A CROSS-SECTIONAL STUDY TO UNDERSTAND THE OUTCOME OF HEALTH INSURANCE CLAIMS AT CARE HEALTH INSURANCE, GURGAON

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

by

Vaishnavi Soni

Under the Supervision and Guidance of

Dr. Sarthak Sengupta

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 **Vaishnavi Soni,** 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 her 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

CERTIFICATE

This is to certify that dissertation titled **A Cross-Sectional Study to Understand the Outcome of Health Insurance Claims At Care Health Insurance, Gurgaon** is a record of the research work undertaken by Vaishnavi Soni in partial fulfilment 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

IIHMR University, Jaipur

Date 16/6/2025

School Dean

IIHMR University, Jaipur

Date 16/6/2025

DECLARATION BY STUDENT

I hereby declare that this dissertation, titled A Cross-Sectional Study to Understand the Outcome of Health Insurance Claims at Care Health Insurance, Gurgaon, is the bona fide 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Vaishnavi Soni

Vaishnavi Soni

(Signature)

Name of Student: Vaishnavi Soni

Date: 16/6/2025

ACKNOWLEDGEMENT

My sincere gratitude to Mr. Sarthak Sen Gupta, Assistant Professor at IIHMR University, Jaipur, for his significant advice, help, and mentorship throughout the course of my dissertation project. The insights and perspectives of have greatly influenced the course of my research and improved the caliber of my work. He has been a constant source of inspiration for me because of him unwavering commitment, forbearance, and encouragement. I sincerely appreciate him for the time and effort he put in me.

I would also like to express my heartfelt gratitude to our respected Dean of Institute of Health Management Research, Dr. Sanjay Gupta, for his continuous guidance and support throughout our MBA course. He has provided us students with a plethora of knowledge and insight of management in the field of healthcare. His mentorship has been extremely helpful in the successful completion of my research.

TABLE OF CONTENTS

Contents

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

CHIL: Care health Insurance limited

IRDA: Indian regulatory and development Authority of India

OPD: Outpatient department

IPD: Inpatient Department

TAT: Turnaround time

TPA: Third Party Administration

DEO: Data Entry Operator

NIA: New India Assurance

SAHIS: Standalone Health Insurance

ABSTRACT

INTRODUCTION:

Health insurance has a key role to play in offering protection against money costs incurred due to medical treatment. Proper management of claims, especially timely and equitable reimbursement, is imperative to ensure trust and satisfaction among policyholders. In the present study, the simultaneous impact of patients' age, nature of treatment, disease group, and geographic region on decision results and turnaround time (TAT) of medical insurance claims settled at Care Health Insurance Limited (CHIL), Gurgaon, has been explored.

METHODOLOGY:

A descriptive cross-sectional study was carried out with retrospective data of 200 reimbursement claim cases processed at CHIL between April and May 2025. Purposive sampling was applied depending on the availability and completeness of the data. Secondary data were obtained from claim processing records, and variables like claim decision, type of treatment, disease, zone, and age of patient were examined.

RESULTS:

The most common outcome was claim approval (33.5%), followed by queries (27%) and non-registrations. Only 3% were denied. The highest volume of both surgical and medical claims occurred in the east zone. Surgical procedures were more frequent among aged patients (mean age ~45 years), whereas medical procedures had a wider range of ages (mean ~39 years). Chronic conditions such as osteoarthritis and anemia were common among elderly patients. Inquiries or investigation claims took much longer TATs, commonly taking more than the IRDA guidelines, while non-registrations or straightforward approvals took less time.

CONCLUSION:

In this study, many health insurance claims were approved (67 cases), followed by queries (54), non-registered cases (44), and a combination of investigation and query (28), with only 6 claims rejected, typically before receiving responses. Surgical treatment claims were more likely to be approved than medical claims, with a significantly higher odds ratio (1.8, $p = 0.02$). The East zone showed the highest utilization of healthcare services and had the highest approval rate (34%), though zone-wise differences were not statistically significant ($p > 0.05$). Cataract and fractures emerged as the most common conditions reported, followed by gastritis and acute febrile illness. Turnaround times were longest for cases involving investigations or queries, while approved and non-registered claims had shorter processing times. The age distribution revealed the highest number of patients in the 31–40 age group, with a notable presence in the 61–70 and 0–10 age groups, indicating that middle-aged and pediatric patients formed a significant portion of the claims, while the elderly population (81–90) was underrepresented.

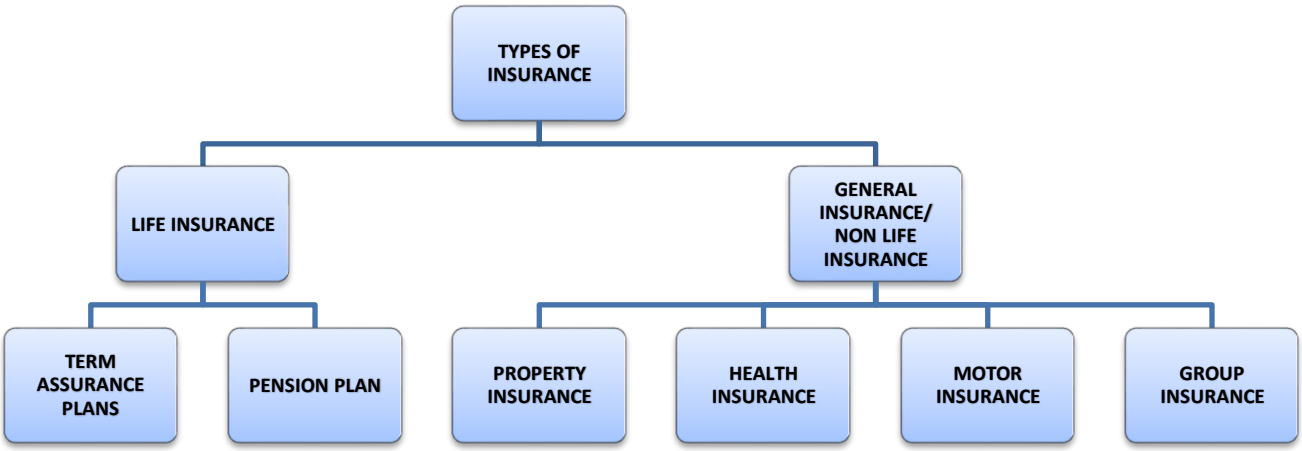
CHAPTER 1 - INTRODUCTION:

Insurance is a type of financial loss protection in which one party agrees to pay another party in the event of a specific loss, damage, or injury in return for a fee [3]. It is a type of risk management mainly employed to guard against the possibility of an unforeseen or contingent loss.

