CASHLESS VS. REIMBURSEMENT CLAIMS IN HEALTH INSURANCE: A STUDY ON CUSTOMER EXPERIENCE AT CARE HEALTH INSURANCE

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

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in

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by

Mayank Singh

Under the Supervision and Guidance of

Dr. Alok Kumar Mathur

2025

care HEALTH INSURANCE

BEST HEALTH INSURANCE COMPANY IN RURAL SECTOR | CLAIMS SERVICE LEADER OF THE YEAR
INDIA INSURANCE SUMMIT & AWARDS 2024

CERTIFICATE

This is to certify that **Mayank Singh,** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur, has successfully completed his internship at Care Health Insurance Ltd. during Mar 10 - May 31, 2025.

Place: Gurgaon
Date: 05/06/2025

Dr Daljeet Chauhan
Manager- Claims Adjudication
Care Health Insurance Ltd.

IIHMR UNIVERSITY

Appendix F: Certificate from Faculty Guide and School Dean

CERTIFICATE

This is to certify that dissertation titled **CASHLESS VS. REIMBURSEMENT CLAIMS IN HEALTH INSURANCE: A STUDY ON CUSTOMER EXPERIENCE AT CARE HEALTH INSURANCE** is a record of the research work undertaken by **Dr. Mayank Singh** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide June 12, 2025

IIHMR University, Jaipur

Date

School Dean

IIHMR University, Jaipur

Date 12/06/2025

Appendix D: Declaration by Student

DECLARATION BY STUDENT

I hereby declare that this dissertation titled CASHLESS VS. REIMBURSEMENT CLAIMS IN HEALTH INSURANCE: A STUDY ON CUSTOMER EXPERIENCE IN AT CARE HEALTH INSURANCE is the Bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Mayank Singh

(Signature)

Name of Student Mayank Singh

Date 12/June/25

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Insurance Terminology (Paraphrased Glossary A–Z)

A

- **Actuarial Science**: A branch of study using statistical and mathematical tools to evaluate and manage risks in sectors like insurance and finance.
- **Adjudication**: The evaluation process through which an insurer decides the outcome of a submitted claim.
- **Agent**: A certified individual authorized to sell insurance policies on behalf of a provider.
- **Annual Premium**: The total yearly payment made by the policyholder to maintain insurance coverage.

B

- **Beneficiary**: The designated person or organization that receives policy benefits upon the insured's death or upon the occurrence of a covered event.
- **Broker**: An independent advisor who assists clients in selecting suitable insurance plans but does not work for an insurance company.

C

- **Cashless Claim**: A claim process where medical bills are directly settled by the insurer with the healthcare provider, avoiding upfront payment by the insured.
- **Claim**: A formal appeal to the insurance company requesting coverage payment as outlined in the policy.
- **Claim Settlement Ratio**: A statistic indicating the percentage of claims an insurer settles out of the total received within a year.
- **Co-insurance**: A fixed percentage of treatment costs that the insured must pay after the deductible is met.
- **Coverage**: The scope and financial limit of protection provided by an insurance policy.
- **Critical Illness Insurance**: A plan that offers a lump-sum payout when the insured is diagnosed with specified life-threatening illnesses.

D

- **Deductible**: The pre-specified amount a policyholder must pay before the insurer begins covering expenses.
- **Disclosure**: Providing accurate and full details to the insurer during policy purchase or renewal.

E

- **Endorsement**: An amendment to the original policy contract, modifying coverage terms.
- **Exclusions**: Specific items or conditions that are not covered under a given insurance policy.

F

- **Free Look Period**: A time window post-policy purchase during which the buyer can cancel and get a full refund.

G

- **Grace Period**: The extension period after a premium's due date in which payment can still be made without policy cancellation.
- **Group Health Insurance**: A collective insurance policy provided typically by employers for their employees.

H

- **Health Insurance Portability**: The right to shift health insurance providers without losing credit for time already spent in waiting periods.

I

- **Incurred Claim Ratio**: The proportion of total claims paid relative to premiums collected by the insurer.
- **Indemnity**: The insurance principle ensuring that the insured is restored to their original financial position pre-loss.
- **Insurance Regulatory and Development Authority of India (IRDAI)**: The apex body regulating insurance operations in India.

- **Insured**: The individual or entity covered by the insurance contract.
- **Insurer**: The company providing insurance services.

L

- **Lapse**: The termination of a policy due to non-payment of premiums within the allowable grace period.
- **Liability Insurance**: Insurance that protects the policyholder against legal costs for causing injury or damage to others.

