FUTURE SOLUTIONS IN
Customer Experience & Retention
for Private Health Insurance
WHITE PAPER

Leading insights and strategies on improving consumer experience for retention, acquisition and return on investment.

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Executive Summary

The ‘Future Solutions in Customer Experience and Retention for Private Health Insurance’ White Paper has been developed to help Australian health insurers deliver a greater customer experience and customer retention. This paper, based on extensive research, is intended for CEOs, General Managers, marketers, sales and customer service leaders, as well as industry analysts, policymakers and researchers. It is a ‘how to’ guide for getting closer to the consumer from a more complete, holistic perspective in order to drive strategic and tactical business decisions.

Insights in this paper were compiled from analysis of in-depth interviews and presentations from representatives of 10 Australian Private Health Insurance companies. Australia now has a relatively mature Private Health Insurance industry, with over 11 million members and over $21bn annual revenue in 2015. The evolving Australian market is increasingly complex, with consumers having access to over 17,000 different policies currently available for sale and over 25,000 policies in use in the market.

Lapse rates can rise to over 20% of customers with some insurers. This equates to lost revenue exceeding $2bn per annum from an estimated 940,000 members who switched funds in the 2013-14 financial year. These considerably high lapse rates have a significant financial impact on insurers due to the relatively tight net profit margins of most funds. In addition, insurers and customers waste a significant amount of time negotiating and resolving issues related to poor purchasing and claims experiences.

Applying a Systems Thinking approach to this complex problem, we identify a Vicious Cycle occurring in the industry in relation to customer retention and experience. From the consolidated analysis of contributor interviews, the real reason for poor customer experiences can be summarised into 4 major themes. These include customer perceptions of confusion and a perceived lack of value, regulatory and competitive forces, sub-optimal systems, processes and data management, as well as health system dynamics.

Analysis of interviews with industry experts consolidated a number of solutions, with an ‘antifragile’ solution model subsequently developed that is robust, resilient to unpredictability and enables an organisation to learn over time. In short, its execution must be a ‘Virtuous Cycle’ of customer experience (CX Solutions):

1. Define & Refine CX with Vision, Strategy and Objectives
2. Align Leadership and Culture with Change Management
3. Implement Systems and Capabilities to support CX
4. Translate Perceptions into CX Insights & Priorities
5. Apply CX strategically across portfolio, product design and marketing channels
6. Extend CX across healthcare ecosystem

For some organisations the implementation of all these solutions may take months to years and significant financial investment. For time-poor organisations that only have the capacity to do ONE THING that begins to move them in the right direction, improving their current understanding of their customer perceptions is the priority. Every step of the Virtuous Cycle is defined by having deep psycho-emotional insights into customer perceptions. It all begins with the customer in mind, or rather ‘the customer’s mind’.
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Objective of the Paper

The ‘Future Solutions in Customer Experience and Retention for Private Health Insurance’ White Paper is a research paper developed to help Australian health insurers deliver greater customer experience and customer retention. The Paper also benefits the customer acquisition process and consequent return on marketing investment. It is a ‘how to’ guide for getting closer to the consumer from a more complete, holistic perspective in order to drive strategic and tactical business decisions.

At a time of peaking lapse rates and switching amongst many insurers, critical insights into customer behaviour are more important than ever. Insurers are also challenged with rising customer expectations (especially from the Gen Y population) and having to decide on more fragmented marketing channels than ever before. Demographic changes and the increasing complexity of medical care also drive up the cost of claims, applying further pressure on margins. Knowledge of these key factors is essential in order for health insurers to prioritise their resources, focus channel activities, tailor brand propositions and improve return on investment of products and services.

Research in the Gartner 2015 report indicates that 50% of private companies are planning to invest more in customer experience strategies¹. The Customer 2020 report also indicates that customer experience will overtake price and product as the key differentiator². These insights emphasise the importance of meticulously designed and executed customer experience strategies in order to gain an advantage over competitors. For these benefits to be realised, customer experience initiatives must be meaningful and specific to an insurer’s customers.

From an acquisition perspective customer experience also impacts intention to purchase³. Yet there is a clear gap between how well companies consider they deliver a good customer experience and how well customers think companies deliver customer experience: 80% of companies say they deliver superior customer service, yet only 8% of customers agree⁴. Additionally, 70% of buying experiences are based on how the customer feels he or she is being treated⁵, highlighting the fundamental role that customer emotion and perception plays in insurer loyalty.

This evidence, coupled with high industry-wide lapse rates and switching, evidences a growing disconnect between what health insurers believe is being delivered and what customers actually value. Each person’s experience of health insurance is often confounded by the complexity of managing their health needs, navigating the medical system and selecting the most appropriate insurance policy. This paper therefore aims to identify the root causes of the gaps between insurer and customer, providing best practice strategies and solutions for closing that gap and meeting (and exceeding) customer needs.

Methodology

The insights in this paper are drawn from an analysis of in-depth interviews and presentations from representatives of 10 Australian Private Health Insurance companies. The companies involved were Medibank, BUPA, NIB, Australian Unity, Westfund Health, CBHS, Teachers Health Fund, Peoplecare Health Insurance, rt Health Fund, and Phoenix Health Fund. A diversity of roles were individually selected and interviewed including CEOs, Heads of Marketing and Sales, and leaders of Customer Insights, Customer Service and Customer Experience. This mix of roles and companies ensures a deeper and more diverse understanding of private health insurance (PHI) customer experience and retention.

This Paper also includes research from the Private Health Insurance Administration Council (PHIAC), the Private Health Insurance Ombudsman, and international reference sources on industry best practices. PanSensic text analytics technology was also utilized to extract deeper insights from contributor interview transcripts, as well as research articles and websites containing relevant free text data. The paper was also guided by ‘big picture’ trends identified in
The ‘Future Solutions in Australian Healthcare’ White Paper, which interviewed 21 Thought leaders in Australian healthcare, who influence over $30 billion of Australian healthcare expenditure. Collectively, these 2 White Papers (Future Solutions in Australian Healthcare and Future Solutions in Customer Experience and Retention for Private Health Insurance) involved a significant sample of the PHI industry.

The authors of the paper are Dr Avnesh Ratnanesan, M.D., M.B.A. (Dr. Avi), CEO of Energesse, and Paul Howarth, an expert analyst from the UK. Energesse is a leading international healthcare insights firm with a vision to improve the health and wellbeing of one billion lives by 2040. It specialises in advising health insurers and other healthcare organisations in executing world-class strategies and superior customer experiences through expert insight and innovative technology solutions.

Customer Retention ~ A ‘Systems’ Problem

Australia now has a relatively mature Private Health Insurance industry with 34 private health insurers and over 11 million members. The number of people with PHI has been growing steadily, with annual increases of 2.5% over the last decade. In 2014, 47.2% of the population was covered for hospital treatment and 55.2% covered by general treatment policies. The health insurance industry is expected to grow to over $21bn in annual revenue in 2015, with projections of 4-5% annual growth predicted leading up to 2020. It is now the largest individual segment in the insurance sector in Australia. There is an industry ‘centre of gravity’ with the 5 largest insurers (Medibank, BUPA, HCF, NIB and HBF) accounting for over 82% of policies, and the remaining 18% distributed across 29 other companies, mainly not-for-profits. The larger funds therefore have the most to gain financially from improving retention strategies.