Risk transfer and pooling are the cornerstones of insurance. Numerous people contribute modest sums (premiums) to a shared fund that the insurance company oversees. The insurer utilizes this pool to pay the impacted party in the event of an insured loss. This strategy makes losses tolerable for people and sustainable for the insurer by dividing the financial burden by selecting a few among many.

The two main categories of insurance are general insurance and life insurance. In the event of death, life insurance offers the insured's dependents or family financial stability. It may also be used as a long-term investment and savings instrument. In contrast, general insurance covers a broad range of non-life plans, which include health, auto, property, travel insurance, and others. Each kind is designed to satisfy the requirements of people, companies, or organizations and handle their risk. Among the several kinds, health insurance draws a lot of attention because of growing healthcare expenses and a greater understanding of the value of health and well-being. The costs of medical care, hospital stays, operations, diagnostic testing, and occasionally post-care are covered under health insurance.

TYPES OF INSURANCE



in addition to these, there are many other types under life and general insurance. **(4)**

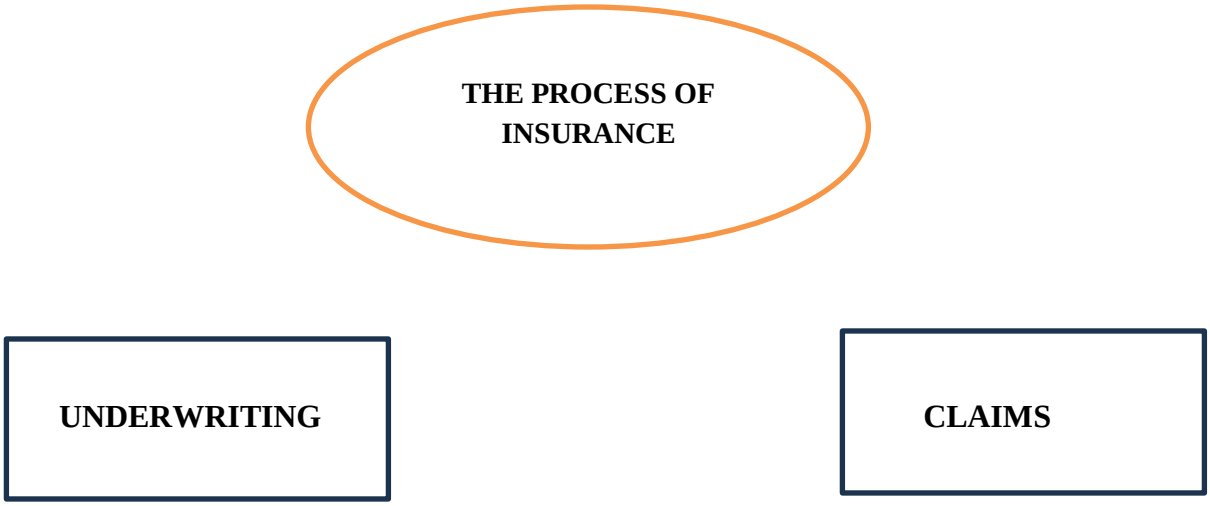
1.1 IMPORTANCE OF HEALTH INSURANCE:

A vast number of people's risks and resources are pooled by health insurance to safeguard each person against financially crippling medical bills which may be caused due to sickness, accident, or disability. [3] Health insurance has evolved as a means of funding or a pre-paying tool for a range of health care benefits, including regular preventive services.

Requests for reimbursement of medical costs incurred for treatment are submitted by the insured to the health insurance company through health insurance claims. The policy's coverage covers these claims. Numerous medical procedures are covered by health insurance, including surgeries, dialysis, chemotherapy, and inpatient and outpatient (OPD and IPD) care.

A cashless method occurs when hospitalized medical costs are paid for directly by the insurance company. The reimbursement procedure, on the other hand, happens when the insured pays the medical expenses first and then requests reimbursement from the insurer. Prompt claim settlement is essential for every health insurance provider to guarantee patient satisfaction.

1.2 PROCESS OF CLAIMS



UNDERWRITER

The process of acquiring and evaluating data from a proposer for risk evaluation is known as underwriting. Based on the facts gathered during this process, they decide whether they want to issue the policy to the client. Based on preset parameters related to morbidity, health insurance applies the risk assessment and pricing mechanism.

CLAIMS

The claim is a formal request to the insurer by the insured to compensate for the loss incurred or event. The insurance company evaluates the loss and approves the amount to be paid.

1.3 TYPES OF CLAIM SETTLEMENT

Table 1.1 Cashless Vs Reimbursement Claim

CASHLESS CLAIMS	REIMBURSEMENT CLAIM
A cashless claim involves visiting a hospital that is on the insurance company's network list (empaneled hospital). Here, the health insurer directly settles the bills.	In claim reimbursement, the insurer bears the upfront cost of treatment and then presents the bills along with other listed documents to the insurer for claim approval.
The insurance company directly settles all treatment expenses within the policy T&C	The insured pays bills first and then files for reimbursement.
In cashless claims, preauthorization is required in case of planned hospitalization.	No claim approval is required.
It is generally a less time-consuming process	Requires a longer time to process claims
Cashless claims are only applicable at network hospitals	Reimbursement claims can be made through any hospital (there are a few terms and conditions as well)

CASHLESS CLAIM

A cashless claim in health insurance is where the insured person can undergo medical treatment without paying the hospital bill at the time of receiving treatment. The payment is directly made between the hospital and the insurance company based on the terms and conditions of the health insurance policy. The process is facilitated at the network hospitals, which share a tie-up with the insurance company or Third-Party Administrator (TPA).

- **Process of Cashless Claim**

The process of making a cashless claim starts with the selection of a network hospital for the treatment. These are the hospitals that have tie-up arrangements with the insurance company. Once the insured gets admitted, they must produce their health insurance card or policy information at the insurance helpdesk of the hospital. The hospital makes a pre-authorization request to the TPA or insurance company, describing the nature of the disease and the approximate treatment cost.

