An Opportunity for HMOs To Use Marketing To Increase Enrollee Satisfaction

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ABSTRACT

Purpose: To identify the combination of marketing components (i.e., service, price, access, and promotion) of commercial health maintenance organizations (HMOs) that are related to overall enrollee satisfaction. The researchers focus on factors that commercial HMOs control directly — specifically, health care organization and financing.

Design: Descriptive (mail order).

Methodology: This study uses national data provided by a major health benefits consulting firm, which collected data from a 1997 calendar year mail survey of HMO administrators. The administrators responded to an extensive survey, which tapped selected HMO marketing-mix components and the percentage of surveyed members who indicated satisfaction with their HMOs. To test hypotheses, researchers treated marketing-mix components as independent variables and enrollee satisfaction as the dependent variable.

Principal findings: This study found statistically significant relationships between overall satisfaction and HMO providers' quality; access, particularly to specialists and out-of-network providers; waiting times for physician services; customer service; and disease prevention/health promotion programs. The researchers did not find significant relationships between overall satisfaction and accreditation by the National Committee for Quality Assurance (NCQA), the presence of physician gatekeepers, numbers of providers, or financial indicators. The relationship between overall satisfaction and utilization was mixed. This study's findings are largely consistent with the literature, consumer- and professional-group position papers, and the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Conclusions: HMOs can use marketing as a way to address problems and pursue opportunities identified by enrollees. As these findings demonstrate, certain features of HMO design are more appealing to patients. By focusing on these preferences, HMOs can adopt a responsive market orientation that gives rise to more effective marketing mixes and hence improves enrollee satisfaction. With improved satisfaction, enrollees generate less need for government intervention through regulation or legislation.

Key terms: Health care marketing, enrollee satisfaction, marketing orientation, HMOs, managed care.

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INTRODUCTION

Approximately 181 million Americans are enrolled in managed care organizations, including 67 million in health maintenance organizations (HMOs).[1] HMOs originally were designed to provide access to high-quality health care while containing costs. The premise of HMOs is that one organization is responsible for organizing and financing health services. Ideally, HMOs assure access through hiring or contracting with a sufficient quantity and a range of providers in appropriate geographic locations. Through prepayment, HMOs work within a finite budget, review utilization, allocate resources rationally, and thus contain costs. HMOs address quality through provider selection, internal peer review, and external accreditation.

This ideal also has a downside. HMOs are a major departure from traditional indemnity health insurance. In comparison with indemnity plans, HMOs generally charge lower premiums, copays, and deductibles. The tradeoff is that HMOs actively manage care and costs. Thirty-five

years ago, MacColl identified conditions necessary for effective comprehensive care. Several of these conditions continue to affect HMO costs and enrollee satisfaction:

- Control of the usage of services;
- Control of the facilities;
- Controls involving the producers (providers) of services;
- Clearly defined terms of the service contract; and
- Tightly integrated and centralized management of the entire operation.[2]

HMOs have an inherent financial incentive to contain cost through rationing expensive services. HMOs do show lower utilization rates of costly services, particularly inpatient hospital services. Enrollees are becoming aware of HMOs' potential conflicts of interest and question whether providers represent their interests (i.e., quality) or those of stockholders (i.e., profit maximization). When there is no definitive answer regarding medical protocol, patient trust in his/her physician's recommendations is paramount. If patients believe that physicians have conflicts of interest, maintaining trust is difficult.[3]

Isaac identifies a sizeable gap between available information and consumer awareness. For example, (1) a majority of Americans had never heard of managed care plans and did not know what the term meant, and (2) managed care enrollees believe that they lack information needed to make informed choices.[4]

Consumers are more likely to be satisfied if they have a choice between managed care and fee-for-service plans.[5,6] To contain health care costs, however, many employers unilaterally switch from indemnity to managed care. Employers commonly do not share with employees published reports on HMO plan quality and patient satisfaction.[7] Regardless of the HMO's merits, employees commonly view their lack of participation in decision making and their subsequent loss of choice as a "takeaway."

Due to a combination of high expectations and historical comparisons with indemnity plans, HMOs are experiencing negative publicity from high-profile errors and everyday disappointments. For example, the article "Health Groups Cut Costs by Dropping Drugs" states that many HMOs eliminated coverage of several new and popular drugs and/or passed on their costs to enrollees.[8] Other headlines illustrate dissatisfaction with managed care (e.g., "The Managed Care Backlash and the Task Force in California").[9] Observing that significant percentages of Americans are reporting dissatisfaction with HMOs and reacting anxiously to highly publicized failures, Blendon et al concluded that there is a backlash against managed care.[10]

Enthoven and Singer summarized HMOs' relationship with enrollees in these terms:

> HMOs are not helpless victims of managed care backlash. Rather, at times, they seem to be their own worst enemies…. Some health plans have been insensitive and unresponsive to consumers and have treated employers instead as their primary customer…. Health plans should involve consumers in a process of continuous quality improvement…. Many plans have done a poor job of recognizing and responding to consumers' and patients' concerns by failing to provide innovative products with attributes that are desirable to consumers.[9]

Consumer and provider groups have issued critical reports and corrective recommendations for managed care organization and financing. In response to this dissatisfaction, President Clinton in 1997 appointed the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This action publicly acknowledged managed care's difficulties, its inability to self-correct, and the potential need for government intervention through regulation or legislation.

