, for example, that more than half of all consumers turning 65 switch health insurers, often because they do not clearly understand what options they have. Payors could use a number of tactics to educate these consumers and ease their transition into a Medicare Advantage, Medicare Part D, or Medicare Supplement plan. For example, they could transfer service calls from such customers to telesales reps who specialize in the Medicare transition or sponsor worksite educational events about Medicare options.

To maximize LTV, payors should utilize a range of levers with each customer. For example, they should attempt to up-sell/cross-sell, perhaps by bundling financial or life products with a health insurance plan. To improve retention rates, they should encourage customers to enroll in auto-payment programs, implement “save desks” for members likely to churn, and develop management programs for members who are late on payments.

In all cases, the key is to make the most of every customer touch point, from the initial sale onwards. To achieve this goal, the frontline staff must be armed with simple tools so that they know what to do in each situation— and why. For example, the sales staff should have a tool that allows them to identify which products to attempt to up-sell to a customer. The claims staff should have tools that enable them to resolve customers’ claims concerns while also identifying whether the customers are late on payment or are likely to churn; the staff could then encourage those customers to enroll in auto-payment programs or transfer them to “save desks” to help increase retention.

Sophisticated analytic models can be used to support the frontline staff. These models can, for example, identify the customers most likely to take a given action (make a purchase, churn, etc.) so that the frontline staff can take the appropriate steps to increase LTV.

**Risk management**

Companies that excel at risk management are able to accurately identify and attract a sustainable mix of customer profiles through strategic consumer segmentation. They then use that segmentation to differentiate how they manage customers as those people move through different events and experiences. These companies are able to price products effectively so that they can balance consumer attraction and retention, and they can steer customers to the right products given their profiles, which improves both the customers’ experience and the companies’ performance.

Progressive, an auto insurer, is an expert in this area. It designs its interactions with customers so that they are consumer-friendly but also allow the company to better understand its customer economics and control costs. For example, Progressive offers customers a device that tracks their driving habits. This device permits people with low-risk driving habits to earn significant discounts, but it also allows the company to gauge the risk profile of all device users.

To ensure the accuracy of its risk profiles, Progressive drills deep into its data. Many auto insurers, for example, place all motorcyclists in a high-risk category. By mining its data, Progressive discovered that many Harley Davidson owners are over age 40, seldom ride their bikes, and are attractive prospects for insurance.
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analytical abilities to better understand cost drivers, member-level economics, consumer behavior, and competitive activities. Just one example: the range of member profitability within the hierarchical condition categories (HCCs) used for commercial risk adjustment will be large. Understanding the cost drivers of this variation will enable payors to better manage the risk for each particular HCC.

Progressive also offers its customers a concierge service to help with accident claims. The service handles all repairs and paperwork, and it provides a rental car while the repairs are being done. The service is a convenience for customers but also helps Progressive maintain tighter control over repair and claims costs.

For payors, risk management is becoming increasingly important. In risk-adjusted lines of business (individual, small group, Medicare, and Medicaid), the relationship between a member’s risk score and that member’s value is complex, non-linear, and dependent on how the risk adjustment is done. For example, in the post-2014 individual market, average profitability may increase with risk scores, at least to a certain extent (Exhibit 4).

Payors that want to excel in such an environment will need to make a step change in their analytical abilities to better understand cost drivers, member-level economics, consumer behavior, and competitive activities. Just one example: the range of member profitability within the hierarchical condition categories (HCCs) used for commercial risk adjustment will be large. Understanding the cost drivers of this variation will enable payors to better manage the risk for each particular HCC.

This type of analytical thinking must be embedded end-to-end across the organization—from sales and marketing to care delivery. The objective should be to identify and act on areas that positively affect payor economics while simultaneously delivering something consumers view as valuable.

