ضمان

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Council of Health Insurance

Whitepaper

Measuring the 'Voice of the Beneficiaries'

The perspective from National Private Health Insurance Regulator KSA.

Contents

Click on the required title

Introduction

This whitepaper aims to showcase one of the first efforts of the Council of Health Insurance (CHI) vision and plan moving towards Value-Based Health Care (VBHC).

To fulfill the CHI commitments to the KSA private health insurance market being Beneficiary centric, CHI has developed a program to involve the Beneficiaries. With this program we directly address the Beneficiaries and measure the performance of the stakeholders in access to care and the day-to-day care delivery.

Up to recent date CHI had the mandate on regulating both the Health Insurers (Payers) and the Healthcare Providers (Providers) therefore is part of the CHI strategy the first aim was to measure the experience and satisfaction of access to care and coordination between the payer and provider.

In 2021 CHI launched the Beneficiary Survey with a clear focus on 5 domains:

1. CHI role
2. Insurance Plan
3. Care Provision
4. Coordination of care
5. Insurance customer service

This whitepaper will describe more details and outcomes and fully focusses on the Beneficiary survey journey.

In 2022 CHI has launched in collaboration with the Ministry of Health (MOH) a Patient Reported Experience Measure survey.

PREMs assess patients' perceptions of their care experience, including organizational features (e.g., the information provided by doctors and nurses), feelings (e.g., attention to pain), and empirical based aspects of their process of care (e.g., waiting time during appointments). Generic PREMs address any patient, while specific PREMs only address patients with a specific disease.

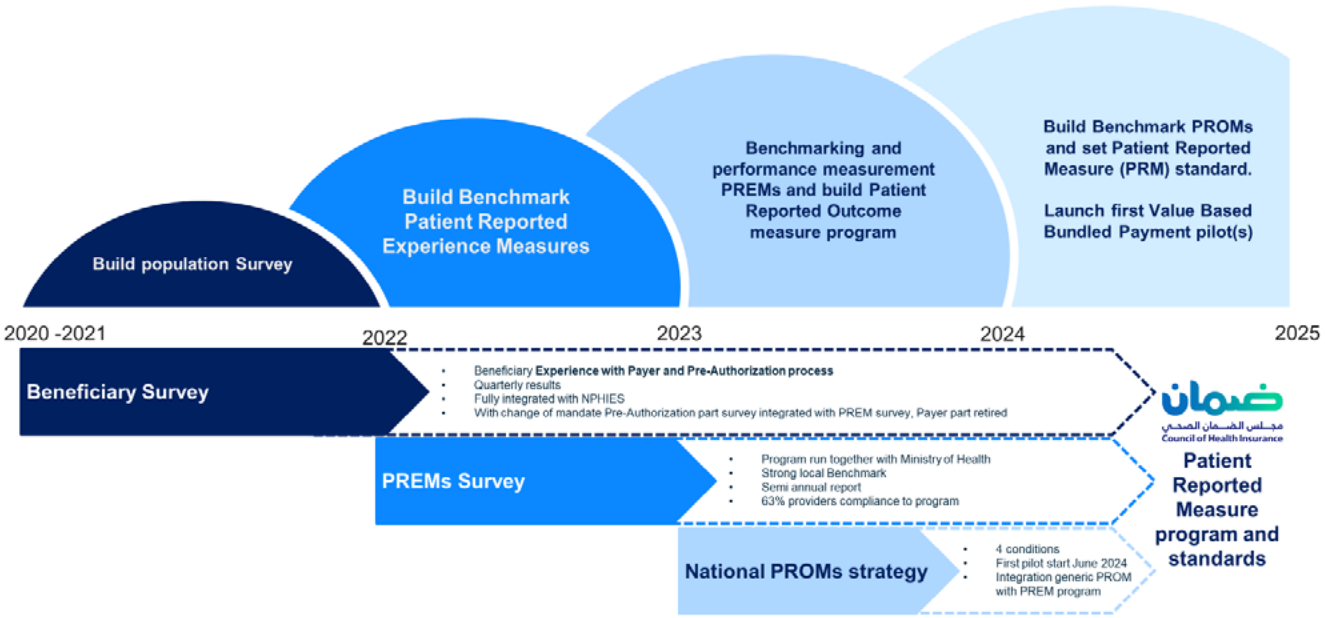
Over the past years, Patient Reported Measures (PRMs) have been strongly encouraged as a means of assessing and improving the quality of care. PRMs (i.e., any report of the status of a patient's health condition, health behavior, or experience with healthcare that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else) [1] are now becoming a widely used tool in developed countries [2-5].

These developments have led to distinguishing Patient Reported Outcome Measures (PROM) and Patient Reported Experience Measures (PREM) [6,7].

PROMs provide patients' views of their health-related quality of life, physical functions, and symptoms (e.g., pain). Generic PROMs are applied to any clinical situation because they measure general symptoms and quality of life, while specific PROMs target a particular disease or group of patients.

Current initiatives at national and international levels lack formal consensus regarding which PRO instruments should be used as QIs [4, 8]. The variability of existing instruments is the first explanation limiting efforts to compare care across practices and organizations on a standard set of PRMs. The absence of a clear definition of the objective of use (i.e., follow-up care, orientation on pain, quality of life, analysis of the impact of a specific intervention) and the level of analysis (i.e., practice or organizational level) gives a second explanation.

Therefore, the Council of Health Insurance (CHI) has taken the initiative to create a strategy to standardize the way we gather and improve the quality of the PRM data.



Kindly we like to refer you to our whitepapers on Value based Healthcare and the National PRM strategy for more information about the CHI initiatives to enhance the Beneficiaries involvement in building a strong Value Based Healthcare ecosystem for the KSA.

Value-Based Healthcare ›

https://chi.gov.sa/MediaCenter/Researchlibrary/Documents/VBHC%20White%20Paper%20Version%20Final.pdf

The National PRM Strategy ›

https://chi.gov.sa/MediaCenter/Researchlibrary/Documents/PROMs%20White%20Paper.pdf

Preface

One of the most important tasks of the Council of Health Insurance (CHI) is the protection of all beneficiaries within the private healthcare sector of KSA.

The CHI strategy 2020 - 2024 calls for action to measure the 'voice of the Beneficiaries' and learning from their feedback. This white paper will describe the learning journey from CHI to build a robust program to measure the beneficiary experience and satisfaction with the health insurance companies (payers), healthcare providers (providers) and the coordination between payers and providers during the pre-authorization process to secure and optimize access to care. As a self-reflection on our strategic approach being a progressive regulator we also ask the beneficiaries with their experience with CHI.