The President's Advisory Commission recommends protecting consumers through provisions that are consistent with the literature. The overall focus is increased satisfaction through improved quality, informed choice, and expanded access: The Bill of Rights and Responsibilities[11] comprises eight broad areas:

I. Information disclosure
II. Choice of providers and plans
III. Access to emergency services
IV. Participation in treatment decisions
V. Respect/nondiscrimination
VI. Confidentiatity of health information
VII. Complaints and appeals
VIII. Consumer responsibilities

Health care organization and financing are addressed through several provisions:

- Choice of plans wherever feasible.
- Choice of providers to ensure access to appropriate high-quality health care.
- Provider network adequacy, in terms of numbers and types of providers, outside the network if necessary.
- Direct access to qualified specialists within networks. Authorizations, when required, should encompass an adequate number of visits under an approved treatment plan.
- Access to emergency services using a prudent layperson standard.

Many of these issues can be addressed through marketing. Throughout the remainder of this paper, the authors apply the Kotler and Clarke definition of marketing:

> Analysis, planning, implementation, and control of carefully for-

> mulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives. It relies heavily on designing the organization's offerings in terms of the target markets' needs and desires, and on using effective pricing, communication, and distribution to inform, motivate, and service the markets.[12]

Drucker writes that the aim of marketing is to know and understand the customer so well that the product or service fits him and sells itself.[13]

A major goal of health care marketing is to meet organizational objectives through satisfying the patient or enrollee. Satisfaction with HMOs is associated with continued enrollment, a favorable influence on potential enrollees, patients keeping appointments, patients complying with regimens, and better outcomes in chronic disease.[14] Dissatisfaction is associated with physician shopping, using nonmedical healers, noncompliance with treatment regimens, disenrollment, and complaints leading to mediation, arbitration, or malpractice litigation.[15] Marketing's emphasis on enrollee satisfaction in clinical and personal services is illustrated in the values statements of two health care organizations: (1) "We practice patient-centered care; we provide outstanding professional care; and we treat each person with respect and integrity, recognizing his or her individual needs"[16]; (2) "Our first responsibility is to our patients."[17]

The authors researched enrollees' satisfaction with selected aspects of commercial HMOs' marketing mix. The research question focused on determining which components within the marketing mix relate to enrollees' overall satisfaction — and which do not. The results offer commercial HMOs the option to emphasize marketing and/or implement changes in marketing strategies. The researchers recognize that health care organization and financing affect providers' diagnoses and treatments. The researchers, however, concentrate on factors that commercial HMOs control directly — namely, health care delivery. The researchers do not address Medicare or Medicaid HMOs, believing that substantial differences in enrollee demographics and financing make these discrete market segments.

METHODS

A major health benefits consulting firm provided data for this study. The firm collected and analyzed data from a 1997 calendar year mail survey of HMO administrators regarding their respective HMOs. The survey requested information on selected marketing-mix components and the percentage of surveyed members who indicated overall satisfaction with their HMO. To test the hypotheses, the marketing-mix components were treated as independent variables and enrollee satisfaction as the dependent variable.

The study universe is 740 HMOs nationwide. While most analysts report approximately 650 HMOs nationally, this study universe is larger because the data source includes plan subsets (e.g., Kaiser Permanente submits separate data for its Northern California and Southern California regions). Useable responses were obtained from 585 HMOs for a response rate of 79.0 percent. The total number of respondents for each question varies, because not all respondents answered every question. This sample is representative of the study universe; thus it is described as a limited universe sample — a proportion of a larger hypothetical universe consisting of all possible limited universes.[18]

The statistical analysis focuses on the relationship between selected marketing-mix components and enrollees' overall satisfaction with their HMO. The cross tabulations involve ordinal/ordinal or interval/interval data. The researchers use the chi-square test to analyze the data. Because this is exploratory research, the authors chose to use three common levels of statistical significance, .05, .01, and .001, with .05 indicating the least amount of significance and .001 indicating the greatest amount of significance. Any hypothesized relationships that elicited significance at any of these levels were considered supported, and the significance levels are indicated accordingly in the tables.