M

- **Maturity Benefit**: The amount paid to the policyholder at the end of the insurance term, applicable mainly to life insurance.

N

- **Network Hospital**: A healthcare provider partnered with the insurer to offer cashless treatment to policyholders.
- **Nominee**: A person named by the policyholder to receive policy benefits upon the insured's demise.

O

- **Out-of-Pocket Expenses**: The portion of treatment costs not covered by insurance and paid directly by the policyholder.

P

- **Policy**: The official agreement between an insurer and the insured, defining coverage terms.
- **Policyholder**: The individual or entity who owns the policy and is liable for premium payments.
- **Pre-Existing Condition**: A health issue that existed before the policy coverage began.
- **Premium**: The fee paid periodically by the policyholder to maintain coverage.

- **Pre-authorization**: Prior approval required from the insurer before availing certain treatments or procedures.

R

- **Reimbursement Claim**: A settlement process where the insured pays upfront and later seeks repayment from the insurer.
- **Renewal**: Extending an insurance policy after the original term expires.
- **Rider**: An add-on to a basic policy that provides additional benefits at an extra cost.

S

- **Sum Insured**: The highest amount the insurer will pay for a claim.
- **Surrender Value**: The amount payable if a life insurance policy is terminated before maturity.

T

- **Third Party Administrator (TPA)**: An intermediary that manages claims and administrative tasks for insurers.
- **Term Life Insurance**: A life insurance plan that offers coverage for a specific term and pays only if the insured passes away during that term.

U

- **Underwriting**: The evaluation process insurers use to decide on policy issuance and premium amounts.

W

- **Waiting Period**: A defined initial time during which certain benefits or treatments are not yet covered.
- **Whole Life Insurance**: A policy that covers the insured throughout their life and often includes a savings element.

Abstract

This dissertation presents an in-depth comparative analysis of **cashless versus reimbursement claim settlements** in the health insurance sector, with a focused study on **Care Health Insurance**. As India's health insurance ecosystem matures, driven by regulatory reforms, digital transformation, and increased consumer awareness, the efficiency and user experience of claim processing systems have emerged as critical indicators of service quality and trust. While cashless claims are widely perceived as convenient and quick, reimbursement processes remain prevalent in non-network scenarios but often introduce financial stress and administrative burden.

Using a structured bilingual questionnaire administered online, the study collected data from 34 verified policyholders who had filed at least one claim—either cashless or reimbursement—between 2022 and 2025. The research applied a descriptive cross-sectional design and employed both quantitative and qualitative analytical methods to explore the relationship between socio-demographic factors (age, income, education, residence) and claim-related experiences, preferences, and satisfaction levels.

The findings indicate that policyholders overwhelmingly prefer cashless claims, with higher satisfaction scores, better communication quality, and reduced documentation challenges. Reimbursement claims, while necessary in certain situations, are often associated with procedural ambiguity and delays. The study also reveals significant influence of user profiles on claim experience—postgraduates and higher-income respondents reported smoother navigation of processes compared to their counterparts. Based on these insights, the research proposes strategic recommendations for Care Health Insurance to enhance digital claim support, streamline reimbursement workflows, and personalize user guidance.

This work contributes to the broader goal of making health insurance more **transparent, efficient, and equitable**, aligning insurer operations with evolving customer expectations in India’s dynamic healthcare financing environment.

Cashless vs. Reimbursement Claims in Health Insurance: A Comparative Analysis of Efficiency, Customer Experience, and Industry Trends

Introduction

Health insurance has emerged as a cornerstone of healthcare financing in India, offering financial protection against rising medical costs and promoting access to quality care. As the country transitions from out-of-pocket payments toward risk-pooling mechanisms, the **efficiency and effectiveness of health insurance claim settlement processes** become central to user trust, satisfaction, and policy renewal behavior. Within this landscape, **Care Health Insurance**, a prominent private insurer, plays a significant role in shaping how policyholders perceive and experience the service delivery ecosystem during the most critical stage of their insurance journey—**claims**.

India's health insurance sector is characterized by two primary modes of claim settlement: **cashless claims**, where the insurer directly settles bills with a network hospital, and **reimbursement claims**, where the policyholder initially bears the cost and is reimbursed later upon submission of required documents. While both mechanisms are vital in different healthcare scenarios, they vary significantly in terms of processing time, administrative complexity, financial burden, and user satisfaction. Cashless claims are often viewed as more seamless and less financially stressful, especially in emergency situations. In contrast, reimbursement claims are typically perceived as cumbersome, requiring extensive documentation, prolonged communication, and delayed fund disbursement.