CHI strongly believes in transparency and has built a program to share the learnings from the different surveys with the public and both the payers and providers.

Sincerely yours,

supporting protection of all our Beneficiaries.

DR. SHABAB ALGHAMDI
Secretary General
Council of Health Insurance

Abstract

CHI has developed and launched in 2021 a survey to measure the "voice of the Beneficiaries". With the Beneficiaries Survey program, CHI measures the level and experience with receiving the insurance information, access to care and how the beneficiaries assess the overall experience with the insurer (payer) and the experience with level of coordination with the payers and healthcare providers (providers). The outcome of the survey is shared on a quarterly basis with the payers on their individual average scores and data is made available for them to see all the details. A public report on sector average performance is shared via social media.

Over the course of the four studied quarters, Q4 2022 – Q3 2023, the market average Overall Csat with the payer decreased in parallel with the overall Csat for the pre-authorization process. This indicates that the Beneficiaries report a link between a bat experience with the coordination between payers and providers (pre-authorization process) and their experience with the payer after.

The continuous decrease in experience with the payer is also reflected in an increased number of complaints against the payer issued via the customer service team within CHI. Data shows 80% of all these complaints are issued after a (partial) rejection.

Beneficiaries who have received their insurance information in a way that is clear for them have a better experience with the payer.

Based on the Overall conclusions and analysis of the survey data CHI has indicated different levels of improvement across the patient journey with a clear focus on the pre-authorization process.

Measure

In the first section of this whitepaper, the methodology and outcomes for the Beneficiary Survey are described. CHI has developed and launched in 2021 a survey to measure the "voice of the Beneficiaries". Instead of 'patient voice' we particularly mention the 'Beneficiaries voice' because CHI not only measure the experience and satisfaction once you're being treated by a provider as part of the Patient Reported Experience Measure (PREM) survey program. With the Beneficiaries Survey program, CHI is mainly interested in the level and experience with receiving the insurance information, access to care and how the beneficiaries assess the overall experience with the insurer (payer) and the experience with level of coordination with the payers and care providers (providers).

Since CHI also acts on behalf of the beneficiaries in case of a complaint and question towards the payers and providers, CHI also measures the level of awareness of CHI tasks and experience with the service CHI provides.

CHI strategy

The number one strategic objective for CHI is to increase the Beneficiaries protection as part of the 'Beneficiaries Centric thinking' approach.

Therefore, measuring the voice of the Beneficiaries is a strategic program with clear key performance indicators on both the payer and CHI's own performance. In the 'Improve' section of this paper you find the approach from CHI to collaborate with the insurance partners and healthcare providers to enhance the experience for our Beneficiaries, based on the outcome of the survey program.

Vision

To be an international leader in prevention and improving value in health care services for the health insurance beneficiaries.

Mission

Improve the health of beneficiaries through a regulatory environment focused on prevention and enables stakeholders to promote equity, transparency and value-based health care.

Values

Competence

Professionalism

Collaboration

Creativity & Innovation

Customer Experience and Satisfaction is there a difference?

Both terminology's Customer Experience (CX) and Overall Customer Satisfaction (Csat), very often both are used interchangeably. Within CHI, we use the two separately although there's a very high correlation between the two.

Unlike Overall Customer Satisfaction, Customer Experience depends more on the impression left on the beneficiaries over the touchpoints in their journey. Beneficiaries will base their experience, in this case with the payer and provider, on whether they were informed correctly, how simple it was to get the service they needed and ultimately feeling like a valued person during the entire journey. Customer Experience begins the moment they are onboarded as an insured person.

Overall Customer Satisfaction (Csat) is 'simply' a measure of how happy a customer is with a business, a service, or their Overall Customer Experience.

CHI measures the experience on multiple designated touch points in the beneficiaries' journey (see items current surveys on page ...) and the Overall Beneficiaries Experience (overage off all items on experience) is calculated based on a average of these touch points. The overall customer satisfaction score is asked separately.

To use the overall satisfaction as a single Key Performance Indicator (KPI) there should be a strong correlation between the overall experience on multiple touch points and the overall Csat question, which is confirmed as you can see in figure 2.

Figure 2: Private sector average overall Experience and Overall Satisfaction performance

Beneficiary Survey design

The Beneficiary Survey is specifically designed by our partner Health Links ©, a Saudi based company and working under the license of Press Ganey© a world leading US company specialized in designing and reporting customer experience journeys. Since the Beneficiary Survey is custom made and focused on the private health sector in KSA it's very hard to benchmark against other countries like the USA, except for overall payer satisfaction scores.

Customer Satisfaction (CSAT) Ranking

The range of CSAT scores from highest to lowest is just under 9 points, suggesting that all of the top 25 health insurers are highly competitive.

RANK		SCORE
1	UnitedHealthcare	84.1
2	Humana	83.4
3	Kaiser Foundation Health Plan	82.8
4	Aetna	82.7
5	Empire BlueCross BlueShield	82.1
6	UPMC Health Plan	81.7
7	Health Net	81.5
8	Horizon Blue Cross Blue Shield of New Jersey	80.4
9	WellCare	80.3
10	Anthem BlueCross and BlueShield	80.2
11	Highmark Blue Cross Blue Shield	79.8
12	Blue Cross Blue Shield of Michigan	79.8
13	Florida Blue	79.8

RANK		SCORE
14	BlueCross BlueShield of Oklahoma	79.5
15	Highmark Blue Shield	79.3
16	Independence Blue Cross	79.2
17	CareFirst BlueCross BlueShield	79.1
18	BlueCross BlueShield of Texas	78.8
19	Blue Shield of California	78.5
20	BlueCross BlueShield of Illinois	77.4
21	Anthem Blue Cross	77.4
22	Molina Healthcare	77.2
23	Blue Cross of California	77
24	Cigna	76.9
25	CareSource	75.2
AVERAGE		**79.8**

CSAT margin of error is +/- 1.88 points.
Top 25 health insurance providers in the U.S. selected using the National Association of Insurance Commissioners (NAIC) list based on market share.

Overall Csat Payers USA

Due to the differences in the US and Saudi healthcare system, caution to compare one in one is needed. Because the difference between highest and lowest scores in the USA is only just under nine points, shows the maturity of the insurance system. Figure 4 shows the high difference between highest and lowest Csat in KSA. CHI has chosen to build a strong national benchmark for the Beneficiary Survey.

