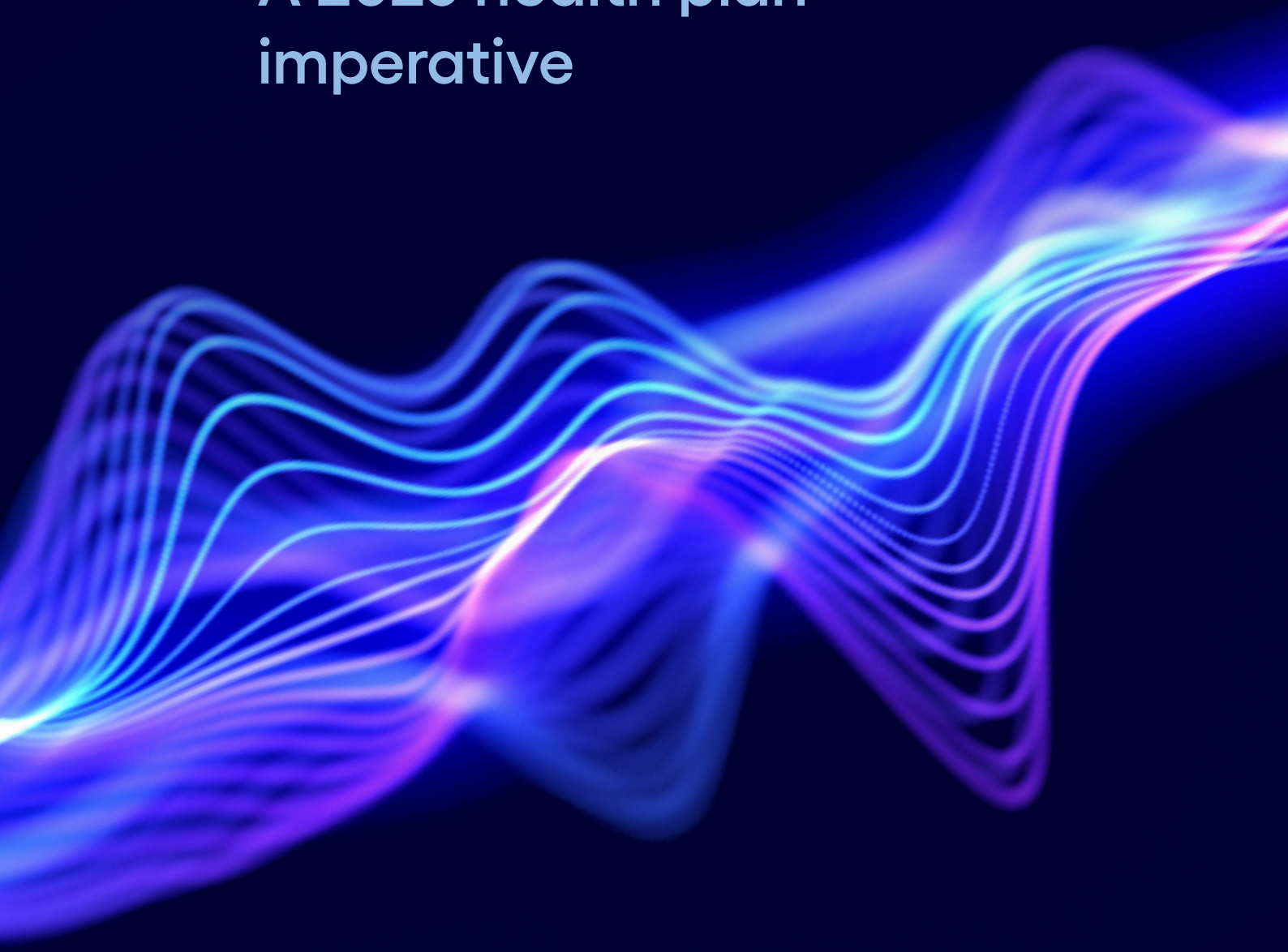
cognizant

Redefining member experience:

A 2026 health plan imperative



In a new, greatly expanded survey, health plan members reveal the experiences that would delight them. Yet our survey results show health insurers still struggle to deliver basic services efficiently.

Delivering the next-gen experience now: **Executive summary**

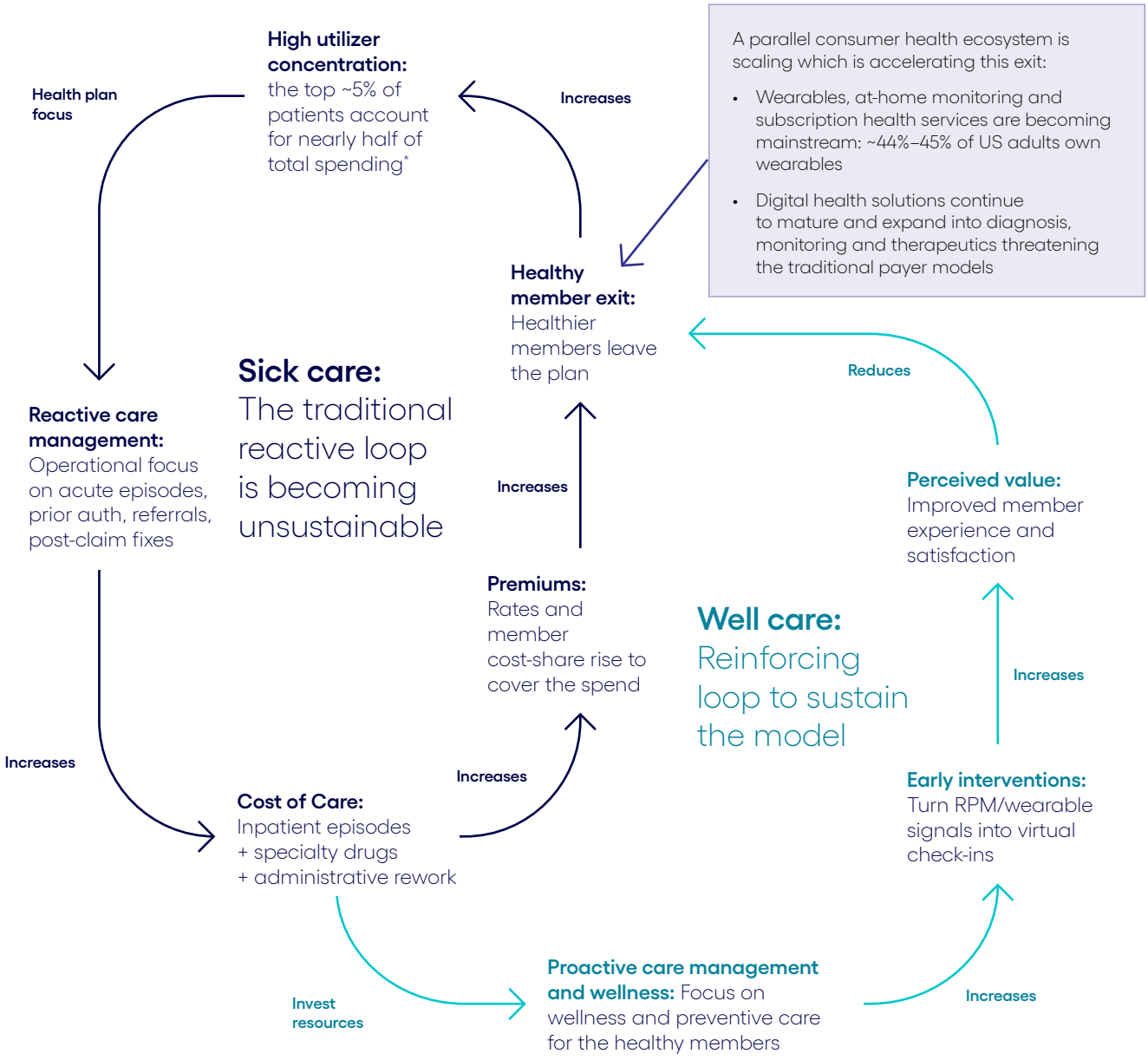
Healthcare has traditionally focused on managing acute episodes for the sickest 5%–10% of members, who generate nearly half of all costs, while overlooking the broader, healthier population. This reactive model is unsustainable, driving up costs and making care inaccessible.

Most health plan members want payers to be involved in managing their overall well-being and to provide digital health and wellness tools. Yet 25% of health plan members wait more than two weeks for appointments, while almost 50% of members report transparency and efficiency issues related to prior authorizations and referrals. In short, while health plans still struggle to deliver their basic core services well, their members are increasingly attracted to alternative models outside of traditional healthcare systems (the "well-care" model). An entire growth industry has emerged to deliver these well-care and "healthspan"-related experiences. For insurance risk pools to remain viable, payers must engage healthy members or risk losing them to emerging digital health-based well-care models.

Refer to the graphic below:

Well-sick care flywheel

Healthy members are moving to a parallel digital health ecosystem. Payers need to orchestrate the well-being journey to retain them.



*Peterson KFF

Those are just a few of the findings and broad conclusions we draw from our fifth biennial Voice of the Member (VOM) survey, our continuing survey of health plan members. For our most recent survey, we tripled the number of survey respondents. The results are based on responses from 7,500 members of commercial, individual, Medicare (Medicare, Medicare Supplement, Medicare Advantage), Medicaid and dual plans offered by insurers ranging from small plans and regional Blues to large national plans (see survey methodology, below).

We also redesigned and added questions to capture the features, services and support that are most important to health plan members. Our findings help our clients understand their members' perceptions of their service quality and how the experiences they deliver compare to those of their competitors. The survey insights reveal where health plans can prioritize investments in building the next-gen experiences that will appeal to healthy members as well as those with chronic conditions or who need acute care.

The layers of the next-gen member experience

The current VOM survey explores whether and how well health insurers are evolving toward being the wellness partners members want by mapping member responses to the three layers of what we call the "experience hierarchy." Each layer in the hierarchy consists of member-facing features and services that combine to create an experience.

The foundation layer consists of the essentials, the basic services or core processes, that every health insurer is expected to deliver, such as claims processing and preauthorizations. The enhancements layer encompasses the features and capabilities that add value to the essentials and services that are a cut above the core services. The last layer, delights, goes beyond expectations with reimagined processes and services to deliver personalized loyalty-building interactions and experiences.

