AN ANALYTICAL STUDY OF REJECTIONS IN CASHLESS HEALTH INSURANCE CLAIMS AND THEIR TRANSITION INTO REIMBURSEMENT CLAIMS IN INDIA

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ABSTRACT

INTRODUCTION:

In India's expanding private health insurance market, cashless claims are designed to offer uninterrupted financial cover while being hospitalized. A large percentage of these claims, however, end up being rejected, forcing the policyholder to seek reimbursement—a process that is time-consuming and more administration-heavy. This research explores the rate and reasons for cashless claim rejections, their conversion into reimbursement claims, and the relative efficiency of both types of claims.

METHODOLOGY:

A cross sectional-analytical study design was followed with a simulated dataset of 400 health insurance claims based on actual industry trends. The dataset contained variables representing rejection causes, reimbursement filing status, and turnaround time (TAT). Descriptive statistics, chi-square, and independent samples t-tests were utilized to study patterns and test hypotheses regarding claim outcomes and processing efficiency.

RESULTS:

30% of the 400 claims were rejected at the cashless point. Of these, 70.8% were subsequently submitted for reimbursement. Errors in documentation were the most frequent cause of rejection at 37.5%, followed by exclusions under policy and non-network hospitalization. While descriptive variation in reimbursement filing rates by reason for rejection was noted, the chi-square test did not detect a statistically significant relationship ($p = 0.075$). Nonetheless, a significant TAT difference was observed: cashless claims were 5.1 days on average, whereas reimbursement claims were 14.3 days on average, which difference was verified by t-test ($p < 0.001$).

CONCLUSION:

The research finds rampant over-reliance on reimbursement after cashless rejection, mostly because of procedural avoidability. The undue delay in reimbursement settlement points to process inefficiencies and a call for systems improvement. The insurers need to invest in electronic documentation tools, more transparent policy communication, and enhanced hospital coordination for lower rejection rates and better customer experience.

KEY WORDS: Claims rejection, Reimbursement, Cashless rejection, IRDA

RESEARCH QUESTIONS

MAIN RESEARCH QUESTION:

Why are some cashless health insurance claims rejected, and how many of them are subsequently processed as reimbursement claims?

SUBQUESTION:

- What are the most frequent causes of rejection of cashless claims?
- Is there a statistically significant correlation between the reason for rejection and the probability of claiming reimbursement?
- Is there a statistically significant difference in turnaround time (TAT) between cashless and reimbursement approvals?