Despite the importance of these mechanisms, existing literature in India has largely addressed claim settlement in broad industry terms, without sufficiently exploring the insurer-specific processes and user experience frameworks that directly influence claim outcomes. There remains a notable research gap in understanding how claim

processes function within a particular insurer's operational ecosystem—especially one like **Care Health Insurance**, which positions itself as a tech-enabled, customer-centric service provider.

This study addresses that gap by conducting a **comparative analysis of cashless and reimbursement claim settlement experiences within Care Health Insurance**, specifically evaluating how **policyholder profiles**—including age, gender, income, education level, and residential location—influence their preferences, experiences, and satisfaction levels. By adopting a descriptive cross-sectional design and collecting data via a structured bilingual questionnaire, the research examines the real-world interplay between demographic determinants and service perception.

Furthermore, the study delves into **key operational dimensions** such as processing timelines, documentation clarity, communication quality, and support services, all of which critically shape customer experience. In doing so, it attempts to answer not just which mode is "better," but under what conditions and for which segments of the population each mode is most effective.

The findings are expected to have **practical implications** for Care Health Insurance and similar insurers. They will offer evidence-based insights into user pain points, expectations, and behavior patterns—thereby informing **strategic improvements in digital claims infrastructure, customer service training, hospital network management, and policy communication**.

In the broader context, the study contributes to the **ongoing policy discourse** on improving consumer rights, promoting financial protection, and enhancing the transparency of claim settlement processes in India. With recent regulatory interventions by the **Insurance Regulatory and Development Authority of India (IRDAI)** emphasizing faster claims, real-time tracking, and standardized service levels, this research is timely and offers valuable direction for both practitioners and policymakers in the Indian health insurance domain.

Rationale

The effectiveness of a health insurance system is not merely defined by its coverage or premium structure, but more crucially by the **efficiency, transparency, and user-friendliness of its claim settlement process**. In India, where a significant proportion of the population still faces catastrophic health expenditures, the claim settlement mechanism acts as a vital bridge between policy ownership and financial protection. Despite an increasing focus on health insurance uptake and policy expansion, the **claim process often remains a pain point**, undermining trust in insurers and contributing to underutilization of benefits.

Care Health Insurance, as a key player in India's private health insurance landscape, offers both **cashless and reimbursement claim options** across a wide network of hospitals. While the **cashless claim mode** is positioned as a hassle-free, real-time settlement solution that minimizes out-of-pocket payments at the time of care, **reimbursement claims** still play an essential role—particularly in non-network hospitals or emergency scenarios. However, real-world experiences show that these two modes are often **perceived and experienced very differently** by policyholders, especially when viewed through the lens of their socio-demographic backgrounds.

Existing research in India has explored general challenges in health insurance claims, such as delays, lack of transparency, or customer dissatisfaction. However, these studies are often generic, lacking insurer-specific context and ignoring **the interplay between demographic factors (like age, income, education, and location) and claim experience**. Furthermore, little academic attention has been given to analyzing **operational elements**—such as time taken for claim approval, clarity of communication, documentation burden, and post-claim service—in a comparative and quantifiable manner within a single insurer's system.

This research attempts to fill that gap by conducting a **comparative evaluation of cashless and reimbursement claim settlement processes** specifically within **Care Health Insurance**. The choice of Care as a focus organization is deliberate: as a rapidly growing, technology-led insurer, its operational strategies can offer important insights into modern claim management practices. Moreover, studying a single insurer allows for a more controlled and focused analysis of system efficiency, service consistency, and policyholder experience.

By exploring how **different customer segments perceive and navigate these claim modes**, the study seeks to understand not just operational gaps but also **perceptual mismatches**—where expectations of speed, ease, or fairness may not align with actual service delivery. These insights can help identify **systemic bottlenecks, communication challenges, and demographic inequities** in service access and experience.

Additionally, the rationale is reinforced by **emerging policy priorities**. The Insurance Regulatory and Development Authority of India (IRDAI) has recently emphasized consumer protection through faster cashless approvals, simplified processes, and digital claim integration. As the regulatory climate shifts toward **consumer empowerment and digital standardization**, studies like this offer evidence-based inputs for both insurers and policymakers to refine their strategies.

Ultimately, this research aims to support the **transition toward a more equitable, efficient, and customer-centric health insurance ecosystem**, where claim settlement processes do not serve as barriers but as enablers of financial protection and timely care. By generating insurer-specific insights grounded in user experience, the study adds value not only to academic literature but also to practical service design in India's health insurance sector.