The researchers define "satisfaction" as meeting or exceeding expectations, as set subjectively by the enrollee. Enrollees base expectations on some combination of internal sources (e.g., previous experience) and external sources (e.g., HMO promotional materials, media articles, published report cards, and advice from friends, family, and physicians). If expectations are met, enrollees are satisfied. If expectations are not met, then enrollees experience dissatisfaction. The greater the disparity, the greater the dissatisfaction. Satisfaction is relative to a personal standard; it also is relative to other comparison groups. Thus, it is important to compare satisfaction rates of HMO enrollees with those of enrollees in other health insurance plans. It also is important to understand satisfaction and dissatisfaction relative to different aspects of HMOs' marketing mix.

RESULTS

In terms of product, there are statistically significant relationships between overall satisfaction and several indicators of product quality (Table 1): overall plan performance (according to the consulting firm's scoring system), federal qualification, number of board-certified primary care physicians (PCPs), and number of board-certified specialists. Accreditation by the National Committee for Quality Assurance (NCQA) is not statistically significant.

Utilization also shows mixed results: Neither average length of stay (ALOS) nor total bed days per 1,000 population show significance. In contrast, maternity ALOS and total discharges per 1,000 enrollees do show significance. Aside from maternity ALOS, the data suggest that enrollees' satisfaction depends more on being discharged than on how long they stay in the hospital. This brings into question allegations that HMOs are discharge patients "quicker and sicker."

The researchers examined three dimensions of access: availability of providers (Table 2), utilization of out-of-network services (Table 3), and waiting time for service (Table 4). With regard to Table 2, none of the availability factors were significantly related to overall satisfaction. In short, there was no statistically significant relationship between overall satisfaction and numbers of providers (PCPs, specialists, hospitals, or pharmacies); numbers of PCPs or specialists accepting new patients; or percentage of PCP or specialist visits, as a percentage of total physician visits. Two relationships, however, did approach statistical significance: number of PCPs accepting new patients and percentage of specialist visits as a percentage of total physician visits. The presence of a gatekeeper was not significant.

Utilization of out-of-network services (i.e., going beyond paneled providers) was related to overall satisfaction. There were significant relationships between overall satisfaction and three related aspects of out-of-network utilization: out-of-network nonspecialists, specialists, and out-of-area nonemergent coverage.

Waiting times showed mixed results. There were statistically significant relationships between overall satisfaction and waiting time in the doctor's office for scheduled appointments and for urgent care. There was no significant relationship with waiting time for routine care or mental health visits.

Overall satisfaction is related to several administrative service products that augment the delivery of care: percentage of employees receiving membership cards, average turnaround time for claims, and average turnaround time for out-of-network claims.

Disease prevention and health promotion programs are related to overall satisfaction. There are significant relationships between overall satisfaction and three product features that augment acute care: number of health promotion and education programs; presence of disease management programs; and sending notices and providing screenings and vaccinations. The presence of a toll-free nurse/info health information line was not significant.

Overall satisfaction showed little relationship to financial factors. The relationship between profit status and overall satisfaction was not statistically significant. Financial performance indicators — operating profit

TABLE 1 Survey of HMO CEOs: Relationship between selected HMO characteristics and overall satisfaction

	(n)	Chi square	DF	Outcome
Structure				
Higher-performance HMOs (per consulting firm ratings) have higher enrollee satisfaction	446	40.065	4	Supported $P<.001$
Federally qualified HMOs have higher enrollee satisfaction	450	15.203	2	Supported $P<.001$
NCQA-accredited HMOs have higher enrollee satisfaction	453	2.032	2	Rejected
MDs				
HMOs with more board-certified PCPs have higher enrollee satisfaction	422	10.229	4	Supported $P<.05$
HMOs with more board-certified specialist physicians have higher enrollee satisfaction	408	13.313	4	Supported $P<.01$
Utilization				
HMOs with longer LOS have higher enrollee satisfaction	335	4.848	4	Rejected
HMOs with longer maternity ALOS have higher enrollee satisfaction	348	14.213	4	Supported $P<.05$
HMOs with fewer C-sections have higher enrollee satisfaction	318	5.281	4	Rejected
HMOs with more bed days/1,000 enrollees have higher enrollee satisfaction	357	7.079	4	Rejected
HMOs with more discharges/1,000 enrollees have higher enrollee satisfaction	347	16.594	4	Supported $P<.01$
HMOs with more total mental health and substance abuse discharges/1,000 enrollees have higher satisfaction	293	5.215	4	Rejected

margin, medical loss ratio, and administrative loss ratio — show no significant relationships with overall satisfaction. Per-member, per-month cost and premium ratios do not show significance. Only one financial indicator, debt-equity ratio, is related to overall satisfaction.