When the insurer receives this request, they process the information and respond with an approval or rejection. If approved, the hospital goes ahead with the treatment, and the bill is directly paid by the insurer after the discharge of the insured. Any expenses which are not covered by the policy, including non-medical expenses, room upgrades, or consumables, are to be paid by the insured.

- **Advantages of Cashless Claim:**

The patient or family members do not have to plan for cash at the time of the medical emergency.
The whole process is taken care of between the hospital and the insurer.
Pre-determined limits, inclusions, and exclusions are transparently communicated.
No long reimbursement paperwork required.

- **Limitations of Cashless Claim:**

Available only in network hospitals.
Approval is policy coverage dependent; not all treatments or expenses may qualify.
Pre-authorization is a requirement.
Certain procedures or pre-existing ailments might not be covered.
Upon rejection, the insured has the option to claim reimbursement later.

REIMBURSEMENT CLAIM

A health insurance reimbursement claim is a process where the insured individual pays the medical bills directly out of pocket while receiving treatment and then receives the amount back from the insurance company. The option is usually used in cases of treatment taken from a non-network hospital or when it is not possible to take a cashless claim.

- **Process of Reimbursement Claim**

The reimbursement process is initiated when the insured becomes hospitalized and pays for the treatment and other related expenses. Once they are discharged, the insured must gather all original bills, discharge summaries, prescriptions, test reports, and other related documents. These documents are then provided to the insurance company or TPA together with a correctly completed reimbursement claim form.

The documents are screened by the insurer, and the claim eligibility is verified under the policy conditions. If everything is correct, the amount claimed is deposited in the bank account of the insured. Discrepancies or exclusions if present, may result in partial approval or rejection of the claim.

Documents Required: Filled claim form, original bills and receipts issued by hospitals, Discharge summary, prescriptions issued by doctors, diagnostic reports, medicine bills, investigation reports, and other documents as required by the insurer

- **Advantages of Reimbursement Claim**

Freedom to go to any hospital: As opposed to cashless claims, treatment can be availed of in any hospital, not necessarily a network one.

Helpful when approval for cashless is not taken beforehand.

Aids in emergency treatments in far-off places or while traveling, where network hospitals are not accessible.

- **Limitations of Reimbursement Claim**

The patient must pay the entire amount immediately.

Involves filling up different original documents.

It can take weeks for the insurer to approve and settle the claim.

Chances of rejection because of errors or a lack of documents

- **When to Use a Reimbursement Claim**

When treatment is available in a non-network hospital.

When the cashless request is refused.

In emergent situations, when there is no time for pre-authorization.

For treatments not included in the cashless arrangement.

1.4 MAJOR PLAYERS IN THE HEALTH INSURANCE INDUSTRY

Insurance players can be mainly divided into 3 types:

1. **PUBLIC SECTOR PROVIDERS (I.E., GOVERNMENT):** Major public sector providers are oriental insurance, New India Assurance (NIA), United India Insurance, etc. **(4)**

2. **PRIVATE SECTOR PROVIDERS:** Private sector health care insurance providers are ICICI Lombard, HDFC ERGO, TATA AIG, Reliance General Insurance, etc. **(4)**

3. **STANDALONE PROVIDERS:** There are 5 mainly stand-alone health care insurance providers, Niva Bupa, Star Health, Care Health, Manipal Health, Bajaj Allianz, Aditya Birla, newly added, Narayana Health Insurance Ltd., Galaxy Health Insurance Company Limited (formerly known as Galaxy Health and Allied Insurance Co. Ltd **(4)**

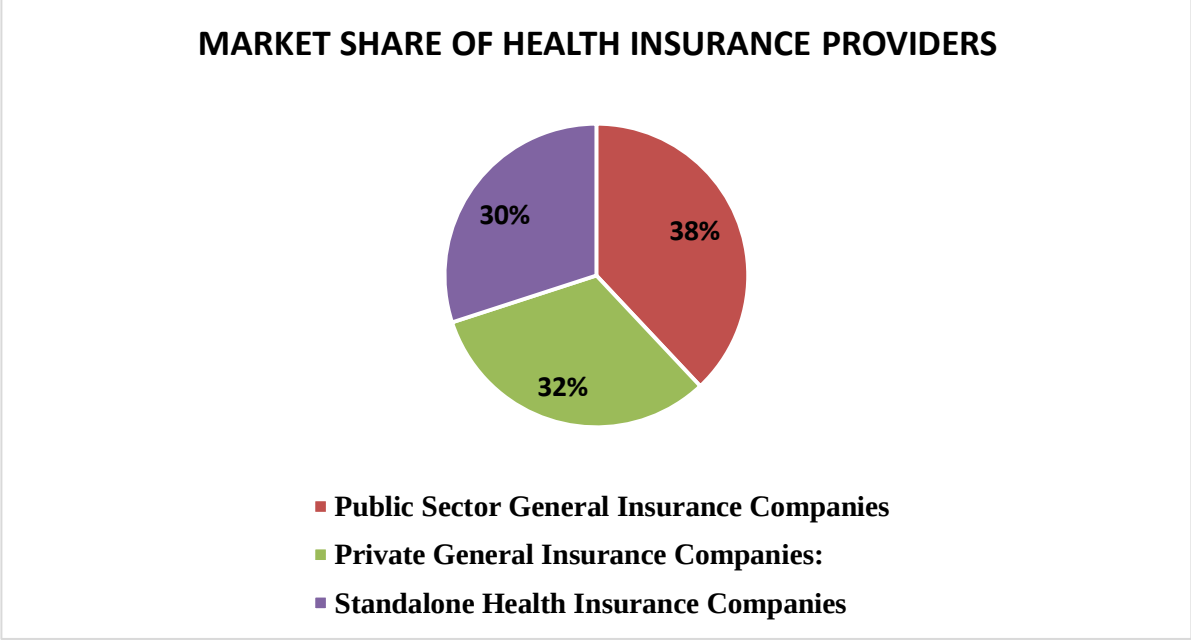


Figure 1.1 Market Share of Health Insurance Providers

1.5 IRDAI

The IRDA (Insurance Regulatory and Development Authority) is the country-level regulator for the Insurance industry (both Life Insurance Companies and Non-Life Insurance Companies) on behalf of the Indian Government, at Hyderabad.

