A PROJECT REPORT ON

Patterns In Claims Processing

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In

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Introduction

The Indian health-insurance landscape has evolved rapidly over the past decade, driven by rising healthcare costs, heightened consumer awareness, and stronger regulatory oversight. At the center of this ecosystem is **claim settlement** - the moment when policy promises are tested and customer trust is cemented or eroded. My 12-week internship at **Care Health Insurance** (CHIL) provided a front-line view of this critical function. Working within the Medical Claims & Analytics Division, I combined operational exposure with the analytical framework of my dissertation, **"Patterns in Claims Processing."** This report chronicles the objectives set, tasks executed, insights gained, challenges encountered, and recommendations proposed. It aims to demonstrate how academic rigor and industry practice converged to deepen my understanding of risk management, data-driven decision-making, and customer-centric service delivery in private health insurance.

Organizational Profile

Founded in 2012, **Care Health Insurance** is a standalone health insurer headquartered in Gurgaon and regulated by the **Insurance Regulatory and Development Authority of India (IRDAI)**. With a claim settlement ratio of 952.77 % (FY 23-24), CHIL underwrites a diverse portfolio:

- **Retail lines:** Individual & family-floater health, top-up covers, personal accident, critical illness, maternity, and international travel.
- **Group lines:** Corporate health insurance, group personal accident, micro-insurance for rural and informal sectors.
- **Wellness ecosystem:** Tele-consultations, disease-management programs, and predictive risk scoring for chronic conditions.

Internship Objectives

- **Comprehend** the end-to-end reimbursement workflow and IRDAI regulatory framework.
- **Shadow** medical adjudicators to learn claim-validation logic, with special focus on documentation, policy terms, and pre-existing diseases (PED).
- **Execute** a mini-analytics project—extracting, cleaning, and visualising 150 recent claims to identify patterns in approvals, rejections, queries, and investigations (basis for dissertation).

- ❖ **Evaluate** the impact of policy tenure, treatment type, and repeat-claim history on decision outcomes.
- ❖ **Recommend** process improvements that could shorten turnaround time (TAT) and enhance customer satisfaction.

Roles & Responsibilities

Phase	*Activities*	*Tools/Artifacts Produced*
Induction (Week 1)	Attended onboarding sessions on underwriting, claims, and IRDAI norms. Completed data-privacy & information-security modules	Induction quiz (scored 92 %)
Process Immersion (Weeks 2-4)	Mapped sub-steps from claim receipt to disbursal. Verified 85 claim files for document completeness (DS, bills, KYC, paid receipts) Shadowed senior adjudicator during 27 live decisions	Standardised **Document Checklist** (v1.0)
Analytics Project (Weeks 5-8)	Extracted 150 anonymised claims (Mar–May 2025) Cleaned variables in Excel Power Query Built pivot tables & heat-maps: claim status × policy age, treatment type, amount, PED, repeat history	18-slide **Insights Deck** + interactive Excel dashboard
Fraud Flagging (Week 9-10)	Applied rule-engine to identify high-risk patterns (PED + No docs + multiple claims) Escalated 3 cases for AUDIT review	**Suspicious Claim Memo**

Key Learnings

Understanding Insurance Fundamentals

- **Risk Pooling & Adverse Selection:** Realised how broader risk pools stabilise premiums; saw underwriting questionnaires mitigate adverse selection.
- **Regulatory Compliance:** IRDAI mandates TAT (30 days for reimbursement) and deficiency-code communication; non-compliance attracts penalties.

Claims Typology

- **Cashless vs. Reimbursement:** Cashless uses pre-authorisation; reimbursement is retrospective and documentation-intensive.
- **Claim Status Codes:** APP, REJ, Q (query), INV (investigation), Q+INV. Each triggers different communication timelines.

Reimbursement Processing Nuances

- **Document Verification:** Learned to cross-match discharge summaries with ICD-10 codes; flagged mismatches in 12 % of reviewed cases.
- **Medical Necessity Reviews:** Understood clinical appropriateness criteria

Medical Claims Adjudication

- **Policy Interpretation:** Example—waiting-period clause denied a typhoid claim for a policy issued 30 days prior.
- **PED Assessment:** Required cross-referencing proposal form, previous claims, and electronic health records (EHR).

Data Analytics & Pattern Recognition

- **Policy Tenure Gradient:** Approvals drop 0.38 percentage-points per month decrease in tenure; < 12 months cohort approval = 48 %.
- **Documentation Impact:** Complete docs → 63 % approval; incomplete → 20 %.
- **Treatment-Type Bias:** Surgical/Daycare approvals 72 %; Medical Management 37 %.
- **Repeat-Claim Amplifier:** Multiple prior claims + missing docs → 80 % rejection/query.

Soft-Skill Enhancement

- **Time Management:** Maintained SLA of 48 hours for file reviews while juggling dissertation analytics.
- **Ethical Judgment:** Navigated grey areas - e.g., borderline PED disclosure -by consulting seniors and documenting rationale meticulously.

Recommendations

Theme	*Recommendation*	*Expected Benefit*
Document Completeness	Integrate hospital **HIS-to-Insurer API,** allowing direct upload of e-DS, e-bills (FHIR standard).	Reduce document-deficiency queries by ≥30 %.
Customer Onboarding	"90-second explainer" videos on waiting periods, required documents, and PED disclosure - pushed via SMS/WhatsApp upon policy issuance.	Lower early-tenure rejection rate; bolster NPS scores.
Standardised Deficiency Codes	Adopt IRDAI-compliant code list (e.g., D-01 = Missing DS; D-06 = PED non-disclosure) across all customer communications.	Enhances transparency; eases regulator audits.
Advanced Analytics	Pilot **Gradient Boosting Model** using 12 variables to predict high-risk claims at the intake stage; integrate explainable AI.	Early fraud detection, smarter resource allocation.

Conclusion

The internship bridged academic theory and industry practice, revealing that claim adjudication is a synthesis of clinical judgment, contractual interpretation, risk analytics, and customer empathy. By immersing myself in daily operations and executing a data-driven mini-project,

I for one

quantified how documentation and policy tenure shape outcomes,

appreciated the regulatory scaffolding that protects both insurer and insured, and

identified process levers that can simultaneously enhance efficiency and trust.

These insights will inform my future career in health-insurance management and contribute to evidence-based improvements within CHI's claims ecosystem.