The evolving Australian insurance market is growing in complexity. Consumers have access to a choice of over 17,000 different policies and over 25,000 policies currently in use in the market. Policy products have become increasingly diverse with a complicated level of cover, exclusions, restrictions, excesses and co-payments. It is almost impossible for consumers to “compare apples with apples” and make rational purchase decisions.

A number of insurers experience lapse rates that exceed 20% of customers. This equates to lost revenue exceeding $2bn per annum from an estimated 940,000 members who switched funds in the 2013-14 financial year. Such high lapse rates have a significant financial impact on insurers due to the relatively tight net profit margins of most funds i.e. an average of 4.1% across all funds in 2013-14. Additionally, insurers and customers waste a significant amount of time negotiating and resolving issues related to poor purchasing and claims experiences, consuming significant financial resources in call centres and branches. At the same time, consumer expectations of value are increasing. They want to be better understood and have access to products and services that specifically meet their needs.

In theory, the broad range of products now available in the market enables more choice in trade-offs between price and coverage for consumers. This strategy is intended to attract different segments of the market to PHI. From an insurer’s perspective, product design also supports diversity of risk in their age and health profiles and is intended to improve the claims experience. Traditional actuarial determination of product design therefore assumes that consumers choose policies based on their expectations of future healthcare needs and their risk profiles relative to premiums. It is questionable whether current methodology is adequately consumer-centric in practice, as noted by the increasing lapse rates.

From a consumer perspective, it is a difficult stretch to believe that consumers can really understand, much less predict, their future health needs. It is also doubtful that this is an actual driver to purchasing or retaining policies with an insurer. Whilst each customer segment behaves differently, expert contributors to this paper acknowledge that today’s customers, particularly Gen Y, demonstrate a greater propensity to switch funds if they are dissatisfied with their experience. This suggests that the current complex environment is leading to poorer customer experience overall.

To add fuel to the fire, the 6.2% average premium rise in 2015 was the second highest health insurance premium increase in a decade, setting the stage for a “perfect storm” of unprecedented lapse rates in the industry. Consumers may also switch in record numbers due to ‘disruptive’ switch campaigns such as Onebigswitch (backed by media conglomerate News.com.au) and the growing adoption of brokers

“Choice is not always a good thing for customers” – Harriet Wakelam, Head of Customer Experience, Medibank
The irony is that switching funds can actually raise premiums as it increases the costs of acquiring new customers\textsuperscript{10}. These costs can then be indirectly passed on to consumers. Along with rising medical claims costs, this phenomenon thereby creates and reinforces a ‘vicious cycle’ of rising premiums in the industry. This negative cycle may be further supported by traditional theories and potentially dated industry ‘myths and assumptions’ about how modern customers actually perceive, value, purchase and retain private health insurance.

In a ‘complex system’ such as the health insurance market, the root causes of issues are often multifactorial. This paper describes those multiple factors from the consolidation of inputs from interviewees. It also adopts a ‘systems thinking’ approach in consolidating those issues and making a more accurate diagnosis of the underlying conditions. This exercise was further aided by PanSensic’s text analytics capability.

As an introduction, ‘systems thinking’ is a sophisticated more complete approach to problem solving. It involves viewing ‘problems’ in the holistic manner of an overall system rather than in its individual parts or silos in isolation\textsuperscript{11}. Systems thinking or ‘system science’ concerns an understanding of a system by examining the linkages, interactions and relationships between individual elements within PHI and the broader health system. Insurers that react to specific parts, silos or company structures ignore the effects on the overall market and consumer outcomes. This potentially contributes to further development of ‘the problem’ such as the ‘vicious cycle’ of premium rises and increasing lapses.

Events such as consumer lapses and bad experiences are often caused by cyclical relationships in a system rather than linear cause-and-effect. It allows executives to see problems as they really are - dynamic processes of change rather than ‘one-time’ snapshots of events. This leads to a search for types of systems structures that are recurring and deeper patterns underlying negative events for insurers and consumers. A systems thinking approach therefore identifies not one root cause or solution, but a set of practices within a system that have become dysfunctional over time\textsuperscript{12}. Such an approach provides more advanced insights in diagnosing complex problems. We shall examine this further in the next section.

### Analysis of Challenges in Customer Retention and Experience

To fully understand problems in customer retention, we need to begin our analysis earlier in the customer journey. This is when the consumer is thinking about making their first or next purchase of health insurance. The fact that lapse rates are highest in the first 12 months also indicates a close relationship between the initial purchase decision and why customers decide to leave a fund. This is because a customer’s expectations and experience are set up prior to initial policy purchase.

From the consolidated analysis of contributor interviews, the real reason for poor customer experiences can be summarised into 4 major themes:

2. Regulatory Changes and Competitive Forces
3. Sub-Optimal Systems, Processes and Data Management
4. Australian Health System Dynamics

#### Customer Confusion and Perceived Lack of Value

‘Price’ has been quoted to be the number 1 driver behind purchasing decision for customers. Interestingly, it has also been quoted as the number 1 reason for leaving an insurer as determined by customer exit interviews and surveys. The reaction to these superficial survey responses is that some insurers develop strategies to ensure their products are priced more competitively. In order to achieve this, they apply more complex exclusions and restrictions to satisfy the customer in the short term.

Inevitably, this strategy has a downside when many consumers realize that what they purchased did not really meet their needs. This is clearly demonstrated by the highest lapse rates in the first 6 months of purchase. This phenomenon is a result of a lack of understanding of the customer’s initial decision-making process at a deep psycho-emotional level.

Price is usually a surrogate term for value. As billionaire investor Warren Buffet famously describes - “price is what you pay, value is what you get”. What consumers really mean when they cite price as a reason for leaving a policy is that they did not understand or sufficiently appreciate the value of the product to their lives. In the initial health insurance purchasing scenario, the customer is faced with a
complex ‘trilemma’ of:

a) “I can’t afford it”
b) “I’m afraid not to have it”
c) “I don’t really understand what I’m buying (and sometimes neither do the staff that I am buying from)”

As a result, there is often a perception among marketers that private health insurance is a ‘grudge purchase’ decision for customers. Whilst there may certainly be a reluctance to purchase health insurance, any purchase based on a ‘fear based’ paradigm can lead to a short-term sale but a medium-term lapse. This is due to ‘buyer’s remorse’ in subsequent months as customers try to emotionally and logically rationalise their new ‘expense’. Staff education on customer ‘grudge purchase’ decision-making can also negatively influence their sales conversations with customers.

In the months following purchase, customers may also discover that their selected policy does not cover a desired treatment, procedure or hospital. In some cases, these additional benefits may require extra payment leading to further remorse. The underlying reasons for this behaviour can be due to a combination of:

- Lack of proper customer education at the time of purchase
- Customer not fully understanding their future healthcare needs.
- Customer only reviewing additional paperwork or word-of-mouth information after purchase
- Policy purchased through third party that miscommunicated information

Whilst no one can predict the future, there is certainly a need to gain a deeper and more holistic view of a customer’s life and health needs before recommending policy options.

“Health insurance is one of those items you purchase and forget about, you may only call you health insurer once a year” – Joshua King, Sales and Marketing Manager, Phoenix Health Fund.

A major aspect of a customer experience with an insurer is when they call an insurer contact centre. Main reasons for an inquiry include:

1. Looking for advice on joining and which policy to choose
2. Finding out if they are covered for a certain procedure or treatment
3. Deciding on which hospital to choose for treatment
4. Initiating or resolving a claim
5. Change in life circumstance
6. Thinking of leaving the fund/questioning the value

These rare opportunities to engage deeper with customers are not often optimised to the fullest extent possible.