IRDA was constituted through an act enacted in the Indian Parliament known as the IRDA Act 1999 and subsequently amended in 2002 to cover future needs, in addition to meeting some deficiencies of the entire insurance system.

The Insurance Regulatory & Development Authority is a development and regulatory government authority that protects the interests of the policyholders and administers, promotes, and ensures the orderly development of the insurance industry.

MISSION OF IRDA

• Toward the protection of the interests of the policyholders.
• Toward promoting, regulating, and ensuring orderly growth of the insurance industry and for matters incidental or connected therewith.
• Conducting insurance businesses in India ethically.

FUNCTIONS OF IRDA

Section 14 of the IRDA Act, 1999, lays down the functions, powers, and obligations of IRDA…

• Issue to the applicant a registration certificate, renew, modify, cancel, withdraw, suspend such registration.
• Interests of policyholders' protection in terms of assignment of policy, policyholders' nomination, insurable interest, payment of insurance claims, surrender value of policy, and other conditions and terms of contracts of insurance.
• Defining the necessary qualifications, code of conduct, and on-the-job training of the intermediary or insurance intermediaries and agents.

• Defining the code of conduct of the surveyors and loss assessors.

•Promoting efficiency in the conduct of insurance business. Promote and regulate professional associations connected with the insurance and reinsurance business

•Requiring information from inspecting, and holding inquiries and investigations, including an audit of the insurers, intermediaries, insurance intermediaries, and other associations associated with the insurance business.

• Control and regulation of the rates, benefits, terms, and conditions which may be offered by the insurers with regard to the general insurance business not so controlled and regulated by the Tariff Advisory Committee under section 64 of the Insurance Act, 1938. Fixing the manner and mode, books of accounts shall be maintained, and accounts statements shall be presented by the insurers and other insurance intermediaries.

Chapter 2 TYPES OF INSURANCE

- **Senior Citizen Health Insurance**

  Plans for senior citizen health insurance are intended to meet the medical requirements of those over 60.

  IPD, day care, pre- and post-hospitalization, yearly physicals, AYUSH coverage, domiciliary hospitalization, ambulance coverage, treatments, and other medical expenses are all covered in senior citizen health insurance.

- **Critical Illness Insurance**

  A critical illness insurance plan is a type of medical coverage that offers insured people financial support if they are admitted to the hospital for a critical illness, such as cancer, catastrophic burns, or coma, as specified by the policy of choice. This all-inclusive and simple-to-get plan is offered as both individual and family health insurance.

- **Travel Insurance**

  A financial buffer created especially to keep you safe while you travel for a variety of reasons is called travel insurance. In unheard-of circumstances like an unexpected hospital stay, losing possessions, or having your vacation interrupted, the plan might be helpful. Travel insurance covers your international travel in a similar way to other types of insurance.

- **Maternity Insurance**

  A maternity health insurance policy is a specific type of coverage that covers costs associated with pregnancy and delivery. Regular check-ups, ultrasound scans, doctor consultations, nursing costs, hospitalization charges for delivery (including caesarean or normal), newborn baby care (including vaccination costs), and congenital birth conditions are all covered under this policy.

2.2 DIFFERENT TEAMS ARE WORKING ON REIMBURSEMENT CLAIMS

Inwards

- Receives courier from the insured, which includes many different documents like discharge summary, investigation documents supporting the diagnosis, bills, ID proof, etc.,
- scanning and segregation of every document, including the courier cover page. Once this part is done, an inward number is generated.
- After segregation and scanning of documents, the next person cross-checks the documents.
- The documents are then stored securely.

DEO (DATA ENTRY OPERATOR):

- Checking of the documents after it is received from the inward team.
- Cross verification with the Genesis (It indicates the status of the policy holder).
- Tag the precise individual who is in the hospital.
- Verification with discharge summary and other documents.
- Providers tagging (Hospital details must be entered), Doctor details, Type of diagnosis (illness, injury, maternity), and room category type.
- Bank details of the primary member (in the event of reimbursement).

- From the last bill, the amounts are classified (room rent, pharmacy, consultation, investigation).
- After filling in all the details, the submission is completed, and a claim ID is created.

MEDICAL ADJUDICATION:

- Verifies the above documents.
- Check whether it's a new policy/a renewal policy/portability.
- The Medical Adjudication Team checks the medical segment (Diagnosis, investigation reports, and investigation).
- Check the tariff rates.
- Mention remarks on the same, which is mandatory to write.
- Lastly provides the approval/reject/query and sends it to the payment team.
- Lastly, the payment process is completed.

2.3 CARE HEALTH INSURANCE'S REIMBURSEMENT PROCEDURE

1. Notify the Insurance Provider: Whether during a hospital stay or an outpatient visit, the member is required to notify the insurance provider of any costs incurred. Initiating the reimbursement procedure requires a timely notice.