DISCUSSION

Quality

Enrollees are concerned about HMO quality, but they have their own decision-making criteria and sources of information. Enrollees present a paradox. While they want cost-effective health care, they accord little weight to data-based, health plan report cards. Instead, they rely more on personal experiences and advice from friends, family, and physicians.[19] The Institute of Medicine concluded that health care service underuse, overuse, or misuse occur with approximately equal frequency in managed care and fee-for-service systems, yet there appears to be widespread dissatisfaction with HMOs.[20]

Families USA, the American Association of Health Plans (AAHP), and the Coalition for Accountable Managed Care advocate that HMOs have obligations to disclose plan information and consumers have the right to information about health plans and how they work. The President's Advisory Commission, in its Consumer Bill of Rights and Responsibilities, addressed realistic expectations, through provisions that consumers:

- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Become knowledgeable about their health plan coverage and health plan options, including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.[11]

This study's findings present a challenge to NCQA and state data agencies to market themselves to large-scale purchasers, their employees, and beneficiaries. HMOs and employers must understand the criteria people use to make decisions and consequently provide necessary information, appropriate formats, and alternative communication channels. Consumer Reports offers a

TABLE 2 Relationship between access (availability) and overall satisfaction

	(n)	Chi square	DF	Outcome
HMOs with more gatekeepers will have higher enrollee satisfaction	453	2.235	2	Rejected
HMOs with more PCPs will have higher enrollee satisfaction	446	0.451	4	Rejected
HMOs with a higher percentage of PCP visits as a percentage of total visits will have higher enrollee satisfaction	244	6.140	4	Rejected
HMOs with a higher number of PCPs accepting new patients have higher enrollee satisfaction	433	9.155	4	Rejected
HMOs with a higher number of specialists have higher satisfaction	419	2.059	4	Rejected
HMOs with a higher percentage of specialist visits as percentage of total MD visits have higher enrollee satisfaction	245	8.800	4	Rejected
HMOs with a larger number of hospitals contracted with/owned have higher satisfaction	442	7.502	4	Rejected
HMOs with a larger number of pharmacies contracted with/owned have higher enrollee satisfaction	408	5.126	4	Rejected

TABLE 3 Relationship between access to out-of-network services and overall satisfaction

	(n)	Chi square	DF	Outcome
HMOs with a higher percentage of nonspecialist visits out of network have higher enrollee satisfaction	159	30.294	2	Supported $P<.001$
HMOs with a higher percentage of specialist visits out of network have higher enrollee satisfaction	172	26.948	2	Supported $P<.001$
HMOs with greater nonemergent coverage out of service area (reciprocity) have higher enrollee satisfaction	454	19.691	2	Supported $P<.001$

model for assessing quality and reporting results to a lay public. It prioritizes criteria, synthesizes and interprets data, and then arrives at a recommendation.

NCQA potentially offers HMOs a competitive advantage based on quality. Through its Web site, NCQA (www.ncqa.org) provides the public with information on accreditation status. The NCQA's report cards on each participating HMO include (1) accreditation outcome (i.e., five rating categories ranging from "excellent" to "denied") and (2) evaluation, relative to other HMOs, in five performance categories.[20]

Accredited HMOs frequently use public relations materials and news articles to inform their stakeholders. Three examples serve as illustration:

> "NCQA accreditation is your assurance that your group health plan passed the toughest quality review of its kind in the industry…. NCQA is considered the industry's gold standard for quality."[21]

> "United Health is only one of three managed care plans in Wisconsin to achieve full accreditation from NCQA…. NCQA is as close as health care gets to providing a Consumer Reports or *Good Housekeeping* Seal of Approval."[22]

> "In the most comprehensive guide to HMOs ever developed, Kaiser Permanente health plans dominate America's Top HMOs. Ten Kaiser Permanente Health Plans received 'four star' rankings, the highest possible."[23]

TABLE 4 Relationship between access (waiting time) and overall satisfaction

	(n)	Chi square	DF	Outcome
HMOs with less waiting time for routine care have higher enrollee satisfaction	282	1.124	4	Rejected
HMOs with less patient waiting time for scheduled appointments with physicians have higher enrollee satisfaction	173	14.631	4	Supported $P<.01$
HMOs with less waiting time for urgent care patients to see physicians have higher enrollee satisfaction	241	12.717	4	Supported $P<.05$
HMOs with less waiting time for patients to receive a mental health evaluation have higher enrollee satisfaction	183	5.590	4	Rejected
HMOs with less waiting time for patients to receive mental health urgent care have higher enrollee satisfaction	190	7.994	4	Rejected

