COMBAT DISENROLLMENT BY ADDING VALUE

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Globally, two elements drive managed care choices made by employee benefits managers: quality and price. Taken together, these two components define a critical dynamic that most managed care providers are not monitoring. That dynamic is value, customer value to be specific. Value is the interaction between quality and price typically represented in the following functional form:

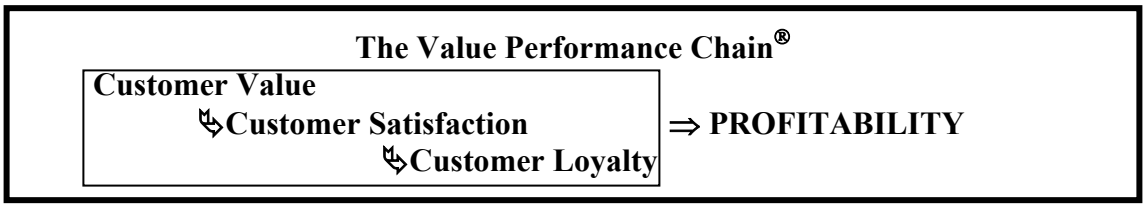
Value = Quality/Price

In many industries quality is easily measured. You can measure the quality of wire in terms of tensile strength, automobiles in terms of miles per gallon or ability to withstand collisions at certain speeds, heavy equipment in terms of down time, or gold in terms of karats. Value then, is the cost of wire at various tensile strengths with typically the highest tensile strength at the lowest cost representing the Outstanding Value. Relatively simple, isn't it?

But how do you measure the product/service offered by managed care providers to their corporate customers? Most managed care providers rely on satisfaction measurement systems to provide feedback. Unfortunately, many HMOs understand that customer satisfaction is not providing them with the operational and strategic linkages necessary to manage their offerings in an extremely competitive environment where customer retention is critical to HMO profitability.

UNDERSTANDING VALUE MEASUREMENT

Measuring value begins with understanding a number of key factors. First, like beauty, customer value is in the eyes of the beholder. It is often perceptual. Second, value is relative-relative to other managed care offerings. Measuring satisfaction in a competitive vacuum, as many managed care operations do, is not only myopic it is delusional. The same holds true for value. Value has no meaning unless it is comparative. Third, to be effective from a strategic and operational standpoint, the customer value measurement system must be capable of linking with other information platforms. If your HMO is like others, you probably collect reams of data that have no linkage to each other. These functional silos of data, as one HMO manager characterized them, become meaningless. They produce a modern analogy of the Biblical Tower of Babel. Fourth, and arguably the most important factor, is that satisfaction is an emotional outcome of some experience. It is an evaluation driven by a calculation producing a sense of happiness or unhappiness. By focusing on satisfaction, managers are attempting to manage the outcome rather than the dynamic that produces the outcome. Our experience shows us that there is a critical chain, what we call the Value Performance Chain®, linking value, satisfaction, loyalty, and ultimately profits.



It is your value proposition that corporate customers evaluate that produces satisfaction that in turn creates loyalty. **And, the highest correlate with profitability, regardless of industry type, is customer retention**. This is the chain that must be managed and monitored.

OPERATIONALIZING VALUE MEASUREMENT

To make operational the concept of quality we need to redefine value to make it more manageable. Consequently, we define value in the following manner. Value is the interaction of the benefits the customer seeks in a transaction relative to the price the customer is willing to pay. Or:

Value = Customer benefits :: customer price

This points out yet another weakness of relying on satisfaction as a monitoring metric. Typical satisfaction measurement systems treat price as an attribute like other benefit attributes. This is too simplistic because it fails to acknowledge the interactive nature of price in the consumer decision making process. Corporate customers rate an HMO on key benefits that they provide but they do so relative to the price they have to pay to acquire those benefits. Price is not independent in this calculation but is interactive.

To measure and to manage value it is critical to understand what benefits the customer seeks in a transaction or relationship and, his/her perception of the price the customer has to pay to acquire the benefits. So, to understand how your corporate customer perceives your value proposition you must understand the non-price and price drivers of value.

VALUE MEASUREMENT: A CASE EXAMPLE

In this actual example of value measurement, we identified two key non-price drivers of value: responsiveness and a willingness to partner with the organization (partner). These drivers emerged from a modeling process involving 500 corporate customers or a large Midwest HMO.

Responsiveness includes such attributes as the HMO's:

- prompt accurate claims administration,
- having knowledgeable/responsive account representatives,
- customer service/problem resolution and

- proactive communications with employees.

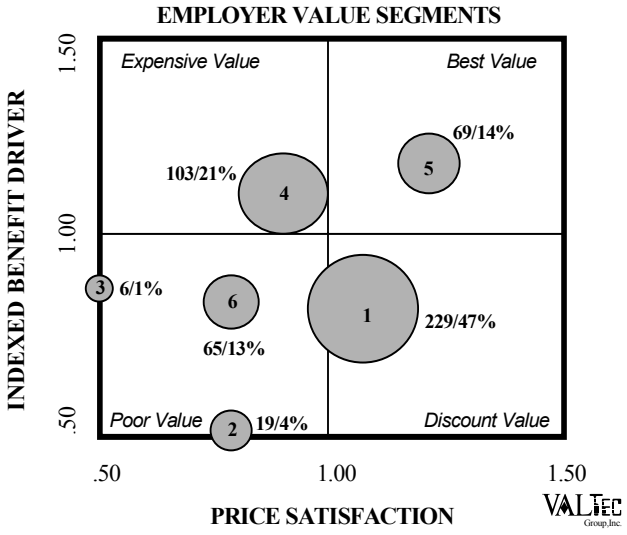
Partnership is comprised of attributes such as:
- encouraging and facilitating a healthcare partnership with employers,
- clear information about utilization/outcomes,
- emphasis on wellness/health promotion, and
- customization of plans.