“A large number of customers call in before they are about to churn” – Brendan See, Head of Marketing and Strategy, CBHS

From a claims perspective, most of the claims experience now happens in the background with nearly 80% of transactions paid with HICAPS and settled instantaneously. Online claiming services are able to make payments within 48 hours. Whilst the majority of these transactions are relatively straightforward, such ease of access also results in there being no price signal to the consumer. They may not be aware of the thousands of dollars of value they have received from the reimbursed costs of medical treatments. The situation is occasionally exacerbated by an inherent mistrust that some healthcare professionals have with health insurers, potentially due to a past negative experience. This negativity may be passed to customers as ‘stories’ that influence their perception.

Occasionally, customers legitimately leave due to more beneficial corporate deals via their employer or a change in life circumstances whereby the product no longer meets their needs. In such situations, it is preferable for an insurer to remain ‘top of mind’ and be engaged with their customers via multiple channels of interaction. Contributor research has shown that

“Most people do not really engage with their insurer, nor do they always obtain a clear financial or health benefit. It can be decades before consumers realise the benefit of their policy choices. This delayed gratification in the value of the product would only appeal to the retention of customer segments with a long-term view of life. The fact that only 5-10% of health insurance consumers ever make a claim reinforces consumer’s perceived ‘lack of value’ in paying health insurance premiums.”

“The probability of a customer lapsing is double in the first 6 months” – Rhod McKensey, Group Executive, Australian Residents Health Insurance, NIB

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customers that have had positive past experiences with their insurers are more likely to purchase policies again with the same insurer.

Finally, customer expectations of insurer services are rising because of global business trends. They often do not distinguish an insurer’s service level with that of their bank, telco or local energy provider. Insurers who only benchmark their service quality against other insurers may overlook this phenomenon. As a general indicator, the number of overall complaints to the Private Health Insurance Ombudsman rose to its highest levels in 2013-14, with approximate 3500 filed. Whilst these numbers are relatively minor when compared to interactions across the industry, they are valid, independent data of more ‘severe cases’ of dissatisfaction. They are also a ‘signal’ of where insurers have been unsuccessful at resolving the consumer issues despite its experiential processes.

According to the Private Health Insurance Ombudsman, the top categories of complaints issues between 2011 and 2014 were:

1. Benefits
2. Service Issues
3. Membership
4. Information
5. Waiting period

Interestingly, rule changes, incentives and cost did not rank in the top 5 categories of complaints. However, such a simplistic categorization of dissatisfaction poses a number of challenges in extracting deep insights related to specific offerings and translating them into actionable improvements. They do not provide sufficient details of the relationship with an insurer’s performance metrics or brand proposition, nor do they assist in the creation of more targeted solutions.

Insurers invest significant resources into their own market research and customer surveys, often tied to a Strategic Net Promoter Score (NPS) or Transactional NPS based on the channel of customer interaction. They are often episodic (dipstick) approaches to measurement that help in some way to discover the root cause of problems. The predominant channels for assessment of NPS are call centre interactions, online correspondence, branches and mobile. In B2C channels, the NPS can be underpinned by other measures such as a Customer Effort score, with a great experience being low effort. In B2B channels however, NPS should be geared more towards measuring the quality of relationships.

It follows that CEOs and Marketing Directors should also assess whether or not NPS scores are linked to profit. Occasionally, high NPS scores can occur in the least profitable segments and thus need to be viewed at a higher strategic level. It also raises the question of whether or not quantitative NPS scores alone provide sufficient intelligence on customer behaviour. As such, most insurers attempt to mitigate this shortfall in performance insights by also obtaining qualitative front-line staff feedback, either informally or through more systematic feedback loops.

“[What insurers are really challenged with is understanding the fine detail of the difficulties customers experience and the complexity of the landscape from the customer’s perspective]”

~ Paul Howarth, Co-Author and Analyst

In summary, reasons for consumer confusion and lack of perceived value include:

During acquisition phase:
- Perceived high cost of policy
- Reluctant or ‘fear based’ purchase decision
- Complexity of policies
- Delayed gratification – paying up front and claiming back later
- Buyer’s Remorse – finding out they are not covered, partially covered, or are required to pay extra

During retention phase:
- No visibility of treatment costs to patient
- Customer’s holistic life and health needs not well understood
- Customers not really aware of future healthcare needs
- Rising customer expectations of service experience
- Change in life circumstances
- Corporate health insurance deals

The high rates of consumer confusion highlight the complexity of health insurance products, some of which are caused by regulatory requirements and others as a response to market competition.

*Regulatory changes and competitive forces*

Contributors overwhelmingly believe that government changes to the Medicare Levy, CPI Index and rebates have a negative impact on customer experience. While pricing is relatively well regulated by government, annual changes create confusion for consumers as they result in frequent adaptations to old policies and the restructuring of exclusions and restrictions to new
ones. These behaviours are further exacerbated by intense competition between insurers, which results in price discounting and potentially devalued health insurance.

With regulatory changes, a series of consequential processes also have to occur. Not only do product design, benefits and terms and conditions have to be revised: marketing communications and training of staff must also take place. This can create internal confusion, which may then be transferred to customers externally during their interactions. The process of product redesign can further be complicated by a lack of integration of an insurer’s systems and processes, which are often antiquated due to legacy structures. This will be explored in further detail in the next section.

Sub-Optimal Systems, Processes and Data Management

Many of the issues related to poor customer experience can be traced back to problems with antiquated systems and deteriorating processes. It can also be due to uncoordinated data management strategies and information architecture. This involves the collection, integration and translation of customer analysis into actionable insights and process improvements. For some of the larger insurers such as Medibank and BUPA, these issues have been exacerbated by multiple acquisitions over the years.

An example of this would be when a customer has a serious claim or complaint with a particular insurer. It would not be uncommon for that same customer to continue receiving e-mails from the same company promoting a number of other products. This is due to a lack of system integration between the two channels, and it can result in embarrassment on the part of both the customer and the call centre agent managing the complaint.

On occasion, basic call centre quality is misguided due to targets or key performance indicators that are inappropriate for the best customer experience. Whilst it is generally accepted that wait times for a call to be answered need to be kept short, some centres also require that the call be resolved or ‘escalated/passed on’ quickly. The latter metrics may deviate from a true resolution of the issue, and can often be ‘sensed’ by emotionally astute customers who are aware they are being rushed so the agent can meet his/her targets.

The Digital Revolution - Pros and Cons

The increasing use of digital channels among consumers has presented both opportunities and new challenges. Whilst customers are keen on utilising digital channels for research and simple transactions such as minor claims, the majority would still prefer to ring in for purchasing. There is a feeling amongst contributors that reliance solely on digital channels can make the products and the organisation feel less personal. They can also convey a more commoditised approach to a product.

The addition of digital channels such as mobile and social media also opens up more volume of feedback to be analysed. Currently insurers have staff reading survey comments, reviewing exit interviews, and manually listening in to calls. These are laborious processes, yet in the emerging world of ‘big data’ these capabilities will determine competitive advantage. Customer frustrations are very difficult to analyse and measure quantitatively, as are most perceptual quality issues. Buying is based on emotions such as excitement, joy, fear and frustration, which are harder to capture systematically en masse.