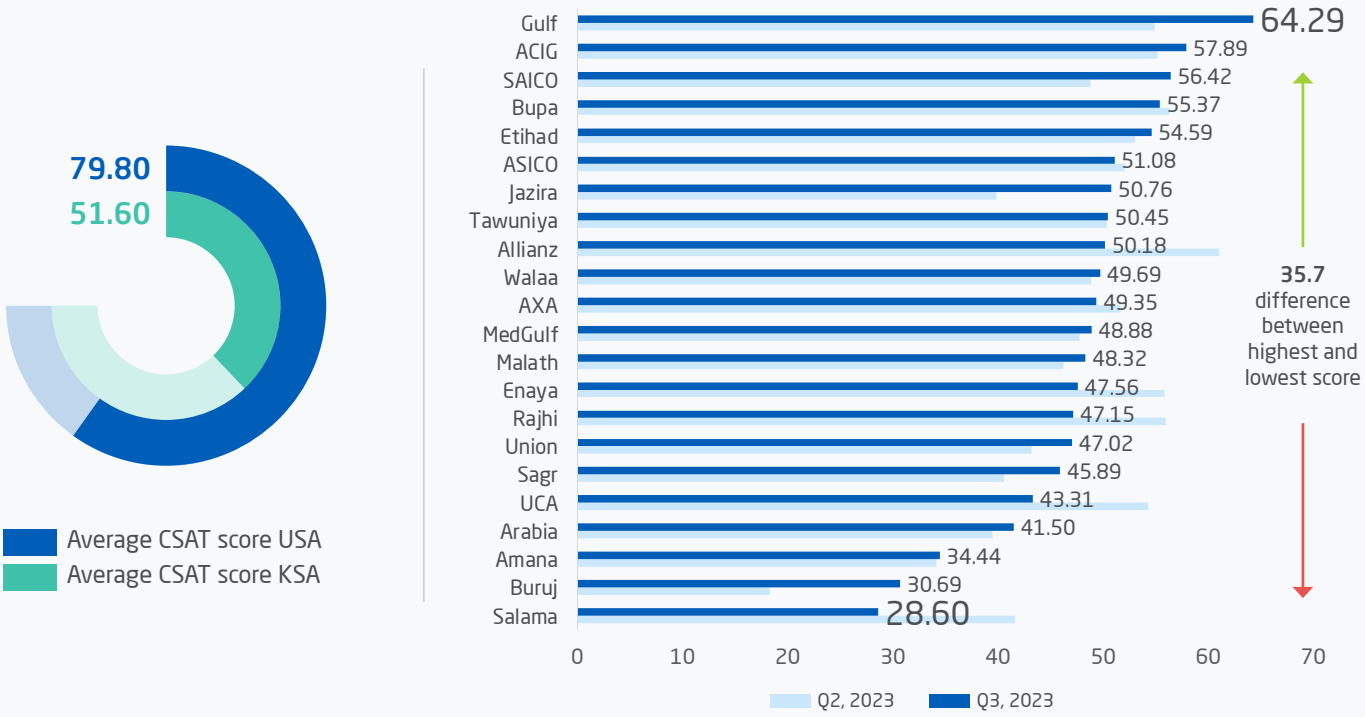


Figure 4 Average Csat scores on Payer level and national average KSA, source; Beneficiary Survey Q3 2023

Survey journey

After the initial design CHI launched the first Beneficiary Survey in late 2021. At that time the focus was on 4 domains:

Survey design launched 2021

45 Items

CHI Role
13 Items

- Awareness
- CHI Role
- Reaching rules & regulations
- UHIP benefits
- Customer Care

Insurance Plan
9 Items

- Insurance information
- Insurance customer service
- Overall Satisfaction

Care Provision
11 Items

- Ease of getting appointments
- Ease of contacting facility
- Staff courtesy
- Treatment plan explanation
- Deductible understanding
- Bill clarity / accuracy
- Overall Satisfaction

Pre-Authorization proccess
07 Items

- Timelessness of approval
- Delay explanation
- Rejection explanation
- Overall satisfaction with coordination

After 4 quarters the care provision was removed from the survey as the PREM survey was launched to the market covering all items on the care provision.

Survey design after enhancement in 2022

21 Items

CHI Role
13 Items

- Awareness
- CHI Role
- Reaching rules & regulations
- Overall Satisfaction

Insurance Plan
9 Items

- IInsurance information
- Insurance customer service
- Overall Satisfaction

Pre-Authorization proccess
07 Items

- Delay explanation
- Rejection explanation
- Overall satisfaction with coordination

Items current survey

Item #	Survey Item (EN)	Scale (EN)
INS-01	Have you received your healthcare insurance coverage information (via booklet, website, or application)?	1 Yes 2 No [Skip to INS-06]
INS-02	Adequacy of insurance information you received to include all details you needed (facilities, covered services, pre-approval limit, co-insurance ... etc.)	1 Very Poor - 5 Very Good
INS-06	Have you contacted the Insurance Company's Customer Care team in the past 6 months?	1 Yes 2 No [Skip to Next Section]
INS-08	Ease of reaching the insurance customer service team	1 Very Poor - 5 Very Good
INS-09	The courtesy of the insurance customer service team	1 Very Poor - 5 Very Good
INS-10	How well the insurance customer service team resolved your enquiries	1 Very Poor - 5 Very Good
INS-11	Your overall satisfaction with your insurance company	1 Very Poor - 5 Very Good
INS-12	Considering your insurance experience, how likely are you to recommend your insurance company to a friends or family?	NPS (0 - 10)
PRV-11	Have you faced any problems accepting your health insurance with a healthcare provider within your network?	1 Yes 2 No [Skip to Next Section]
PRV-12	Please Detail	Free Text
COR-03	Did you experience any delay in processing your insurance approval request (maximum time 60 minutes after pre-authorization request has been send to insurance company)?	1 Yes 2 No [Skip to COR-05]
COR-08	In case of delay (more than 60 minutes), did either the healthcare provider or Insurance company give you a reason for this delay?	1 Yes - 2 No
COR-04	How well the reasons for this delay were explained (in case exceed 60 minutes)	1 Very Poor - 5 Very Good
COR-05	Was your insurance pre-authorization request declined / rejected?	1 Yes 2 No [Skip to COR-07]
COR-09	In case your pre-authorization request was declined / rejected, did you receive a notification through SMS / Call?	1 Yes - 2 No
COR-06	Explanation of why your approval request was rejected in a way you could understand	1 Very Poor - 5 Very Good
COR-07	Your satisfaction with the level of coordination between your healthcare provider & insurance company	1 Very Poor - 5 Very Good
CCHI-01	Have you heard of the Council of Health Insurance (CHI)?	1 Yes 2 No [END SURVEY]
CCHI-14	How did you hear about CHI?	1 Insurance companies 2 Healthcare facilities 3 Family & Friends 4 social media 5 Advertisements
CCHI-02	How well are you aware of what CHI does?	1 Very Poor - 5 Very Good
CCHI-04	Ease of reaching CHI's rules and regulations	1 Very Poor - 5 Very Good
CCHI-15	Overall perception of CHI	1 Very Poor - 5 Very Good
HL_ Disclaimer	I agree on sharing my contact information along the comments with the CHI	1 Yes 2 No