Our findings identify opportunities in each layer that payers should address to close expectation gaps, build lasting member trust and capture optimal lifetime value (see illustration below).

The experience hierarchy for health plans

Essentials build trust. **Enhancements** simplify engagement. **Delights** create emotional loyalty.

Essentials

The core processes that ensure members' basic needs are met consistently and accurately.

"
I can rely on my insurer when it matters the most

Enhancements

Capabilities that simplify daily interactions and help members manage their health seamlessly.

"
My insurer makes managing my health much easier for me

Delights

Differentiators that transform a plan from a traditional insurer to a trusted partner.

"
My insurer knows me and cares about my overall well-being

Experience hierarchy	Health plan capabilities	Digital capabilities
Essentials	• Benefits management • Prior authorization • Referrals • Appeals and grievances • Provider directory • Contact center	• Request/print ID card • Provider search • Access/submit claims • Check claim status • Status tracker* • Customer support*
Enhancements	• Chronic condition management • Cost transparency • SDOH services (transportation, access to healthy food, housing)	• Evaluate providers • Pay premiums • Communicate with care team • Educational content* • Cost estimators*
Delights	• Health and wellness management • SDOH services (social support, translation services, childcare) • Spend management	• Pay providers • Schedule appointments • Guided plan selection* • Side-by-side plan comparison* • Additional coverage options*

*Indicates features related to shopping portal

Here are our key findings about payer experience performance in brief:

Essentials

These are the core processes health plans must deliver with consistency and accuracy to meet members' basic needs and expectations. These capabilities include managing benefits, prior authorizations, referrals, appeals and provider directories and offering related digital capabilities, such as printing ID cards, searching for providers and customer support (see chart above).

> I can rely on my health plan when it matters the most

Our relevant findings:

Finding 01

Core processes frustrate members

Members cite delays, paperwork, lack of transparency and inaccurate provider directories as reasons for their significant dissatisfaction with core insurance processes.

Finding 02

Confusion increases costs and erodes value

Unclear benefits drive avoidable call center use and underutilization of services, raising both medical and administrative costs.

Enhancements

These are member-facing features and functions that health plans use to simplify daily interactions and help members manage their health seamlessly. Enhanced services range from providing clear, easily understood information, well-designed web and mobile platforms for completing transactions such as premium payments, and services that address social determinants and chronic health conditions.

> My insurer makes managing my health much easier for me

Finding 03

Plans offer many chronic-condition management programs, but members report that these don't deliver meaningful value to them

Health plans must put members' needs first when designing these programs.

Finding 04

The largest experience gaps for Medicaid members cluster in critical services—transportation, food and housing—but their relative importance is demography specific, so a one-size-fits-all fix misallocates resources

Failing to deliver key services to alleviate adverse social determinants endangers members' health.

Finding 05

Members consistently seek clear, upfront healthcare cost information, yet estimates are rarely accurate

Health plans need to empower members by giving them transparent, accurate data.

Delights

These are the personalized, intelligent services that transform a traditional insurer into a trusted health and well-being partner in the eyes of members. Services here include programs and offerings that anticipate member needs and that offer flexible support, delivered digitally.

> My insurer knows me and cares about my overall wellbeing

Finding 06

Members want real-time tools to manage healthcare spending, yet few insurers offer these

Designing holistic experiences to help members manage their healthcare dollars offers payers an opportunity for market leadership.

Finding 07

Members increasingly expect their plans to shift from traditional insurers to partners that leverage digital tools to improve their overall well-being

Members expect their health plans to offer proactive health and wellness support, not just financial and claims-related transactions. This is an especially important value proposition for members of employer-provided health plans.

Digital member and shopper findings

These are the qualities required across all layers of the experience hierarchy:

Finding 08

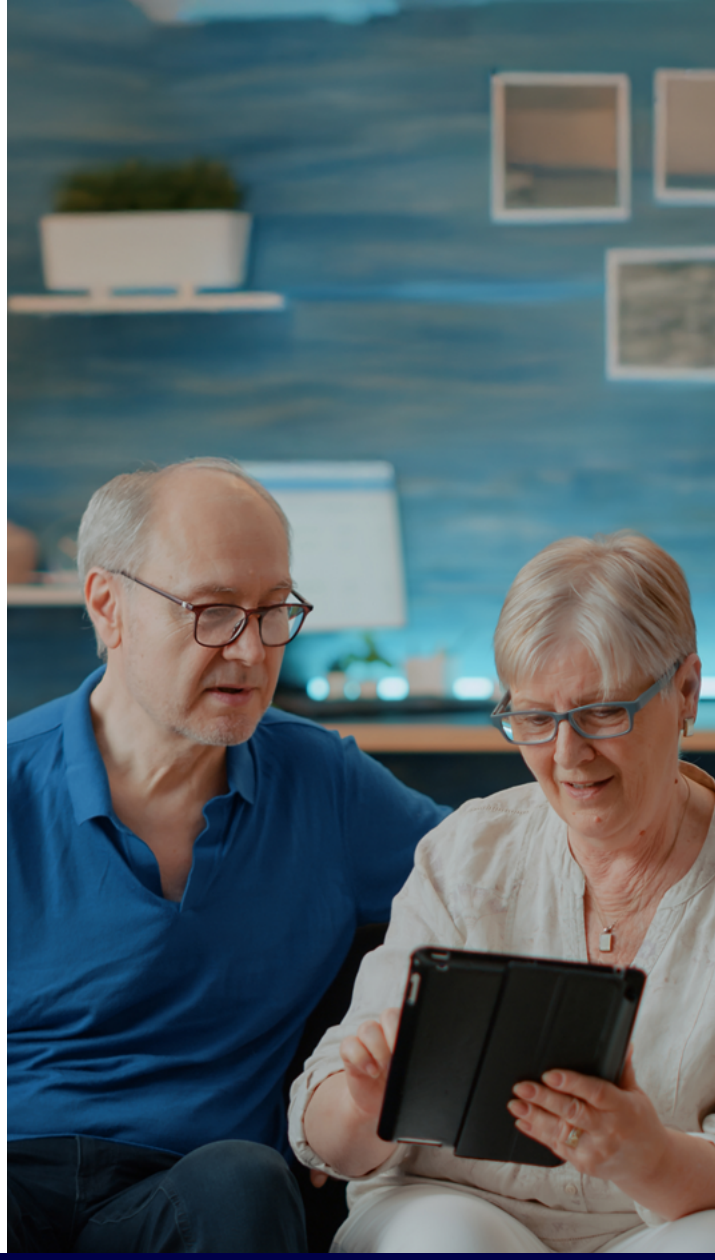
Proactive outreach and contextual triggers, not just digital availability, are essential to spark digital interaction with members while seamless, intuitive tools that reduce effort and eliminate service friction are critical to sustain engagement

Digitally unengaged health plan members do use the digital services offered by their banks and other service providers. Health plans need better, and better promoted, digital tools to increase digital adoption.

Finding 09

As members shop for health plans, payers need to go beyond essentials and empower members through clarity, choices and tailored shopping journeys

For example, Medicare members prefer a simple, guided path while individual/dual members prefer flexible self-service.



In the following paper, we examine these findings closely, with supporting survey insights, and provide recommendations for where payers should invest in better capabilities across the experience hierarchy and offer some industry examples.

Payers that integrate all three layers of the hierarchy into next-gen experiences will benefit from attracting healthy members and improving outcomes for those with chronic conditions. They should also see higher member satisfaction and better Star rating and HEDIS® metrics along with increasing revenues and reduced medical and administrative operating expenses. These benefits make a compelling business case for delivering the next-gen member experience today.

Survey methodology

The 2026 Voice of the Member survey was conducted using a robust online methodology, with fieldwork carried out over seven weeks in June and July of last year. A random sample of 7,500 consumers across the US completed the survey. Participants accessed the survey via a secure web-based platform that was fully compatible with mobile phones, tablets, laptops and desktop computers, enabling respondents to use their preferred device. Respondents were screened for eligibility and uniqueness, and all responses underwent standard data validation checks before analysis to ensure data quality and reliability.

To enhance representativeness, the data was structured to align with US population distributions, particularly across key age groups and primary healthcare insurance coverage categories, including employer-sponsored insurance, private individual plans, Medicare, Medicaid and dual-eligible beneficiaries. Responses were monitored in real time for completeness and consistency, ensuring the resulting dataset accurately reflects the broader US consumer landscape.

Cognizant Voice of the Member survey

7500 members	**166+** health plans	**8** key satisfaction indicators
3,750 Employer/group	**13%** Small/regional plans	• Shopping experience
1,688 Medicare	**35%** Blue plans	• Benefits and coverage
1,312 Medicaid	**52%** National plans	• Access to care
750 Individual/exchange		• Cost transparency
		• Social Determinants of Health (SDOH) services
		• Health and wellness
		• Digital engagement
		• Customer support