OBJECTIVES OF THE STUDY

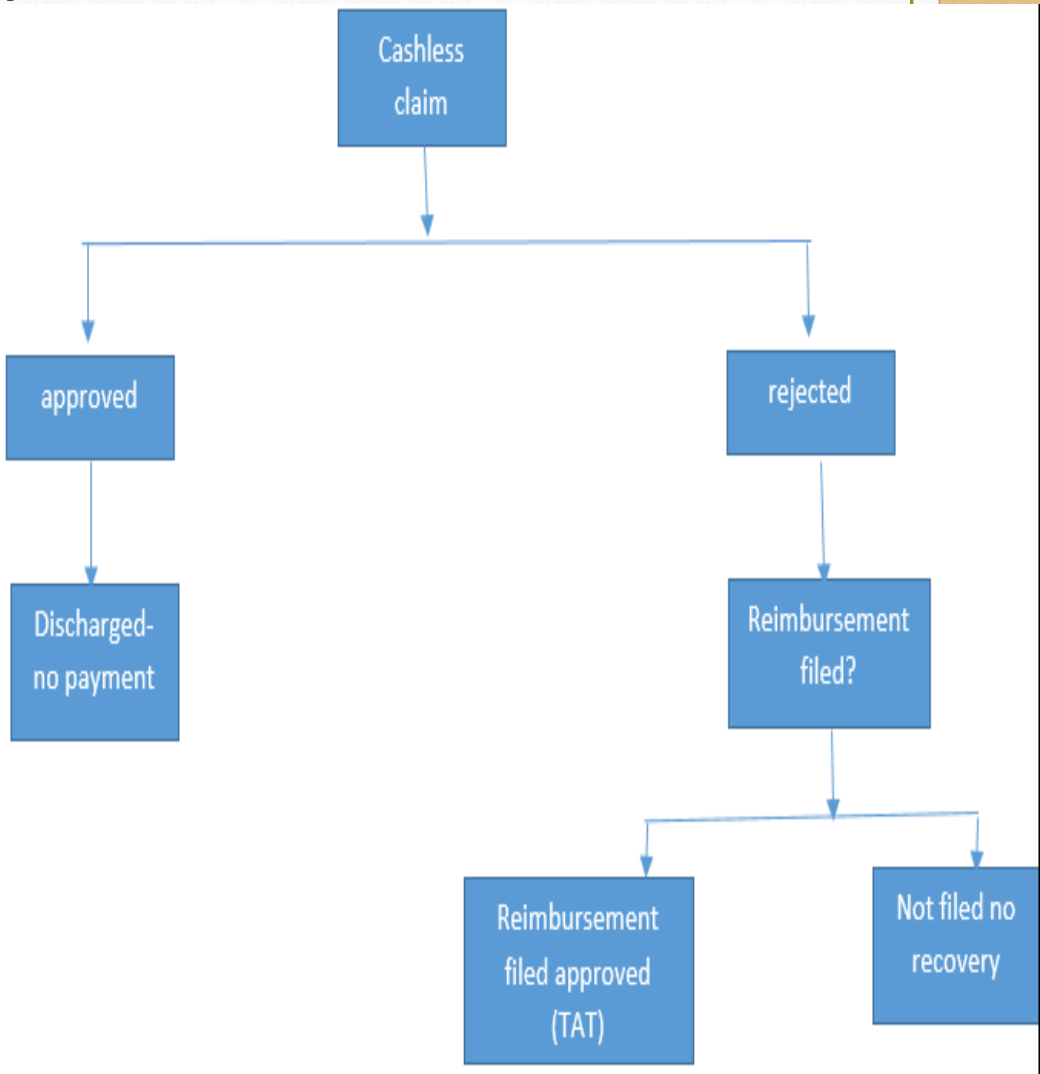
- To determine and classify the common causes of rejection of cashless claims in health insurance.
- To establish the percentage of rejected cashless claims that are subsequently sent as reimbursement claims.
- To investigate if the reason for rejection has a strong relationship with the ruling to claim for reimbursement.
- To contrast the turnaround times for direct cashless approval and claims processed by way of reimbursement upon rejection.

SCOPE OF THE STUDY

- The study's scope is concentrated on the process of settlement of claims for the private health insurance market in India.
- It further concentrates on tracing the path of claims which were originally presented under the cashless facility but later rejected.
- The study also traces these claims further to see how many were subsequently presented for reimbursement and compares disparities in processing times.
- The analysis is conducted on a simulated dataset of 400 health insurance claims, with variables including claim status, reason for rejection, reimbursement filing, final outcome, and turnaround time.

CASHLESS TO REIMBURSEMENT PHENOMENA

- A key trend observed in literature and professional experience is the re-submission of rejected cashless claims as reimbursement claims. This phenomenon is a key inefficiency within the health insurance system, placing greater financial pressure on the patient and administrative redundancy on all parties.
- Insurance practitioner expertise supports this trend, and it is cited that most claims rejected at first in the cashless process return later as reimbursement claims and are thereby approved. This indicates that a rejection could not be necessarily because of invalid claims but due to procedural, documentation, or timing errors inherent in the cashless process.
- The reasons for this phenomenon are strict pre-authorization rules, time pressure during admitting, varying meaning of policy terms at preauthorization and post-treatment review, and maybe strategic denial to postpone payment. The consequences are serious: patients experience upfront payment burden and delayed reimbursement, hospitals deal with redundant processes, and insurers pay more administrative costs for handling the same claim twice in two ways.