Methodology

The Beneficiary Survey is sent to a sample of the population after the pre-authorization process, based on the size of the payer. The beneficiaries receive an SMS with a survey link which brings them to the full survey. Since we are unable to trace who opened the survey link, the Customer Experience team in CHI is unable to send a reminder in case people don't start or do not finish the survey resulting in an average not completed surveys.

The survey originally was sent to a sample of the private healthcare population who receive or have received treatment. Since CHI was highly dependent on receiving the sample dataset from the payers, the survey was sent with a delay in the worst-case scenario up to 2 months. After the launch of the NPHIES platform (NPHIES stands for the National Platform for Health and Insurance Exchange Services in Saudi Arabia. It's a secure digital platform that facilitates the exchange of essential health information and data between various stakeholders in the healthcare and insurance sectors (payers, providers, employers, patients/beneficiaries, governments entities) CHI was able to see all the transactions between payer and providers and able to pull the sample data from the NPHIES platform and sent survey within 24 hours after interaction with payer and provider.

The outcome of the survey is shared on a quarterly basis with the payers on their individual average scores and data is made available for them to see all the details.

A public report on sector average performance is shared via social media.

2021 **Building survey**

Launch survey 4 domains:

1. CHI
2. Payers
3. Providers
4. Coordination Payer & Provider

- 45 items
- Send in one batch
- Delay receiving survey up to 2 months

2022 **Launch enhanced survey 3 domains:**

1. CHI
2. Payers
3. Pre-Authorization

Domain care provision measured in PREM survey

- 21 items
- Send in one batch
- Delay receiving survey up to 2 months

2023 **Integration with NPHIES platform**

- 21 items
- Send 24 hours after Pre-Authorization in NPHIES

2024 **Plan: full integration with PREM survey**

Figure 5: The CHI Beneficiary Survey Journey

Outcome and analysis

			Baseline	12 Months, Most Recent Data			
			Q2 2020 - Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Response rate calculation	Average number surveys send per quarter				90000		
	Incomplete survey response		3733	7709	10379	5969	7803
	Fully submitted survey responses		2585	6583	2868	2584	3086
	Total responses		6318	14292	13247	8553	10889
	Response rate agianst average number surveys send		7%	16%	15%	10%	12%
Outcomes are calculated on the fully submitted survey responses							
	Item / question	**Type of score**		**Outcome**			
CHI	Have you heard of the Council of Health Insurance (CHI)?	Responses	23109	6583	2868	2584	3086
		Responses with YES	14938	4063	1779	1686	2033
		% YES	64.64%	61.72%	62.03%	65.25%	65.88%
	How well are you aware of what CHI does?	score 0-100	63.53	60.70	62.55	62.49	63.45
	Overall perception of CHI *)question added after Q3-2022	score 0-100	n/a*	67.06	67.63	68.28	70.24
Payer	Have you received your healthcare insurance coverage information?	Responses	22896	6544	2784	2563	3064
		Responses with YES	11140	3918	1663	1499	1824
		% YES	48.65%	59.87%	59.73%	58.49%	59.53%
	Adequacy of insurance information.	score 0-100	66.99	66.27	64.32	63.29	62.87
	Have you contacted the Insurance Company's Customer Care team in the past 6 months?	Responses	22719	6544	2771	2554	3058
		Responses with YES	12493	3918	1698	1612	1903
		% YES	54.99%	59.87%	61.28%	63.12%	62.23%
	Ease of reaching the insurance customer service team	score 0-100	51.19	44.32	46.23	45.07	43.85
	The courtesy of the insurance customer service team	score 0-100	55.78	51.28	52.29	45.07	49.47
	How well the insurance customer service team resolved your enquiries?	score 0-100	51.16	44.40	44.77	50.90	41.31
	Average experience with Customer Service	score 0-100	52.71	46.67	47.76	47.01	44.88
	Your overall satisfaction with your insurance company	score 0-100	51.44	48.09	45.8	44.12	42.82
Pre - Authorization Process	In case your pre-authorization request was declined / rejected, did you receive a notification through SMS / Call? **)question added after Q3-2022	Responses	n/a**	4172	1847	1773	2117
		Responses with YES	n/a**	2834	1202	1210	1401
		% YES	n/a**	67.93%	65.08%	68.25%	66.18%
	Explanation of why your approval request was rejected in a way you could understand	score 0-100	21.76	17.20	16.68	16.26	16.04
	Your satisfaction with the level of coordination between your healthcare provider & insurance company	score 0-100	49.14	47.55	44.61	43.30	43.37
CHI process data	Pre - Authorization rejection rate friom NPHIES	Denail rate on item level in %	27.90%	29.00%	28.34%	30.35%	28.37%
	Complaints from beneficiaries against Payer, per quarter. (for Baseline, averge per quarter)	Total number of medical complaints	27383	44418	45768	43951	55888
Indepth Analysis							
In case the respondents replied with YES: Have you received your healthcare insurance coverage information (via booklet, website or application)?							
Your overall satisfaction with your insurance company			59.42	54.95	51.56	50.51	48.94
Your satisfaction with the level of coordination between your healthcare provider & insurance company			54.61	53.05	49.11	48.22	48.37
In case the respondents replied with YES: Have you received your healthcare insurance coverage information (via booklet, website or application)? And scored the adequacy 75 or higher:							
Your overall satisfaction with your insurance company			73.28	71.96	69.03	69.31	67.14
Your satisfaction with the level of coordination between your healthcare provider & insurance company			65.34	66.88	62.22	63.81	63.63

Conclusion

In quarter three 2022 multiple signific changes were applied on the items in the survey; Overall Csat with CHI was added, items were made clearer to avoid ambiguities and made more compliant with pre-authorization process. Therefore, for the in-depth analysis and reporting the most recent four quarters results were compared with the baseline average of previous period from first survey in 2021 till quarter three 2022. Although all survey responses (partially and fully submitted) are taken in account for normal quarterly analysis and reporting, for this paper only the results for the fully submitted responses were taken in account.