Whilst quantitative analysis of customer behaviour is commonly performed, the only way to really understand customer’s frustrations is through the qualitative analysis of their feedback. Data collection and analysis methods have to be improved significantly, as most companies have not discovered how to quickly analyse large volumes of rich feedback. They instead limit themselves to ‘dipstick’ analysis of call data and the occasional customer story or ‘quote’. While stories can provide powerful insights for innovation, if interpreted wrongly or in isolation they can also lead to inaccurate solutions to longstanding, recurrent problems. Appendix A at the end of this paper lists 8 Common Mistakes Marketers Make in Valuing Customer Data.

The acquisition of data from multiple channels in a timely manner and formatting them for management decision-making can be a complex process. It requires extensive analytical skill, IT support and, occasionally, teams of analysts to build a broader picture of the challenges to be prioritised. With larger insurers, these teams can operate in isolation, and an effective exchange of consumer insights may not occur. Research activities can also be duplicated internally and cost even more.

There is also pressure to develop the right insights and conclusions from the analysis, as decisions to prioritise internal projects for the best return on investment must also be made. Changing how products are redeveloped and redefined can cost tens of millions
of dollars in subsequent sales success or losses. Wrong decisions on how to interpret consumer emotions and the range of insurance products being offered can also result in a negative customer experience, increasing customer drop-off and damaging the brand. This can be particularly toxic in regards to social media, with sites such as Facebook and Twitter allowing examples of customer dissatisfaction to spread quickly.

“Why is it easy to identify who had the bad experience, it’s more of a challenge to identify the pain points that caused the bad experience, and where to look for them. We need to isolate the ‘big fish’.”

~ Ashi Singh, Head of Customer Analytics, Medibank

**Health System Dynamics**

As industry stakeholders become wiser about tracking a consumer’s health journey, insurers realise that customer experience is dependent on dynamics within the overall health system. The increasing availability of medical services, medical specialisation and continued innovations in medical procedures provides significant benefit to consumer health outcomes. Combined with increased efficiencies in the health system (supply of hospital and medical care), we now observe increasing consumption of health services. Longer life expectancies of an ageing population also contribute to the demand.

In addition, the high cost of labour in healthcare and expensive capital outlays in medical technology results in higher increases in costs relative to the Consumer Price Index. These cost increases and increased utilisation of services are the main drivers of premium increases. Modern lifestyle choices leading to obesity, heart disease, diabetes and cancer further apply pressure to government-funded care as well as private providers. This leads to variable service quality, long wait times and poor patient experience. Despite this, some patients play off both systems when they believe the public sector offers the required service or a better version of it.

Whilst health insurers would like to have more influence over the care pathway to improve overall experiences, they are restricted in influencing primary care and aged care, as legislated in the Private Health Insurance Act. They are also limited in containing costs as funding follows treatment of illness rather than prevention; the economics of the system is based on volume rather than value or true outcomes. This increases the cost of healthcare as incentive structures are based upon increasing volume of work, rather than reducing it. Whilst these are economic rather than experiential factors, they fundamentally influence where customers seek care and the health benefits they consequently perceive from their health insurer.

“In our health system, the money follows illness not wellness” ~ Simone Tregaglè, COO, rt Health Fund

**Analysis of the Major Challenges and Industry Response**

The 4 major categories of reasons for poor customer retention and experience affect health insurers in many ways. Nonetheless, all insurers have to respond in the context of increasing pressure to maintain margins or grow them. This is true even for not-for-profit funds. Although they are less commercially driven, they also have tight profit margins and a need to deliver positive returns relative to costs in order to ensure long-term sustainability.

Diagram 1 shows a simplified flow of industry dynamics, where health insurers have several options of how to respond to these pressures:
1. Increase volume of customers
2. Increase margins
3. Reduce costs
4. Diversify business model outside health insurance (excluded from scope of this Paper)

In terms of increasing volume, insurers can attract more through increasing marketing and advertising efforts, niche and differentiate products, improving value for money or further customising communications. Alternatively, they can also choose to improve retention through improving experience, engagement and accessibility.

“Customers are more likely to shop on price, but stay for service” ~ Matthew Moore, rt Health Fund

The alternatives are to increase margins potentially by adjusting product ‘quality’ i.e. through restrictions, removal of benefits and re-evaluating pricing based on updated risk profiles. Another alternative is to reduce costs such as healthcare provider costs. This is often achieved via vertical integration of ‘extras’ such as dental and optical services. The other option is to seek internal overhead cost reduction through efficiencies, which is measured by the management-expense ratio.
Market Complexity and the ‘Vicious Cycle’

Essentially the response of industry to these competing pressures is for insurers to introduce an ever more complex mix of product policies into the market. Marketers therefore woo customers away from competitors with cheaper but more complex policies. Educated consumers have a chance of making sense of their policy criteria yet they are in the minority. The majority of the market is unaware of the level of hospital and extras covered due to this market and product complexity.

Generally, customers do not know what their future healthcare needs are, nor do they fully understand the difference in services provided by the public and private healthcare system. Cover exclusions, complex rebates and jargon are mostly unfamiliar. Matching true needs to the right products are a chance occurrence at best.

As such, the more complex insurers make the purchase of policies the less they can understand the real reasons why they lose customers. In an era of personalisation, there is even less understanding of what the areas of ignorance and confusion are. In such a scenario the only inevitable outcome is spiralling cost within the industry and negative customer experiences. Applying a Systems Thinking approach to this complex problem, we find a Vicious Cycle occurring in the industry in relation to customer retention and experience.

The Vicious Cycle in Diagram 2 demonstrates that when consumers do not understand their policy, they contact the most relevant customer service channel. From here, their issue is resolved or they are passed around. When a claim or inquiry is escalated, there is extra cost and frustration. This phenomenon is known as ‘failure demand’ i.e. an increasing demand is created in call centres due to a failure of the product to meet a need or adequately communicate its utility. This then leads to customers leaving, reduced profitability and negative margins. In turn, this leads to the cycle reinforcing itself.

“Call volumes are going up relative to cost growth, which seems to be a trend across industries”
- Rhod McKensey, Group Executive, Australian Residents Health Insurance, NIB
Solutions to Improve Consumer Retention and Experiences

Following the analysis of interviews with industry experts, we are able to consolidate themes of solutions. The solutions are also supported by the latest international research on Customer Experience to provide a detailed strategy for Australian health insurers. Several strategic themes are apparent in the execution of superior customer experience amongst health insurers. Whilst some of these strategies may seem obvious to executives, it is the ability to integrate their capabilities and execute them effectively that will actually deliver competitive advantage and higher customer retention. Otherwise, they are just words on paper. It is also important to reiterate that in complex problems like this one, solutions are cyclical, rather than linear.

Some organisations make the mistake of assuming that one solution in one department will solve the systemic system problem of customer retention and experience. The solutions in Diagram 3 below should hopefully rectify that thinking. The ‘antifragile’ solution model must also be robust, resilient to unpredictability and enable an organization to learn over time. In short, its execution must be a ‘Virtuous Cycle’ of positive change.