CASHLESS VS REIMBURESMENT CLAIMS

CASHLESS CLAIM	REIMBURSEMENT CLAIM
Visiting a hospital that is on the insurance company's network list (also known as an empaneled hospital) is required for a cashless claim. In this case, the invoices are paid directly by the health insurance.	When it comes to claim reimbursement, the insurer pays for the treatment up front and then submits the invoices and other specified documentation to the insurer for approval.
All treatment costs are paid for directly by the insurance company under the terms and conditions of the policy.	After paying bills, the insured submits a claim for reimbursement.
Preauthorization is necessary for cashless claims when a hospital stay is scheduled.	Approval of the claim is not necessary.
In general, the procedure takes less time.	Takes more time to handle claims.
Only network hospitals are eligible to accept cashless claims.	Any hospital may submit a reimbursement claim; however, there are some restrictions.
Claim transparency is high as it is tracked in real time.	Claim transparency is moderate as it is dependent on insurer communication.
Rate of rejection is around 20-35%.	Rate of rejection is around 10-15% (usually after initial denial)

METHODOLOGY

STUDY DESIGN

The research adopts a cross sectional and analytical study design. The descriptive section seeks to systematically enumerate the causes of cashless claim rejections and identify the percentage that roll over into reimbursement claims. The analytical section is concerned with hypothesis testing through quantitative approaches to assess statistical associations and differences in turnaround times (TAT).

POPULATION AND SAMPLE

- Sample Size: There are 400 claims covered.
- Sample Distribution:
  - **Cashless Approved:** 280 claims (70%)
  - **Rejected Cashless:** 120 claims (30%)
  - **Reimbursement Filed in Rejection:** 85 out of 120 rejected claims (70.8%)

HYPOTHESIS

Hypothesis 1:

- H0: No relationship between reason for rejection and filing of reimbursement.
- H1: There exists a relationship between reason for rejection and filing of reimbursement.

Hypothesis 2:

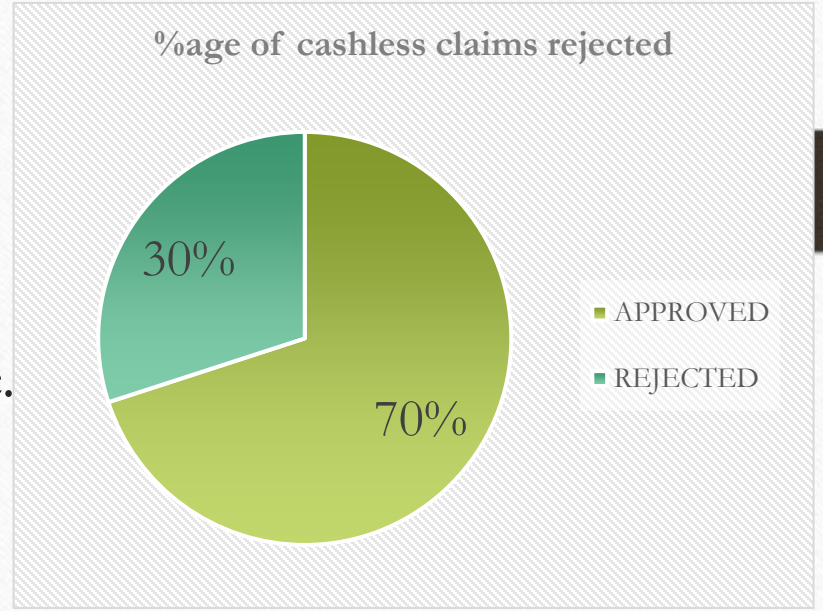
- H0: There is no difference in TAT between the two groups.
- H1: There is a significant difference in TAT between the two groups.