Process

- After the integration with NPHIES the total responses increased, quarter four survey was sent in one sample batch pulled from the NPHIES platform, resulting in a significant higher number of fully submitted responses (6583) compared to baseline (average response per quarter 2585). Total responses more than doubled.
- After integration with NPHIES, sending the survey within 24 hours after the pre-authorization process, the average responses were higher but unfortunately fully submitted surveys only slightly increased. This could indicate that Beneficiaries are more likely to open the survey but unable to finish the full survey.

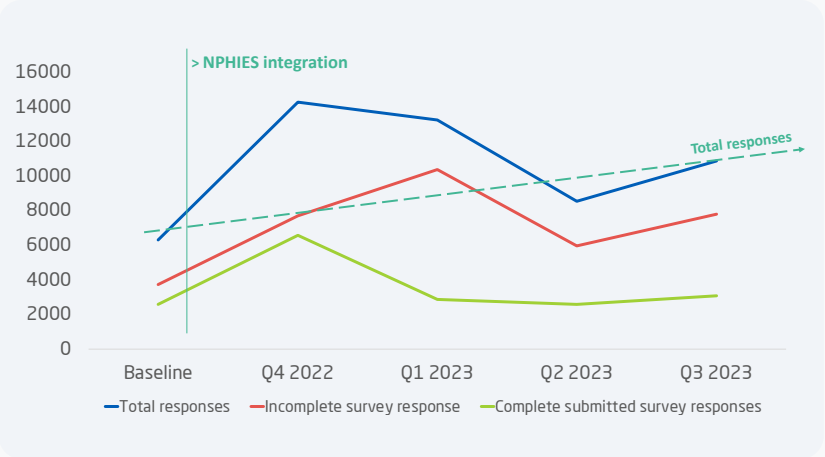


Figure 6: Response reporting Baseline compared with most recent four quarters.

Beneficiary survey results

Beneficiaries experience and satisfaction with CHI:

The data shows a higher level of awareness and experience with CHI in the baseline data compared with quarter four 2022, over the following three quarters at all levels the experience and satisfaction level seem to be restored.

When analyzing the outcome for the different insurance levels, the lower class insured class C, report a higher level of awareness and understanding of the role of CHI compared to VIP insured. Furter study is needed to link this outcome to a higher number of complaints CHI receives from the class C insured. Current available data was too immature to confirm this assumption.

		Average all insurance classes	Per insurance class			
			VIP	A	B	C
Sample size (Q2 2020 - Q3 2023: complete and incomplete responses)		64831	15485	14423	16314	18609
Item / question	*Type of score*	*Outcome*				
How well are you aware of what CHI does?	score 0-100	**63.49**	**60.76**	**62.93**	**62.00**	**67.69**
Overall perception of CHI **)question added after Q3-2022	score 0-100	**68.17**	**66.52**	**67.49**	**66.57**	**72.36**
Your overall satisfaction with your insurance company	score 0-100	**49.71**	**53.41**	**49.99**	**49.96**	**46.27**
Your satisfaction with the level of coordination between your healthcare provider & insurance company	score 0-100	**47.83**	**48.77**	**46.72**	**47.96**	**47.78**

Figure 7: Difference in outcomes compared between different insurance levels.

Beneficiaries experience and satisfaction with the Payer:

Over the course of the four studied quarters the market average Overall Csat with the payer decreased in parallel with the overall Csat with the pre-authorization process. This indicates that the Beneficiaries report a link between a bat experience with the coordination between payers and providers (pre-authorization process) and their experience with the payer. Basically "blaming" the payer for experiencing a rejection during this process. This finding is seen across all insurance levels for all payers.

The continuous decrease in experience with the payer goes is also reflected in a increased number of complaints against the payer issued via the customer service team within CHI. Data shows 80% of all these complaints are issued after a (partially) rejection.

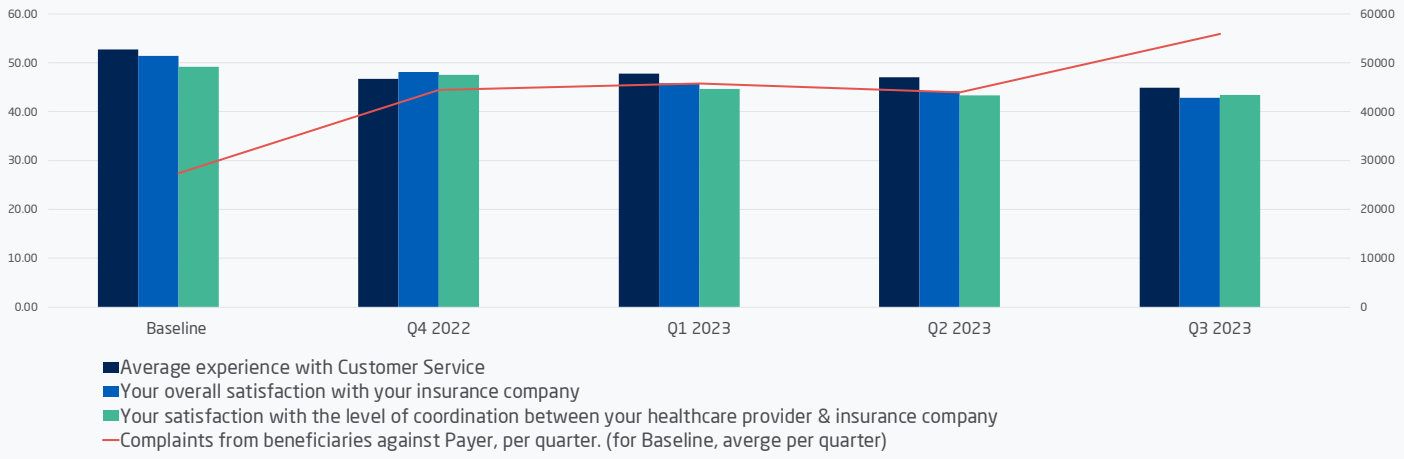


Figure 7: Correlation between Overall Csat with Payers / Overall Csat Pre-Authorization process / Average experience with Payer customer service and number of complaints against Payer.