These two drivers are weighted in terms of their individual importance in defining value and combined into an indexed benefit driver.

The **price** driver is comprised of items such as:
- predictable costs,
- lowest prices, and
- competitive prices.

Juxtaposing the indexed benefit driver with the price driver produces a Value Matrix® such as the one shown here.

The Customer Retention Matrix® is divided into four quadrants based upon employer perceptions of their satisfaction with the HMO's performance on the indexed benefit driver and their satisfaction with the price driver. The top right quadrant is the **Outstanding Value** quadrant so-called because employers located in this quadrant feel that the HMO is providing above average performance on the indexed benefit driver and the price driver. The circle, group 5, represents 14% of the HMO's employer customers who feel that the HMO is delivering high value. To the right is the **Expensive Relationship** quadrant, so named because employers located in this quadrant, group 4 representing 21% of the employer base, feel that the HMO is delivering high satisfaction on the benefit driver but at a high price producing low price satisfaction. The **Poor Value** quadrant contains 3 employer groups, groups 3, 6, and 2. Taken together they represent 14% of the employer base that feels they are receiving below average benefits at a high price that produces low price satisfaction. While all three groups are located within the Poor Value quadrant, they are located here for three different reasons. First, group 3, is highly dissatisfied with the price they are paying and marginally dissatisfied with the benefits they are receiving. Group 2, by contrast, is telling HMO management that they are very dissatisfied with the benefits while "somewhat" dissatisfied with the price element. Finally, group 6, the largest group of Poor Value corporate customers, shares a similar view of benefit delivery as group 3 and a similar view of price as group 2. In the **Discount Relationship** quadrant there is a group of employers, group 1, comprising 47% of the employer customer base. These employers feel they are receiving below average performance on the benefit driver but at a price that is producing above average price satisfaction.



CUSTOMER VALUE IS THE KEY TO LOYALTY

The implications of managing the value provided to HMO corporate customers are seen in looking at how value affects satisfaction ratings of these customers. On a scale ranging from "Extremely satisfied" (5) to "Not at all satisfied" (1) corporate customers ere asked to rate their overall satisfaction with the HMO. The average satisfaction score for the **Outstanding Value** corporate customers is 4.70 out of a possible 5.00. For the **Poor Value** groups, in stark contrast, satisfaction scores are substantially and significantly lower. For example, for the **Poor Value** group 6, satisfaction scores averaged 3.74 out of 5.00. Satisfaction scores for group 3 averaged 2.58 out of 5.00 while for **Poor Value** group 2 satisfaction scores averaged 2.67. In between the **Poor Value** customers and the **Outstanding Value** customers are their **Expensive Relationship** and **Discount Relationship** counterparts. Satisfaction of the **Expensive Relationship** customers averaged 4.11 while satisfaction scores for the **Discount Relationship** customers averaged 4.34. What we see here is that the lower the perceived value on the part of corporate customers, the lower their satisfaction with the HMO. This finding is in keeping with the proposition put forward in our Value Chain®. Satisfaction is an emotional response to the value proposition delivered by the managed care operation. The implications are clear. **To create satisfied customers manage the value you deliver to them.**

Of particular interest is how value ultimately affects customer loyalty. An analysis of corporate defectors over the past year showed that of the four major defectors, 2 corporate defectors were from the **Poor Value** 2 group, one was in the **Expensive Relationship** group, while the other was in the **Discount Relationship** group. **No corporate customer in the Outstanding Value group changed managed care providers.** Your customers who feel that they are getting outstanding value from you should be viewed as an annuity, one that will continue to pay dividends in the future. Poor value customers are the most likely defectors willing and often eager once a contract expires to take their business elsewhere. And, given the competitive nature of healthcare, there are many options available to them. This is the ultimate test of value on retention and points out that the only loyal customers are those that perceive outstanding value from their managed care providers.

What to do about those customers in lesser value positions? First, by linking your customer value information system with your other information systems you can put a cost of poor value on these customers. This will tell you how much revenue you stand to lose if and more likely when these customers defect. You can then decide whether you actually want to retain this customer. Once a retention decision is made we recommend conducting a failure analysis. The objective of a failure analysis is to understand why customers in **Poor** Value groups do not perceive the kind of value that their counterparts in the **Outstanding Value** group do. We know what the key value drivers are and the constituent attributes that comprise these drivers. These become the basis for identifying why the provider is not delivering outstanding value. Questions concerning the partnership driver might focus on:

- How can we provide clearer information on utilization and outcomes? How can we work with you to make sure you are getting the kind of information when you need it? What information that you are getting is not needed? What information are you not getting?
- How can we better partner with you to provide your healthcare needs? How can we better promote wellness with your employees? How can we better customize plans to fit your needs?

Questions for improving performance on the responsiveness driver might include:

- Why are our claims not perceived as accurate? Is there a real problem or a misunderstanding in the form or format? How can we speed up the process?
- What is happening in our problem resolution process that is causing problems? Is the discontent limited to only those for whom the process decides against or is it a problem involving all claimants?
- How can we make the communication process more effective and responsive? What communication problems are we experiencing? Are these universal or are they isolated?

This failure analysis should be the focus of continuous improvement teams. They should be charged with the objective of improving the value proposition of customers who are not in the **Outstanding Value** quadrant. System changes should be implemented and monitored for their ability to deliver value. This is a continuous

process-one that constantly seeks to improve the value you provide your customers. Failing to understand what is necessary to increase value and failing to act on this information makes these valuable customers easy targets for competitors who are more willing to provide the value they want and need.