The Virtuous Cycle of CX Solutions is as follows:

1. Define & Refine CX with Vision, Strategy and Objectives
2. Align Leadership and Culture with Change Management
3. Implement Systems and Capabilities to support CX
4. Translate Perceptions into CX Insights & Priorities
5. Apply CX strategically across portfolio, product design and marketing channels
6. Extend CX across healthcare ecosystem

1. Define Customer Experience with Vision, Strategy and Objectives

Every major organisational initiative needs a vision, strategy and clear objectives. In the health insurance sector, there is a need to be bold and courageous with improving customer experience as customer expectations are rising rapidly. Five years ago, a basic online presence was acceptable; today, many younger customers want to be able to conduct ALL their transactions online. The key is to map your organization’s baseline in relation to customer experience and develop a strategy based on future priorities. This one unified vision of CX should be regularly and systematically communicated and translated across all business divisions. Internal CX messaging should also integrate with the overall company vision.

As an organization increases in size, it has to spend more effort on strategy alignment. For a CX strategy to work, health insurers need to systematically and regularly collect staff and customer feedback from the bottom up and from multiple channels. In my experience advising senior executives, I recommend they allocate specific time every month in direct contact with customers (‘Customer Days’). This can be
sitting in call centers or ‘on the road’ with stakeholders to gain real insight into the how their company vision is perceived externally. These should then be translated into insights for the CX strategy refinement. As health insurers exceed 200-500 employees in size, that strategic planning and communication process requires time, investment and planning. IT decisions in particular should be based on customer needs, rather than efficiency needs, as higher IT alignment is proven to drive customer experience.

Once the vision has been articulated, strategies and goals need to be set with the involvement of the senior management team. **There is often a need to prioritise 1-2 ‘big bets’, which are potential game changing projects** that can revolutionise the customer experience and deliver significant competitive advantage. The reason only 1-2 major projects are suggested is that management literature has often observed that organisations trying to implement many projects fail due to a lack of focus. It is important to note that these initiatives are not continuous improvement projects, but that they are intended to provide innovative breakthrough results in customer experience and retention. In order to embed such strategies most effectively, the insurer’s leadership and culture must also be aligned.

**2. Align Leadership and Culture with Change Management**

“Culture eats strategy for breakfast”
- Peter Drucker, Author and Management Expert

Once an organisational-wide strategy for CX has been determined, it needs to be prioritised across all departments. Insurers need to have ‘customer obsessive’ values as part of the culture. CX leaders need to work with Human Resources and Communications team to verbalise these priorities and drive positive actions and behaviours. Organisations cannot replicate ‘tone and spirit’ of high-performing competitors and as such each organisation needs to develop its own flavour of customer-centric culture.

“Incentives and recognition programs that boost staff motivation drive positive behaviours. Front line employees with a higher morale produce higher service quality. While most insurers believe they are doing this well, it is arguable whether this is really the case across all organisations, individual call centres or call centre teams. Call centre excellence is certainly a main objective for most insurers to ensure a high degree of customer satisfaction.

However, ‘excellence’ means different things to each organisation. For some, it involves ‘first call resolution’ as a key performance indicator (KPI). This is the aim of having the customers issue resolved in the first call rather than having to be passed on. These organisations choose not to time phone calls (or put a target limit on call length). They would rather the call take as long as possible so that the issue is resolved and the customer is provided with a high degree of comfort and reassurance. This empowers agents to
take more ownership of the customer enquiry.

In larger contact centres with more complex suite of products, skills-based call routing is utilised. In this case, calls are directed to a dedicated area specialist who is an expert in an area. These areas often require good recruitment procedures that recruit the right person for the right job i.e. someone with the technical capability and customer service aptitude. Ongoing training and development of staff is required to motivate and retain high performers. Many companies claim personal ‘1-on-1’ coaching is one of the most effective forms of training in contact centres. Managers are also funded to attend external training courses and conferences.

A mixture of ‘hard’ & ‘soft’ KPIs is considered ideal to measure customer experience. For example, most insurers include Net Promoter Scores (NPS) as part of their primary targets and some have integrated them into employee incentive structures. Whilst this can be appropriate for front line staff incentives, feedback has to be made relevant to the individual agent or customer service representative. It is important when assessing call centre performance to understand how individual agents are judged by customers, and not just managers. While NPS scores are useful, detailed analysis of customer conversations is critical to defining whether issues were related to lack of product knowledge, staff expertise, attitude, jargon, accents or wait times.

By understanding exactly what specific factors confuse and frustrate customers, issues can be resolved more simply. For example, if jargon is the issue then there is a need to understand and translate medical terms for staff and customers, and communicate with them in a non-scientific manner. Analytics tools such as PanSensic can now perform this analysis and guide insurers to implement the most efficient and accurate solution to improve customer experience.

"Customers want someone who knows what they're talking about, not throw them a rule book”
- Grahame Danaher, CEO Westfund Health

Where possible, feedback loops should also be immediate. Peoplecare, a health insurer with a track record of customer satisfaction awards, provides small gifts and rewards to call centre staff as soon as a positive behaviour has been noticed. Customer-centric processes such as waiting times need to be sped up and be as close to real time as possible to counter growing customer impatience. Call centre benchmarking is a useful tool here.

“We've got a very hard target of answering the phone in excess of 95% of the time within three rings. We have also got very tight turnarounds on any clients that come through to us. Most of the time we’re processing an excess claim within 1.5 days and then straight into their account. And we are prepared to pay a premium to offer customers that very exceptional experience of high levels of service, very quick responses and being available when they need us. We know that costs us a little bit more. We think we are an efficient organization but we’re not aiming for efficiency at the expense of that service experience”
- Anita Mulrooney, Head of Customer Service and Marketing, Peoplecare Health Insurance

Another interesting strategy for managers is to have staff set their own KPIs. Whilst this might seem incredulous at first, some organisations report that these targets can often be more ambitious than those set by management. Ultimately, managers should only ‘measure what you can manage’. Measurements are a time consuming and costly exercise and therefore should only be done if action is going to be taken on the results. In many insurers, quality assurance measurements seem to occur for at least 5% of calls.

In many of the larger centres, outbound sales and inbound claims centres are in separate locations. This can present a missed opportunity in some cases; when a customer calls in for a complaint that is then successfully resolved, it is also a good time to make a sale. This is a practice often utilised in the telecommunication industry. Inbound contact centres are therefore ‘switch hubs’ and the best opportunity for repeat sales. Results from a Perdue University study, illustrated in Diagram 4, showed that the probability of re-purchase increases if a customer has had an issue that is resolved successfully rather than never had an issue at all 19. To achieve this, inbound teams and sales teams should at least be trained and equipped with a basic checklist approach to selling.

"Over 40% of new sales is via telephone, which has grown as a total percentage of new sales”
- Brad Joyce, CEO Teachers Health Fund and Chairman Members Own Health Fund

Call centres are fairly stressful environments as many agents have long hours listening to complaints all day. As such, a positive working environment needs to be actively nurtured to enhance morale. Companies have introduced massage, wellness advice and healthy food such as fruit into the workplace. Others sponsor sporting teams and corporate social responsibility initiatives to encourage a team culture outside the workplace.
Studies from the Gallup Organisation have shown that employees are more likely to be engaged when they have a ‘best friend’ in the workplace [20]. Work-life balance needs to be integrated with allowance for long holidays and scheduled rostered days off. In highly engaged teams, workforce planning and scheduling is less of an issue; agents are known to voluntarily start their work shift before a call centre officially opens to reduce queues (customers start queuing before opening hours). These actions can be enhanced with the right internal systems and capabilities.