Finding 01

Core processes frustrate members

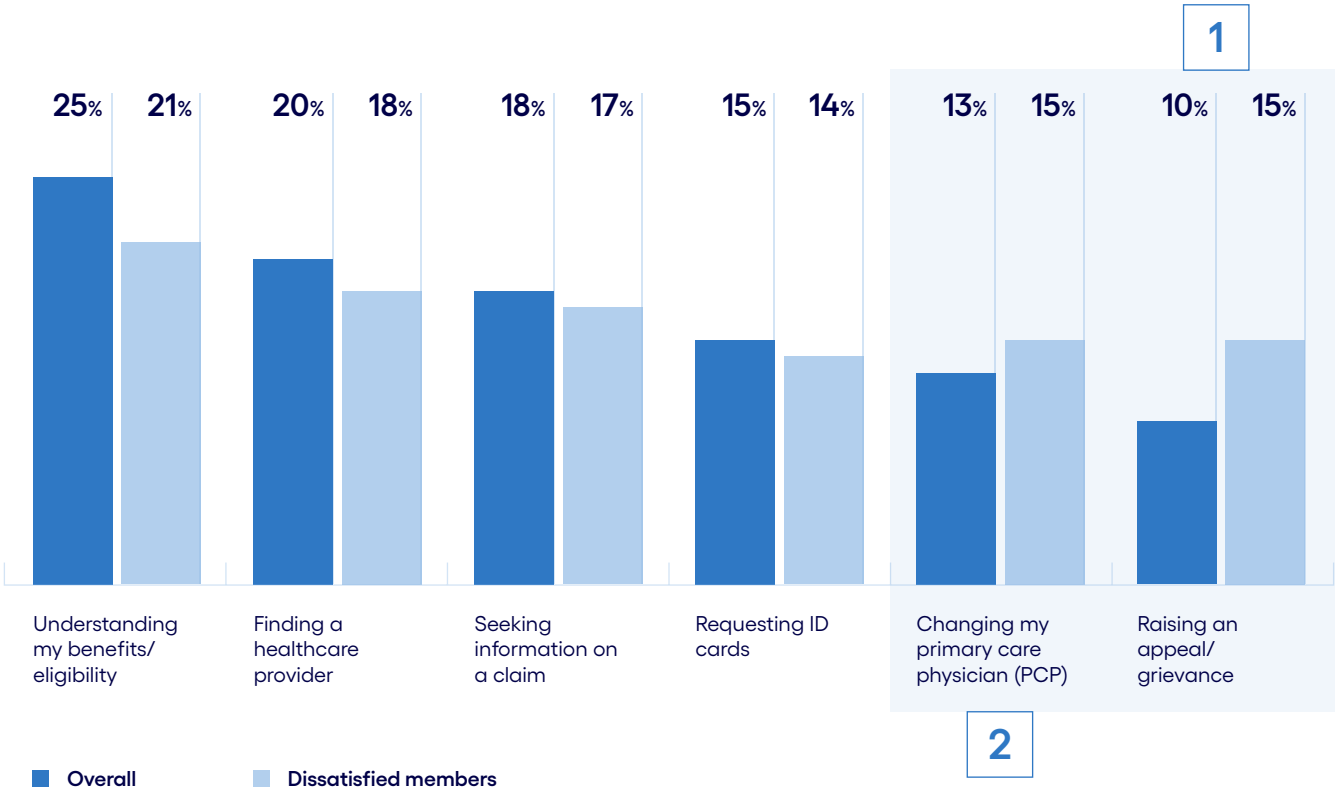
Members cite delays, paperwork, lack of transparency and inaccurate provider directories as reasons for their significant dissatisfaction with core health insurance processes.

Members expressed unhappiness with many basic health plan services. Core processes such as changing primary care physicians (PCPs), referrals, prior authorizations and appeals were among the specific pain points (see graphic below). This indicates many payer processes don't deliver the seamless, intelligent workflows that characterize modern digital customer experiences. Broken processes potentially affect quality of care: 29% of members wait more than two weeks for appointments with PCPs or specialists. Frustrations with basic services also drive members to the contact center, increasing operating expense.

Essential processes frustrate plan members

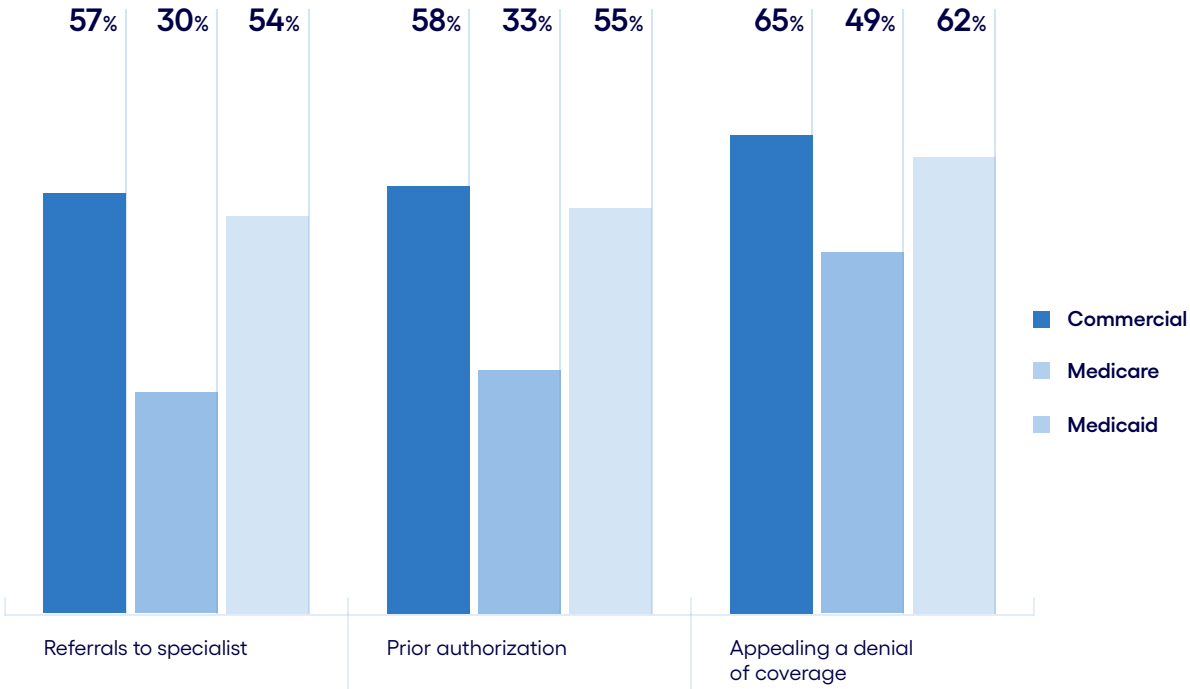
Member dissatisfaction while calling the contact center was most evident in interactions tied to primary care physician changes and initiating appeals.

Which of the following categories have you called a contact center (1-800) for in the last year?



1 The frustrations indicate system problems, with more than half of the members struggling with basic processes.

% of members who faced issues with these insurance processes



Top three issues

	Referrals to specialist	Prior authorization	Appealing a denial of coverage
1. Took too long	23%	22%	20%
2. Too much effort/ paperwork	16%	16%	20%
3. Lack of explanation	14%	14%	18%

2 Long waits for appointments and dissatisfaction with care often push members to switch—driving many of those PCP change requests.

29%
of members wait more than two weeks for PCP/specialist appointment.

31%
of members expressed dissatisfaction or were neutral with the speed of scheduling an appointment with PCP/specialist and receiving care.

Inaccurate provider directories drive up avoidable costs

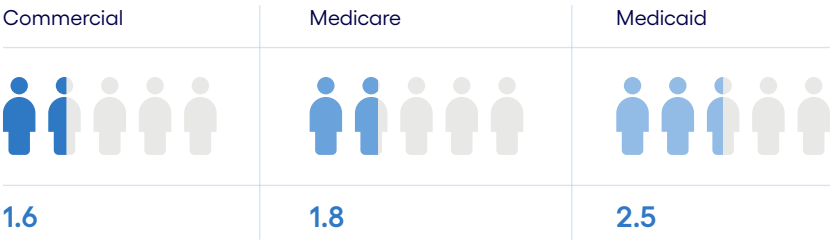
Members rank provider search as essential and is one of the most valued features.

91%

of members expressed high importance for the ability to search for healthcare providers (e.g., hospital, doctor) in their insurance plan and compute out-of-pocket expenses.

Yet it remains a top frustration, with most members dissatisfied by inaccurate provider information.

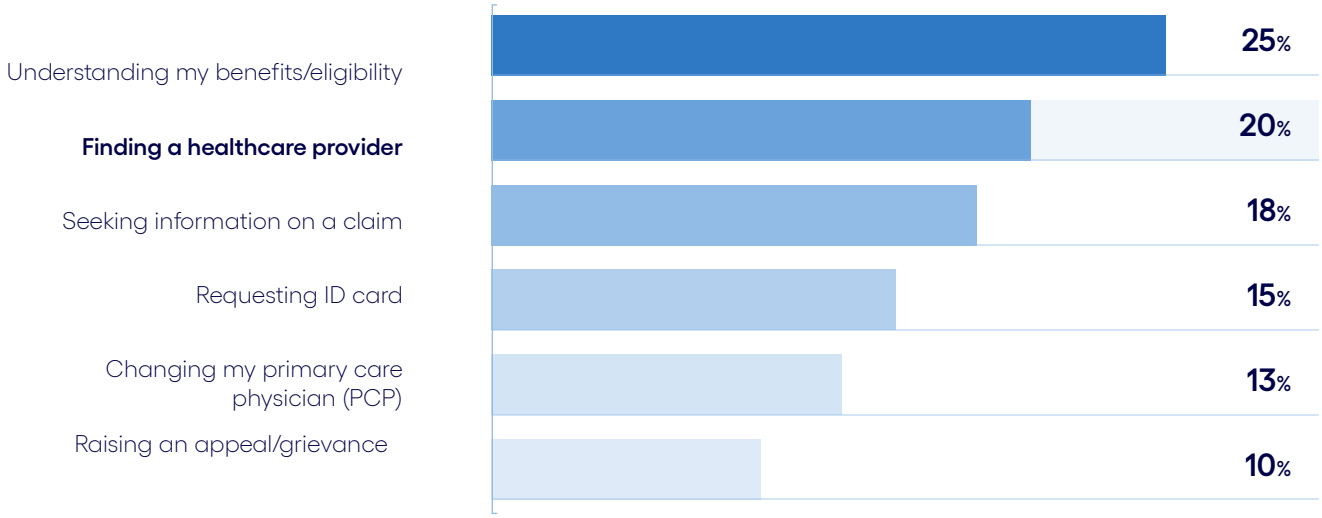
How satisfied are you with the provider directory offered by your health insurance to find doctors, specialists or other medical services? (Normalized score out of 5)



Note: Satisfaction scores are derived by normalizing member-reported satisfaction ratings to a 1–5 scale

Members frequently turn to call center to find a healthcare provider—an avoidable cost…

For which of the following categories have you called a contact center?



…but members still don't get accurate answers, because it is a data problem, not a channel problem.

Inaccurate provider directories especially frustrate members, driving higher call center volumes. Unreliable directories potentially increase medical costs if care is delayed because members have difficulty finding and accessing a provider. Further, the Centers for Medicare & Medicaid Services (CMS) has provider data accuracy on its radar. A September 2025 rule requires Medicare Advantage plan providers to attest to the accuracy of their directories, update them within 30 days of learning about new information and provide directory data to CMS in a specified format.[1] Industry analysts think the rule could trigger CMS to impose fines for inaccurate directories, which could be as high as $25,000 per beneficiary.[2]

Recommended actions:

Invest in data integrity as a strategic priority.

