



# Reimagining customer experience in US health insurance:

## A path to cost reduction, retention, and superior service



Healthcare Member Experience Report 2026

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# Foreword

Despite significant investments in advanced technology and artificial intelligence (AI), many organizations find themselves grappling with a critical disconnect: These innovations are consistently failing to yield tangible improvements in top-line growth or bottom-line financials. At the heart of this challenge lies an inability to demonstrate how customer experience (CX) translates into commercial value.

As an industry, we are navigating a perfect storm. Escalating medical costs, surging drug prices, and rising loss ratios are creating immense financial pressure, which cannot simply be absorbed by members.

Simultaneously, increasing regulatory demands for interoperability and secure access to medical records impose significant IT burdens, further straining resources already impacted by reduced government funding. This financial squeeze is exacerbated by a palpable decline in member satisfaction.

Public dissatisfaction with the healthcare system has intensified in recent times, driven by a combination of rising costs, access barriers, and poor service experiences. Structural inefficiencies - including long wait times, staffing shortages, breakdowns in communication, rushed consultations, lack of empathy, and widespread confusion over insurance coverage - compound this frustration, which in turn affects trust and satisfaction.

The core issue we observe is that some payers equate CX strategy with technology implementation itself, rather than leveraging technology to enable and support a strategy rooted in genuine member needs. This leads to the proliferation of inefficient, siloed solutions that ultimately increase costs and further erode member trust, instead of building it. Internal departmental structures,

conflicting metrics, and disconnected teams directly impede the delivery of an efficient customer experience and also inflate costs.

In this report, we advocate shifting from a narrow focus on individual touchpoints to understanding the entire member journey and helping ensure all processes and experiences deliver extensive value. This requires intentional design of member experiences, aligning the operating model to value creation and considering where AI could reduce downtime and operational expenses.

Payers are awash with data, and we recommend using existing operational data, customer interaction logs, claims information, and feedback as critical diagnostic tools for identifying "Strategic Optimization Points," areas where targeted interventions will make a quick and sustainable improvement in both costs and member satisfaction.

A truly superior customer experience, in this context, is not merely a desirable outcome; it is a critical driver of profitability and sustainability.



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# 1 Research findings



# Section 1: Research findings

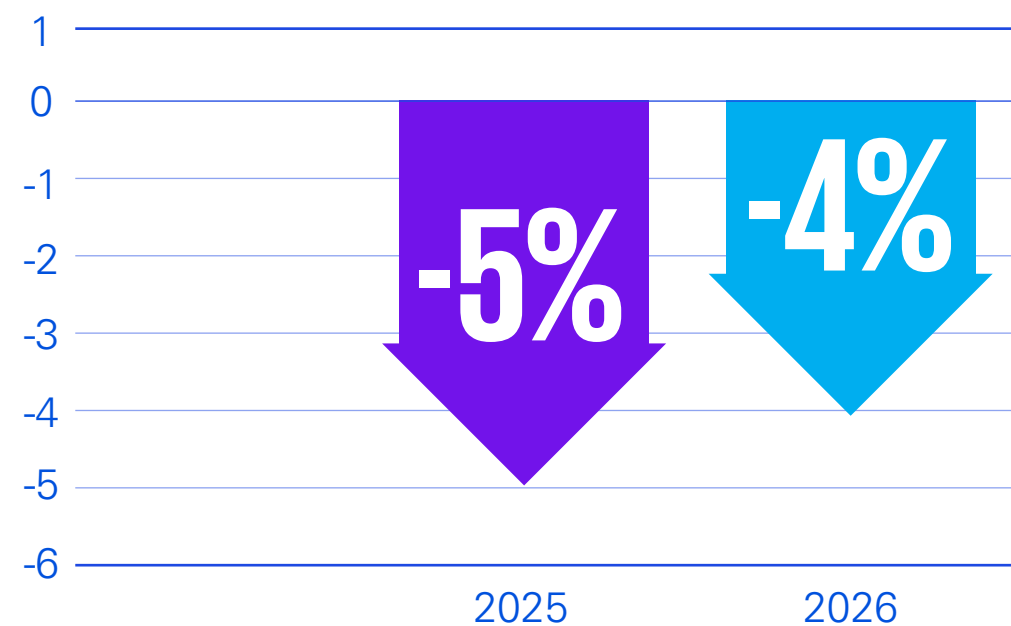
This year's research in healthcare shows the continuation of a decline in customer perceptions of the experiences they receive from payers that started in 2022 following the pandemic and is this year accelerated by significant declines in perceptions of trust and value.

