L.E.K.

EXECUTIVE INSIGHTS

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Pinpointing the Drivers of Health Plan Member Disenrollment

The equation for improving the Return on Investment (ROI) for retention is simple: payers gain a higher return on their sales and marketing investments the longer a member remains with them. Although the metrics for retention success are clear, the formula for reducing disenrollment is highly elusive. Despite the integral role that retention plays in a plan's long-term financial performance, many health insurers can't accurately identify or rank the top reasons why members leave their plans, and therefore are unable to address the problem effectively. With reform driving rapid expansion of the individual/retail market while also increasing margin pressure, it's critical that plans crack the code on reducing disenrollment now.

To help health plans address the challenge of reducing disenrollment, L.E.K. Consulting has detailed its approach to developing accurate and actionable insights into the true root causes of why their members leave.

Calculating Retention ROI

The economics of reducing disenrollment are compelling. Based on L.E.K.'s research, a "typical" 50,000-member Medicare plan with $600-$650 million in annual revenues can generate $70 million in incremental revenue during a two-year period by reducing annual disenrollment from 18% to a best-in-class rate of 10%.

In addition to the direct financial advantages, there are also three primary indirect benefits of reducing disenrollment:

1. Retention is central to successful care management – you cannot influence a member if they are only with you for a short period of time, and you cannot accrue the benefits of superior care management if they do not stay with you

2. High retention rates indicate high customer satisfaction, which can lead members to recommend their insurance plans to other prospects

3. Medicare Advantage Star Quality ratings and bonuses consider retention

Small Issues Combine to Fuel Churn

L.E.K. finds that disenrollment reasons vary significantly based on a myriad of factors with complex combinatorial effects. Reasons vary by plan type, geographic region, whether the member left before or after the initial on-boarding period (rapid vs. regular disenrollment), the selling agent or agency, whether the agent is an internal salesperson or a broker, etc. And each unsatisfied member often has multiple reasons for disenrolling rather than a single, obvious trigger. Some individual issues are relatively benign on their own, but multiple small experiences can create a "tipping point" that causes individuals to leave a plan. Without understanding and addressing the root causes, payers will not be able to reduce churn.

During our retention work with payers, we've seen a wide range of examples that illustrate this point. In one case, a

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48-year-old male expressed initial frustration with his health plan due to higher co-pays for doctor's visits, which he required monthly due to a medical condition. The individual made the decision to change insurers after his doctor complained about the difficulty of getting reimbursed by the health plan. In another example, a 33-year-old mother of four changed plans to access a broader network of pediatric specialists but the change was triggered by her irritation with multiple claims processing problems that she felt the health plan failed to address in a timely manner.

Two Keys to Identifying Causes of Disenrollment

Below, L.E.K. outlines the two critical steps to identifying the underlying reasons for disenrollment.

1) Intelligence Gathering During Exit Interviews

Despite the clear benefits of reducing churn, many insurers don't allocate significant resources to using member exit interviews to better understand this issue. Rather, it is often treated as a tactical customer service initiative to comply with corporate expectations – such as outbound survey calls or mailers to former members. As such, many traditional off-boarding programs aren't designed to effectively identify and analyze true disenrollment drivers or develop actionable mitigation plans.

L.E.K. finds that in-depth qualitative interviewing across a representative group of former customers is the most robust methodology to collect critical information. Using this approach, qualitative interviews are structured to be interactive and to pursue responses in a way that helps to highlight underlying issues. Consumer feedback is collected verbatim then synthesized and categorized into clearly defined categories (i.e., categories are developed from the research rather than being pre-determined).

Standard research methods often provide false or incomplete signals, whereas a dialogue with former members is critical to identifying true root causes.

The following example demonstrates how an in-depth interview can yield not only more insight, but a completely different answer than a high-level exit survey would. A standard disenrollment survey from a 77-year-old man from the Northeast initially indicated "PCP not in network" as the main reason for leaving the plan. At first this issue did not seem readily addressable. However, an in-depth qualitative interview revealed that the member was assigned to the wrong PCP by membership accounting and that related pervasive errors in the membership accounting system prevented member services from correctly reassigning the member to the appropriate PCP. This caused the member to feel misled by the selling agent and perceive poor service from member services. As a result of this and similar interviews, the payer identified underlying administrative system and process issues that contributed to member disenrollment that may have otherwise gone undetected.

Another example reveals how in-depth qualitative interviewing can provide additional details regarding the root causes of disenrollment and inform specific mitigation steps. A 74-year-old grandmother from a Midwestern suburb who disenrolled initially indicated on a standard disenrollment survey that "selling process misinformation" was the main reason for disenrollment. During the interview, however, the woman raised more specific concerns including:

- Formulary tiering and co-pay on one drug was incorrectly communicated, resulting in total monthly out-of-pocket prescription costs that were higher than her prior plan, despite most co-pays in the plan being lower

- The prior authorization process was not clearly communicated during the selling process and the member viewed the process as too cumbersome