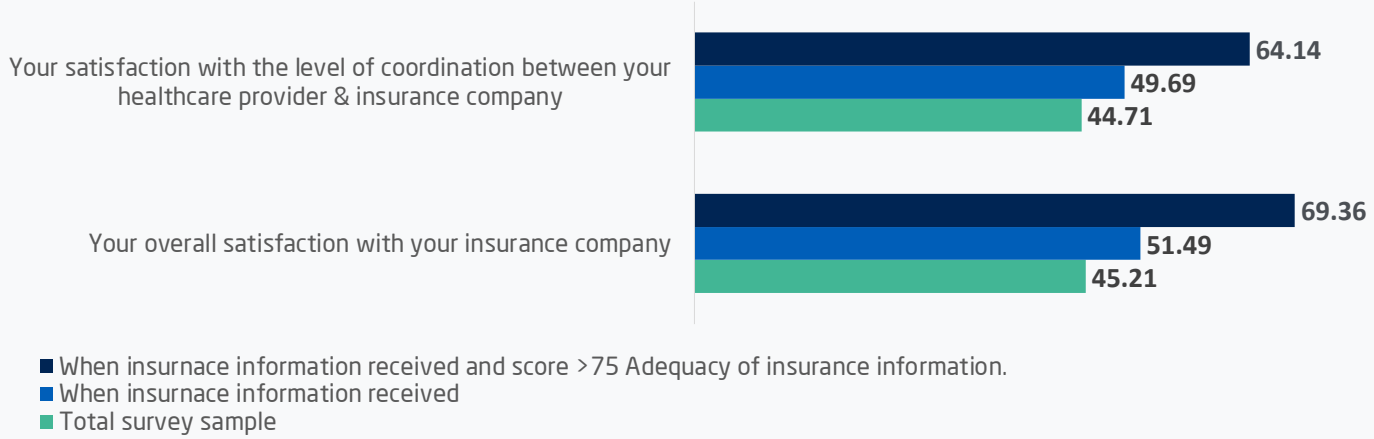


Figure 8: Correlation between Overall Csat with Payers / Overall Csat Pre-Authorization process and insurance information received.

Beneficiaries level of education and impact on the level of satisfaction with the Payer:

Figure 8 clearly shows the improved level of satisfaction with both the payer and the pre-authorization process once beneficiaries have received the insurance information (59% of survey population answered with yes) and payers make information clear for them. (Item score higher than 75 for question: Adequacy of insurance information you received to include all details you needed.) Unfortunately, the number of beneficiaries having responded to this item in the survey and score are declining. This indicates that Beneficiaries who have received their insurance information in a way that is clear for them have a better experience with the payer.

Beneficiaries experience and satisfaction with the pre-authorization process:

Process data in NPHIES shows an average rejection rate for pre-authorization requests from the provider to the payer of 29%. When a rejection is confirmed by the payer, they need to inform the Beneficiary in a way they understand the reason for the rejection as stated in the so-called By-Laws to protect the Beneficiaries rights. 67% of the Beneficiaries report they have indeed received a confirmation for rejection but the score on the explanation is very poor and has declined over the course of the four quarters to a score of 16.04 on the scale of 0-100!

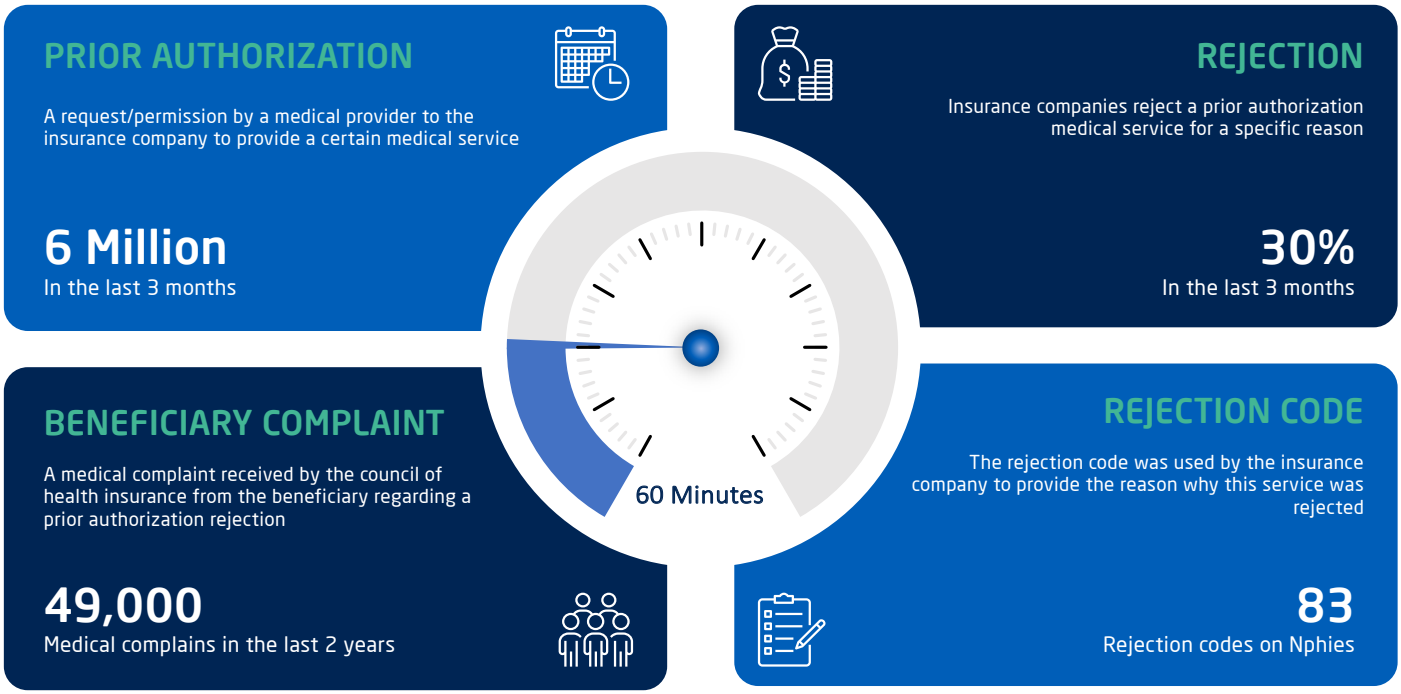
67%
received notifiction after pre-authorization rejection