Improving provider data accuracy is a foundational infrastructure issue and should be a top priority. Health plans can deliver accurate directories with automation and real-time validation.

Simplify and incentivize provider collaboration.

Make it easier for providers to update their information and build trust through shared accountability and aligned incentives.

Integrate member feedback loops into directory management.

Incorporate feedback mechanisms into digital and call center channels to continuously refine and validate provider data, turning frustrations into actionable insights.

Adopt a multipronged strategy across technology, operations and experience.

Success requires coordinated efforts across these three groups. For example, AI tools can cleanse data efficiently, operations can improve outreach to providers and intuitive search interfaces improve the member experience.

Finding 02

Confusion increases costs and erodes value

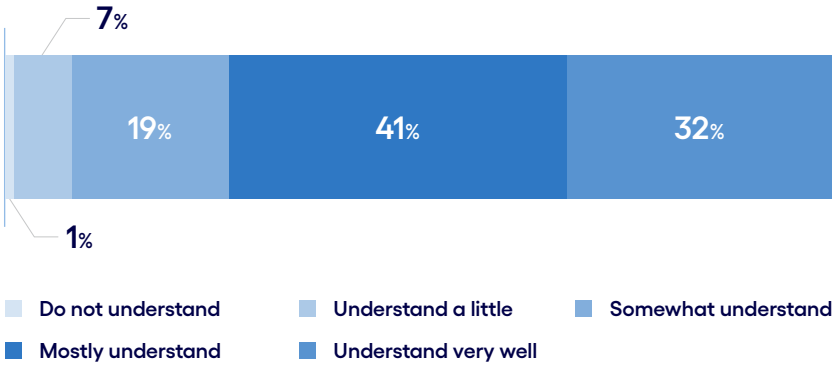
Unclear benefits lead to increased call center use and underutilization of services, increasing avoidable medical and administrative costs. Almost 30% of members are not confident about how well they understand their plan benefits. One-quarter of the survey respondents have called member services for help in deciphering their benefits and eligibility.

Further, members can't participate in plan benefits and programs they don't know about. Members who are unaware of their plans' preventive, chronic and well-care options may generate higher medical costs in the future.

Confusion about benefits drives high-cost calls

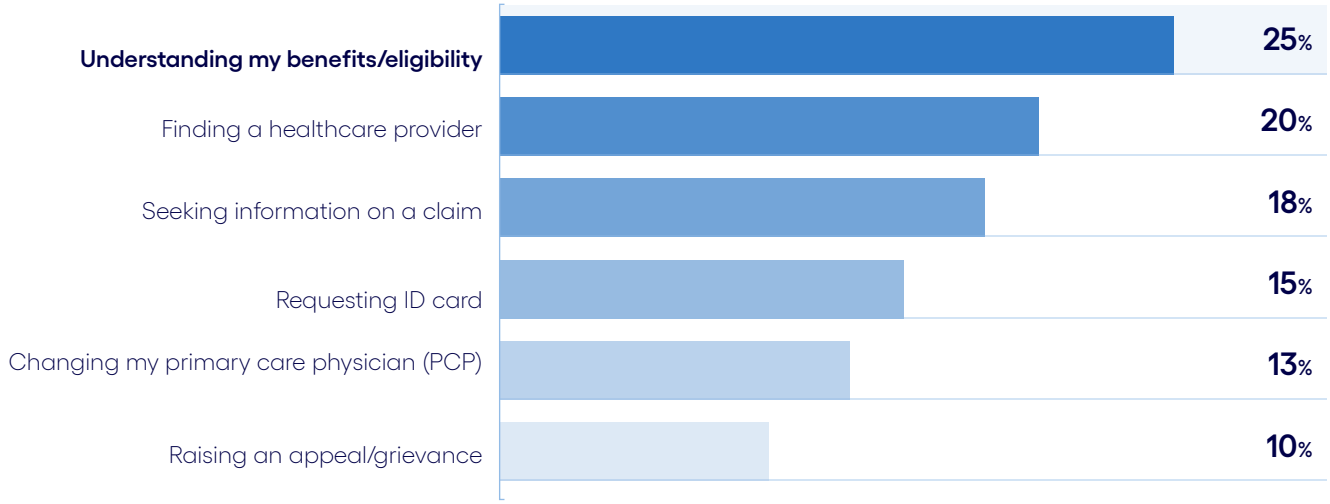
One out of four members remain unclear about what's covered, what it costs, and how to access services.

How well do you understand your current medical insurance benefits?



Members often resort to call centers for basic benefit questions—creating avoidable operational expenses.

Which of the following categories have you called a contact center (1-800) for in the last year?



Additionally, unclear benefits lead to underuse of services, leading to higher downstream medical costs.

25%
of members with chronic conditions are not aware of or have not used the chronic care management services.

34%
of members are not aware of or have not used the wellness features.

26%
of Medicaid members are not aware of or have not used the SDOH services offered.

Industry example

How a large national payer is improving benefit awareness and driving self-service

The health plan engages members with accessible, tailored educational materials and provides real-time assistance, empowering informed healthcare decisions and benefit utilization.

- An app and website provide easy navigation of benefits, provider search and personalized health resources. The plan also offers a curated marketplace for wellness products. Digital content is available in multiple languages.[3]
- A virtual assistant handled more than 65 million inquiries in 2024, delivering real-time, personalized answers on benefits, coverage and costs, escalating complex issues to human agents.[4]
- Member feedback and usage data drive ongoing refinement of benefits, educational materials and communication strategies.[5]

Recommended actions:

Make benefits simple and accessible.

Provide clear, multilingual digital content and intuitive navigation through apps and websites to reduce confusion and improve self-service.

Leverage AI and real-time support.

Deploy conversational AI and virtual assistants to answer benefit questions instantly, reducing members' reliance on call centers and improving member confidence in responses.

Integrate benefits into daily digital touchpoints.

Embed benefit tips and cost transparency, including context-aware nudges, into scheduling, billing and telehealth workflows so education about available benefits happens naturally during these interactions.

Target vulnerable segments with tailored education.

Use community outreach and learning programs for Medicaid and dual-eligible members to simplify complex benefit information.

Continuously optimize through data insights.

Analyze member feedback and usage patterns to refine educational materials and communication strategies for better engagement and outcomes.

Finding 03

Plans offer many chronic-condition management programs, but members report that these don't deliver meaningful value to them

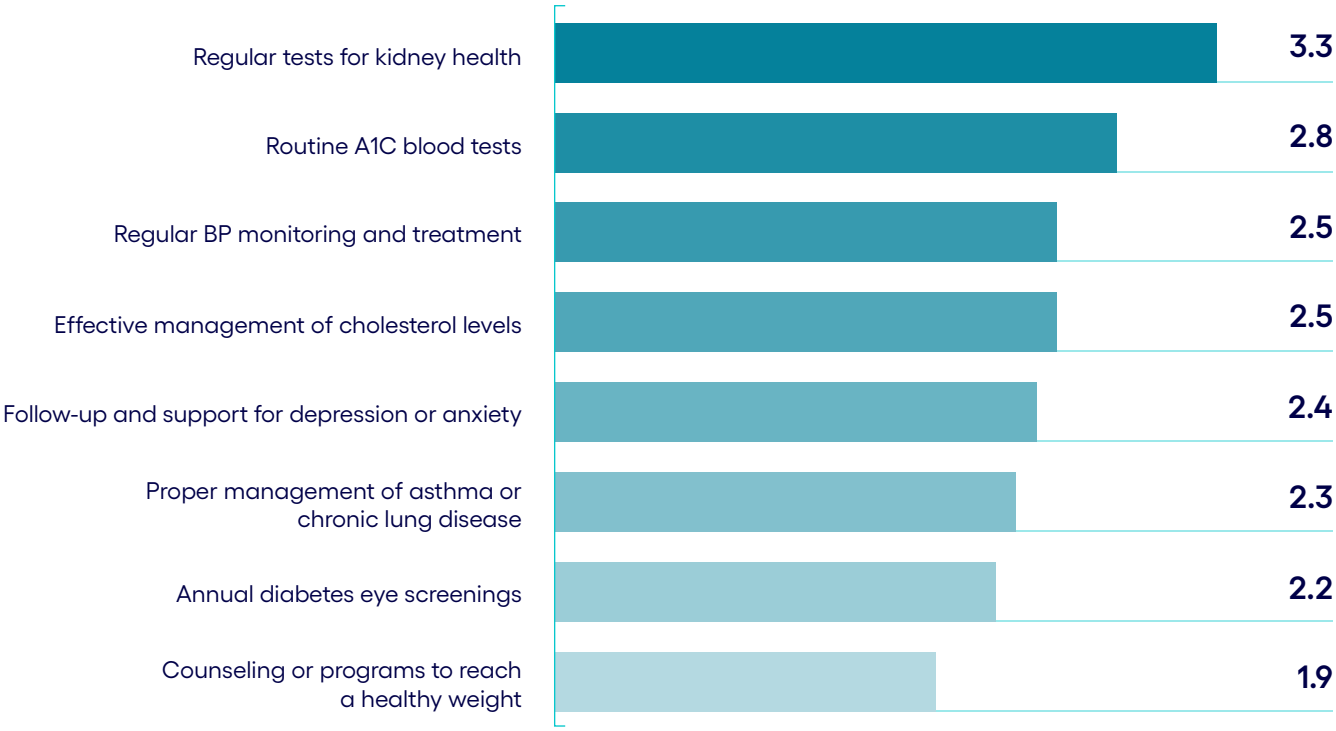
Among members who have used their plans' chronic care programs, satisfaction rates are low across virtually all offerings. Members with chronic conditions said such services are important to them, so their dissatisfaction suggests issues with how health plans structure or deliver these programs.

Long-established programs, such as blood pressure and cholesterol management, earn only average satisfaction marks. Services designed to prevent complications, such as annual eye screenings for diabetic members, also earn low scores.

Members increasingly expect their health plan to support emotional health. Plans are falling especially short here, with member ratings for follow-up care for depression and anxiety among the lowest of all services.

Members get minimal satisfaction from payer clinical programs

If you have received any of these types of clinical care or monitoring services, how satisfied were you with the quality and effectiveness of the care?