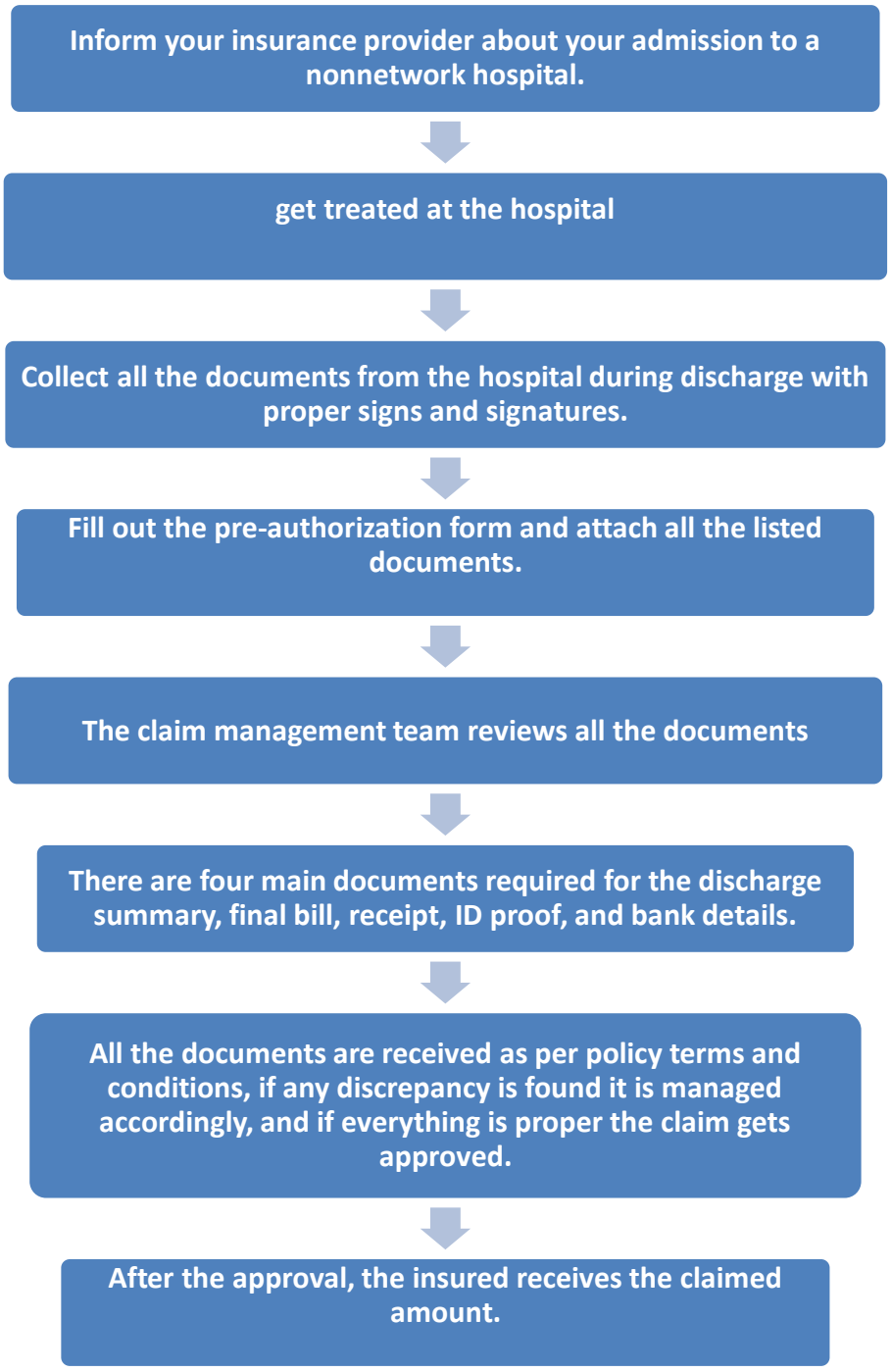
2. Submit the Necessary Documents: According to the guidelines given by the insurance provider, the member must submit all pertinent claim documentation. To prevent delays, proper documentation is essential. Along with a pre-auth form filled by the insurer

3. Verification and Processing of Claims: The insurance provider will examine the filed paperwork. The members will be contacted to supply any other information that may be required. After all the paperwork is in place, the claim will be processed.

4. Claim Decision and Payment: The insurer will decide based on the information provided. By the terms and circumstances of the policy, the member's account will receive reimbursement immediately upon approval of the claim.

2.4 REIMBURSMENT CLAIM PROCESS

Table 1.2 Flow chart of reimbursement process



2.5 TERMINOLOGIES

- **Claim** - A claim is a monetary advantage you get from your health cover plan under a medical emergency or hospitalization.
- **Claim Settlement** - Getting the claim amount is claim settlement. The insurance company usually has two modes of settlement of claims. The first is the reimbursement method, where you pay for the treatment and claim reimbursement of the cost later. The other is a cashless claims method, where the insurance firm directly pays your medical bill to the network hospital.
- **Co-payment** - A co-payment is a part of the claim sum which the policyholder has to pay from his/her own pockets, and the insurance company settles the remaining amount. Thus, the cost incurred on treatment is shared between the policyholder and the insurance company concerned. Policies with a co-payment provision show this liability as a percentage. Before choosing a co-payment plan, ensure you learn how much of a financial burden such a program leaves you with in the event of medical emergencies.
- **Daycare Procedures** - Daycare treatment is nothing but a procedure that involves hospital or clinical admission. But the admission never exceeds 24 hours and thus disqualifies it from regular healthcare coverage. Chemotherapy, dialysis, angiography, etc., are some of the day care procedures. Only health insurance schemes that cover daycare treatment compensate you for the amount paid for availing the same.
- **Network Hospitals** - Any nursing home or hospital that offers cashless treatment under your health insurance company is referred to as a network hospital. Getting treated at network hospitals is advantageous, as policyholders are entitled to use cashless claim facilities at the billing department of the hospital.
- **Non-network Hospitals** - Your insurance company does not work with all hospitals or clinics. Such ones that have no connection whatsoever with your insurance company are non-network hospitals. If you get treated at these hospitals, you cannot benefit from cashless claims. Rather, you will have to depend on reimbursement claim procedures.

- **Pre and Post-Hospitalization Coverage** - Your financial requirement is not over after staying in the hospital. In certain situations, patients begin piling up enormous medical expenditure even before hospitalization. If your insurance company reimburses you for medical expenses for as long as 30 days prior to admission to the hospital, it is referred to as pre-hospitalization. Likewise, if the insurance company pays for medical bills for as long as 60 days subsequent to hospital discharge, it is referred to as post-hospitalization coverage.
- **Reimbursement** - If you choose to get treated in non-network hospitals, you have to pay the entire medical bill from your pocket. Subsequently, you can submit a claim with your insurer to obtain reimbursement for the treatment.
- **Health Insurance -** A money-saving instrument called medical insurance or health insurance protects your funds in case of a medical emergency or a scheduled surgery. You can minimize the expense load of any medical crisis with the help of health insurance coverage. Under Section 80D of the Income Tax Act, you can save tax up to ₹25,000 on the premium.