TABLE 5 Relationship between customer service and overall satisfaction

	(n)	Chi square	DF	Outcome
HMOs with more full-time service representatives have higher enrollee satisfaction	357	8.679	4	Rejected
HMOs with higher percentage of enrollees receiving membership cards have higher enrollee satisfaction	252	12.221	4	Supported $P<.05$
HMOs with shorter average turnaround time for claims have higher enrollee satisfaction	369	22.600	4	Supported $P<.000$
HMOs with shorter average turnaround time for out-of-network POS claims have higher enrollee satisfaction	280	17.549	4	Supported $P<.01$

Access (availability)

Overall numbers of providers did not appear to affect satisfaction. This suggests that enrollees give greater weight to obtaining service when they want it (e.g., getting an appointment or being admitted to a hospital) than to the presence of large panels. One difference with the literature is lack of relationship between presence of a gatekeeper and overall satisfaction. This suggests that enrollees perceive gatekeepers more as PCPs and coordinators of family care rather than as resource allocators who ration utilization of costly services.

The importance of access is emphasized by several consumer- and provider-group position papers. Families USA identifies eight protections needed by managed care consumers. For four of these, respective emphasis is on access to (1) emergency services, (2) needed care and specialists, (3) specialists for those with special needs, and (4) sufficient and accessible providers.[24] AAHP advocates a philosophy of care that (1) patients should have the right care, at the right time, in the right setting and (2) access to affordable, comprehen-

sive care that gives consumers the value they expect and contributes to the peace of mind that is essential to good health.[25] The Coalition for Accountable Managed Care identified its first principle as "access to plans and services."[26]

Access (out of network)

Out-of-network access, especially to out-of-network nonspecialists, specialists, and out-of-area nonemergent coverage, highlights the importance that enrollees assign to obtaining care where they want it. Out-of-network access may be related to several factors: an HMO's small number of providers; enrollee's desire to maintain relationships with previous providers or be treated by a specialist not on the panel; and the need for services when travelling or vacationing. HMO "swing out" options (i.e., the ability of enrollees to utilize non-HMO providers but be reimbursed at a lower percentage) and point-of-service plans allow members access to more providers in exchange for higher copays and deductibles. We infer that enrollees value autonomy and freedom of choice in medical decisions. Restricted access, especially for laypersons in emergent and urgent situations, is an emotional issue that highlights potential conflicts between HMOs and enrollees. We anticipate that United Healthcare's action to eliminate prior authorization will be closely watched by its competitors.

Access (waiting time)

There are statistically significant relationships between overall satisfaction and waiting time in the doctor's office for scheduled appointments and for urgent care. The former represents an opportunity cost; enrollees must sacrifice another activity. The doctor office visit necessitates time for travel, parking, registration, and waiting in both the waiting room and exam room. Enrollees consider their time to be important and expect to be seen at the time appointed. Treatment for urgent care promises relief of pain or anxiety, or both. Enrollees expect to be "worked into" their physician's schedule or be treated at an HMO-affiliated ambulatory center.

Customer service

The inference is that prompt administrative service is a normative expectation. Enrollees want membership cards so they can use their HMO benefits, and they want to be reimbursed for out-of-pocket payments of covered services. HMOs can respond to these concerns by reviewing and improving administrative systems and processes. The Federal Employees Health Benefit Program evaluates only six criteria: three of these are customer service, claims processing, and the courteousness and helpfulness of office staff.[27] The literature also notes other value-added services including reminders

TABLE 6 Relationship between disease prevention and health-promotion programs and overall satisfaction

	n	CHI SQUARE	DF	OUTCOME
HMOs with more promotional & educational programs have higher enrollee satisfaction	455	22.875	4	Supported *P*<.001
HMOs with more disease management programs have higher enrollee satisfaction	422	16.333	4	Supported *P*<.01
HMOs with more health screenings & vaccinations have higher enrollee satisfaction	448	22.431	2	Supported *P*<.001
HMOs that send screening reminder notices to members have higher enrollee satisfaction	397	29.007	4	Supported *P*<.001
HMOs that provide toll-free nurse/info health information line have greater enrollee satisfaction	453	2.032	2	Rejected

TABLE 7 Relationship between selected financial indicators and overall satisfaction

	n	CHI SQUARE	DF	OUTCOME
HMOs with for-profit tax status have higher enrollee satisfaction	455	5.159	2	Rejected
HMOs with a higher operating profit margin have higher enrollee satisfaction	353	7.574	4	Rejected
HMOs with lower average monthly premiums average premium/member/month have higher enrollee satisfaction	309	6.971	4	Rejected
HMOs with lower medical cost/member/month have higher enrollee satisfaction	341	2.057	4	Rejected
HMOs with lower debt-to-equity ratio have higher enrollee satisfaction	355	37.183	4	Supported P<.001

to get preventive care, access to drugs that members believe are best for their conditions,[28] short waiting times, and personal communication with patient financial services representatives.[29]

