Creating Member Value: A Rx for Success

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Einstein once said that "You can't solve current problems with current thinking. Current thinking caused current problems!" While it is not likely that Einstein was thinking about managed care when he uttered this basic truism, it is nonetheless apropos. No longer can managed care continue to rely on the current thinking that produced the cost cutting initiatives that dominated HMO strategy. New thinking is required - thinking that focuses on the creation of value for the different key constituencies that it serves. These constituencies include members, patients, physicians and benefit managers. One client HMO, has modified its traditional performance outcome measures to give management the added power that a focus on customer value provides.

WHAT IS VALUE?

The concept of value is not new. Typically, value is defined as the relationship of some benefit to the cost of acquiring that benefit, represented by the following equation:

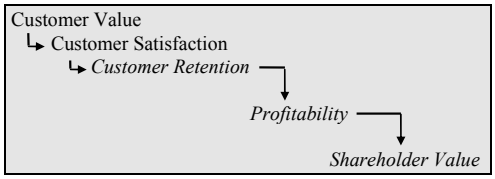
$$\text{VALUE} = \frac{\text{Benefits Sought in Transaction}}{\text{Cost of Acquiring Those Benefits}}$$

Transactional benefits, of course, vary from industry to industry as do the costs of acquiring those benefits. To deploy a value orientation then, it is incumbent upon HMO management to identify and understand the benefits sought by the various constituencies and deliver those benefits at a price that the customer feels is fair.

Many of these benefits are perceptual in nature. While the tinsel strength of cable or the mileage per gallon can be measured in a physical sense, access to healthcare or prompt service is perceptual. Moreover, it is important to understand that an individual's perception of value is relative, relative to other competitive sources and providers of value.

What is new with regard to using value as a strategic weapon, is the ability to measure value. With this ability comes the additional power to manage value and to create a differential value advantage that leads to superior performance. Failing to actively manage the value proposition provided by your organization means that the value perceived by current constituencies is actually being managed by your competition.

Value is important because it is a vital link in what we call the ***Value Performance Chain***, which is depicted below.



Many HMOs are diligently and slavishly measuring customer satisfaction. Typically this process involves the identification of a large number of items to which customers provide a response on a 5 or 7 point scale anchored by very or highly satisfied and very or highly dissatisfied. Included in this list is an item or two which measures respondent satisfaction with the price that they pay for their healthcare.

Unfortunately, this approach fails to understand the critical linkages among the various elements in the ***Value Performance Chain***. It fails to understand what customers are really satisfied with. Satisfaction is an emotional response to an outcome. Satisfied customers are happy with something. They are pleased when they are satisfied and they are displeased when they are dissatisfied. But pleased or happy with what? Each of the myriad items measured in the questionnaire? Unlikely, because of the information processing required. What they are happy and pleased about, satisfied, if you will, is the value proposition provided by their HMO.

Satisfaction with an individual item has been shown to be fleeting. However, satisfaction with the value provided by a product/service offering is significantly more enduring. Customer reactions to value are much more stable.

Perhaps more importantly, the real evaluative dynamic does not treat price as an independent element in the decision process. Individuals evaluate not only what they get or want (benefits) but they do so in conjunction with the price they have to pay to acquire those benefits. Typical satisfaction approaches do not treat price as an interactive element of the decision process. Rick Dorazil, benefits director at Motorola

clearly points this out when he states, that value is a function of quality, access, and cost (price).
The enduring nature of value and its critical role in influencing satisfaction is important because both factors are instrumental in forming the customer's decision to stay with a healthcare provider or to leave. Customer retention, we know, is the strongest determinant of organizational profitability and shareholder value. It is the entire ***Value Performance Chain*** that must be managed.

Accordingly, it is the entire ***Value Performance Chain*** that must be measured and monitored. Here is how measures the critical linkages in this chain s they pertain to their members.

THE VALUE CREATING MODEL

The HMO modified its traditional customer member satisfaction system to provide a value perspective. How does the HMO's product stand up to member's value assessment? The answer to this question required several intermittent steps.

Identifying Key Member Benefits

First, instead of relying on individual questionnaire items, we factor analyzed the evaluative items to determine the underlying dimensional nature of them. How do members cognitively organize the various evaluative items into broader and more interpretable dimensions?