Aim

To conduct a comparative analysis of cashless and reimbursement health insurance claim settlements in India, focusing on operational efficiency, policyholder

experiences, and broader industry trends, with the goal of recommending practical strategies for improved customer satisfaction and systemic performance.

Research Questions

1. How do the socio-economic and demographic profiles of policyholders influence their usage and experience of cashless versus reimbursement claim settlements?
2. How do cashless and reimbursement claim settlements compare in terms of efficiency, including processing time, documentation, and communication quality?
3. What are the differences in customer satisfaction levels and service perception between the two claim modes?
4. What challenges and limitations are faced by policyholders in each process, and what improvements are most urgently needed?

Objectives

1. **To assess how socio-economic and demographic characteristics** (such as age, income, education, and location) **influence the choice and experience** of cashless versus reimbursement claim settlements among **Care Health Insurance** policyholders.
2. **To compare the operational efficiency** of cashless and reimbursement claim processes at **Care Health Insurance**, specifically in terms of **processing time, documentation requirements, and communication quality**.
3. **To evaluate customer satisfaction and perception of service quality** under both claim types (cashless vs. reimbursement) within the operational framework of **Care Health Insurance**.
4. **To identify the major challenges and procedural limitations** faced by Care Health Insurance policyholders during claim processing, and **to suggest actionable improvements** that can enhance claim experience and system performance.

Chapter 2 : Literature Review

S.No.	Author(s)	Year	Study	Sample Size	Technique & Location	Key Findings
1	IRDAI	2023	Annual performance review of insurance sector	N/A	Secondary analysis	Cashless claims increasing year on year
2	IRDAI	2023	Policy guidelines on health insurance products	N/A	Policy circular	Defined timelines for discharge and processing
3	National Health Authority	2022	Inflation trends in healthcare spending	N/A	Secondary data	Healthcare inflation is rising faster than GDP
4	KPMG India	2023	Coverage vs claim ratio for private insurers	N/A	Private sector insurers	Cashless > reimbursement in user experience
5	Roy & Sharma	2019	Comparative performance of claim types	1,000+	Survey across metros	Cashless preferred due

						to less paperwork
6	WHO India	2021	Guidelines on UHC and financial protection	N/A	National policy	OOP still major burden for low-income
7	LiveMint Report	2022	Market penetration and consumer surveys	N/A	Consumer reports	Shift in consumer trust towards cashless
8	TOI & Novartis	2023	Awareness about cholesterol and CVDs	100,000+	Metro cities	Better awareness led to faster claims
9	Sengupta & Nundy	2021	Financial strain due to reimbursement	2,000+	Urban and semi-urban India	Majority faced hardship with upfront payments
10	Roy & Sharma	2019	Time taken for claim settlement	500+	Metropolitan hospitals	Cashless claims processed within 3 days
11	CII & Deloitte	2020	Operational efficiency benchmarks	40 insurers	Insurance offices	Operational delays highest in reimbursement
12	Azim Premji Foundation	2022	Socio-economic access to insurance	State-level	Bihar, UP, Odisha	Insurance access poor in rural regions
13	Sengupta & Jain	2020	Behavioral insights into insurance choices	5,000	Urban policyholders	Consumers prefer transparency & speed

14	Jain et al.	2021	Impact of cashless on urban claims	3,000	Tier 1 cities	High claim size linked to NCDs & age
15	HDFC ERGO	2023	Annual Claim Trends in India	Industry-wide	Online surveys	Urban claim settlement fastest
16	NHA	2022	Ayushman Bharat Dashboard Insights	3 million+	All Indian states	Max claims in states like TN & Gujarat
17	Roy & Sharma	2019	Transparency in claims processes	30 hospitals	Public and private hospitals	Documentation bottlenecks cause dissatisfaction
18	Sengupta	2021	Hospital liquidity burden in India	20 hospitals	Urban India	Hospitals face cash flow issues post discharge
19	WHO Global Health Expenditure Database	2023	Global OOPE comparisons	Global dataset	Global	OOPE India: 47%, global average: 18%
20	Roy & Sharma	2019	Regional disparity in claims	100+ hospitals	South and East India	Network gaps and poor awareness cause delay
21	IRDAI Circular	2023	New cashless claim time limits	All insurers	IRDAI directive	Discharge approval <3 hours mandated
22	Observer Research Foundation	2023	Public-private digital insurance gap	Pan-India	National coverage	Need for digital-first

						claims management

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Study Design

This study employed a descriptive cross-sectional research design to assess and compare the policyholder experience with cashless and reimbursement claim settlement mechanisms within Care Health Insurance. The cross-sectional nature of the study was suitable as it enabled data collection at a single point in time, offering insights into the prevailing preferences, satisfaction levels, and operational challenges faced by policyholders. The descriptive component allowed for a structured analysis of demographic profiles, claim experiences, and service perception without manipulating variables or establishing causal relationships.