## Research summary

The data indicates that the negative shift in customer experience is not an isolated event but a sustained and worsening trend. The initial decline postpandemic in 2022 has not only continued but also intensified, suggesting deeper systemic issues beyond the immediate impact of the pandemic.

Overall satisfaction within the sector has fallen by 4 percent and follows last year's decline of 5 percent. Significant declines in Integrity by 5 percent, Resolution by 4.5 percent, and Value by 4 percent tell a clear story.

### Customer satisfaction decline trend



- Erosion of trust and value:** The acceleration of decline is directly linked to significant drops in customer perceptions of trust and value. This is a critical insight, as trust and value are foundational to any customer relationship, especially in a vital sector like healthcare. A lack of trust stems from perceived unfairness, lack of transparency, or issues with fulfilling promises, while declining value relates to perceptions of high costs relative to benefits or service quality.
- Significant drop in overall satisfaction:** A 4 percent fall in overall satisfaction this year, building on last year's 5 percent decline, signifies a substantial deterioration in how customers view the sector. This consistent downward trend indicates that payers are struggling to meet evolving customer expectations.
- Specific areas of failure:** The detailed declines in Integrity (5 percent), Resolution (4.5 percent), and Value (4 percent) provide a clear picture of specific pain points for customers:
  - Integrity:** A 5 percent decline suggests customers perceive a lack of honesty, ethical conduct, or transparency from payers. This could relate to policy terms, billing practices, or communication about coverage.
  - Resolution:** A 4.5 percent decline in resolution points to difficulties customers face when trying to resolve issues, claims, or disputes. This can lead to significant frustration and dissatisfaction.
  - Value:** A 4 percent drop in value reinforces the idea that customers feel they are not getting adequate return for their premiums or contributions, especially given rising healthcare costs and potentially complex benefit structures.



Integrity  
down by **5%**

Resolution  
down by **4%**



Value  
down by **4%**

The data paints a clear picture of a US healthcare payer sector facing a crisis of confidence from its customers. The accelerating decline in trust and value, coupled with significant drops in overall satisfaction and key service attributes like integrity and resolution, indicates that current operational models and customer engagement strategies are likely falling short.

For payers, these trends suggest an urgent need to re-evaluate their approaches to transparency, claims processing, customer support, and the perceived fairness and worth of their offerings to rebuild trust and help improve customer perceptions.

## Methodology

This year almost 3,000 customers rated their experiences with leading health insurance companies across six dimensions of experience: Integrity, Resolution, Expectations, Time and Effort, Personalization, and Empathy (the Six Pillars of Experience).

These pillars have been demonstrated from over 8 million customer evaluations, conducted globally, to be the DNA of superior experiences as perceived by the customer. Organizations that deliver against the Six Pillars of Experience consistently display superior commercial results.

Respondents have interacted with these companies at least once in the last six months. Respondents provided scores for each of these pillars based on their experiences; this provided a compound metric that was then used to generate a league table or index.



# Key trends affecting healthcare payers and health insurance companies

Working with clients, we have observed the following trends that either directly or indirectly affect the member experience:

## Administrative cost and legacy systems

A significant portion of administrative costs in healthcare is attributed to outdated claim systems and the ongoing transition to cloud-based solutions. This “legacy tech debt” hinders the ability to fully leverage new technologies like AI.

## Interoperability and operational processes

Interoperability hurdles stem from fragmented data silos and a lack of real-time visibility into healthcare service utilization, which hinders coordinated care and impacts reimbursement. Technical complexities arise from incompatible electronic health record systems, one-way data transfer, and a lack of standardized data formats.

## Member abrasion

Consumers of healthcare compare their healthcare experience to that of social media platforms. They desire ease and simplicity but often find health insurance interactions cumbersome and frustrating. This leads to a lack of positive sentiment towards health insurance companies.

## Provider abrasion

Healthcare providers also face challenges working with insurance companies. This includes difficulties in getting claims paid, frequent rejections, and the administrative burden of submitting and resubmitting documentation. This friction makes providers reluctant to work with certain insurance networks.