Score 0-100
16.55
Explanation of why your approval request was rejected in a way you could understand

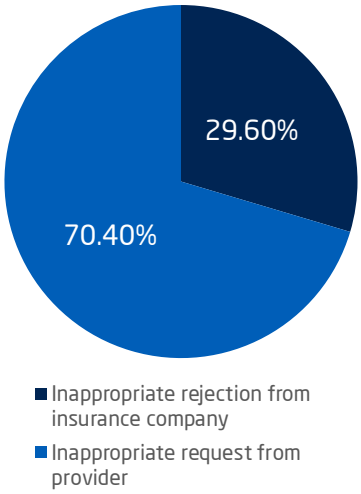
In the section 'Beneficiaries experience and satisfaction with the Payer' it was stated that the Beneficiaries basically 'blame' the payer for the rejection. A study performed by CHI's medical team has shown that most rejections were caused by an inappropriate pre-authorization request from the provider. Due to limited survey sample size on provider level CHI is unable to map the provider behavior related to the pre-authorization process. A counter measure to solve this issue is described in the next chapter 'Improve'.

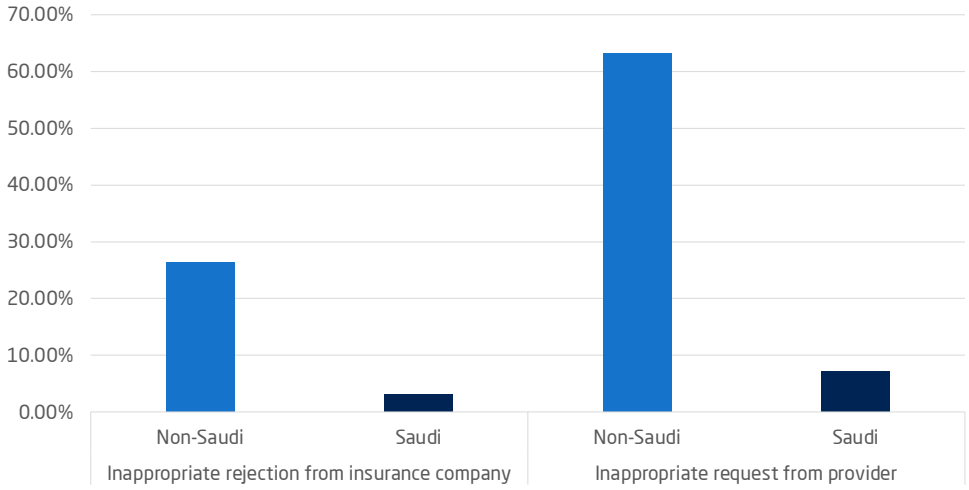
About Prior Authorization & Rejection

Insurance Company Rejection Analysis



Who was at fault for the rejection of the prior authorization request – the insurance company or the medical provider?





Overall conclusion outcome and analysis

Process

1. To improve the fully submitted survey rate, CHI needs to improve the survey design in a way that they can send a reminder to the beneficiaries.

2. To evaluate the provider's behavior on the pre-authorization, process the sample size of the survey needs to be enlarged.

Beneficiaries survey results

1. The low overall Csat with the payer performance is linked to the low satisfaction on the Pre-authorization process and poor coordination between payer and provider.

2. Beneficiaries who have received their insurance information in a way that is clear for them have a better experience with the payer.

3. Beneficiaries give a low score on the explanation when they have experienced a rejection after a pre-authorization request. Over the course of the four quarters to a score of 16.04 on the scale of 0-100!

4. 70% of rejections were caused by an inappropriate pre-authorization request from the provider.

Improvement

Based on the overall conclusions and analysis of the survey data CHI has indicated different levels of improvement across the patient journey with a clear focus on the pre-authorization process.

Background

Health Insurance Beneficiary Experience performance had been consistent since the beginning of the measurement program. As described earlier the main, the domain Experience with Coordination Level (PA Process) is given the lowest score on the survey. And in this domain, the lowest score is given to the touch points related to communicating delays, and rejections reasons.

Based on these findings, improvement efforts should focus first on enhancing the process and communication. A major CHI project is currently ongoing to streamline the Pre-Authorization Process focusing on improvement in major PA functions such as: Minimum Data Set, Denial Codes, Clinical Practice Guidelines, and PA Policies. Another important enhancement is improving communication about rejection and its reasons. Communication about Coordination is provided to beneficiaries in three modes:

1.
Text Messages
By Insurance Companies

2.
Patient and Provider Interaction
By Health Care Providers

3.
Patient Education and Awareness
By CHI, Insurance Companies and Healthcare Providers

Since text messages are generated based on the PA request depending on the status of the request, it is essential to ensure its effectiveness in enhancing the understanding about rejection reasons. This is also part of the CHI Pre-Authorization Project, and it is linked to the implementation of Denial Codes.

Improvement Framework:

The Customer Experience Department at CHI developed a framework to inform the improvement initiatives targeting CHI Beneficiary Experience. The guiding principles for this framework is Co-Design and active engagement of the stakeholders during the improvement phase. This framework is targeted for CHI staff who contributes to improving beneficiary experience. Flexibility and agility are advised based on context and needs.

Co-design involves the equal partnership of individuals who work within the system, individuals who have lived experience of using the system and the 'designers' of the new system. It takes a staged approach that uses different methods to understand the experiences of people receiving and delivering services. Co-design aims to design a new product, re-design a current process, or develop an engagement relationship that optimizes the knowledge, and resources of the involved stakeholders in order to achieve better outcomes or improve efficiency.