For both waiting time and customer service, the Health Employer Data and Information Set (HEDIS) Member Satisfaction Survey offers a standardized performance evaluation tool. The survey asks enrollees to rate overall health plan performance; overall health care; access/availability to service; courteousness and helpfulness of office staff; customer service; personal physician or nurse care; and claims processing. Health plans with the highest HEDIS scores have the most satisfied members, and health plans with the most satisfied members have the highest HEDIS scores. NCQA studies show that, across every measure of performance, plans that allow NCQA to publicly report their HEDIS scores outperform plans that do not.[30]

Disease prevention and health promotion

Disease prevention and health promotion are frequent subjects in the professional and popular media and a major emphasis of the U.S. Public Health Service. Several individual and community-based intervention programs demonstrate favorable benefit-to-cost ratios. HMOs can offer traditional programs (e.g., smoking cessation) and innovative programs (e.g., stress management). They can apply new communication channels, such as the Internet, for health risk appraisal and information dissemination. Many HMOs have their own Web sites, e.g., «http://www.kaiserpermanente.com». Others, like Intermountain Health Care «http://www.ihc.com», enhance their Web sites by providing information from another site, such as DrKoop.com «http://www.drkoop.com». With increasing numbers of personal computers being used, HMO enrollees can be expected to access health information from a wide range of sources that may include the Mayo Clinic «http://www.mayohealth.com» as well as Andrew Weil, M.D. «http://www.drweil.com».

Disease prevention and health promotion services help HMOs expand their image beyond illness treatment into the maintenance of positive health. With defined, prepaid populations, HMOs can develop enrollee databases, calculate disease incidence and prevalence and their related risk factors, and develop interventions. Such programs augment benefits, reduce health care costs, and complement work site health promotion programs.

Financial aspects

These findings suggest that enrollees do not perceive a conflict between overall satisfaction and financial factors. Enrollees do not perceive HMOs sacrificing service for financial gain. These findings challenge popular assumptions and expert opinions that Americans need to reconcile their views as taxpayers with their views as patients who want no limits on the care they or their loved ones can receive. Consumers need to have realistic expectations regarding what patients can have in a cost contained health system.[9]

Marketing's voluntary exchange rarely is ideal for either providers or consumers. Both parties seek to attain their own goals within finite resources. Our data infer, however, that there already is a meeting of the minds between HMOs and enrollees regarding reasonable expectations of benefits and costs. HMOs and enrollees are distinguishing between want (personal preferences), need (professional standards of care), and demand (the price one is willing to pay for services rendered).

Large-scale purchasers, namely employers and government, decide which HMOs to offer as well as the related benefits, premiums, and user fees. Thus, they have the power to negotiate with HMOs over various rights and responsibilities. Additionally, purchasers may make NCQA accreditation a threshold for even taking an HMO under consideration.

Limitations

The limitations in this study largely are related to health care satisfaction research, in general. Measuring and evaluating satisfaction present problems. Satisfaction surveys commonly yield high rates of satisfaction. Isaacs finds that surveys tend to passively accept consumer opinions without probing their responses for additional information.[4] MacStravic characterizes consumers as limited with respect to identifying their own needs and wants and translating them into service preferences, especially when they are unaware of available options.[31] Consumers may be satisfied or dissatisfied with their HMO, but may not have the opportunity to comment or sufficient knowledge to suggest improvements. Additionally, satisfaction surveys have been criticized on grounds that accreditation may not be a valid indicator of quality, that methodology is flawed, that such evaluations weight opinions of healthy enrollees more heavily than sick enrollees, and that the evaluation does not focus on areas of greatest concern to consumers.[32,33,34]

Researchers can enhance their evaluation of enrollee satisfaction through triangulation. This involves using surveys, interviews, and focus groups. Accurately understanding consumers requires trained interviewers who actively listen and ask follow-up questions to determine the actual meaning of a particular response. Focus groups provide an opportunity to stimulate interaction between researchers and enrollees.

CONCLUSION

As competition increases among health care organizations, HMO marketing is becoming a normative com-

ponent of management's responsibility to develop strategies for surviving and thriving.

HMOs that do not take full advantage of the benefits offered by marketing limit their range of options.

If, however, HMOs choose to see the value of marketing, they can convert enrollee wants, needs, and desires into opportunities. HMOs can identify patient expectations, respond to reasonable expectations through the marketing mix, and thus increase enrollee satisfaction. This leads to an enhanced outcome for HMOs and enrollees; both meet their objectives.