## Network as a key differentiator

The size and quality of a provider network are crucial selling points for health insurance companies. If a network is not extensive enough, then it creates problems for both members seeking care and the insurance company trying to attract and retain customers.

## Prior authorization reform

Prior authorizations are a major source of both member and provider abrasion. They can delay necessary care, leading to frustration and potentially negative health outcomes. There’s a significant push in the US for reform in this area.

## Rising healthcare costs and affordability

The overall cost of healthcare is increasing, driven by various factors, including political decisions (e.g., changes in Medicaid funding). This trend will likely lead to higher premiums and reduced access to care, as hospitals may cut services that are “loss makers.”

## Industry consolidation

The health plan market is experiencing significant consolidation through joint ventures, affiliations, and acquisitions. This trend is driven by the unsustainability of smaller plans and will likely result in fewer choices for consumers.





# 2 Cost and customer experience are inextricably linked

# Section 2: Cost and customer experience are inextricably linked

From soaring medical and drug costs to increasing regulatory burdens and diminishing returns on traditional cost-cutting measures, the imperative for efficiency has never been greater. Yet, amid this relentless pursuit of the bottom line, a critical truth remains: and costs are not only related, but also inextricably linked.

For too long, the member experience has been viewed as a “soft” concern, an investment primarily driven by market differentiation rather than a fundamental driver of financial health.

Conversely, a truly superior member experience is not merely a choice; it is a powerful engine for profitability and sustainable growth. By proactively addressing member needs, simplifying complex processes, and fostering genuine engagement, payers can dramatically reduce operational inefficiencies, decrease service costs, help improve retention, and unlock new avenues for value creation.

The challenge, then, lies in shifting from a piecemeal approach to one that systematically defines, measures, and improves the member journey across all critical touchpoints.

This is where the KPMG Six Pillars of Experience emerge as a powerful and actionable framework. Research by the KPMG Customer Experience Excellence Center over the past years has consistently shown that these are the DNA of leading experiences and key drivers of superior customer outcomes.

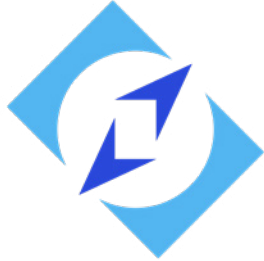

Applied to the specific environment of health insurance companies, these pillars, Personalization, Integrity, Expectations, Time and Effort, Resolution, and Empathy, provide a detailed lens through which to assess, design, and improve every facet of the member experience, in the context of the cost it saves or the revenue it enhances.

They move beyond fragmented initiatives to offer a holistic, integrated approach, helping ensure that every strategic decision and technological investment serves to enhance the member journey while simultaneously delivering tangible financial returns.




By adopting this pillar-driven methodology, payers can precisely identify the root causes of both member dissatisfaction and hidden costs, transforming their operating model from one that conceals liabilities into one that champions efficiency, effectiveness, and distinguished member satisfaction.



# The KPMG Six Pillars of Experience

Pillar	Description	Key attributes	Cost implications
 <b>Integrity</b>	Building and maintaining member trust through unwavering transparency, honesty, ethical practices, and reliability in all aspects of policy, benefits, and claims administration	<ul style="list-style-type: none"> <li>• Clear policy language</li> <li>• Transparent claims processing</li> <li>• Data privacy and security</li> <li>• Ethical marketing and sales practices</li> <li>• Reliable customer support</li> <li>• Acting in the members' best interests</li> <li>• Keeping promises and commitments</li> </ul>	<ul style="list-style-type: none"> <li>• Legal, regulatory fines and penalties</li> <li>• Reputational damage and loss of market share</li> <li>• Increased member complaints and escalations</li> <li>• Higher claims litigation costs</li> <li>• Increased compliance overhead</li> </ul>
 <b>Resolution</b>	The effectiveness, fairness, and empathy with which the insurance company addresses and resolves member issues, inquiries, complaints, and appeals	<ul style="list-style-type: none"> <li>• Clear and accessible complaint channels</li> <li>• Fair and transparent appeals process</li> <li>• Proactive issue detection and mitigation</li> <li>• Efficient dispute resolution</li> <li>• Compassionate support during difficult times</li> </ul>	<ul style="list-style-type: none"> <li>• Escalated complaints and regulatory involvement</li> <li>• Increased churn and negative public relations</li> <li>• Higher cost per issue</li> <li>• Legal fees and settlements</li> <li>• Loss of employee morale and productivity</li> </ul>
 <b>Expectations</b>	Consistently meeting or exceeding member expectations regarding the clarity of benefits, ease of access to information, responsiveness of support, and the overall value provided by their health plan	<ul style="list-style-type: none"> <li>• Easy-to-understand benefits</li> <li>• Prompt and accurate claim processing</li> <li>• Accessible and responsive customer service</li> <li>• Up-to-date and accurate provider directories</li> <li>• Efficient digital self-service</li> <li>• Legal, regulatory fines and penalties</li> </ul>	<ul style="list-style-type: none"> <li>• Increased member contact for clarification</li> <li>• Increased member churn</li> <li>• Higher administrative burden</li> <li>• Negative feedback and brand damage</li> <li>• Rework and error correction</li> </ul>