CHAPTER 3 - REVIEW OF LITERATURE

S.NO	TOPIC (YEAR)	AUTHOR	SUMMARY
1.	Leveraging Blockchain for Secure and Transparent Insurance Claim Processing (2022)	Shravan Kumar Joginipalli	• The paper discusses the possibility of blockchain's distributed and unalterable ledger and smart contracts in automating claim approvals, minimizing fraud, and fostering trust among insurers, policyholders, and regulators. • It offers an in-depth overview of blockchain use in insurance claims with an emphasis on the advantages of preventing fraud, efficient processes, and practical implementations. • It also offers a conceptual model for the integration of smart contracts in claims processing to facilitate automation and dispute resolution. Regulatory compliance, scalability, and integration with systems are addressed as challenges that call for more development and collaboration in the industry to gain widespread implementation. • Overall, blockchain is seen as a promising technology to transform insurance claim management to be more secure, transparent, and efficient.

2.	Health Insurance in India – Opportunities and Challenges (2017)	Binny, Dr Meenu Gupta	• The paper discusses the existing health insurance landscape in India, the growth drivers, and the prevalent impediments. The industry has expanded quite quickly on the back of increasing healthcare expenditure, awareness, rising incomes, and favorable government policies like RSBY, AABY, and UHIS. Insurance market liberalization enabled private and international operators to participate, encouraging competition, innovation, and enhanced delivery of services. • Tax relief in terms of Section 80D of the Income Tax Act and technological progress in digital technology have also supported expansion. The industry, nevertheless, is confronted by various challenges such as low penetration of insurance in rural regions owing to insufficient awareness and trust. Other concerns are inflated claim ratios, increasing cost of treatment, intricate policy designs, and regulatory barriers. • Mismatch between policyholder expectations and coverage under the policy, fraudulent claims, and infrastructure constraints add to the complexity. • The authors emphasize simple, transparent, and customer-friendly products, increased public awareness, regulatory initiatives, and public-private partnerships to enhance coverage and efficiency. With strategic changes and emphasis on inclusivity, India's health insurance sector has the potential to contribute considerable strength to the vision of universal health coverage.
3.	Claim Settlement: The Moment of Truth in Health Insurance (2019)	Amarendra Ku. Pattnaik, Satya Narayan Misra, Sanjaya Kumar Ghadai	• The paper highlights that the process of claim settlement is a turning point for health insurance in which the trust and satisfaction of the customer are essentially established. It is necessary to have a customer-friendly claim settlement system to minimize the fears patients experience in the event of health emergencies. • The process determines whether the insurance company delivers on its promise of timely and equitable financial help made while selling the policy when the policyholder makes a claim. Good claim settlement not only increases customer confidence and loyalty but also improves the reputation and market standing of the insurer. • The system must focus on transparency, efficiency, understanding, and open communication to make the experience of the insured at the time of vulnerability a good one. Generally, the claim settlement process is presented as the actual "moment of truth" of health insurance, where theoretical guarantees become real support and relief for policyholders.

4.	Health insurance sector in India: an analysis of its performanc e (2020)	Madan Mohan Dutta	• The article examines the underwriting profit or loss of the health insurance industry in India. The industry, even as premium earnings showed appreciable growth in the past years, persists in making underwriting losses, mainly because of the increasing claims, commissions, and administration expenses, which exceed premium income. • Based on regression analysis, the research observes a significant and counterintuitive negative correlation between premium expansion and underwriting profit, meaning that premium growth results in mounting losses and not profits. • The industry requires improved management of expenses and claims, product development, and regulation to move into profitability, particularly in the new post-liberalization environment and the COVID-19 pandemic challenges.
5.	Fraud: A Problem Troubling the Insurance Industry (2016)	**Suryakant P. Parwat Aslesha Parwat-Mukadam Dr. Pramod Deo**	• It is a study of the rising phenomenon of insurance fraud in India's health insurance market. It discusses how fraudulent claims raise insurers' expenses and result in policyholders' increased pr emiums. The research classifies different kinds of insurance frauds, recognizes the participants involved—such as applicants, policyholders, third-party claimants, and professionals— and outlines the triggers that can lead to suspicious conduct. • It underscores the implementation of holistic risk management practices, such as fraud risk assessment and prevention, to counteract the negative impacts of fraud on insurers as well as legitimate customers. The article also includes advice for insureds and insurers to identify and avoid fraudulent activities.

AIM:

Identify the various stages and components involved in the lifecycle of a health insurance claim, from submission to outcome (approval, rejection, partial approval) at Care Health Insurance, Gurgaon.

- **RESEARCH QUESTION**

- What are the most frequent decision outcomes in the medical insurance claims process at Care Health Insurance Ltd.?
- Does the type of treatment (medical and surgical) influence the approval of insurance claims?

- **OBJECTIVES:**

- To examine the frequency and pattern of various decision results (Approve, Query, Non-register, Investigation, Query, Reject) to identify the prevailing trend in claim processing.
- To assess the impact of geographic location on healthcare service utilization and claim approval rates, and to determine if regional factors contribute to it.

CHAPTER 4 -METHODOLOGY

Study Design: A cross-sectional study design was used in this research.

Setting: The study took place in the working environment of Care Health Insurance Limited, Gurgaon. This setting allowed access to the related claim processing records.

Study Population: The study population includes 200 policyholders who filed reimbursement claims to Care Health Insurance Limited. The analysis specifically covered the cases that were delegated to me.

Inclusion Criteria: Policyholders who claimed reimbursement at Care Health Insurance Limited were studied. The emphasis was particularly on the cases delegated to the rest of India zone for processing from April–May 2025.

Exclusion Criteria: Those claims that had been labeled as fraudulent were excluded from the study to ensure data integrity. Claims that were already involved in legal disputes were also excluded to eliminate possible biases and complexities.

Study Tools: Care Health Insurance Limited's existing claim processing records were the main data collection and analysis sources. Microsoft Excel was used as the major software tool for the organization, cleaning, and initial analysis of data. Followed by SPSS for other analysis.

Duration of Study: The research was undertaken over a period of two months, that is, the month of April 2025 through May 2025. This period provided for an orderly collection and preliminary handling of the chosen data.

Sample Size: A sample of 200 reimbursement claim cases was chosen for this research.

Sampling Technique: Convenience sampling was utilized as a sampling method. Cases were shortlisted based on their availability and the availability of associated complete data, so that only feasible records were taken into consideration for analysis.