3. Implement Systems and Capabilities to support CX Strategies

Health insurance marketers realize that they need to get closer to the customer mindset to understand aspects of the customer journey that they do not fully understand i.e. ‘know what you don’t know’. This includes understanding the actual personal drivers of a customer at a deep emotional level. This granular level of intelligence allows insurers to apply more specific solutions that truly add value to the customer and simplify doing business with them.

Speed is an important and overlooked factor for health insurers. Smaller health funds are able to achieve higher satisfaction ratings due to shorter feedback loops, rapid responsiveness to customers, and local accessibility. Bigger funds could restructure business units to get closer to customer segments and respond quicker. However, their bureaucratic processes and fragmented silos lead to inertia to adapt. In order to overcome this they must also explore more collaborative models for innovation.

‘Multiparty collaboration’ is also a future trend for corporations, large or small [17]. For example, smaller not-for-profit funds have collaborated to maximise their advantages via the formation of Members Own Health Funds. Collectively these 15 funds, comprising approximately 20% of market share, can pool marketing resources and demonstrate higher member satisfaction scores at an aggregate level. Larger insurers can form ‘ideas hubs’ made up of cross-functional teams that sit outside existing company structure, disrupting their own business models and working with more agility. Customer experience teams would therefore involve talent from multiple disciplines such as Social Scientists, Data Analysts, Community Managers and Marketers.

"The world is too big to be thinking small. In the emerging healthcare paradigm, a collaborative mindset beats a competitive one any day of the week"  
- Dr Avnesh Rattanesean, CEO Energesse

Insurers have to develop internal capabilities in CX, particularly in relation to people, process and systems. These capabilities should also be organised such that insurers can adapt and learn faster than they did previously - change continues to happen at a faster rate. As an example, ‘Kaizen’ and ‘Lean Six Sigma’ methodology took 20 years to be adopted by business, yet NPS has taken approximately 5 years to be adopted by industry.

Knowing all this is one thing; yet implementing it is a completely different kettle of fish. From a people perspective, it is clear that demand and funding for customer experience initiatives are increasing. However, there is variability in practitioner capability and many companies have to outsource this expertise at different levels in order to truly obtain rapid results. This is because insurers need to fundamentally change employee’s mental models i.e. the mindset of how the problem of customer retention is viewed. Mindset changes are critical and probably the most important mental capability to develop in any change to a ‘system problem’.

“We don’t believe what we see, we see what we believe” - Dr David C. Aron, University Hospitals Case Medical Center Cleveland, Ohio

Fundamentally, the thinking of participants in
systems' such as front-line employees and senior management teams need to evolve to match the true expectations and emotive drivers of customers. This takes time and effort. At a practical level, this may involve needing to influence the ‘sceptics’ in the organisation e.g. the Head of IT, or Operations or Finance, on the value of customer experience and the need to invest in these capabilities. Nonetheless, a ‘learning organisation’ mentality is required by CX leaders, employees and IT systems to rapidly learn from successes and failures.

“Customer experience is not that hard, it’s change that’s hard”
- Harriet Wakelam, Head of Customer Experience, Medibank

Effective collection and utilisation of consumer data is vital. Understanding data means understanding people and how they behave. In the world of ‘big data’, organisations have to integrate consumer data into a dynamic customer experience architecture. There are 3 types of data collected on customers:

1. Personal - Name, address, age, gender, email,
2. Behavioural - Preferences, Interests, Channel, Date & Time, Location, anniversary dates e.g. membership dates, family make up
3. Value - RFV Analysis (Recency, Frequency, Lifetime Value), Survey feedback, Product Mix

Mass Personalisation is certainly a future trend and the level of personalised contact and communications for each customer determines how connected a customer is with an organisation. CRM systems need to enable contact centre agents to go the extra mile in forming an emotional and empathetic connection with consumers and their circumstances.

“Our customer service consultants have access to all the documents on their screen. They have access to every piece of correspondence with that member. They actually have a record of every phone conversation with that member. So they have all the information they need generally at their fingertips. Perhaps we might have to contact the provider to find more information that might require resolution. But apart from that we should have the people in the team that can resolve the vast majority of the inquiries on the spot.” - Anita Mulrooney, Head of Customer Service and Marketing, Peoplecare Health Insurance

Many health insurers agree that their current data systems are largely reactive. For instance, when customers have made a transfer request to change insurer, retention teams are deployed to win back that customer. This is a useful exercise, though it is late in the customer’s decision-making process. Organisations are moving proactively to identify ‘early warning signs’ of people thinking of leaving before they leave, and using data to be predictive. Technologies like PanSensic can identify keywords in call transcriptions to study patterns of leaving. Conversely, insurers are also increasingly using data and propensity models to be proactive about meeting future expectations of customers. In the supermarket industry, analysts can predict a woman’s pregnancy with a high degree of probability by the items she is purchasing!

Data analytics tools and technologies are therefore becoming vital to improve customer experience, particularly if used intelligently to gather data on customer pain points. Many health insurers could gather a lot more intelligence with simple solutions such as proactive online chat interactions and high converting ‘lead capture’ forms on their websites. Mobile will become an increasingly important channel as customers look for convenience with transactions e.g. processing simple claims via apps. Forrester Research have indicated that consumer-driven security applications, where consumer are empowered to decide on the security settings of their data, will also be the future of apps.17

“‘It’s about having the right people with the right culture or mindset. Combine that with the appropriate investment in technology that gives them the tools to do the job. But tools without attitude and attitude without tools just doesn’t cut it”
- Michael Bassingthwaighte AM, CEO, Peoplecare Health Insurance

Consumer research has shown that Australians prefer online or in-store channels for browsing or researching. They often want low-touch, self-serve options for these types of tasks. But when something goes wrong or they are confused, they want high-touch, personalised and real-time attention. In the future, contact centres will become more ‘crisis’ centres as more people call in mainly to deal with serious issues. Diagram 5 shows global studies by Gartner, which indicate that by 2018, an increasing percentage of customer interaction will be via online, mobile and social media channels.1 This research
indicates that insurers have to gain capabilities across multiple channels to have meaningful access to customers. However, interactions alone are not enough: they need to be translated into actionable insights for improvement and strategic priorities need to be modified.

4. Translate Perceptions into CX Insights & Priorities

In order to gain highly valuable insights into customer retention and customer perception at a deeper level there are ‘4 forces of switching’ which need to be examined and resolved:

a) The ‘Push’ of the Present (Current Policy/Insurer)

b) The ‘Pull’ of the New Solution (New Policy/Insurer)

c) The Habit of the Present

d) The Anxiety of the New solution

These forces are illustrated in Diagram 6 (see next page). An important exercise for marketers is to analyse the customers that have recently switched and their reasons for doing so. It highlights the criteria that are important to customers and is real data from which decisions and strategies can be formulated. This helps prioritise the ‘trade-offs’ of exact specific product features required and avoids ‘feature bloat’ i.e. the addition of too many complex, unwanted features in a product. To undertake this exercise, study customers who have switched in the last 1-3 months but not as a result of automatic renewals or gifts. They must have made an explicit choice to switch.

To minimise the ‘push’ of the customer’s present situation such as triggers of dissatisfaction, ‘Pain Relievers’ can be applied. These are service enhancements that fix poor CX issues, which cause customers to look elsewhere. For example, good claims resolution at contact centres and providing necessary policy information that is easy to comprehend. In this regard, marketers need to understand triggers that ‘push’ a customer first such as sources of frustration, lifestyle changes or product restriction issues.