Note: Satisfaction scores are derived by normalizing member-reported satisfaction ratings to a 1–5 scale

Recommended actions:

Personalize beyond standard programs.

Tailor outreach instead of using generic clinical protocols. Use digital nudges, AI-driven care paths based on member histories and condition-specific coaching.

Integrate physical and mental health.

Embed behavioral health services into chronic care programs with virtual visits and easy scheduling for anxiety and depression support.

Blend human expertise with digital innovation.

Combine nurse-led care management with predictive analytics, virtual partnerships and AI-powered tools for seamless member experiences.

Innovate with predictive engagement.

Use AI and data analytics to anticipate member needs and deliver proactive interventions, demonstrating how these prevent complications.

Measure value through outcomes and satisfaction.

Track adherence, complication prevention and member-reported satisfaction—not just program enrollment—to fine-tune programs and demonstrate their impact.

Finding 04

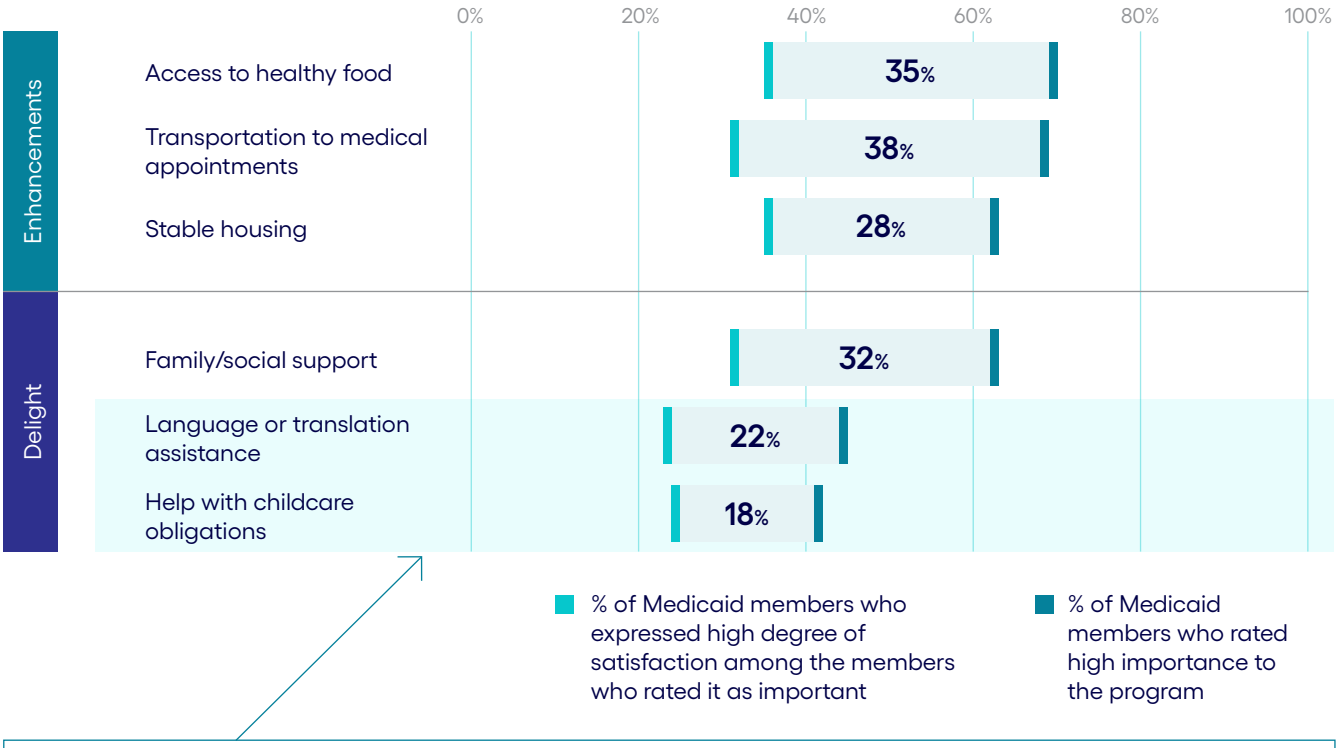
The largest experience gaps for Medicaid members cluster in critical services—transportation, food and housing—but their relative importance is demography specific, so a one-size-fits-all fix misallocates resources

Medicaid members are not monolithic. Members rank their "most important" needs differently so health plans must know their member cohorts well to design and deliver appropriate services.

Services medicaid members need most don't satisfy

Medicaid Members say transportation, food and housing matter most—yet these are where their satisfaction is lowest.

Experience gap: Gap between **importance** and **satisfaction**



How important is it for your health insurance to help address the following challenges that might make it hard for you to take care of your health?

67%

of Black Medicaid members place higher value on childcare support.

47%

of low- income Medicaid members (annual income <$25,000) place higher value on childcare support.

56%

of Hispanic Medicaid members place higher value on language and translation assistance.

Recommended actions:

Prioritize core needs.

Invest in transportation, food and housing as essential benefits—these areas show the largest experience gaps and lowest satisfaction.

Design culturally responsive solutions.

Build flexible offerings that reflect community priorities (e.g., childcare support, language assistance, culturally tailored wellness programs).

Target high-need segments.

Address unique needs of vulnerable populations such as Medicaid, dual-eligible and low-income members through tailored outreach and support.

Measure impact and iterate.

Use member feedback and data analytics to refine programs, ensuring investments translate into improved health outcomes and satisfaction.

Industry example

How a large integrated healthcare organization integrates social health into member care

A leading health organization in the western US delivers holistic healthcare by addressing social determinants of health (SDOH) through integrated, community-focused initiatives that improve member well-being and satisfaction. These include:

- $400M investment to create 30,000 affordable housing units by 2030; connected 1,400+ families to legal assistance for housing stability[6]
- Free online resources and call center screening for food, housing, transportation, childcare and language needs, which linked more than 170,000 members to resources in 2022[7]
- Setting up a community support hub addresses transportation and childcare needs by connecting members to local programs, along with language assistance services to ensure accessibility of care and support for diverse populations[8]
- Coordinating with public programs, scaling evidence-based interventions, investing in communities and forging private partnerships to reduce hunger and improve health equity[9]

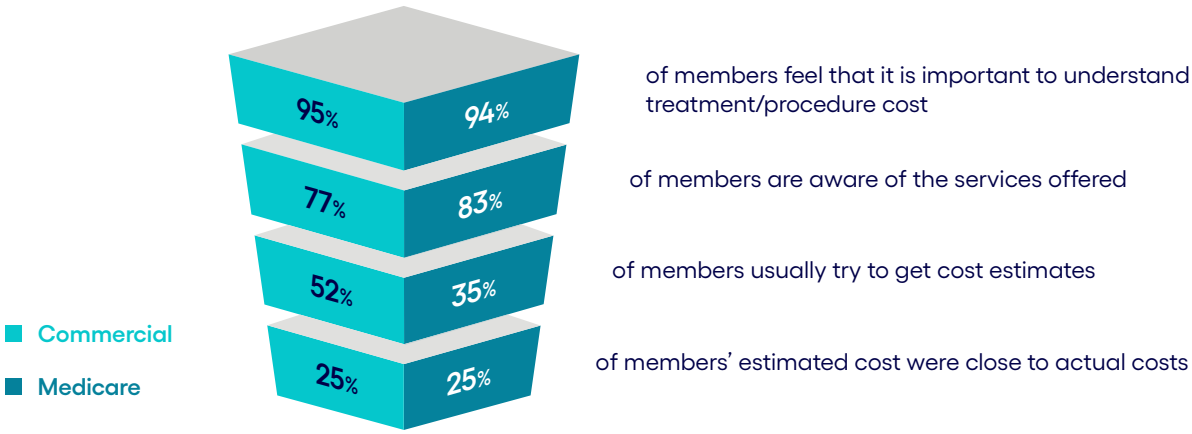
Finding 05

Members consistently seek clear, upfront healthcare cost information, yet estimates are rarely accurate

Healthcare organizations still struggle to provide accurate cost estimates. A high percentage of members think understanding the cost of a procedure or treatment is important, and more than 50% of commercial plan members attempt to get estimates (see graphic below). But 75% of the estimates were not close to the actual costs billed.

Payer cost estimates are often inaccurate

Almost every member wants to know what their care will cost, but only one in four get an estimate close to the actual cost.



Sources: Fierce Healthcare | UnitedHealthcare | UHC

Recommended actions:

Make cost clarity a strategic priority.

Invest in AI-powered tools for accurate, upfront pricing. Adopt plan designs that eliminate deductibles.

Redesign for simplicity.

Build cost tools that are as intuitive as those offered by retailers. Use plain language, clean interfaces and guided choices.

Industry example

How a large national healthcare organization is leveraging technology to improve cost accuracy

A leading health plan is transforming cost transparency through a suite of digital innovations, AI-powered tools and business decisions, including:

- AI that translates member-friendly terms back into clinical language and delivers personalized cost estimates[10]
- Innovative benefit design that eliminates deductibles and shows actual care costs up front as simple copays[11]
- An advocacy program that proactively alerts members to potential surprise bills, helping them make effective spending choices[12]

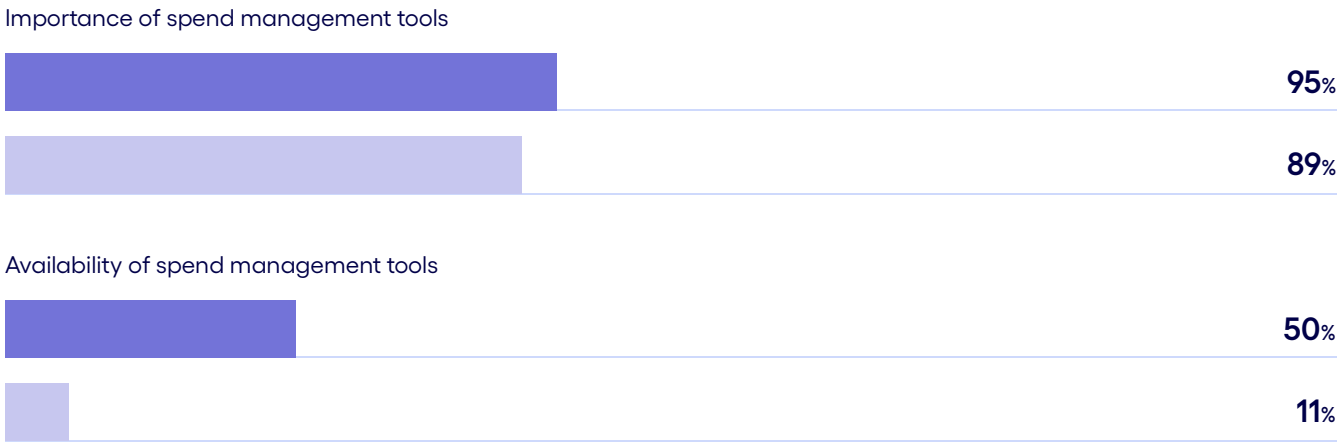
Finding 06

Members want real-time tools to manage healthcare spending, yet most payers don't offer these options