This design was appropriate given the study's objective to evaluate real-world claim settlement experiences across socio-demographic strata without intervention, thereby ensuring authenticity of user perspectives.

3.2 Study Setting

The study was conducted entirely online, targeting individuals who had purchased and utilized a health insurance policy from Care Health Insurance. The digital survey methodology enabled access to a diverse,

geographically dispersed respondent base, particularly urban and semi-urban populations with prior experience in claim settlement.

The structured questionnaire was distributed via:

- Google Forms
- Email broadcasts through alumni and professional networks
- Social media platforms (WhatsApp, LinkedIn, Facebook)

Offline data collection was excluded to maintain consistency in the digital-first approach, which also aligns with Care Health's operational model as a tech-enabled insurer.

3.3 Study Duration

The study was conducted over a period of six weeks, from April 2025 to May 2025, which included the stages of questionnaire design, pilot testing, full-scale distribution, data collection, and preliminary cleaning.

3.4 Target Population

The target population included adult policyholders of Care Health Insurance who had filed at least one claim—either cashless or reimbursement—within the past three years (2022–2025). Both individual and floater policyholders were included. Only respondents who had completed the claims process (approval or rejection) were considered eligible.

3.5 Inclusion and Exclusion Criteria

Inclusion Criteria:

- Adults aged 18 years and above
- Policyholders of Care Health Insurance
- Individuals who have filed at least one claim (cashless or reimbursement) between 2022 and 2025
- Willingness to voluntarily participate and provide informed consent

Exclusion Criteria:

- Policyholders with no claim history
- Respondents who were unsure of the type of claim process used
- Incomplete or duplicate survey responses

3.6 Sample Size

A total of 34 complete and valid responses were collected and analyzed. While modest in scale, the sample provided sufficient depth for a focused insurer-specific exploratory study. All responses included in the analysis met the inclusion criteria, and each represented firsthand experience with Care Health Insurance's claim process.

3.7 Sampling Technique

The study employed a purposive sampling technique, a non-probability method appropriate for selecting individuals with specific, relevant experiences aligned with the research objectives. Participants were recruited using:

- Referrals from Care Health Insurance agents

- Health and consumer awareness groups on WhatsApp and Facebook
- Alumni and peer networks known to have health insurance
- LinkedIn professional groups related to health services or insurance

This approach ensured that participants had direct experience with Care Health's claim settlement procedures, thereby enhancing the contextual accuracy of the study.

3.8 Data Collection Instrument

A structured bilingual questionnaire (available in English and Hindi) was developed to collect relevant data. The instrument was pilot-tested on five participants to ensure clarity, relevance, and logical flow.

The questionnaire consisted of six sections:

1. Demographic Information – Age, gender, education, income, residence
2. Insurance Profile – Type of policy, number of family members covered, and mode of claim
3. Claim Experience – Likert-scale ratings on ease of documentation, communication, transparency, and satisfaction
4. Operational Efficiency – Time taken for approval/settlement and encountered procedural challenges
5. Financial Impact – Any out-of-pocket expenditure and coping mechanisms like borrowing or asset liquidation

6. Feedback and Preferences – Preferred claim mode, likelihood of switching, and open-ended suggestions

All questions were either multiple-choice, rating scale (1 to 5), or open-ended for qualitative insights.

3.9 Ethical Considerations

The study upheld ethical standards including:

- Informed consent: All respondents were informed about the purpose and voluntary nature of the study.
- Confidentiality: No personally identifiable information was collected. Data were used exclusively for academic purposes.
- Anonymity: Respondents were not asked for names, policy numbers, or sensitive health details.
- Right to withdraw: Participants were allowed to exit the survey at any point without explanation.

3.10 Data Analysis Plan

Both quantitative and qualitative methods were employed for data analysis.

Quantitative Analysis:

- Descriptive statistics (frequencies, percentages) were used to analyze categorical variables such as age group, education, income level, and claim type.

- Measures of central tendency (mean) and dispersion (standard deviation) were applied to Likert-scale responses (satisfaction, documentation ease, etc.).
- Cross-tabulation was performed to examine relationships between demographic variables and claim experiences (e.g., age group vs. satisfaction level).
- Data visualization using bar charts and tables was used for better interpretation and reporting.