## The KPMG Six Pillars of Experience (continued)

Pillar	Description	Key attributes	Cost implications
 <h3>Time and Effort</h3>	<p>Reducing the time and effort members need to invest to understand their benefits, enroll in a plan, submit claims, find providers, and resolve any inquiries or issues with their health insurance</p>	<ul style="list-style-type: none"> <li>• Streamlined enrollment and onboarding</li> <li>• Effortless claims submission</li> <li>• Intuitive online portals and mobile apps</li> <li>• Rapid call resolution</li> <li>• Proactive notifications</li> </ul>	<ul style="list-style-type: none"> <li>• Increased member contact (process navigation)</li> <li>• Higher abandonment rates</li> <li>• Increased staffing needs</li> <li>• Reduced digital adoption</li> <li>• Member churn/lost business</li> </ul>
 <h3>Personalization</h3>	<p>Tailoring insurance plans, communications, health programs, and support to individual member needs, preferences, and health circumstances; this involves moving beyond demographic segmentation to truly understand and cater to each member's specific journey and requirements</p>	<ul style="list-style-type: none"> <li>• Customized plan recommendations</li> <li>• Individualized health management programs</li> <li>• Preferred communication channels and frequency</li> <li>• Proactive alerts and guidance</li> <li>• Tailored digital experience</li> </ul>	<ul style="list-style-type: none"> <li>• Increased member churn and acquisition costs</li> <li>• Ineffective program utilization and wasted investment</li> <li>• Suboptimal health outcomes</li> <li>• Reduced cross-sell/up-sell opportunities</li> </ul>
 <h3>Empathy</h3>	<p>Demonstrating a deep understanding of and responsiveness to members' emotional states, health-related concerns, and their overall human experience navigating the healthcare system from an insurance perspective</p>	<ul style="list-style-type: none"> <li>• Understanding health challenges</li> <li>• Compassionate and active listening</li> <li>• Offering support and resources beyond benefits</li> <li>• Flexible and understandable solutions</li> <li>• Emotionally intelligent interactions</li> </ul>	<ul style="list-style-type: none"> <li>• Increased "difficult" contact volume (emotional distress/repeat contacts)</li> <li>• Higher churn rates</li> <li>• Negative brand perception</li> <li>• Lower health program engagement</li> <li>• Increased employee burnout and turnover</li> </ul>



# The Six Pillars span employee experience and customer experience

Exceptional experiences are not created by technological improvements alone - they are built on a progressive foundation of trust, clarity, and care. This model shows how the KPMG Six Pillars of Experience operate in a hierarchy, not unlike Maslow's pyramid of needs. At the base are foundational expectations - clarity of purpose, reliable support, and consistent delivery - without which higher-order experiences are unsustainable.

The link to Net Promoter Score (NPS) is clear: organizations that reliably deliver on the basics earn moderate advocacy, but those that build from that base to deliver on recognition, empathy, and personal relevance create strong emotional loyalty - and exceptional performance. Investing in sophisticated technologies to drive personalization or proactive engagement will have limited impact if trust-eroding events - like inconsistent service, lack of transparency, or delayed resolution - persist in the experience.

This model applies equally to employee experience and customer experience, highlighting the dual importance of internal culture and external delivery. Organizations that perform best understand that customer excellence begins with employee clarity, support, and purpose.