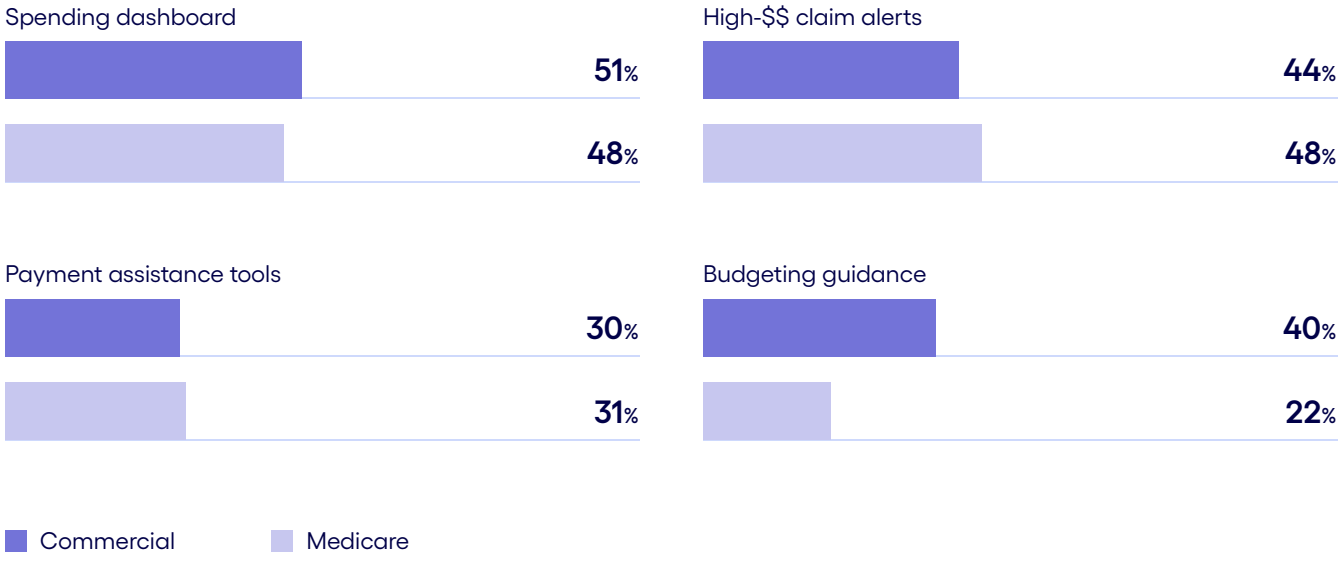
Beyond estimates for care, plan members want better ways of managing their overall healthcare spending. Payers who step up to the challenge of offering budgeting tools have an opportunity to differentiate themselves from competing plans.

Payer opportunity: Offer real-time healthcare budgeting tools

Members want help in managing healthcare costs, but the tools they need are largely missing.



What members need:



Recommended actions:

Reimagine the member payment experience with a consolidated medical bill payment service.

Simplify the post-care billing experience for members by becoming a single payment portal for all health bills and expenses associated with an episode of care or continuing condition management. Only payers have visibility into all the healthcare service providers that a member may visit, from PCPs to specialists to labs and hospitals. Turn this comprehensive view into one-click payment convenience for members by aggregating all outstanding bills for an episode of care or condition. This helps ensure timely payment to providers while simplifying the experience for members.

Shift from reactive to proactive spend management.

Provide members with digital dashboards, alerts and savings guidance that help them actively manage healthcare dollars. Payers could also team up with financial service providers to offer payment plans and other financial assistance.

Integrate financial insights into the care journey.

Deliver real-time cost insights at every touchpoint, from scheduling to discharge, via providers, care coordinators and digital channels.

Industry example

How a large national payer supports healthcare expense management

This leading payer empowers members through digital tools on its app and website, offering:

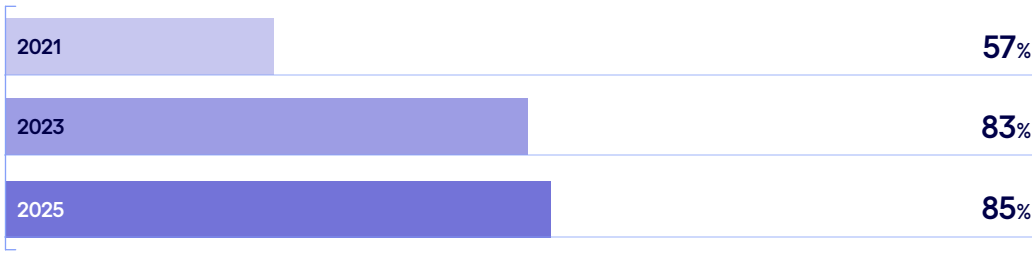
- Personalized cost tracking tools to track in-network and out-of-network spending, monitor deductibles and easily access claims associated with those costs[13]
- Better visualization of claims through a “donut” chart which clearly breaks down claim costs, helping members better understand what they owe[14]

Finding 07

Members increasingly expect their plans to shift from traditional insurers to partners that leverage digital tools to improve their overall well-being

Members have consistently told us their insurers should be healthcare partners.

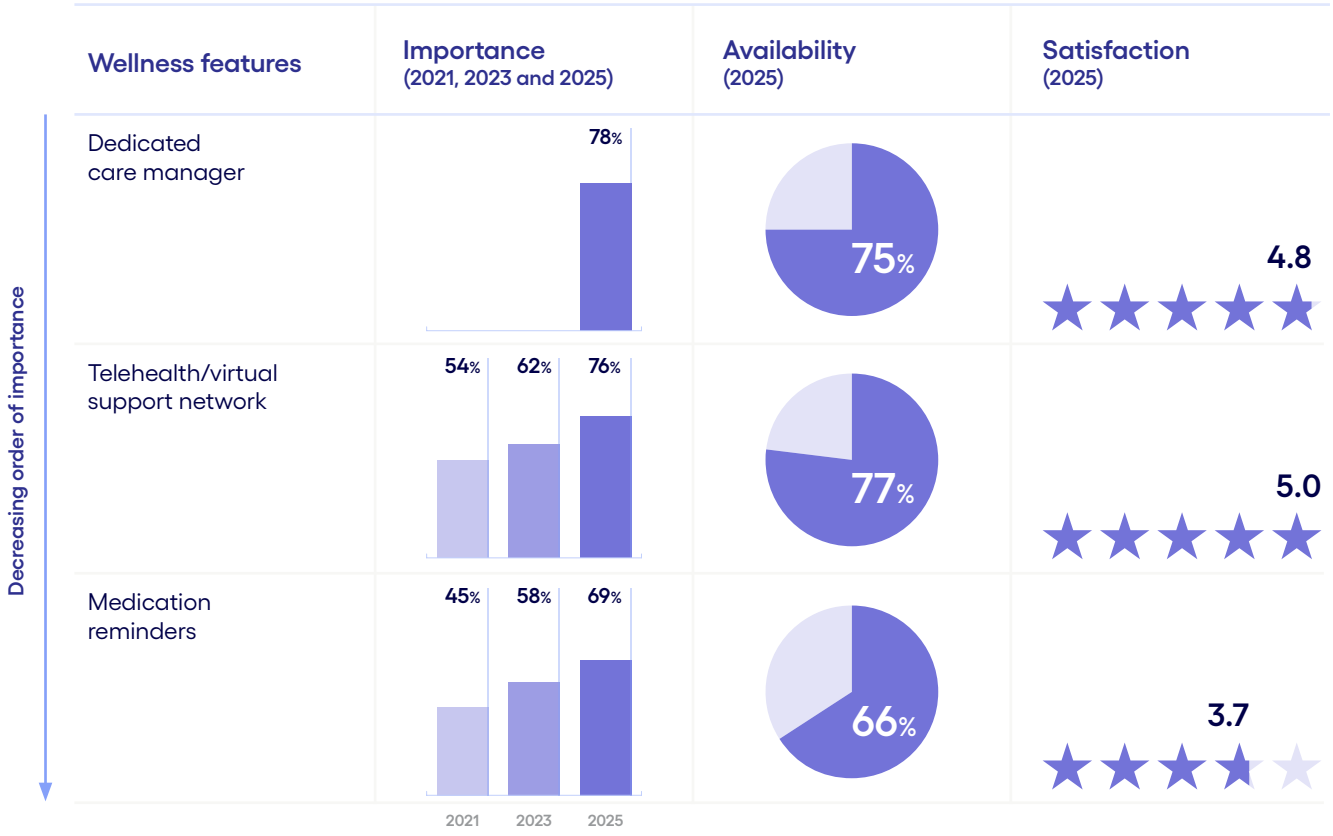
Members who want insurers to play a part in their overall well-being



In our most recent survey, we found that expectation especially high among members of employer-sponsored health plans, with nearly 85% of those members expecting health plans to take an active role in orchestrating their health.

In addressing this critical employer-benefit demand, payers must recognize members value wellness features that offer direct access to human support, including dedicated care managers and virtual support networks. Technology should enhance, not replace, human connections (see chart below).

Members want wellness features with a human touch



Note: Satisfaction scores are derived by normalizing member-reported satisfaction ratings to a 1–5 scale

Recommended actions:

Develop a unified digital front door.