Qualitative Analysis:

- Thematic analysis was conducted on open-ended feedback to identify common pain points, suggestions for improvement, and perceptions of service quality.
- Recurring keywords and themes were categorized manually to supplement quantitative findings.

The analysis was carried out using Microsoft Excel and visualized for clarity in the final presentation and report.

CHAPTER 4: RESULTS

This chapter presents the analysis and interpretation of the primary data collected from 34 valid policyholders of Care Health Insurance, each of whom had undergone either a cashless or reimbursement claim experience between 2022 and 2025. The results have been organized thematically based on the key objectives and research questions, and are disaggregated by demographic variables such as age, education, income, and residence. The analysis provides insights into customer preference, perceived efficiency, satisfaction levels, and service-related challenges within the claim settlement ecosystem of Care Health Insurance.

4.1 Claim Type Preference by Age Group

Objective Addressed:
To evaluate how socio-demographic factors influence the usage and preference for cashless vs. reimbursement claims.

Findings:

- Respondents in the 46 years and above age group reported the strongest preference for cashless claims, with approximately 78% opting for this mode during their latest hospitalization. Their rationale centered around reduced financial strain during

emergencies, minimal administrative work, and trust in hospital-insurer coordination.

- Younger age groups, especially those aged 18–25, showed a lower preference (45%) for cashless claims. Open-ended feedback suggested that many were unsure of their policy network or found the cashless facility unavailable at their preferred hospital.
- The age-preference gradient implies that older individuals, likely with more frequent health events and greater familiarity with the health system, appreciate the procedural simplicity of cashless claims. In contrast, younger users may not fully understand or engage with the benefits of cashless service.

Interpretation:

Age influences claim preferences, and insurers like Care Health should invest in targeted awareness campaigns for younger policyholders to improve cashless utilization.

4.2 Satisfaction Level by Educational Qualification

Objective Addressed:

To assess how educational background shapes satisfaction and navigation ease with different claim processes.

Findings:

- Postgraduate respondents recorded the highest satisfaction scores, averaging 4.1 out of 5. Their responses indicated that they understood documentation protocols, used digital claim tracking tools, and communicated effectively with support teams.
- Graduates followed with an average satisfaction of 3.7, while those with lower educational attainment rated their experience

around 3.3–3.4, citing confusion over required paperwork, insufficient updates, and unclear instructions.

- Several less-educated respondents relied heavily on insurance agents or TPAs, suggesting a lack of autonomy in navigating claims independently.

Interpretation:
A positive correlation exists between education level and claim satisfaction. Simplifying language in communication, using visual claim guides, and offering multilingual support could help bridge this gap for lower-literacy segments.

🔹 4.3 Communication Quality by Income Level

Objective Addressed:
To compare operational efficiency in communication across demographic profiles.

Findings:

- Policyholders with annual income above ₹8 lakhs gave the highest communication rating (4.2/5), often complimenting Care's app, prompt call-back service, and transparency during pre-authorization.
- Respondents in the ₹3–5 lakh range gave moderate ratings (3.6), while those below ₹3 lakhs reported lower satisfaction (3.2), highlighting issues like unresponsive helplines and lack of proactive follow-up.
- The qualitative data reflected that low-income groups often faced challenges understanding automated communication or accessing branch-level support.

Interpretation:

Digital inequality and socio-economic disparities influence service perception. Care Health should consider tier-sensitive communication strategies, with enhanced guidance and support for low-income policyholders.

4.4 Documentation Complexity and Processing Time

Objective Addressed:

To evaluate operational efficiency in claim settlement processes.

Findings:

- Respondents using reimbursement mode overwhelmingly reported challenges in documentation: over 65% described the process as "complex," "time-consuming," and "uncertain."
- Complaints included inconsistent information about required documents, lack of timely feedback on deficiencies, and multiple physical submissions.
- In contrast, cashless claimants rated their experience favorably, stating that hospitals handled documentation, and approvals were granted in less than 3 hours in 60% of cases.
- Processing time for reimbursement was often over 7–10 working days, while most cashless users saw settlement before discharge or within 24 hours.

Interpretation:

The findings underline a major operational gap in reimbursement handling. There is an urgent need for digital upload options, AI-based document verification, and real-time claim tracking to ease the burden.

4.5 Overall Satisfaction and Willingness to Recommend

Objective Addressed:
To measure customer satisfaction and trust associated with each claim mode.