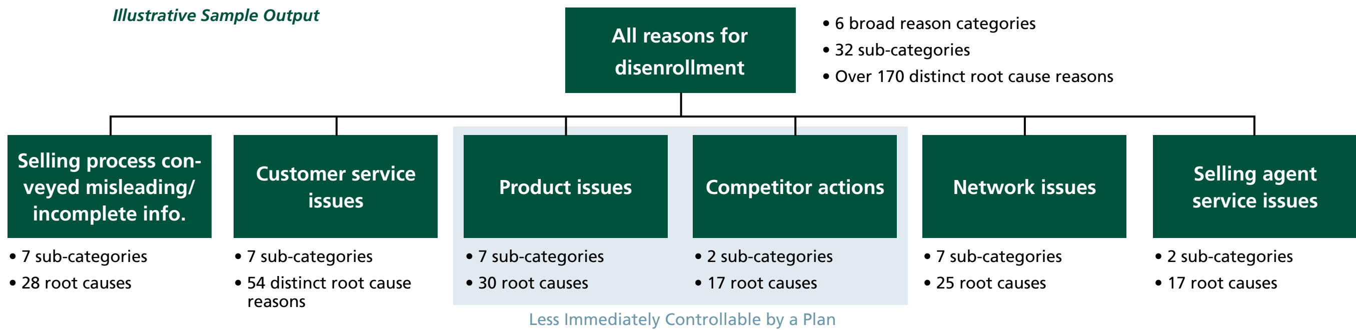
Her experience led her to drop the coverage after three months. Combined with similar interviews, the organization was able to identify and retrain problematic sales agents as well as enhance overall sales training by focusing on common problem areas.

2) Analyzing Root Causes

Completed interviews need to be converted into a root-cause hierarchy based on careful interpretation of each former member's story. This includes weighting the responses based on their contribution to the decision to disenroll, and coding the responses by category and sub-category. Each key reason is categorized into multiple tiers based on the underlying root

Figure 1

A Root Cause Hierarchy of Disenrollment



Source: L.E.K. Consulting

cause driving disenrollment. For example, a single reason could be categorized as Tier 1 = Sales, Tier 2 = Sales Training and Tier 3 = Explanation of the Formulary. This approach enables payers to prioritize corresponding initiatives and assign departments or teams to "own" specific categories or sub-categories as well as enabling broader communication of which issues are most important to address.

Figure 1 illustrates a health insurer's member disenrollment root cause hierarchy, including six categories, 32 sub-categories and more than 170 root-cause reasons. It is critical to break this information down into the most granular level of detail in order to analyze the data effectively and understand which root causes drive disenrollment on their own versus in combination with other factors.

Once the response information is catalogued and structured, payers can then use cross-tab analysis to identify the disenrollment factors that are unique to each product type, market, network and other variables (see Figure 2). This example

Figure 2

Region 1 Disenrollment Reasons: Rapid vs. Regular

		2010				2011			
		Rapid		Regular		Rapid		Regular	
Tier Two Reasons	Tier Three Reasons	Implied N	% of Subtotal	Implied N	% of Subtotal	Implied N	% of Subtotal	Implied N	% of Subtotal
Service Issues	Customer service conduct	58	13.5%	74	9.2%	75	27.8%	136	20.0%
Service Issues	Member communication issues	171	39.9%	215	26.6%	100	37.0%	83	12.2%
Service Issues	Operational issues – transportation	–	0.0%	62	7.7%	–	0.0%	81	11.9%
Service Issues	Customer service gave confusing/ unclear info	–	0.0%	19	2.4%	34	12.6%	120	17.6%
Service Issues	Customer service could not address network questions	7	1.6%	47	5.8%	6	2.2%	104	15.3%
Service Issues	Customer service could not explain benefit issues	55	12.8%	–	0.0%	–	0.0%	57	8.4%
Service Issues	Operational issues – enrollment/ eligibility	40	9.3%	120	14.9%	17	6.3%	40	5.9%
Service Issues	Member billed/provider education issues	29	6.8%	231	28.6%	13	4.8%	37	5.4%
Service Issues	Operational issues – provider claims	69	16.1%	39	4.8%	9	3.3%	–	0.0%
Service Issues	Operational issues – PCP assignment/ provider referrals	–	0.0%	–	0.0%	16	5.9%	22	3.2%
		429		807		270		680	

Source: L.E.K. Consulting

compares level two and level three service issues between rapid and regular disenrollments during FYs 2010 and 2011. Using this approach, plan executives can quickly see that the share of regular disenrollees who cited member communications as a reason for leaving declined nearly 15% points (more than 50% on a relative basis) between 2010 and 2011. However, rapid disenrollees reported less than a 3% point decrease during the same time period.

In addition to analyzing key drivers of disenrollment by various market, product and member characteristics, this approach can also identify strong positive correlations between two or more root cause issues, which can imply a "multiplier" or "cause-and-effect" impact on member satisfaction. For example, a complex product that is difficult for a member to understand or fails to meet expectations may also be difficult for customer service to explain.

Key Takeaways

When managed strategically, understanding the true drivers of disenrollment can provide insurers with clarity into performance gaps that can negatively impact members. Focused primary research and diagnostic analysis enable health plan leaders to identify true root causes and previously overlooked patterns systematically – such as member complaints that are individually benign but in combination can drive the decision to disenroll. Health plans should reevaluate their current exit programs to determine how they can use insights from in-depth member disenrollment interviews to identify and eliminate existing performance problems.

L.E.K.'s next *Executive Insights* on this topic will examine best practices for translating the precision disenrollment analysis discussed here into a pan-enterprise retention improvement plan.

L.E.K. Consulting is a global management consulting firm that uses deep industry expertise and analytical rigor to help clients solve their most critical business problems. Founded nearly 30 years ago, L.E.K. employs more than 900 professionals in 20 offices across Europe, the Americas and Asia-Pacific. L.E.K. advises and supports global companies that are leaders in their industries – including the largest private and public sector organizations, private equity firms and emerging entrepreneurial businesses. L.E.K. helps business leaders consistently make better decisions, deliver improved business performance and create greater shareholder returns.

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Note: all member examples have been edited to maintain payer and member confidentiality.

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