Payers can consolidate all member touchpoints into one super app that is intelligent and intuitive. It should deliver the following:

- Unified data: A 360-degree view of the member by breaking down silos between claims, wellness and partner data.
- Frictionless access: One identity, one wallet for all benefits and one central place members may go to for any needs.
- Foundation for AI: The unified member view is a prerequisite for proactive, personalized insights.

Proactive ecosystem-led wellness.

Payers can aid members by orchestrating an ecosystem of services targeting the root causes of chronic conditions. The services should include:

- "Prescriptive partnerships": Go beyond premium credits to partner with meal prep and delivery services to offer members condition-specific meal plans as prescribed by their providers.
- Orchestrated journeys: These trigger proactive interventions and blend services to develop cohesive care pathways. For example, high blood pressure values would trigger a virtual visit and automatically populate a grocery list.

Human-led, high-touch advocacy.

This provides a trusted human advocate to guide members through healthcare's most complex and stressful moments. These services include:

- Empowered concierge: Highly trained concierge services, not scripted call center agents, with end-to-end ownership of the episode to handle everything from specialist appointment scheduling to coordinating care to resolving billing issues.
- Moments that matter: A premium benefit that focuses on high-anxiety events where delivering a positive experience improves health outcomes and creates a brand advocate.

Finding 08 Part 1

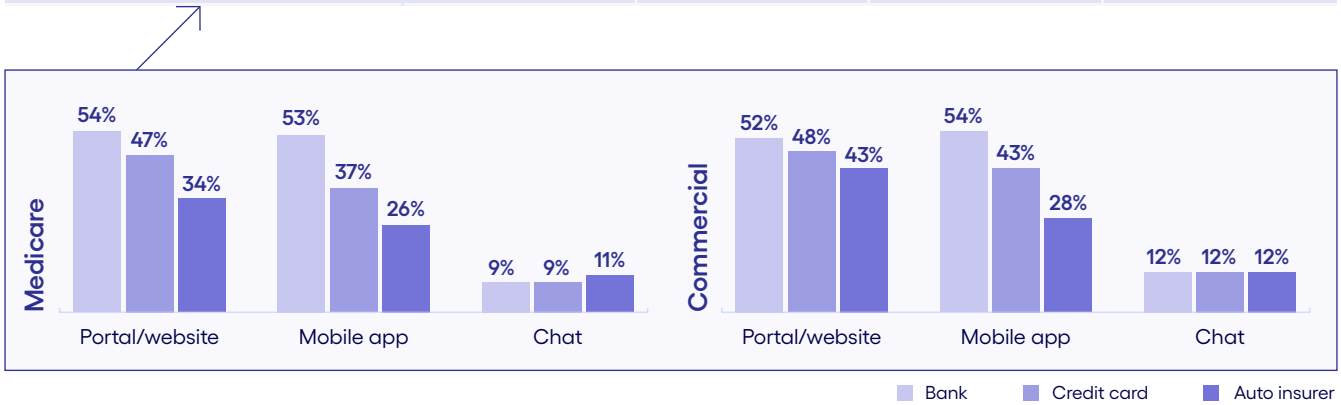
Proactive outreach and contextual triggers, not just digital availability, are essential to spark digital interaction with members … while seamless, intuitive tools that reduce effort and eliminate service friction are critical to sustain engagement

While nearly 10% of Medicare and Medicaid members have not adopted any of their health plan's digital capabilities, they do use similar capabilities offered by their banks, credit card companies and auto insurers. So an inability or general unwillingness to use digital is not driving their low adoption.

Why the adoption difference? Other service providers have succeeded in embedding their services into their customers' daily or weekly routines and making them essential to carrying out transactions. These companies stimulate digital use with triggers, such as reminders of payment due or new features. They also heavily promote the availability and benefits of their digital capabilities.

Digitally unengaged members do use digital with other service providers

		Subscriber member	Individual	
	Overall	Commercial	Medicare	Medicaid
Registered on the member portal	63%	65%	66%	54%
Downloaded the company app for smartphone or tablet	54%	58%	47%	49%
Signed up for email reminders	40%	40%	41%	39%
Followed the company on social media (e.g., Facebook, Twitter)	16%	18%	9%	14%
None of the above	5%	3%	9%	8%



Delight

Members who don't use any of their health plan's digital options do use the portals, websites, mobile apps and chat functions offered by their banks, credit card companies and auto insurers. For example, while almost 10% of Medicare members report not using any of their health plan's digital features, nearly 55% of them use their banks' portals, websites and mobile apps (see above).

Recommended actions:

Invest in targeted, creative marketing.

Use contextual, high-visibility campaigns—TV, digital and in-person placements—to build awareness and urgency around app usage.

Personalize outreach and trigger engagement.

Deploy proactive, event-based notifications (e.g., screenings, billing, scheduling) to convert awareness into action and reinforce relevance.

Simplify onboarding and core tasks.

Ensure frictionless app setup and intuitive access to high-value features like bill pay, telehealth and family health management.

Collaborate across functions and learn from other industries.

Emulate best practices from banking and insurance by combining marketing, tech and service design to build trust and habitual digital engagement.

Industry example

How a leading regional plan drives digital engagement

A regional health plan is driving digital adoption through a blend of creative marketing and technology-driven trigger points that promote easier, on-demand healthcare access whenever and wherever patients need it:

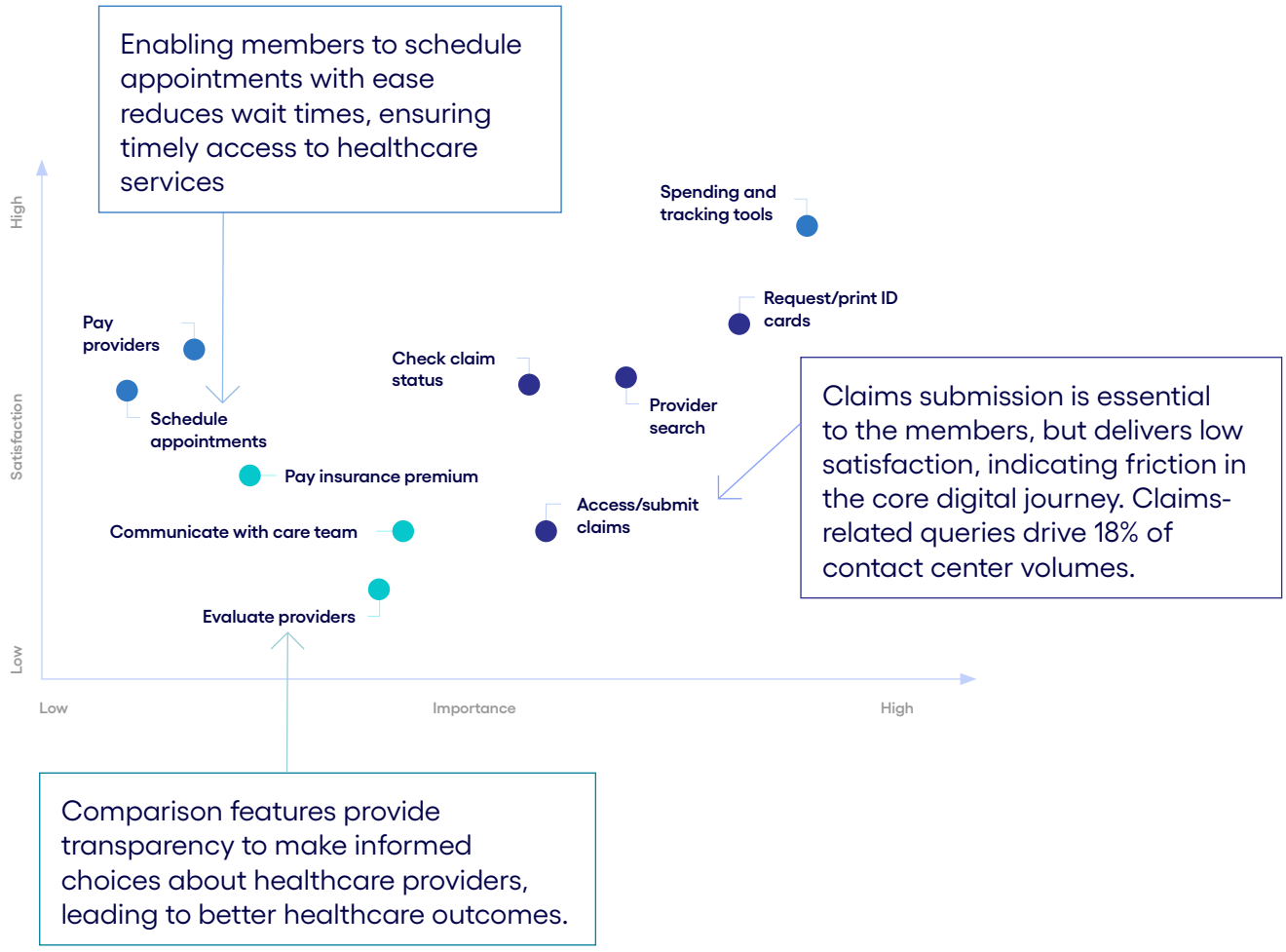
- Uses humorous TV ads, real-time digital ads on social channels and strategic placements (airports, grocery stores) to improve outreach[15]
- Aligns messaging with everyday scenarios—weekend illness, travel, errands—prompting immediate app downloads for "right now" help[16]
- Leverages email and push notifications tied to health events (e.g., screenings, billing, scheduling) to drive natural app usage[17]
- Offers a single-account view for family health, lab results, bill pay and telehealth—creating clear value moments for members[18]

Part 2

Proactive outreach and contextual triggers, not just digital availability, are essential to spark digital interaction with members … **while seamless, intuitive tools that reduce effort and eliminate service friction are critical to sustain engagement**

Members said their plans make many digital features available, but they are increasingly dissatisfied with them because they are not easy to use and/or don't deliver on expectations for delivering frictionless service.

Availability of digital features doesn't equal satisfaction



Essentials | Enhancements | Delight

Recommended actions:

Position digital as a strategic differentiator.

Treat digital capabilities as a core element of the member experience strategy, not just as the means of achieving operational efficiency.

Create an intelligent, connected ecosystem.

Integrate AI-driven assistance, real-time transparency and personalized guidance into every touchpoint.

Enable instant digital ID access.

Provide always-available ID cards in apps and portals for easy viewing, downloading and sharing to eliminate delays.

Deploy AI for complex queries.