Data Collection Procedure: Data was collected systematically from the original claim processing records as kept by Care Health Insurance Limited. This method ensured that original and related information about reimbursement claims was pulled out for study while maintaining confidentiality.

CHAPTER 5 – RESULTS

1. DECISION DISTRIBUTION

A higher number of cases were approved, totalling 67. Following this, there were 54 queries, 44 nonregistered, and 28 cases involving a combination of investigation and query. A smaller number of cases were rejected (6), typically before query and investigation responses were received. The high number of settled or pending claims, awaiting further information, indicates a flexible, information-driven assessment strategy. In addition to this, claims for surgical treatments are approved more frequently than medical treatment claims. According to a regression analysis, surgical claims had a higher odds ratio (1.8, P = 0.02).

2. TREATMENT TYPE BY ZONE

The East zone shows the highest healthcare service utilization, encompassing medical and surgical treatments. Claims originating from the east zone have a higher approval rate than others. A chi-square test was used to compare approval rates across zones, which shows approval rates did not differ by zone ($p > 0.05$).

Approval distribution east (34%), north (32%), south (33%), west (31%)

3. DIFFERENT DISEASES:

The bar chart entitled "Different Diseases" shows the occurrence of different diseases in a population surveyed. The most common condition is cataract, with 20 cases, followed by fracture (16), gastritis (15), and acute febrile illness (14). Typhoid and fever each have 11 cases, and urinary tract infection (UTI) is reported 10 times. The less frequent diseases are abscess (5 cases), calculus (6 cases), and the following conditions: bronchitis, COPD, and cancer (each 4 cases). Hypertension, backache, and CVA are each mentioned 3 times. There are several other diseases, like hepatitis, diabetes mellitus, and pneumonia, with only 2 cases and 1 case. This distribution highlights that cataract and fracture are the most reported diseases in this dataset, while a wide range of other conditions appear less frequently

4. TURNAROUND TIME BY DECISION (TATs)

The longest turnaround times (TATs) are observed in cases involving “investigation” or “investigation/Query.” Approved and non-registered cases generally have shorter TATs. Delays are often associated with decisions or the need for additional information; streamlining these processes could reduce waiting times.

5. FREQUENCY OF AGE DISTRIBUTION

The bar graph titled "Frequency of Patient Age" displays the distribution of patients across various age groups. The highest patient concentration is seen in the 31–40 age group (39 patients), followed closely by 61–70 (33 patients) and both 41–50 and 51–60 age groups (32 patients each). Interestingly, the 0–10 age group also accounts for a notable number of patients (31), reflecting a significant presence of pediatric cases.

Conversely, the 11–20, 21–30, 71–80, and particularly 81–90 age groups have comparatively lower frequencies, with only 2 patients in the 81–90 group.

The pattern indicates middle-aged and older adults as many health insurance claims, with very young and very old patients appearing less often