RESULTS

❖ **Summary of Types of Claims**

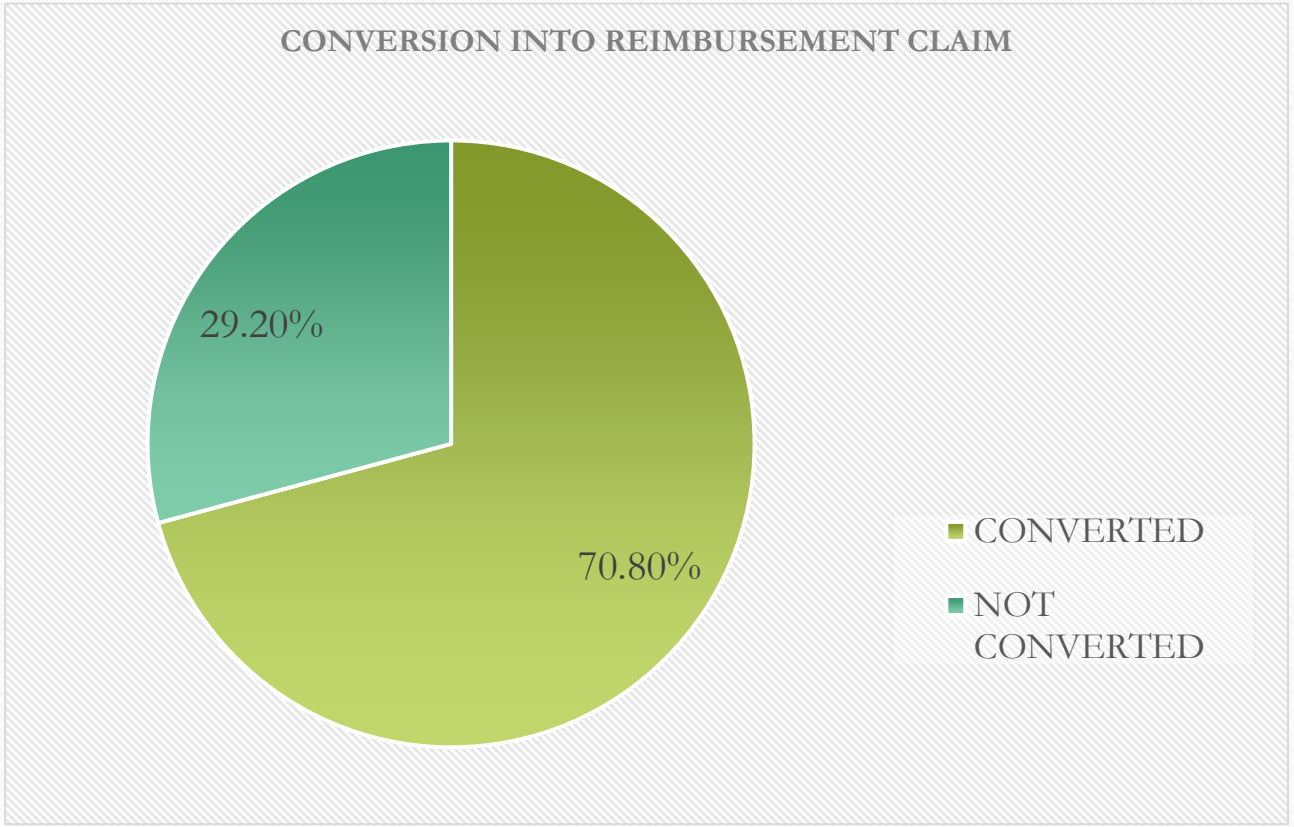
Out of the total number of 400 claims:

- 280 (70%) were settled as cashless claims.
- 120 (30%) were rejected at the cashless claim stage.