Use generative AI assistants to handle benefits, claims status and provider searches, with seamless escalation of complex queries to experienced human agents.

Enable personalized provider matching.

Use AI-driven tools to recommend providers based on member health needs, location and preferences for better care alignment.

Tie digital success to business outcomes.

Link members digital adoption and satisfaction metrics to organizational goals, driving accountability and continuous improvement.

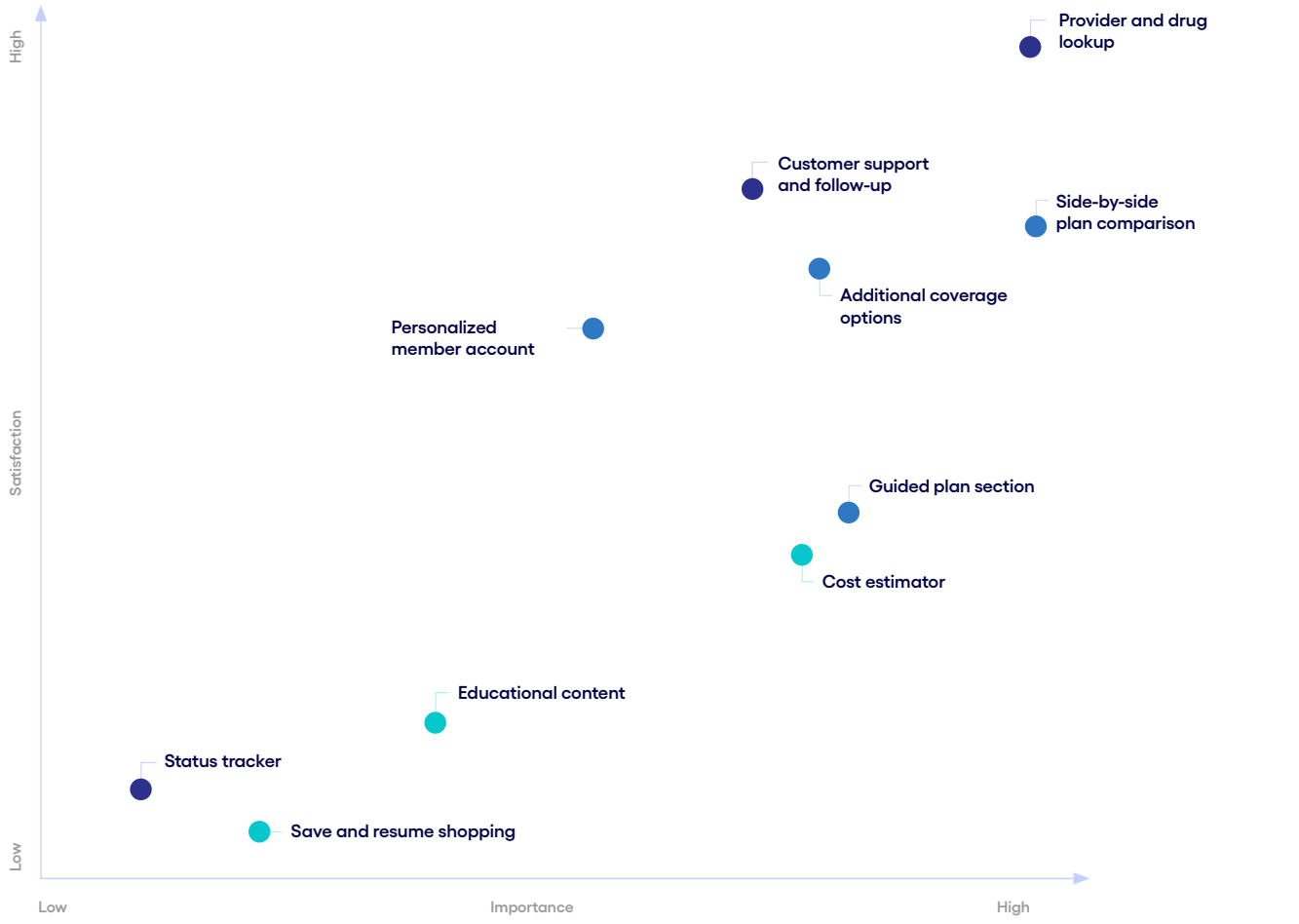
Finding 09

As members shop for health plans, payers need to go beyond essentials and empower members through clarity, choices and tailored shopping journeys

Side-by-side comparisons of plan features and benefits are the top-ranked demand from all members shopping for plans. Members prioritize clear information about specific plans vs. general educational content.

Among members, those searching for Medicare Advantage plans want clarity and a simplified, guided journey that efficiently leads them to a decision. Duals place highest overall value on digital features. These members put a high value on educational content, cost estimators and customer support.

How members rank essential, enhanced and delightful shopping features



Essentials | Enhancements | Delight

How members rank importance of plan shopping features

How important are each of these features when choosing a health insurance plan online from the health insurer's website? (% of members who rated moderate to high importance)

Feature	Individual	Medicare	Duals
Side-by-side plan comparison	95%	94%	95%
Guided plan section	93%	90%	94%
Provider and drug lookup	93%	95%	96%
Cost estimator	92%	89%	93%
Customer support and follow-up	91%	88%	92%
Additional coverage options	91%	90%	93%
Personalized member account	90%	85%	90%
Educational content	89%	80%	91%
Save and resume shopping	86%	78%	87%
Status tracker	84%	75%	86%

Recommended actions:

Deliver transparent comparison tools.

Provide side-by-side plan comparisons with accurate, real-time data to reduce uncertainty and empower confident decision-making.

Personalize journeys by segment.

Create guided, simplified flows for Medicare members and flexible, self-service experiences for individual/duals, ensuring each segment receives what they value most.

Enhance support with omnichannel assistance.

Combine digital tools with high-touch support options (chat, call center, home visits) to help members navigate complex decisions seamlessly.

Leverage AI for smart recommendations.

Adopt AI-driven platforms to guide plan selection using member-specific data (health conditions, provider preferences, medication needs) for tailored recommendations.

The importance of tailoring experiences across hierarchy layers

Healthcare has traditionally focused on managing acute episodes for the sickest 5% to 10% of members, who generate nearly half of all costs, while overlooking the broader, healthier population. This reactive model is unsustainable, driving up premium costs and making care inaccessible. Further, payer inefficiencies in core services persist, so members in this category receive poor experiences, as the results of our survey have shown.

As we discussed earlier, a parallel digital health ecosystem is emerging. In this universe, consumers and companies focus on "healthspan," or how to remain healthy and active until the end of life. Companies targeting this space help consumers follow such wellness frameworks as Medicine 3.0, popularized by such books as "Outlive" by Peter Attia, M.D., as well as research on how to age well from Harvard, USC, the National Institutes of Health and more. These companies help people actively manage their health through wearables, at-home devices and direct-to-consumer services for drugs and lab work (e.g., mail-order weight-loss drugs, functional health—subscription-based blood work, healthspan testing, Oura health panels). These wellness companies are expanding into traditional healthcare spaces, such as diagnosis and medication, through subscription models. This shift poses a significant challenge, as healthier populations could abandon traditional insurance, jeopardizing the industry's viability (refer to the well-sick care flywheel graphic).

Payers need to retain healthy populations for their risk pools to work. They can attract and retain these healthy people by tailoring experiences that meet their wants and needs. Simultaneously, payers must serve members facing acute or chronic care needs with better experiences. The table below shows how payers could prioritize services across the experience hierarchy to serve these groups:

Experience hierarchy	Sick-care	Well-care
Essential services	Critical to this population	Insurance is for emergencies only
Enhancements	Chronic condition management and SDOH mitigation are key to retaining these members	Wellness tools and features are critical to retention
Delight	Not as critical as essential/ enhancement	New benefits that can help them manage their proactive and preventive wellness efforts

By integrating technology, incentivizing preventive behaviors and engaging the healthy population, payers can disrupt their business models based on reacting to care needs, shift to becoming partners in member health and well-being and reduce costs sustainably.

As leading payers make this shift and tailor experiences to different groups of members, they would do well to keep in mind the following conclusions, made clear by the 7,500 members who responded to our survey:

Essentials, unsurprisingly, are the foundation for higher enhancement and delight experience scores

No plan with poor scores in its essentials was able to score well in the enhancement layers. Broken basics such as prior authorizations, referrals, appeals, inaccurate provider directories, difficulties changing PCPs and other poor workflows cannot be glossed over with window dressing enhancements.

Yet, essentials alone are not fully satisfying

High satisfaction scores on essentials did not carry over into high scores for delights. The industry continues to struggle to turn operational excellence into superior member experiences.

Member-centered service delivery goes a long way

One large integrated system stood out for delighting its members—even though its essential and enhanced scores were not exceptional. What it does have is a member-centric delivery model.

Addressing the needs and expectations of healthy consumers as well as at-risk members should be a critical business driver for health insurers. Plan members who will age into Medicare eligibility in the next few years have been using smartphones and digital capabilities for almost twenty years. Many will likely be focused on their healthspans and want their payers to help extend them. Payers that don't meet these expectations for intelligent, frictionless services will be at a disadvantage that goes beyond dissatisfied members. The features that will please members will also reduce payer operating costs and improve member loyalty. Most importantly, payers that deliver the proactive wellness and chronic management features members want should see better health outcomes and reduced medical costs. That's a clear path toward capturing optimal member lifetime value while members enjoy optimal lifetime health.

Author

Jagan Ramachandran is a Senior Partner, Consulting at Cognizant, leading the Healthcare Payer segment and driving large-scale transformation across some of the most complex and influential organizations in the industry. Previously, he served as Managing Partner at Gartner's Healthcare Consulting practice. Over the years, Jagan has led numerous high-impact consulting engagements for National Plans, Blues, and Regional Plans—each contributing to the evolution of healthcare strategy and the broader consulting discipline.

The Consulting Report recently ranked him among the **Top 25 Strategy Consultants and Leaders of 2025, placing him 2nd among an incredible group of strategists**. In the Dec 2025 edition, **The CXO Magazine** featured his interview titled "Leading the Charge in Healthcare Innovation." In the Jan 2026 edition, **The CIO Times** featured his interview titled "Transforming Healthcare: A Senior Consulting Leader's Impact."

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Footnotes

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