The analysis produced four factors:

Doctor Choice:
Ease of seeing the doctor of your choice
Number of doctors you have to choose from

Responsiveness:
The Service Center (SC) representative follows up on any commitments made to you
Situations or problems are resolved to your satisfaction
Questions are responded to quickly and efficiently
The SC rep confirms your satisfaction before ending the conversation
Your needs are satisfied
The SC rep has knowledge of HMOs products, services, policies and procedures
Empathy is shown by the SC rep when discussing a difficult or upsetting situation
Your self-esteem is maintained during the conversation
The SC rep acknowledges you promptly and courteously
Administrative ease of the delivery system

Access to Medical Care:
Access to a hospital if you need it
Access to medical care in an emergency
Coverage for illness visits, treatments, or hospitalization
Range of services covered by your plan
Coverage for preventive care and routine office visits

Perceived Healthcare Cost:
The part of the premium you pay for covered costs
The amount you pay out-of-pocket (copays)

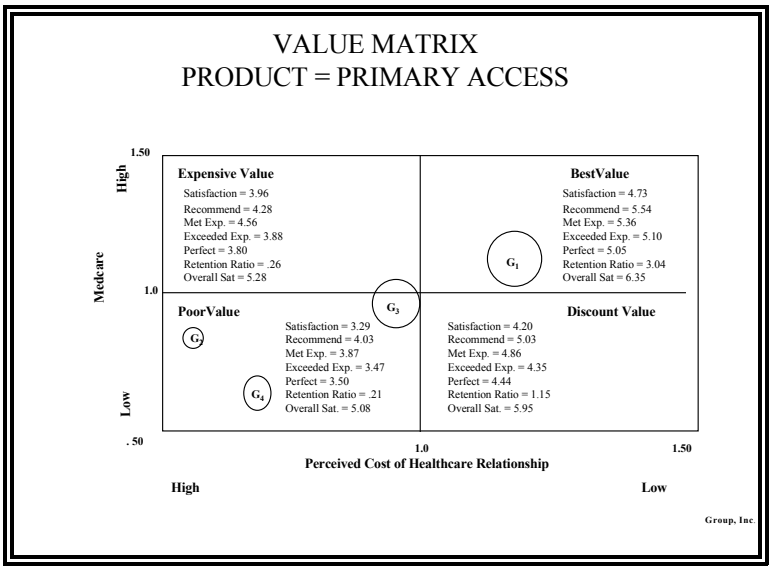
Deriving Benefit Importance

Since it is not likely that all three dimensions were equally important in the determination of a member's satisfaction, the three dimensions (Responsiveness, Doctor Choice, and Access to Medical Care) were input into a regression model to determine their relative importance. The traditional approach would be to correlate each item with the satisfaction measure. Because of the confounding effects of multicollinearity, these correlations would be done one-by-one, disallowing any potential interactive effects. Such an approach is naive and will produce misleading results.

The three dimensions were regressed against a measure of satisfaction of the HMO's product. The three dimensions explained 60% of the variance in the member's satisfaction rating. This is a strong relationship. The individual dimensions could then be ranked in terms of their relative importance in explaining satisfaction with the healthcare product. Access to Medical Care was the dominant dimension, followed by Responsiveness and Doctor Choice. The latter two dimensions were found to be similar in derived importance.

Identifying Your Value Proposition

A typical value analysis would examine the value proposition for each of the three dimensions. However, for the sake of illustration we will look at the most important benefit, Access to Medical Care. It will be recalled that value is a relationship between the benefit sought in the transaction and the cost of acquiring that benefit. In this case we are looking at the Access to Medical Care relative to the Perceived Healthcare Cost. This is done by creating the following ***Value Matrix*** and mapping member reactions to the value of their healthcare plan onto the matrix.



The ***Value Matrix*** juxtaposes the key driver of satisfaction, Medcare (Access to Medical Care) with the Perceived Cost of the Healthcare Relationship. This produces four quadrants. The upper left hand quadrant represents high ratings on the Medcare dimension but also perceptions of high cost. Because of these ratings we refer to this quadrant as the Expensive Value quadrant. The Poor Value quadrant represents those members who feel that they are receiving below average access to medical care and are paying a high price for it. The Discount Value quadrant corresponds to perceptions of low rating s on access to medical care but perceptions of a low cost for that access. The Best Vale, and actually the only real value option, corresponds to perceptions of high ratings of access to medical care and low costs of that access.

Member's perceptions of value are mapped onto the ***Value Matrix*** by use of a clustering technique which groups members based on their perceptions of access to medical care and their perceptions of the cost of healthcare. The size of the circles represents the relative size of the member groups. The largest group of members G_1 falls into the Best Value quadrant. This group constitutes about 47% of the membership, G_2 6%, G_3 38%, and G_4 9%. Two groups, G_2 and G_4, clearly fall into the Poor Value quadrant, while G_3 is a marginal group.