HMOs commonly function in markets characterized by physician and hospital surpluses, value conscious purchasers, declining reimbursement, increasingly costly technology, and demanding enrollees.

Marketing encompasses several related terms. The marketing concept starts and ends with customers rather than providers.[35] It emphasizes the importance of listening to consumers, interpreting their wants and needs, and developing services that respond efficiently and effectively. Through a marketing orientation, HMOs pursue patient satisfaction to meet their own needs.[36] A successful marketing orientation is based on organizational mission, culture, and work environment. Customer-driven organizations are characterized by their understanding of their customers, knowing how customers perceive the firm, and delivering quality and value.[37] Such an organization knows that customers want providers to go beyond reacting to individual problems and instead takes initiative for planning delivery systems that prevent problems. Group Health Cooperative (GHC) synthesizes these marketing dimensions by emphasizing that successful HMOs ensure access, so that members receive timely and appropriate care for the best possible health outcomes. Its comprehensive perspective on appropriate care includes getting through on the telephone, making appointments without hassle, and receiving medical advice in the middle of the night. The bottom line is: "Can I get care when I need it, from my own doctor?"[38]

From a national perspective, our study showed significant relationships between overall satisfaction and several marketing-mix variables. At the local level, each HMO should research the extent of these relationships among its own enrollees. If these relationships prevail, HMOs should act on them. If enrollees show statistically significant relationships between overall satisfaction and selected quality indicators, access to out-of-network services, customer service, waiting times, disease prevention, and health promotion programs, HMOs can respond with new programs and improve existing ones. HMOs can apply this practical definition of marketing: "Find out what they want, and give them more of it."

HMOs also can take the initiative to educate their enrollees on health care-delivery issues, such as NCQA credibility and consumer rights and responsibilities. HMOs' promotion mix of advertising, public relations, sales, and promotions should help customers make informed choices.[39] HMOs can make promotional materials more understandable to the enrollee; can better educate corporate purchasers, their human resource managers, and enrollees; and can provide multiple communication channels.

HMOs can become more "user friendly" by providing information on how to access the system, including available providers, days, hours, and locations of operation; benefits and exclusions; financial responsibility for copayments and deductibles; and the importance of disease prevention and health promotion. HMOs can reinforce enrollment decisions by providing enrollees with information on services provided and benefits received. Additionally, it is advisable for an HMO to maintain communications with enrollees and to provide a defined method of dispute resolution.

While marketing is not a panacea, many HMO problems can be addressed via improved marketing. Through marketing, HMOs may be able to pre-empt action for government regulation, litigation, or legislation. With satisfied enrollees, there is a lessened need for outside intervention. HMOs can apply marketing to remove themselves from controversies surrounding any patients bill of rights, and to help to re-establish their original purpose and prestige.

HMOs still have time to act rather than simply react. The marketing issues confronting HMOs do not necessitate new theory, marketing information systems, or technology. Kaiser Permanente, GHC, and United Healthcare have successfully demonstrated the value of marketing. Additional exemplary marketing strategies can be found in other service industries as well. The resolution of HMOs' major marketing issue lies chiefly in finding the will to change the way business is done and then in adopting an effective marketing orientation.

REFERENCES

1. U.S. Department of Health and Human Services. *Health, United States, 1998*. Hyattsville, Md. Accessed March 5, 2000: «http://www.cdc.gov/nchswww/data/hus98.pdf».
2. MacColl W. *Group Practice and Prepayment of Medical Care*. Washington: Public Affairs Press; 1966: 20.
3. Mechanic D. Changing medical organization and the erosion of trust. *The Milbank Quarterly*. 1996; 74(2):171–190.
4. Isaacs S. Consumer information needs: Results of a national survey. *Health Affairs*. 1996;15(4):31–41.
5. Davis K, Collins K, Schoen C. Choice matters: Enrollees' views of their health plans. *Health Affairs*. 1995;1(2):99–112.
6. Ullman R, Hill J, Scheye E, and Spoeri R. Satisfaction and choice: A view