Out of the 120 rejected claims:

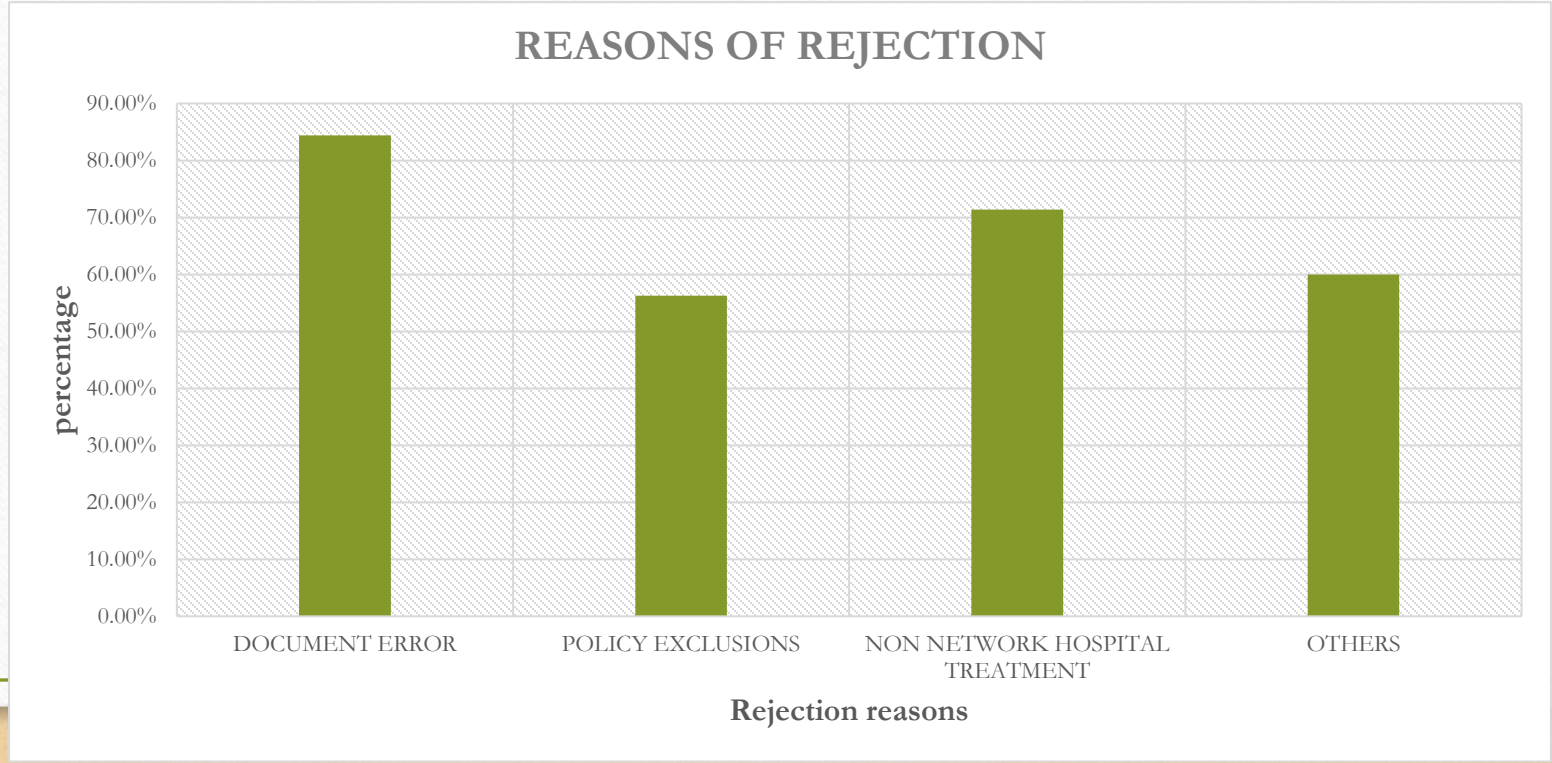
- 85 (70.8%) were subsequently submitted as reimbursement claims.
- 35 (29.2%) were not followed up with a reimbursement claim.