# 3

## A blueprint for improvement

# Section 3: A blueprint for improvement

A simple first step is to focus on connecting the data that payers already have. By meticulously analyzing operational data, customer interaction logs, claims information, and feedback, payers can precisely pinpoint disconnects between member expectations and service delivery.



Data can also reveal conflicting processes (e.g., specific doctor coding practices leading to unexpected claim denials that then generate further inquiries and manual rework) and unnecessary costs (e.g., excessive transfers between departments, redundant data entry across systems, or the financial burden of managing reactive, rather than proactive, issue resolution).

This is a proactive, evidence-based strategy, utilizing data to pinpoint specific areas that are likely to drive high costs or poor experience, formulating data-supported hypotheses, and then rapidly proving or disproving them to deliver measurable financial value.

Many current solutions address symptoms rather than underlying problems. By connecting disparate systems and data points, payers can identify the true root causes of issues, such as specific doctor coding practices leading to claim denials or confusing narratives causing member inquiries. Addressing these root causes proactively, rather than reactively, is crucial for sustainable cost reduction and improved experience.

Aligning internal incentives to reward resolution and improved member experience is essential for fostering a customer-centric culture.

## Areas for focus

In complex ecosystems like the payer industry, it's easy to be overwhelmed by a multitude of challenges, operational inefficiencies, fragmented member journeys, technological debt, and a relentless pressure on costs.

The temptation is often to initiate broad, sweeping changes or to reactively address every perceived symptom as it arises. However, this scattergun approach rarely yields sustainable results and often dissipates valuable resources.

## Strategic Optimization Points

Strategic Optimization Points (SOPs) represent high-leverage areas within the member journey and underlying operational value streams where targeted intervention can generate the most significant and measurable improvements in both customer experience and financial performance.

These are not merely “problem areas”; rather, they are specific junctures where a critical disconnect exists between member expectations and service delivery, or where hidden costs are disproportionately concentrated.

By identifying and strategically addressing these SOPs, payers can avoid the pitfalls of addressing symptoms and instead implement changes that lead to sustainable cost reduction, enhanced member satisfaction, and a truly competitive advantage in the market. It is about working smarter, not just harder, to transform the end-to-end operating model.

Examples include:

**1** **Fragmented member inquiry resolution:** Disconnected internal systems, processes, and departmental handoffs for member inquiries lead to redundant contacts, increased call handling times, and higher operational costs, as members are repeatedly transferred or forced to re-explain their issues across multiple touchpoints.

**2** **Reactive claims management and error correction:** A reactive approach to claims processing, which primarily focuses on resolving errors or denials after they occur rather than proactively identifying and correcting root causes (e.g., specific doctor coding practices, incomplete patient information, or system configurations), results in inflated administrative overhead, appeals processing costs, and diminished provider satisfaction.

**3**

**Ineffective digital self-service platforms:** Digital self-service channels (e.g., member portals, AI chatbots) that are designed to address isolated questions rather than the holistic, interconnected needs of members lead to high abandonment rates, member frustration, and costly escalations to more expensive human-assisted channels for issues that should have been digitally resolvable.

**4**

**Inadequate member education and benefit literacy:** Insufficiently clear, personalized, or timely communication regarding member benefits, coverage limitations, and financial responsibilities drives a higher volume of preventable member inquiries, increased call center utilization, and greater administrative burden related to explaining basic plan information.

**5**

**Misaligned provider engagement and data exchange:** A lack of seamless, bidirectional data exchange and proactive communication between payers and providers regarding network status, prior authorizations, and claims submission guidelines creates administrative rework, payment delays, and increased costs associated with managing provider inquiries and disputes.

**6**

**Siloed organizational structures and conflicting incentives:** Internal organizational structures with departmental silos and performance metrics that reward efficiency within individual functions rather than holistic member issue resolution inadvertently perpetuate customer frustration and drive-up overall service costs due to unresolved underlying problems.

**7**

**Poor proactive risk identification and intervention:** A lack of robust data analytics and integrated care management programs to proactively identify members at high risk for preventable health events or noncompliance with care plans results in higher long-term medical expenditures due to more severe, acute interventions and costly hospitalizations.



# 4 The path to member experience excellence

# Section 4: The path to member experience excellence

The path forward is not about choosing between improving customer experience and reducing costs; it's about recognizing that these objectives are mutually reinforcing.