To maximise the pull of the new policy, ‘Gain Creators’ can be applied. This involves understanding what the customer actually wants from the policy and delivering it in a better way e.g. providing a concierge service to claimants within a hospital to help processing. Gain Creators are used to encourage a customer to switch from a competitor policy or insurer. Insurers can also minimise on-boarding efforts and educate customers on how to easily sever ties with competitors.

To maintain habit of the present, i.e. more engagement with a policy, an insurer can apply ‘Drugs’ so the existing policy is more ‘sticky’. For example, this may be direct debits, importation of data history so customer preferences are understood, or bundling additional value-add services that the customer uses for their life goals.

To acquire new customers, insurers can minimise the anxiety of joining their product by adding ‘Catalysts’. This may be offering free trials, money-back guarantees and return policies. It could also involve enhancing word-of-mouth recommendations.

Transforming Data into CX Insights

Whilst many health insurers perform a combination of quantitative and qualitative research to develop insights into consumer drop-off, the data that is collected is often rarely fully optimised for insights. Quantitative research is useful for analysing WHERE the problem is occurring (e.g. at which time point most consumers drop-off, what age groups have the highest drop off). It is less effective at pointing out WHY the problem is occurring and this where qualitative insights add value. For example, many
customer questionnaires use NPS and Likert scales which allow the mass collection of quantitative data that identifies where specific problems are occurring. Often these are ‘closed questions’ which take a narrow snapshot of where the problem is with a particular customer experience.

Experienced marketers now understand that they need to listen very carefully to customer stories and narratives. They need to ask more ‘open questions’ for deeper insights. Customers are often relating enough already with all the inbound contact and as such some major insurers do not engage in vast quantities of market research. NPS surveys occasionally also include ‘free text’ fields, which can collect much richer data, and point to root causes of problems. However, this data is largely underutilised for raw intelligence, especially when needing to understand ‘detractor’ segments.

“[If we see each problem] as separate, and approach each separately, the solutions we come up with will be short-term, often opportunistic, “quick fixes” that do nothing to address deeper imbalances.”

- Peter M Senge, Management Expert and Author of ‘The Necessary Revolution” and “The Fifth Discipline”

Technologies such as PanSensic are now able to gather deeper insights from qualitative data sources such that better solutions can be developed to solve consumers’ problems. In some instances however, customer behaviour must be observed to find out what’s really going on with their experience. This is more the case as society moves more into the ‘internet of things’ where insurers will be utilising more connected devices in healthcare service delivery and marketing such as watches, phones, home monitoring, displays and chairs.

Insights into customers thought patterns and emotional processes when they decide to leave a company allow a company to solve their concerns more effectively and cost-effectively. Companies can also save hundreds of thousands of dollars in staff training, system improvements and staff resourcing by simply beginning with the most accurate insight about where, why, how and when the problems are occurring from a customer’s perspective. Accurate priorities are determined by accurate insights.

Sources of ‘big data’ qualitative datasets that are already routinely collected but often underutilised by health insurers include:

1. Customer surveys, questionnaires, feedback forms and customer narratives.
2. Customers complaints (verbal or text) – in branches,
3. Call centre recordings via the customer hotlines
4. Staff surveys and feedback forms.
5. E-mails from customers
6. Recordings or Transcripts from Workshops, Focus Groups and Internal meetings
7. Records in Customer Relationship Management databases (CRM) and Sales calls
8. News reports and traditional media articles
9. Social Media – Facebook, Twitter, Blogs, online community forums about insurance products

“'The only sustainable competitive advantage is an organisation’s ability to learn faster than the competition” – Arie de Geus, Business Theorist & former Head of Shell Oil Company’s Strategic Planning Group

PanSensic Analysis of Customer Insights – a Tool for Prioritisation and Mapping

Insurers are challenged with managing the enormity of data inputs and consumer feedback from surveys, complaints and internal sources of information. Much of it is disregarded even though they hold vital answers to deliver enhanced consumer experience and solve retention issues. It is not surprising as the manual
processing of this information is laborious. It is also incredibly boring to listen to so many consumers. How do you rapidly understand 5000 comments on a particular product and develop sensible insights?

Singularly, individual pieces of customer verbatim form weak signals of insight. So how do you capture the voice of the customer first-hand, and separate the breakthrough insights from all the noise? PanSensic is able to do this by analysing large volumes of customer verbatim (in unstructured text) with algorithms that interpret keywords, keyword phrases and metaphors. It is similar to combining many weak signals from multiple data sources to understand where the strong signal is. Common reasons for pain points in the customer journey can now be understood and priority solutions introduced.

By implementing PanSensic lenses on qualitative data to develop high quality insights, health insurers will also be able to enhance their overall brand value proposition and create a more focused funnel of process improvements. These should generate the highest return on investment that focuses marketing effectiveness on initiatives that provide customers with greater satisfaction. They will also improve the level of customer retention and generate more sales because there is a deeper understanding of consumer needs; offerings can therefore be customized accordingly. These analyses can also be transformed into

"Whoever learns faster from the most brains wins" - Steven Berlin Johnson, Author of ‘Where Good Ideas Come From: The Natural History of Innovation’
ongoing monthly or quarterly dashboards that provide early signals of poor experiences and potential lapses.

“There is definitely value in analysing unstructured data. Big data includes capturing voice as well as web and social media chatter to identify behaviours, sentiment and how customers interact with a brand.”

~ Athi Singh, Head of Customer Analytics, Medibank

Once specific customer frustrations are collected and understood, marketers can plot them against their customer journey maps. This should include 'Baseline Journey Mapping' and 'Future State Mapping' which defines the aspirational ‘Dream End State’ for the customer. These maps should include all major customer touch points and pain points. Once completed, they need to be communicated and understood in a common language across the service organisation. In health insurance, particularly ‘sensitive’ touch points include when customers first sign up and immediately after they have joined.

Plotting journey maps helps an organisation understand frustrations from a customer’s perspective. They should also be triangulated with pain points for front-line staff. Often mapping reveals ‘fault lines’ in the journey; parts of the process not owned by any particular division where customers ‘slip through the cracks’ and get a bad experience. These insights allow insurers to map the demand according to the 80:20 Pareto rule; generally 80% of call centre demand comes from 20% of the problems. Fixing these priority issues will allow customer experiences and NPS scores to be improved. They also facilitate strategic transformation of the portfolio, as well as new products and marketing channels.

5. Apply CX strategically across portfolio, new product designs and marketing channels

Health insurance marketers are often challenged in determining exactly who their target ideal customer is for certain products and which segments are best to attract, convert and retain. High-level management decisions are required to determine which products require more CX investment to optimise return on investment. New products often receive healthy investment and as such it is encouraged that flexibility is built into new product designs to accommodate evolving needs in future.

“Price competitiveness is not what it was 10 years ago. These days there’s a lot more stripping out benefits in product design that has seen a doubling in the number of restricted and exclusionary products in the last 5 years to now represent nearly 50% of all PHI policies” ~ Brad Joyce, CEO Teachers Health Fund and Chairman Members Own Health Fund

Portfolio strategy involves making trade-offs, and these decisions should be made with the customer in mind. For example, despite one of the highest premium rises in the industry in 2015 at over 7.9%, Westfund Health strategically chose to enhance its service level rather than remove benefits to provide their customers with good value for money.