❖ Cashless Rejection Reasons

Of the 120 denied claims, the reasons were as stated below:

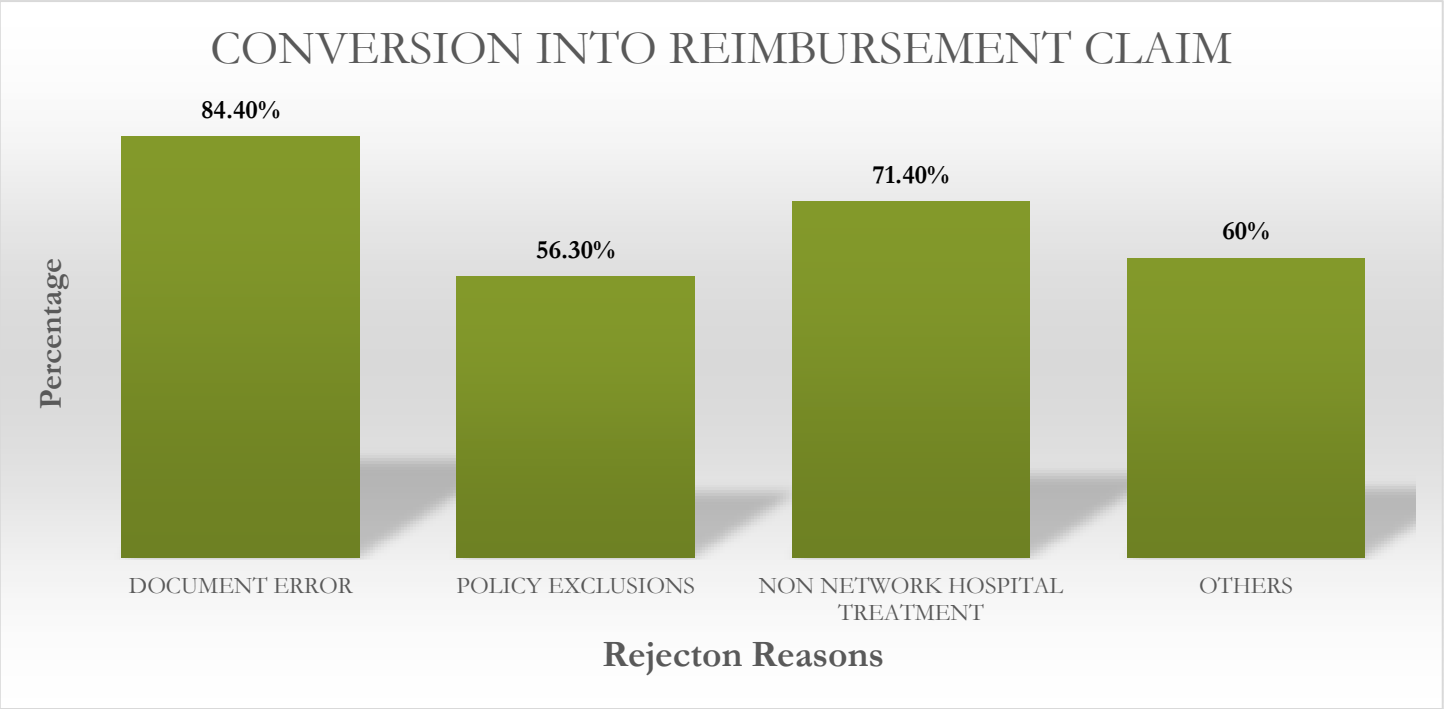
- Documentation error: 45 claims (37.5%)
- Policy exclusions: 32 claims (26.7%)
- Non-network hospital treatment: 28 claims (23.3%)
- Others (e.g., pre-existing condition limitations, lack of prior authorization): 15 claims (12.5%)