For example, a payor’s care management function must be able to develop a deep understanding of members’ risk profiles so that it can

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**EXHIBIT 4** Profitability of most member segments will change significantly post-reform

Individual-market member-level contribution margin by risk score and claims spend

<table>
<thead>
<tr>
<th>Claims spend</th>
<th>Below median</th>
<th>Above median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-reform</td>
<td>$8</td>
<td>$11</td>
</tr>
<tr>
<td>Post-reform</td>
<td>$140</td>
<td>$24</td>
</tr>
<tr>
<td>Pre-reform</td>
<td>$(176)</td>
<td>$54</td>
</tr>
<tr>
<td>Post-reform</td>
<td>$46</td>
<td>$71</td>
</tr>
</tbody>
</table>

1Does not include reinsurance or risk-corridor payments.

Source: McKinsey Advanced Health Analytics Roll Forward Model; data from Truven Health Analytics, Inc.

Pre-reform:
- $(176)
- $140
- $46

Post-reform:
- $54
- $24
- $71

$ PMPM, weighted by member months

1Does not include reinsurance or risk-corridor payments.
People would welcome the convenience of disposable mini-toothbrushes. P&G also follows a rigorous, insights-driven product development process that starts with consumers. To ensure that it stays focused on consumers’ unmet needs, it has created a 3D simulation of a retail store so that it can test how consumers will react to the most promising new ideas and then speed the launch of new products.

Payors now have a significant opportunity to introduce new products—not only because of health reform but also because of employers’ growing interest in defined contribution (DC) plans and private exchanges. Our research reveals that many families covered under DC plans may be willing to spend all of their funds and then pay more out of pocket to purchase supplemental products, including dental, vision, and disability insurance (Exhibit 5). It also suggests that the families willing to pay the most out of pocket are interested in both health-related and non-health-related products.

In our research, no product type was appealing to all consumers or even to all families, a finding that underscores the importance of deep insights into the needs of specific customer segments.

We have found, however, that most payors are still fairly slow to get innovations off the ground, often taking a year or more to launch a new product. They are also slow to modify their existing products; features change very little from one year to the next.

Payors should innovate more rapidly. They should begin with solid market research—the design of new products should be based on deep insights into consumers’ needs, likely...
future trends, and how a new product could alter consumers’ usage behavior. In addition, they should adopt a rapid-cycle approach to product design and launch. Greater transparency in healthcare is apt to shorten the lifespan of any competitive advantage, and thus the ability to bring new products to market quickly will become increasingly important. To support rapid-cycle design, payors will have to become more flexible and make greater use of modular systems that enable them to combine the right set of features based on consumer demand.

Perhaps most important, payors should adopt design-to-value (DTV) techniques (Exhibit 6). The DTV process involves two steps. First, as many non-value-adding features as possible are eliminated to minimize the cost to deliver. Then, value-adding features are put in—but only if the cost of including them can be justified either by what customers are willing to pay for them or by how much they can lower payors’ medical or administrative costs. DTV techniques will be especially important as payors develop new products for the large proportion of consumers who are price-sensitive.

No payor needs to master all five of these strategies—even leading consumer companies concentrate on just one or two. Instead, each payor

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**EXHIBIT 5** In defined contribution plans, many consumers with families are likely to spend the entire contribution plus more out of pocket

<table>
<thead>
<tr>
<th>Total average spending, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined contribution</td>
</tr>
<tr>
<td>Overall</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spending (in $), % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-pocket spending</td>
</tr>
<tr>
<td>&gt;1,000</td>
</tr>
<tr>
<td>500 – 999</td>
</tr>
<tr>
<td>0 – 499</td>
</tr>
<tr>
<td>0 – 499</td>
</tr>
<tr>
<td>Unspent defined contribution</td>
</tr>
<tr>
<td>&lt;0 – 249</td>
</tr>
<tr>
<td>&lt;250 – 749</td>
</tr>
<tr>
<td>&lt;750</td>
</tr>
<tr>
<td>&lt;750</td>
</tr>
</tbody>
</table>

- On average, respondents spent almost all the defined contribution (DC) amount allocated to them
- Employees with families were more apt to spend additional out-of-pocket funds to purchase coverage
- More than half of respondents with families spent out-of-pocket

The authors would like to thank the following individuals for their contributions: Shonu Gandhi, Lukasz Paszek, Mahi Rayasam, and Prashanth Reddy.