“Health insurance is a very personal product – commoditisation is what will churn them and turn them” ~ Grahame Danaher, CEO Westfund Health

There are numerous opportunities to increase visibility and education on benefits rather than removing them. This can help patients understand the value they receive from products, as most are not aware of the costs of claims. Assets can be developed to provide more transparency of specialist rates and doctors performance. One example is the Whitecoat.com.au platform developed by NIB for community rating of dentists and other health practitioners.

Other funds choose to empower consumers on their
own health journey by providing timely advice, apps and online resources to help keep people healthier. This includes advice on exercise regimes and eating well. Medibank has partnered with gym chains like YMCA, Fernwood, Anytime Fitness and Goodlife Health Clubs to extend these experiential benefits even further and increase policy ‘stickiness’.

Health insurers are also sometimes challenged in determining their optimal marketing channel mix i.e. which ones produce the best return on investment (ROI). Marketing effectiveness is a dynamic process and insurers have to ensure a relatively consistent experience across channels. Customers are engaging more via multiple touch points and have basic expectations in each one. These basic expectations, such as manners and timeliness, are often determined by their experiences in other service industries as well.

“With customer experience, it’s important to just get the basics right first”
- Natalie Vogel, General Manager Retail, Australian Unity Ltd

When collecting feedback via these channels, marketers should not accept at face value what customers say are their basic expectations. It is more important to understand the emotion behind their expectation in order to determine how to exceed them. Customers will not always tell you how to make something amazing, or how to deliver a WOW moment that they did not expect and tell all their friends about. Apple founder Steve Jobs was a proponent of this theory, amongst other notable innovators.

“If I asked customers what they wanted, they would have asked for a faster horse”
- Henry Ford, inventor of the car

However, in order to get referrals or word-of-mouth recommendations, insurers need to deliver the WOW moments where exceptional service is also exceptionally useful – functionally or emotionally. While most insurers seem to generally apply these principles ad-hoc, WOW moments come from insights into understanding the consumer’s ‘dream state’, also known as ‘outcome driven experiences’. These WOW situations are good instigators for building customer communities that can be leveraged as a source of customer intelligence and word-of-mouth promotion.

“Word-of-mouth is our strongest from of endorsement”
- Brad Joyce, CEO Teachers Health Fund and Chairman Members Own Health Fund

Using qualitative research, marketers should also try to understand not only how customers choose to use their policy, but also how to help customer’s best set and achieve their health goals. WOW moments can happen by understanding important aspects of their healthcare journey outside of traditional health insurance policy benefits.

6. Extend CX across Healthcare Ecosystem

It is common for health insurers to form partnerships with healthcare service providers to enhance patient pathways. One of the biggest health trends will be the empowerment of patients, who want access to medical information 24/7. Health insurers can also play a role in providing such information and the coordination of care. The key to this is in understanding the areas of need, as well as problem areas or ‘fault lines’ in the health system that are relevant to members.

Although there are legislative restrictions within the Private Health Insurance Act as to how health insurers can get involved, there are emerging opportunities to engage with primary care providers. Examples include Medibank’s CareFirst pilot in Queensland that provides chronic disease management programs for members when they are referred by their GP. The Primary Health Networks are another example of where a number of insurers including BUPA, Peoplecare Health Insurance and HCF are engaging with local providers to deliver services.

As new healthcare models emerge, insurers are in a position to build, partner or acquire more service providers. Optical and dental services are typical areas for reducing out-of-pocket costs, saving member claims and developing deeper engagement with consumer health. Companies such as NIB have even ventured internationally, via its medical travel services, to provide better quality and faster care for its members. Health insurers are therefore able to lend their analytical capabilities and in-house expertise to determine pain points in the patient journey and address the community needs, particularly in target geographies and underserved segments.

“Telehealth is necessary and needs to be done for regional members over the next 5 years – private health insurers could facilitate that. In these areas, patients may have to travel a long way for short consultations”
- Grahame Danaher, CEO Westfund Health

Finally, health insurers continue to be in a position to support preventative services, rather than just curing illness. This can be done through promoting wellness
through political channels, funding health screening initiatives and youth education. As the health system continues to evolve, there are also opportunities for an ‘Australian managed care’ model, where a single payer can pay for sickness and wellness services. This should be outcomes-focused, with patient experience in mind, and possibly through capitated or ‘blended’ payment schemes.

“Health insurers hold the right model to fund prevention, but many regulations have to change”
- Brendan See, Head of Marketing and Strategy, CBHS

In a healthcare system that is seeking to become more sustainable, large amounts of time, money and resources will be saved in implementing solutions that are tailored to the needs of members and empower them further on their health journey.

**Next Steps to Solving Customer Experience & Retention**

This White Paper has demonstrated a Vicious Cycle occurring in the health insurance industry, reflected in poor rates of retention for some organisations that are often driven by inconsistent experiences. In order to reverse this trend, **health insurers have to view the problem more holistically through using ‘Systems Thinking’ to solve issues comprehensively and produce better results.** This would allow an insurer to break negative recurring patterns that are apparent in the market and create an internal ‘Virtuous Cycle’ of antifragile solutions that deliver a positive customer experience and higher retention rates.

For some, the implementation of all these solutions may take months to years and significant financial investment. They may also require a significant internal cultural change. As such, for those organisations that are time poor and can only do ONE THING to begin moving in the right direction, **understanding their customer perceptions much better than they are doing now is paramount.** Every step of the Virtuous Cycle is largely defined by having deep psycho-emotional insights into current customer perceptions i.e. their frustrations, anxieties and attraction points related to service issues. It all begins with the customer in mind, or rather ‘the customer’s mind’.

If you are a health insurer that wishes to improve customer experience, retention and profitability, please contact the lead author of this White Paper Dr. Avi Ratanesan. Dr Avi is the CEO of Energesse and has over 20 years experience in healthcare and business, solving major challenges to help achieve their goals. Energesse provide strategic insights and advisory services to CEOs, senior executives and analysts, using leading edge thinking and technologies. This includes the implementation of ‘systems thinking’, PanSensic and the antifragile solutions mentioned in the Virtuous Cycle. For inquiries regarding speaking, facilitation, consulting or training materials on this topic, contact:

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“Only a life lived for others is a life worthwhile”
- Albert Einstein
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Appendix A

8 Common Mistakes Marketers Make in Valuing Customer Data

There are several mistakes that are often made in determining how to truly understand their customer needs from data and translate them into marketing investments.

1. Confusion that more volume of data equals better insights. Whilst can be the case, deep insights come from a combined analysis of quantitative and qualitative data focused on the solving the problem.

2. Undervaluing customer experience as a driver of retention. Marketers occasionally do not dig deep into the emotional analysis and root cause of frustrations and deal with problems superficially.

3. Treating demographic segments the same way – ignoring stories and verbatim which are often the key insights to innovation.

4. Using same parameters for acquisition as for retention as metrics of success.

5. Underutilisation of existing data. Information asymmetries occur between organisations due to lack of technical expertise or awareness of available methodologies.

6. Extrapolating general industry behavioural data to its own customers - and implementing solutions because “everybody else is doing it”.

7. Prioritising solutions based on subjective insights (e.g. loudest voice, tenure, organisational politics) and ignoring objective evidence from consumers.

8. Asking the wrong questions or in the wrong way. The emphasis is often on closed questions or Likert scale responses, which are simple to analyse, rather than open questions with rich experiential information.
References

4. The Customer Experience Index, 2012, Forrester
18. The Rewired Group