Reimbursement Filing Rate by Reason for Rejection

The percentage of rejected claims submitted for reimbursement by reason:

- Documentation error: 38 out of 45 (84.4%)
- Policy exclusion: 18 out of 32 (56.3%)
- Non-network hospital: 20 out of 28 (71.4%)
- Others: 9 out of 15 (60%)



HYPOTHESIS TESTING

Hypothesis 1: Relationship Between Cause of Rejection and Reimbursement Claiming

- Null Hypothesis (H0): There is no significant relationship between the cause of rejection and the claim for reimbursement.
- Alternative Hypothesis (H1): There is a significant relationship between the cause of rejection and the claim for reimbursement.
- Statistical Test: Chi-Square Test of Independence

Result:

- Chi-Square value: 6.91
- Degrees of Freedom: 3
- p-value: 0.075
- **Interpretation:** As the p-value is more than 0.05, we do not reject the null hypothesis. There is no statistical difference between the cause of rejection and the probability of applying for reimbursement, even though descriptive trends indicate some variation.

Hypothesis 2: Turnaround Time Comparison

- Null Hypothesis (H0): There is no difference in mean TAT between reimbursement on direct cashless approval and reimbursement following rejection.
- Alternative Hypothesis (H1): Average TAT for direct cashless approval is significantly different from average TAT for reimbursement after rejection.
- Statistical Test: Independent Samples t-test

Mean TAT:

- Direct Cashless Approval: Mean = 5.1 days, SD = 1.8
- Reimbursement after Rejection: Mean = 14.3 days, SD = 3.2
- Result:
- t-value: -26.48
- Degrees of Freedom: 363
- p-value: < 0.001
- **Interpretation:** Because the p-value is below 0.05, we reject the null hypothesis. There is a statistically significant turnaround time difference, with reimbursement claims taking much longer.

SUMMARY OF KEY FINDINGS

- **Claim Distribution:** 30% of all cashless claims were rejected, an interesting percentage that calls for procedural investigation.
- **Reimbursement Conversion:** 70.8% of rejected claims were actually sent in for reimbursement, which implies that policyholders frequently do not accept the rejection passively.
- **Reason Analysis:** Error in documentation was the most frequent cause of cashless rejection. These claims had the greatest probability to be resubmitted for reimbursement.
- No Statistically Significant Association was noted between reason for rejection and reimbursement filing likelihood, though patterns differed descriptively.
- **Substantial Delay in TAT:** Reimbursement claims after rejection took almost three times more time than direct cashless approval, indicating greater administrative burden and delayed financial relief to policyholders.

RECOMMENDATIONS

According to the findings and literature review, the following recommendations are advanced:

1. Digital Integration for Documentation: Insurers ought to automate documentation processes to avoid human errors and provide policyholders and hospitals with real-time access to mandated forms and updates.

2. Proactive Communication: Special claim support units should be made operational for real-time clarification of queries, particularly during hospitalization. Missing document or potential rejection reasons alerts should be automated.

3. Policyholder Education: Insurers need to start education programs, brochures, and video guides for policyholders while purchasing a policy to minimize misconceptions.

4. Hospital Coordination: Hospitals need to designate special insurance liaison officers to simplify pre-authorization and cashless claim settlement, minimizing unnecessary rejections.

5. Monitoring TAT Metrics: Insurers and regulators need to regularly track and release TAT metrics to promote performance enhancement and transparency to consumers.

6. Appeal and Grievance Mechanisms: An easy, accessible grievance redressal system needs to be available to support policyholders in challenging unjust rejections and accelerating reimbursements.

7. Data Sharing Between Insurers and Hospitals: A common claim database may assist in identifying repeat errors or suspicious patterns, thus enhancing accuracy and minimizing fraud.

8. Integration with Ayushman Bharat/PM-JAY systems to harmonize public-private claim workflows.

9. Incentivizing hospitals with performance-linked cashless claim ratios to boost compliance.

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