**Jenny Cordina** is a principal in the Detroit office (jenny_cordina@mckinsey.com). **Ali Keshavarz** is an expert associate principal in the New Jersey office (ali_keshavarz@mckinsey.com). **Rohit Kumar** is a consultant in the Chicago office (rohit_kumar@mckinsey.com). **Shubham Singhal**, a director in the Detroit office, leads the Health Systems and Services Practice in the Americas (shubham_singhal@mckinsey.com).

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### EXHIBIT 6
**Health insurers can use design-to-value techniques to create products consumers want**

<table>
<thead>
<tr>
<th>Current product</th>
<th>Access-induced utilization</th>
<th>Benefit-induced utilization</th>
<th>Selection effects of product design</th>
<th>Leakage</th>
<th>Lowest possible cost</th>
<th>AV delivered to specific target segments</th>
<th>Insurance elements with high perceived value</th>
<th>Differential services</th>
<th>Select supplemental</th>
<th>New product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>• Providing broader access than necessary</td>
<td>• Same copay for urgent care and ER care</td>
<td>• No chiropractic limits</td>
<td>• Claims adjudication</td>
<td>• Accident forgiveness</td>
<td>• Vanishing deductible</td>
<td>• Improved customer service</td>
<td>• Some aspects of vision</td>
<td>• Dental</td>
<td></td>
</tr>
<tr>
<td>Examples</td>
<td>• Limited pre-auth/UM</td>
<td>• Higher private-duty nursing limits</td>
<td>• Higher private-duty nursing limits</td>
<td>• Benefit giveaway</td>
<td>• Lower-cost prescriptions for drugs</td>
<td>• Wellness programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No wait period</td>
<td>• Richer formulary</td>
<td>• Richer formulary</td>
<td>• AV leak-age, AV creep</td>
<td>• Policy cancellation</td>
<td>• Policy cancellation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AV, actuarial value; ER, emergency room; pre-auth, pre-authorization; UM, utilization management.

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should build a basic level of competence in all areas but select one or two areas of focus. The choices made should be based on the payor’s current capabilities and talents and a realistic appraisal of which approaches would give it a competitive advantage. Once the choices are made, the payor should establish a vision of how it will differentiate itself (e.g., will it be a Ritz Carlton or a Hampton Inn?) and then rally the organization around this vision. In addition, it must make the necessary bets—large investments in both money and management time and energy—to ensure that it can reach its vision.
This article leverages proprietary research and analysis that McKinsey has conducted over the past 18 months. This appendix describes the major tools and data sources we used.

**McKinsey’s annual Customer Experience Survey**
McKinsey’s Customer Experience Survey is an annual survey of US consumers that focuses on customer satisfaction and its drivers. In 2013, about 27,000 consumers were surveyed across a range of industries, including healthcare payors and providers. Key highlights of the 2013 survey’s results include:

- Top-line satisfaction and net promoter scores for hundreds of specific companies
- Detailed models that illustrate what matters most for driving satisfaction, by industry
- “Mini journeys” that test consumer satisfaction throughout the customer lifecycle relationship

Payors can use the survey to understand where they stand on customer experience (in comparison with other payors and other industries), diagnose the major pain points their customers encounter, and identify high-value-creating interventions (both table stakes and differentiators).

**McKinsey’s research into leading consumer companies**
McKinsey’s Consumer Experience practice conducted research into 75 leading consumer companies to identify best practices in creating a strong consumer experience. The research included interviews to better understand how each company performs on different elements of consumer experience. Best practices were identified through those interviews as well as through McKinsey’s extensive experience serving clients on this topic.