Profiling the Different Value Groups

The real power of the ***Value Matrix*** and value analysis comes from being able to profile the constituent groups in terms of their various attitudes and opinions regarding the healthcare product. These profiles reveal important information about how member perceptions of value affect subsequent decisions. Members were asked the following questions:

1. How satisfied are you with your healthcare plan (1 to 5)?
2. How willing are you to recommend this HMO to others (1 to 6)?
3. To what extent does your plan meet your expectations (1 to 6)?
4. To what extent does your plan exceed your expectations (1 to 6)?
5. To what extent is your plan perfect for you (1 to 6)?
6. What are your plans with respect to staying with the provider or switching to another provider (definitely stay, probably stay, probably switch, definitely switch)?
7. How satisfied are you with your overall healthcare (1 to 6)?

While most items are measured on a 5 point or 6 point scale and are readily understood, the retention ratio represents a different kind of metric. The retention ratio is calculated in the following manner. Only those members who indicated that they were definitely staying with the plan were considered as loyal members. Those who indicated that they would either probably stay, probably switch, or definitely switch were considered as switchers. The retention ration then is the ratio of stayers to switchers.

Let's begin with a comparison of G_2, a group of members who perceive poor value in the HMO offering and G4, their high value counterparts. The scores for each group on these key questions are shown next to the groups. Not only are there differences in

the scores but the magnitude of these differences is substantial.

Item Rating	G2 Score	G1 Score	Difference
1. Satisfaction with healthcare plan	3.96	4.73	0.77
2. Willingness to recommend	4.28	5.54	1.26
3. Plan met expectations	4.56	5.36	0.8
4. Plan exceeded expectations	3.88	5.1	1.22
5. Plan is perfect for me	3.8	5.05	1.25
6. Retention ratio	0.26	3.04	2.78
7. Overall satisfaction with healthcare	5.28	6.35	1.07

Of particular importance is the difference in the elements that constitute the ***Value Performance Chain***. Members who perceive superior value in their healthcare relationship also indicate superior satisfaction and significantly stronger loyalty. Of particular importance is the retention ratio. G_1 members had a retention ratio of 3.04. That means for every individual who indicated they would probably stay, probably switch or definitely switch, over 3 of the members who perceived outstanding value indicated they would definitely stay. G_2 members, on the other hand, had a retention ratio of .26. Members who perceive a superior value proposition clearly are significantly more loyal. Customer retention, it will be recalled from the earlier discussion of the ***Value Performance Chain***, is the direct link to profitability. This comparison can be made for all four member groups. The clear implications of this analysis points out that the closer groups of members approach the Best Value quadrant, the better the scores (see G_3).

Conduct a Failure Analysis

This value analysis leads directly to the next step in the process, a failure analysis. The failure analysis focuses on the question, "Why has the HMO's plan failed to produce less value for groups G_2 and G_4 than for group G_1?" This failure analysis is made even more effective if the customer value information system is linked to member records. In so doing, members in the different value groups can be identified. This will enable management to conduct a revenue and cost analysis of the different groups. Are some groups less profitable than others? If so, why? Do we need to design a different healthcare product for these groups that will provide greater value? What do we need to do to increase the value proposition for these low value members?

Directing this focus are the items that comprise both the medical care access dimension and the items that comprise the perceived cost of healthcare. For example, why do members in these low value groups feel as though:

1. they do not have access to the hospital if they need it?
2. they do not have access to medical care in an emergency?
3. their coverage for illness visits, treatments, or hospitalization is not adequate?
4. the range of services covered by the plan is insufficient?
5. their coverage for preventive care and routine office visits is not adequate?
6. the part of the premium they pay for covered costs is not acceptable?
7. the copays are not acceptable?

THE POWER OF VALUE

As Katherine Kunkle, vice president of the National Business Coalition on Health in Washington DC points out in an interview appearing in *Hospitals & Health Networks* (April 20, 1996, pp. 33-54), "People - employers want to buy value." The current thinking of cost cutting must be supplanted by new thinking-thinking that focuses on creating outstanding value for the different constituencies that comprise the customer base for HMOs and other healthcare providers. Value is a critical link that generates the satisfaction that forges loyal constituencies. These loyal constituencies are the basis for superior performance leading to profitability and shareholder value. This HMO's management is in the forefront of this new thinking. They are beginning to understand the power of delivering superior value to their members and other constituencies.