from the plans. *Health Affairs.* 1997 May/June; 16(3):209–217.
7. National Committee for Quality Assurance. *Health Plan Performance Data: Are Purchasers Providing the Results to Consumers?* Report prepared for the Commonwealth Fund, July 1995.
8. Galewitz P. Health groups cut costs by dropping drugs. *Salt Lake Tribune.* May 25, 1999.
9. Enthoven A, Singer S. The managed care backlash and the task force in California. *Health Affairs.* 1998;17:95–110.
10. Blendon R, Brodie M, Benson J., Altman D, Levitt L, Hoff T, and Hugick L. Understanding the managed care backlash. *Health Affairs.* 1998; 17:80–94.
11. U.S. Department of Health and Human Services. President's advisory commission releases Consumer Bill of Rights and Responsibilities. Accessed Jan. 19, 1999: «http://www.dhhs.gov/news/press/1997».
12. Kotler P, Clarke R. *Marketing for Health Care Organizations.* Englewood Cliffs, N.J.: Prentice-Hall, 1987:5.
13. Drucker P. *Management.* Harper & Row, 1973:64.
14. Schmittdiel J, Selby J, Grumbach K, and Quesenberry C. A choice of a personal physician and patient satisfaction in a health maintenance organization. *JAMA.* 1997;278: 1596–1606.
15. Hays R, Brown J, Spritzer K, Dixon W, Brook R. Member Ratings of Health Care Provided by 48 Physician Groups. *Arch Intern Med.* 1998;158:785–790.
16. University of Colorado Hospital. Visitor Center. Accessed Sept. 10, 1999: «http:// www.uch.uchsc.edu/visitorscenter»
17. Loma Linda University Medical Center. Mission Statement. Accessed Sept. 5, 2000: «http://www.llu.edu/llumc/ mcmissn.html».
18. Hagood MJ, Price DO. *Statistics for Sociologists.* New York: Henry Holt, 1952: 293–295.
19. Henry J. Kaiser Foundation/Agency for Health Care Policy and Research/ Princeton Survey Associates Poll (Storrs, Conn.: Roper Center for Public Opinion Research).July 26, 1996.
20. Lawrence D. Is medical care obsolete? Kaiser Permanente news release, July 14, 1999. Accessed Nov. 4, 1999: «http://www. Kaiserpermanente.org/newsroom/releases/speech.htm».
21. Group Health Cooperative. NCQA accreditation is your assurance of quality care. Accessed Feb. 11, 1998: «http:// www.ghc.org/quality/ncqa.html».
22. United Healthcare. United receives full accreditation from NCQA. Accessed Sept. 3, 1999: «http://www.thedacare.org/news/archives/ncqa.htm».
23. Kaiser Permanente. Kaiser Permanente dominates ranks of "America's top HMOs." Accessed Jan. 26, 1998: «http:// www.ghc.org/quality/ncqa.html».
24. Families USA. Families USA outlines eight protections needed by managed care consumers. Accessed April 30, 1998: «http://www.familiesusa.org/press3_6html».
25. American Association of Health Plans. Our philosophy of care. Accessed March 17, 1998: «http://www.aahp.org/services/homepagelinks/homelinksaboutaahp.htm».
26. Coalition for Accountable Managed Care. Principles for accountable managed care. July 1997. Accessed April 17, 1998: «http://www.aamc.org/hlthcare/princip.htm».
27. U.S. Office of Personnel Management. *Federal Employees Health Benefits Guide 1999.* Accessed July 31, 2000: «http://www.opm.gov/insure/99/guides/hmo70–71.pdf».
28. Bayer Pharmaceutical Division. *Guide to Improving Member Retention.* Accessed March 17, 1998: «http://www.bayermch.com/mcmrt/gmr».
29. Gustafson D. A well-staffed PFS call center can improve patient satisfaction. *Healthcare Financial Management.* 1999;53(7):64–67.
30. National Committee for Quality Assurance. 1999 NCQA's State of Managed Care Quality Report, Quality Compass '99, show simple formula for health care quality: accountability. Accessed July 28, 1999: «http://www.ncqa.org/ pages/communications/news/somcqrel.htm».
31. MacStravic RS. *Creating Consumer Loyalty in Healthcare.* Chicago: Health Administration Press, 1999.
32. Chernew M, Seanton D. Health plan report cards and insurance choice. *Inquiry.* Spring 1998;35(1)9–23.
33. Williams B, Coyle J, and Healy D. The meaning of patient satisfaction: An explanation of high reported levels. *Social Science and Medicine.* 1998;47(9): 1351–1360.
34. Schall M, Evans B, Lottinger A. Evaluation predictors and concomitants of patient health visit satisfaction: An empirical study focusing on methodological aspects of satisfaction research. *Health Marketing Quarterly.* 1998;15:1–24.
35. Kotler P. *Marketing Management.* 9th ed. Upper Saddle River, NJ: Prentice-Hall, 1997.
36. Berkowitz E. *Essentials of Health Care Marketing.* Gaithersburg, Md.: Aspen Publications, 1996.
37. Aaker D. *Strategic Marketing Management.* 2nd ed. New York: John Wiley & Sons, 1988.
38. Group Health Cooperative. 1995 HEDIS report: Member access and satisfaction. Accessed Feb. 9, 1999: «http://www. ghc.org/quality/hedisch3».
39. Herzlinger R. *Creating New Health Care Ventures.* Gaithersburg Md.: Aspen Publishers, 1992.