Here is a series of immediate next steps payer organizations can take, designed to simultaneously enhance member experience and drive down the costs to serve.



#### Pinpoint SOPs with data diagnostics:

- **Action:** Initiate a rapid, data-driven diagnostic to identify specific SOPs. This involves analyzing existing operational data (e.g., call logs, claims processing times, portal abandonment rates), member feedback (surveys, complaints), and financial metrics (e.g., cost per contact, member churn).
- **CX and cost impact:** This step precisely identifies where high customer friction (poor CX) directly correlates with high operational costs (increased costs to serve), enabling targeted interventions that deliver dual benefits. For example, a high volume of calls following explanations of benefits (EOB) delivery points to an SOP in communication clarity.

#### Targeted customer journey and value stream mapping:

- **Action:** Select one or two high-impact SOPs identified in the diagnostic (e.g., new member onboarding, complex claims inquiry). For these chosen areas, meticulously map the current-state end-to-end customer journey and the underlying operational value stream.
- **CX and cost impact:** This exercise visually exposes pain points for members (poor CX) and their operational root causes (inefficiencies, manual handoffs, system disconnects, high costs to serve). It moves beyond symptoms to identify core areas for improvement across the Time and Effort and Resolution pillars.

#### Deploy intelligent automation and AI agents strategically:

- **Action:** Based on the mapped journeys and SOPs, strategically implement intelligent automation (e.g., robotic process automation, AI agents) to streamline repetitive, error-prone tasks and eliminate manual handoffs within the selected value streams.
- **CX and cost impact:** By automating routine inquiries and administrative processes, AI agents' free human talent for more complex, empathetic interactions (improving Empathy and Resolution for high-value cases), while simultaneously reducing processing times and overall operational costs. This directly addresses the hidden costs of inefficiency.

#### Empower and upskill talent:

- **Action:** Reallocate human resources freed by automation to higher-value activities. Invest in focused training for front-line staff on empathetic communication, complex problem-solving, and leveraging a unified member view (enabled by technology).
- **CX and cost impact:** Empowered and empathetic staff provide superior resolution and enhance empathy, leading to higher first-contact resolution rates and reduced escalations, thereby lowering the cost per issue and improving member loyalty.



#### Standardize and simplify member communications:

- **Action:** Review and revise key member communications (e.g., EOB, policy documents, digital portal content) related to the identified SOPs. Focus on using plain language, clear calls to action, and addressing common member questions proactively.
- **CX and cost impact:** Clearer, more transparent communication reduces member confusion and inbound inquiries (lowering member contacts), directly improving member expectations and demonstrating integrity, leading to tangible reductions in costs to serve.

#### Improving communications with providers:

- **Action:** Proactively disseminate clear, concise updates on policy changes, reimbursement schedules, and medical necessity guidelines. Establish dedicated provider support teams and feedback mechanisms to help ensure that concerns are addressed promptly and that communication processes are continuously refined based on provider input.
- **CX and cost impact:** Streamlined communication can lead to fewer claims denials and faster approvals, improving cash flow for providers and reducing the need for costly rework for payers. For providers, this translates to a more efficient and less frustrating experience as customers of insurers, allowing them to focus more on patient care rather than administrative burdens.

#### Implement real-time feedback loops and performance metrics:

- **Action:** Establish continuous measurement systems that track both operational efficiency (e.g., process cycle time, cost per transaction) and member experience outcomes (e.g., CSAT, NPS, first contact resolution) for the targeted SOPs. Integrate member feedback channels for ongoing insights and metrics for the payer/provider relationship such as administration efficiency, cost management, and quality of care.
- **CX and cost impact:** This creates an agile improvement cycle, allowing organizations to rapidly assess the impact of changes, demonstrate the financial return on investment of CX improvements, and continuously refine their approach to optimize both member satisfaction and operational costs. It helps ensure that changes deliver on both CX and cost reduction promises.

By systematically addressing these steps, payer organizations can move beyond a reactive, fragmented approach to one that strategically interlinks customer experience improvements with sustainable cost efficiencies, driving both member loyalty and financial strength.

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**To learn more about how we help healthcare organizations, please visit: [read.kpmg.us/navigatinghealthcare](https://read.kpmg.us/navigatinghealthcare).**

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