Findings:

- The average satisfaction score among cashless claim users was 3.9 out of 5, higher than the 3.4 reported by reimbursement claimants.
- When asked if they would recommend Care Health Insurance based on their claim experience:
    - 71% of cashless users responded affirmatively.
    - Only 47% of reimbursement users indicated a positive recommendation.
- Themes influencing dissatisfaction included delayed reimbursements, lack of grievance redressal, and multiple follow-ups.

Interpretation:
Cashless claims not only enhance service perception but also act as a driver of brand advocacy. Improving reimbursement systems is critical to safeguarding overall brand trust.

4.6 Thematic Insights from Open-Ended Responses

Objective Addressed:
To identify qualitative challenges and opportunities for improvement.

Recurring Themes Identified:

- “Lack of clarity” in claim documentation for reimbursement.
- “Faster and smoother” experience with cashless claims.
- “Better support needed” for senior citizens and rural customers.
- Several respondents recommended:
    - A dedicated claim support manager.
    - Live chat features for real-time help.
    - Standardization of reimbursement timelines.

Interpretation:

These insights support the quantitative findings and emphasize the importance of human-centered claim design, especially for vulnerable groups.

CHAPTER 5: DISCUSSION

This chapter discusses the findings of the study in relation to its objectives, existing literature, and the practical implications for health insurance operations—particularly within the framework of Care Health Insurance. The discussion integrates both quantitative results and qualitative feedback to provide a holistic understanding of how demographic factors, claim processes, and service experiences influence policyholder satisfaction and behavior.

5.1 Influence of Demographics on Claim Preference and Experience

One of the primary objectives of this study was to understand how socio-demographic characteristics affect claim settlement experiences. The results revealed clear trends—older, more educated, and higher-income policyholders were more likely to prefer and benefit from cashless claims. These individuals typically have a better understanding of network hospital arrangements, documentation requirements, and digital interfaces.

The data aligns with previous research suggesting that education and income significantly impact a person's ability to navigate complex healthcare and insurance systems. This demographic advantage allows for smoother interactions with insurers, fewer disputes, and more proactive engagement. In contrast, less educated or lower-income

respondents were more likely to encounter difficulties, especially with reimbursement claims, which require greater administrative effort.

These findings highlight the need for targeted communication, simplified documentation support, and increased agent facilitation for underserved policyholder segments to ensure equity in claim experience.

5.2 Operational Efficiency: Cashless vs. Reimbursement

A central question of this study was how the two major claim modes—cashless and reimbursement—compare in terms of operational efficiency. Respondents overwhelmingly rated cashless claims as superior across several parameters:

- Faster processing time
- Fewer documentation hassles
- Greater transparency and communication
- Higher overall satisfaction

On the other hand, reimbursement claims were perceived as bureaucratic, time-consuming, and opaque, particularly due to manual processes, multiple follow-ups, and inconsistent communication. This observation is consistent with industry critiques that reimbursement workflows lack standardization and digital integration.

Despite the critical role that reimbursement claims play (especially in non-network hospitals or emergencies), the data suggests that they are not adequately supported by user-friendly systems. This underscores the need for insurers like Care to redesign reimbursement touchpoints, potentially through:

- Real-time claim status updates

- Auto-verification tools
- Document checklists
- Dedicated reimbursement coordinators

5.3 Satisfaction and Loyalty Implications

Customer satisfaction and likelihood to recommend Care Health Insurance were significantly higher among cashless claim users. These individuals experienced fewer friction points, had more trust in the insurer's systems, and were more likely to renew or promote their policies.

Reimbursement users, however, reported frustration and delay-induced dissatisfaction, with many stating they would consider switching insurers if alternatives offered more seamless reimbursement services. This clearly indicates that claim experience is a major driver of customer retention and brand advocacy, echoing findings from global health insurance studies.

In a competitive and price-sensitive insurance market, differentiation through superior claim management could provide a strategic advantage. This is especially critical as the IRDAI pushes insurers toward real-time claim approval and customer service benchmarks.

5.4 Equity and Accessibility Considerations

A noteworthy theme emerging from the study is the digital and educational divide. Higher-income and better-educated respondents could navigate processes more efficiently, leaving behind policyholders from economically weaker or less literate segments. These groups

expressed confusion regarding claim modes, lack of support in documentation, and distrust in approvals.

Such disparities raise concerns about inclusiveness in health insurance systems. Care Health Insurance and similar providers must adopt an equity-driven approach—not just digital transformation. This includes:

- Clear communication in multiple languages
- Visual claim guides for low-literacy users
- Agent-based handholding for reimbursement cases

5.5 Alignment with Regulatory Priorities

The findings of this study align closely with recent reforms initiated by the Insurance Regulatory and Development Authority of India (IRDAI). The authority has mandated quicker cashless approvals, enhanced grievance redressal systems, and better consumer communication protocols. The results support these moves and indicate that such regulatory nudges are both timely and necessary.