Customer Experience Co-Design Process

1 Priorities Identification — 2 Co-Design Workshop — 3 Palnning — 4 Implementation — 5 Concluding Workshop

1. Priorities Identification

- Use performance reports.
- Use customer feedback.
- Identify frontliners' pain points impacting customers' pain points.
- Summarize the priorities for improvement

2. Co-Design Workshop

- Conduct a workshop that includes all Health Insurance Stakeholders: CHI, payers, providers, beneficiaries.
- The workshop is uses active engagement and participation, and the following steps are conducted:

Improvement Opportunities

- Present improvement opportunities

Analyze Root Causes

- Analyze and understand the causes
- Define the problem

Ideation

- Brainstorm as many possible solutions with stakeholders
- Solutions should focus on fixing the root causes in addition to quick wins that tackle immediate issues low hanging fruit'

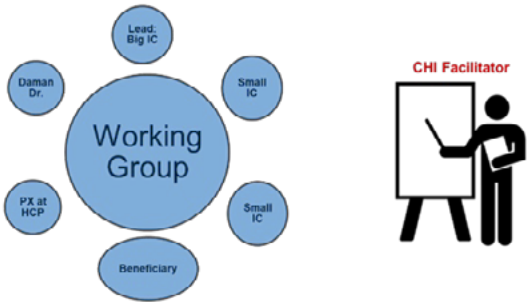
Plan Action

- Prioritize solutions (achievable, and impact etc.)
- Select solutions
- Create an action plan to implement the selected solutions

Iteration

- Implement plan
- Check results
- Refine and re-replan

- The participation involves all the stakeholders' groups are made to be diverse and work together which is facilitated by a CHI representative.



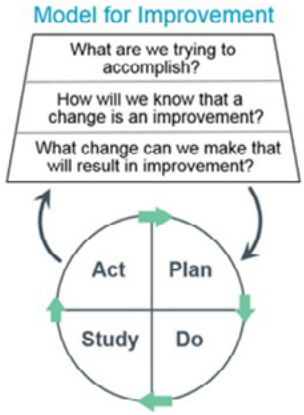
3. Planning

- Improvement Plans should be mapped to ongoing initiatives.
- Objectives should be SMART: Specific, Measurable, Achievable, Relevant, Timely
- Plans should clearly indicate the action, the responsible staff/team, and the timeline.
- Plans should include testing on a small scale before spreading the change.

4. Implementation Phase

- All stakeholders should implement the agreed upon Shared Responsibility Action Plan.
- Prototyping and iteration are encouraged by the Co-Design principles which allows testing solutions on a small scale to allow refinement and prevent wasting resources.
- Implementation should be in the form of rapid improvement cycles
- One suggested methodology for improvement is **PDSA**
- To support the ongoing implementation CHI conducts site visits to monitor the progress and provide support.

    a. The aim of the visits is to support, advise, monitor, learn and coach. They are not for supervision, inspections or audits
    b. Visits shall be planned with the sector.
    c. Visits shall focus on the agreed plan; however other aspects can be included whenever needed.
    d. Visits must include at least one member of staff from CX and staff from another department as needed.
    e. Visits must provide the stakeholders with identified learning opportunities and suggested improvements, all discussed and sent officially.
    f. Action Plans will be evaluated using the IHI Assessment Tool, and a report must be shared after the visit.



BREAKTHROUGH SERIES COLLEGE

Assessment Scale for Collaboratives

Assessment/Description	Definition
1.0 Forming team	Team has been formed; target population identified; aim determined and baseline measurement begun.
1.5 Planning for the project has begun	Team is meeting, discussion is occurring. Plans for the project have been made.
2.0 Activity, but no changes	Team actively engaged in development, research, discussion but no changes have been tested.
2.5 Changes tested, but no improvement	Components of the model being tested but no improvement in measures. Data on key measures are reported.
3.0 Modest improvement	Initial test cycles have been completed and implementation begun for several components. Evidence of moderate improvement in process measures.
3.5 Improvement	Some improvement in outcome measures, process measures continuing to improve, PDSA test cycles on all components of the Change Package, changes implemented for many components of the Change Package.
4.0 Significant improvement	Most components of the Change Package are implemented for the population of focus. Evidence of sustained improvement in outcome measures, halfway toward accomplishing all of the goals. Plans for spread the improvement are in place.
4.5 Sustainable improvement	Sustained improvement in most outcomes measures, 75% of goals achieved, spread to a larger population has begun.
5.0 Outstanding sustainable results	All components of the Change Package implemented, all goals of the aim have been accomplished, outcome measures at national benchmark levels, and spread to another facility is underway.

Stakeholders Engagement and Communication:

Enhancing beneficiary experience required enhanced communication and transparency to enable the sector. Beneficiary protection is the one of CHI's strategic objectives, which requires an enabled sector to achieve. CHI plans and implements various communication programs targeting the sector including for the purpose of engagement and enablement:

Publication and Training about Clinical Practice Guidelines, Policies, Regulations

Catalyst for CHI Major Projects and Initiatives through awareness and communication

Content creation and design to enhance Communication Channels (website)

CX Individual Performance Reports are regularly sent to stakeholders and followed by discussion Webinars

CHI Excellence Award is conducted annually to recognize best performers in the sector

Moreover, CHI conducts direct communication programs targeting the beneficiaries in order increase their protection including:

- A series of campaigns focusing on beneficiary rights and protection
- Healthcare services awareness and utilization: such as primary care awareness and screening
- Health Awareness Campaigns such as Breast Cancer Awareness

Epilog

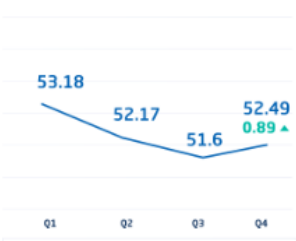
Just before publishing this white paper the results were analyst for the quarter four 2023 survey results. For the first time after a continuous decline in performance the Beneficiaries gave more positive feedback in their experience and satisfaction with both the payer and pre-authorization process.

The data shows payers are improving their performance to inform the Beneficiaries on all levels. For both receiving information about the insurance package and reason for rejection fat pre-authorization process the score increased with 3 points. This slight improvement confirms earlier conclusions, well informed beneficiaries are more satisfied with overall process.

The sector average in Q4 compared to previous periods in 2023

Health Insurance Companies Key Performance Indicators[1]

Beneficiaries experience with Insurer



Overall Experience Score

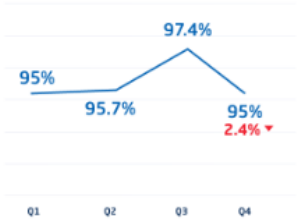
Complaints Handling

Response Rate within SLA 3 Working Days

No. per 10,000 insured

Pre-Authorization Process[2]

Response Within SLA 60 minutes



Beneficiaries's Experience within process

1. This indicator calculation methodology has been updated
2. Coordination Between Insurer and Provider

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- The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement | Institute for Healthcare Improvement
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Whitepaper

Measuring the 'Voice of the Beneficiaries'

The perspective from National Private Health Insurance Regulator KSA.