**McKinsey’s annual Consumer Health Insights (CHI) survey**
This unique survey provides information on the opinions, preferences, and behaviors of thousands of consumers, as well as the environmental factors that influence their healthcare choices. It also enables insights into the current market environment and can be used to make predictions about the choices and trade-offs consumers are likely to make in the post-reform environment. The survey has been conducted every two years since 2007; this year’s survey included 7,000 respondents.

The CHI collects descriptive information on all individuals who participate in the survey and their households. It also assesses shopping behaviors; attitudes regarding health, healthcare, and the purchase and use of healthcare services; awareness of health reform; opinions about shopping for individual health insurance and using an insurance exchange; preferences for specific plan designs (including trade-offs among coverage features, such as benefits, network, ancillaries, service options, cost sharing, brand, and price); employee perceptions of the employer’s role in healthcare coverage;
attitudes about a broad range of related supplemental insurance products; opinions, use, and loyalty levels regarding healthcare providers; and attitudes and behaviors regarding pharmaceuticals and pharmacies.

We supplement the information from the CHI with data from other sources, such as information on a consumer’s estimated lifetime value to a payor, consumer behavior, and marketplace conditions. This combination provides a holistic view of healthcare consumers that is not available through other means.

We have used CHI data in a range of customized analyses that address both current and post-reform healthcare issues. We expect that payors and others will primarily use the information in applications that assist with product design, marketing strategies, consumer segmentation, consumer targeting, network configuration design, and assessment of new channel opportunities.

**McKinsey’s Consumer Exchange Simulation**

With this tool, users (typically, payors) design a suite of insurance products that can then be sold on a simulated online exchange. Consumers browse the exchange, which highlights information on premiums, deductibles, coverage tiers, and other key product attributes, before making a selection. As of the end of 2012, nearly 150,000 consumers across the United States had participated in simulations. On average, it takes each consumer about 25 minutes to complete the process.

The exchange simulation collects a wide range of demographic data about the participating consumers, as well as information on their current coverage, health status, and prior purchase behavior. Thus, the simulation allows users to:

- Assess the impact of different product attributes (including brand name, price points, network designs, and availability of dental care or other additional services) on consumer buying preferences and choices
- See what types of consumers purchased their products, as well as the types that preferred competitors’ products
- Estimate how their product offerings would fare in terms of revenue, margin, medical loss ratio, and market share in a real market
- Understand local market dynamics, competitive issues, and the effect of subsidies on insurance choices

The “real” consumer feedback gives users unique insights into consumer preferences and what their behavior on the exchanges is likely to be, information that is not available through any other source.

Several payors have already used the McKinsey Consumer Exchange Simulation to support product design, off-exchange strategies, and strategies for handling the transition of existing members from employer-sponsored insurance to individual plans.

**McKinsey Advanced Healthcare Analytics’ Private Exchange Simulation**

The Private Exchange Simulation allows payors to better understand their employees’ behavior and preferences. This tool simulates
a defined-contribution environment in which group-insured employees are given a fixed sum of money that they can use to purchase a range of major medical and supplemental products in an online market. Thus, the simulation allows users to:

- Assess employee preferences to buy up or down (compared with their current level of coverage) and their willingness to spend more or less than the defined-contribution amount

- See what types of consumers purchased which categories of products and whether certain categories of supplemental products are more valued than others

- Understand employee preferences for product breadth versus payor breadth within a private exchange

- Allow payors to create and test bundles of major medical and supplemental products that are based on value

The “real” consumer feedback gives users unique insights into consumer preferences and what their behavior on the private exchanges is likely to be. A payor can then use these insights to create or refine its private-exchange strategy because the information helps answer such questions as: Should the payor create its own private exchange or participate in a multi-payor private exchange? What types of supplemental products should it offer on the private exchanges, and what should its total portfolio of products on those exchanges include? What type of bundling strategy should it consider?