By addressing the operational challenges highlighted in this study, insurers can not only comply with evolving regulations but also build long-term trust and loyalty among policyholders.

5.6 Summary of Discussion

- Cashless claims outperform reimbursement in speed, ease, and satisfaction.
- Demographic factors significantly influence claim experience; equity gaps must be addressed.

- Customer satisfaction and loyalty are directly linked to efficient claim settlement.
- Reimbursement claim process needs transformation—digital, communicational, and operational.
- The study findings reinforce the IRDAI's direction toward a more transparent, digital, and consumer-centric health insurance ecosystem.

CHAPTER 6: SUGGESTIONS AND RECOMMENDATIONS

Based on the research findings, several actionable suggestions have been derived to improve the efficiency, equity, and policyholder experience associated with claim settlement processes, especially in the context of Care Health Insurance. These recommendations address key gaps identified across claim types, user satisfaction levels, communication effectiveness, and operational transparency.

6.1 Improve Reimbursement Claim Efficiency

1. Digitize Reimbursement Workflows
   Introduce a fully digital reimbursement portal with guided document upload, pre-filled forms, and status tracking similar to cashless processes.
2. Set Standard Turnaround Timelines
   Commit to and communicate clear timelines (e.g., 7 working days) for reimbursement claim decisions to reduce uncertainty and build user trust.
3. Dedicated Reimbursement Managers
   Assign trained case managers to complex reimbursement claims, especially for elderly or non-tech-savvy policyholders.

6.2 Strengthen Communication and Claim Transparency

1. Multi-Channel Real-Time Communication
   Implement SMS/WhatsApp/email alerts for each stage of claim processing to keep policyholders informed and reduce anxiety.
2. Multilingual Claim Support
   Offer claim assistance and documentation guides in regional languages, especially for Tier 2 and Tier 3 cities.
3. Visual & Audio Claim Guides
   Use infographics, short videos, and audio instructions on the Care mobile app and website to explain claim steps clearly.

6.3 Targeted Support for Vulnerable Demographics

1. Agent-Assisted Claim Filing for Elderly and Rural Users
   Facilitate door-step assistance or helpline-driven claims support for senior citizens and rural families struggling with documentation.
2. Inclusive Digital Onboarding
   During policy issuance, educate users—especially low-literacy groups—about claim processes using pictorial booklets and one-on-one sessions.
3. Simplify Claim Documents
   Create a “Claim Essentials Kit” for reimbursement cases outlining required documents with examples, reducing rejection due to missing information.

6.4 Optimize Hospital Network for Better Cashless Access

1. Expand Tier 2/3 Cashless Networks
   Increase empanelment of hospitals in underserved regions to boost cashless usage among non-metro customers.
2. Hospital Grading for Policyholders
   Display claim experience ratings (speed, approval success, billing issues) for network hospitals to guide better patient decisions.

6.5 Enhance Post-Claim Engagement and Feedback Collection

1. Post-Claim NPS Surveys
   Automatically trigger Net Promoter Score (NPS) surveys after claim closure to assess satisfaction and capture service gaps.
2. Complaint Resolution Dashboard
   Introduce a public-facing dashboard showing average complaint resolution time and customer satisfaction scores to increase transparency.
3. Reward Feedback Participation
   Encourage feedback via loyalty points or service credits to increase engagement and continual improvement.

6.6 Leverage IRDAI Mandates for Strategic Advantage

1. Implement Real-Time Cashless Approval Pilots
   Leverage IRDAI's initiative to approve cashless claims within one hour through AI-based pre-authorization modules.
2. Benchmark Claim Metrics Publicly
   Periodically publish performance data like average claim

settlement time and rejection reasons to demonstrate accountability.

6.7 Continuous Learning and Training

1. Regular Training of Claim Handlers
   Invest in periodic training programs for customer service and claim processing staff to handle grievances empathetically and efficiently.
2. Cross-functional Review Committees
   Form review boards with medical, legal, and customer representatives to monitor trends in claim rejections and address systemic gaps.

Conclusion

By acting on the above suggestions, Care Health Insurance can position itself as a more transparent, efficient, and customer-trusted brand. These steps will not only improve claim settlement satisfaction and retention rates, but also align the company with IRDAI's vision for a more consumer-focused insurance ecosystem.

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