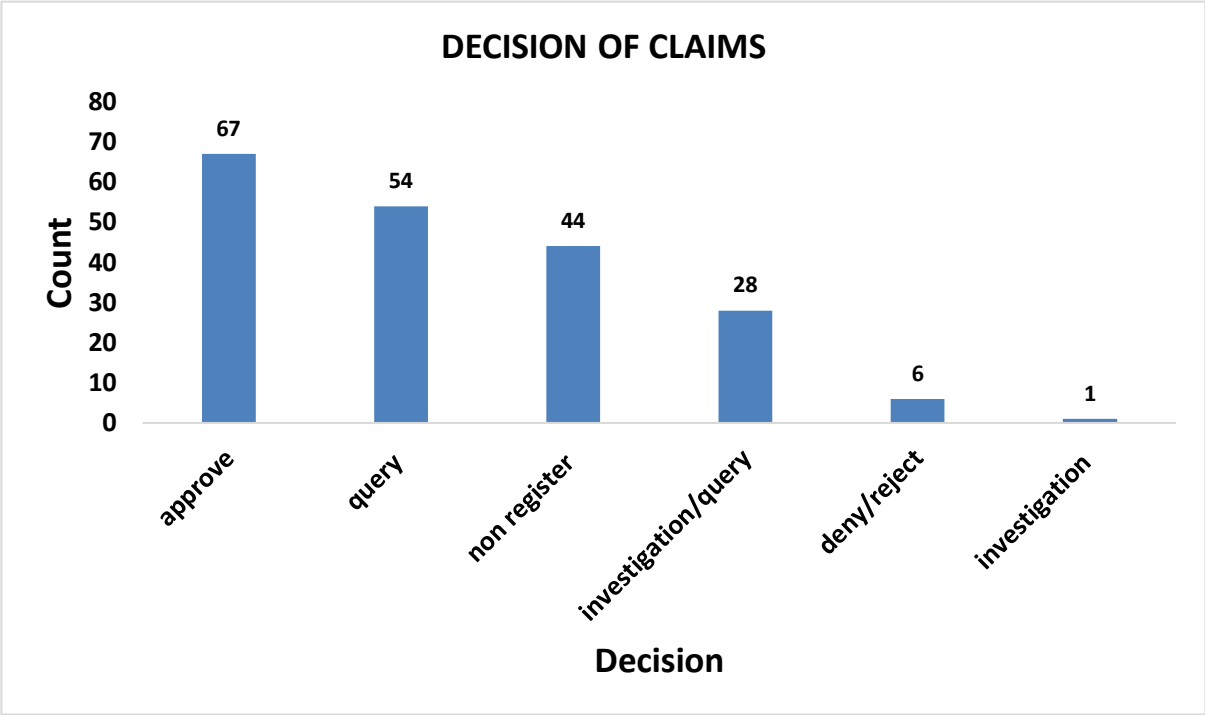


FIGURE 1.2 Decision of Claims

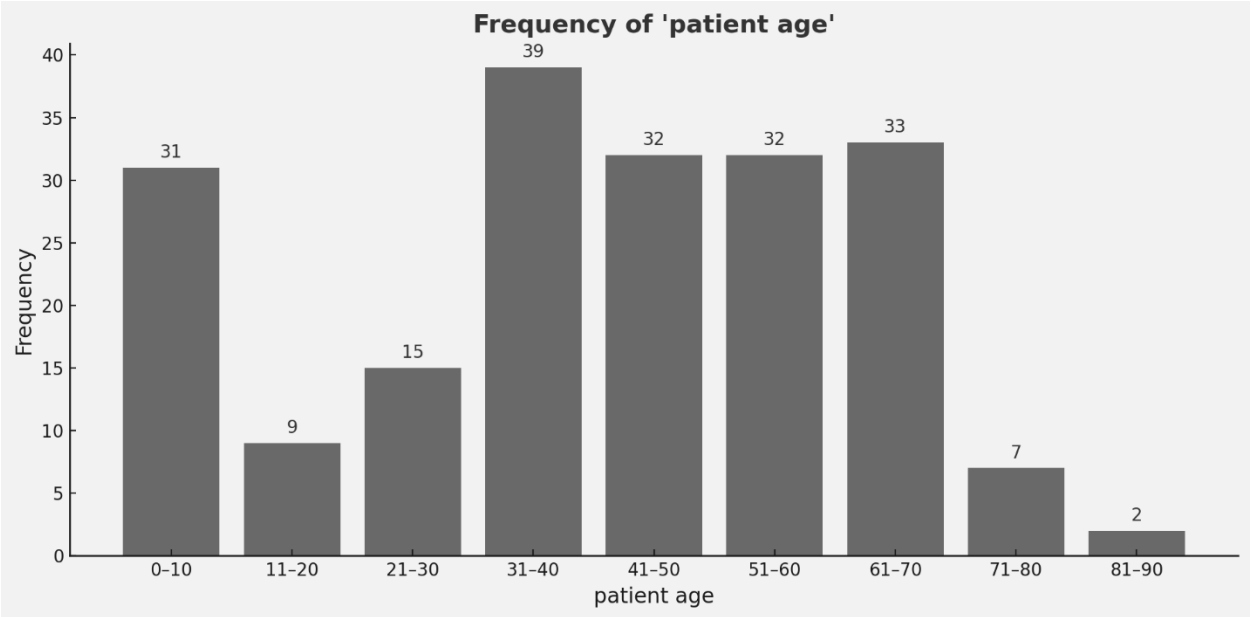


FIGURE 1.3 Age-Wise Distribution of Patients

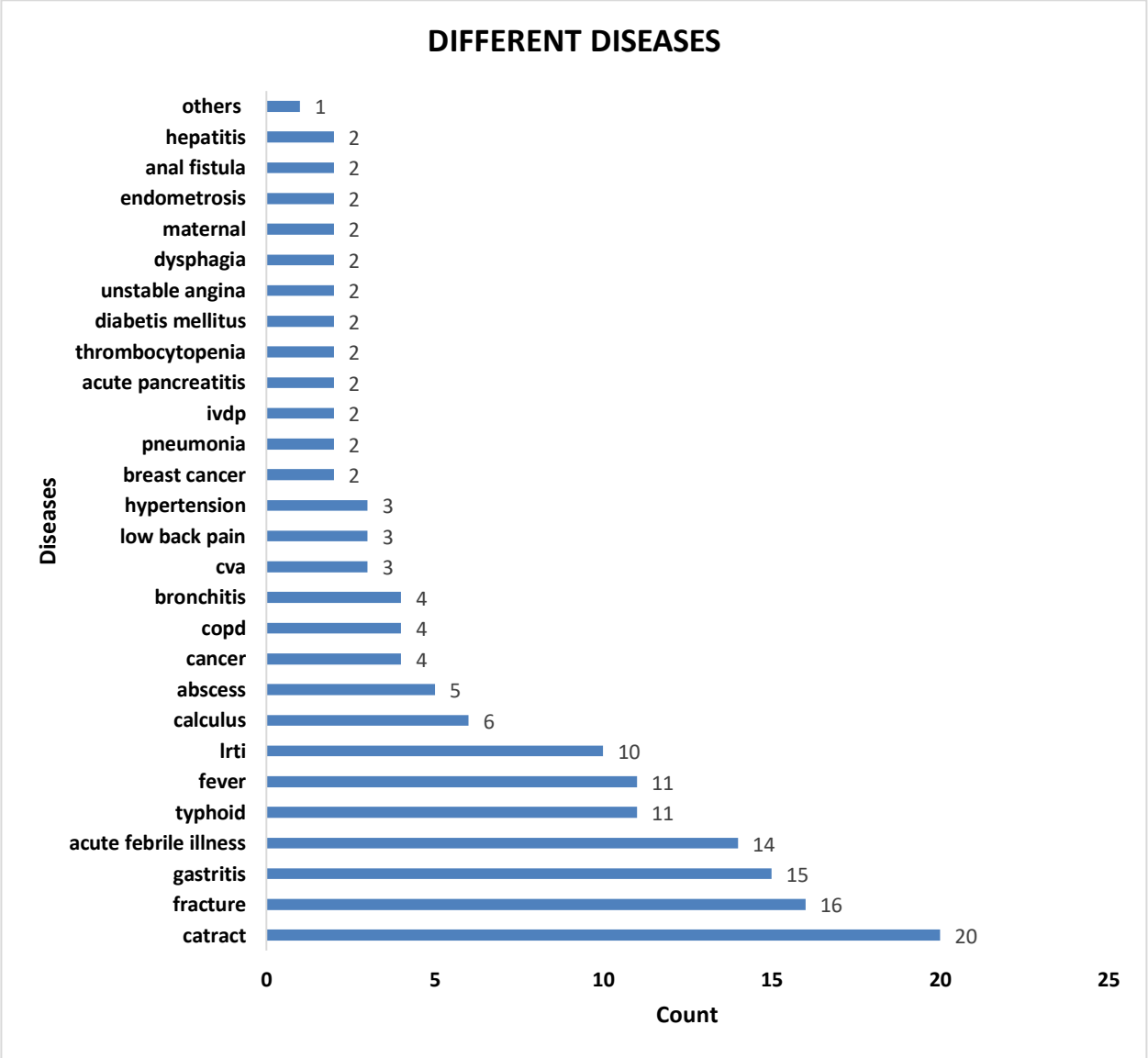


FIGURE 1.4 Distribution of Reported Diseases

Others include diseases such as carpal tunnel syndrome, CSF leak, lumbar puncture, radiotherapy, ganglion, ectopic pregnancy, adenoids, pterygium, etc.

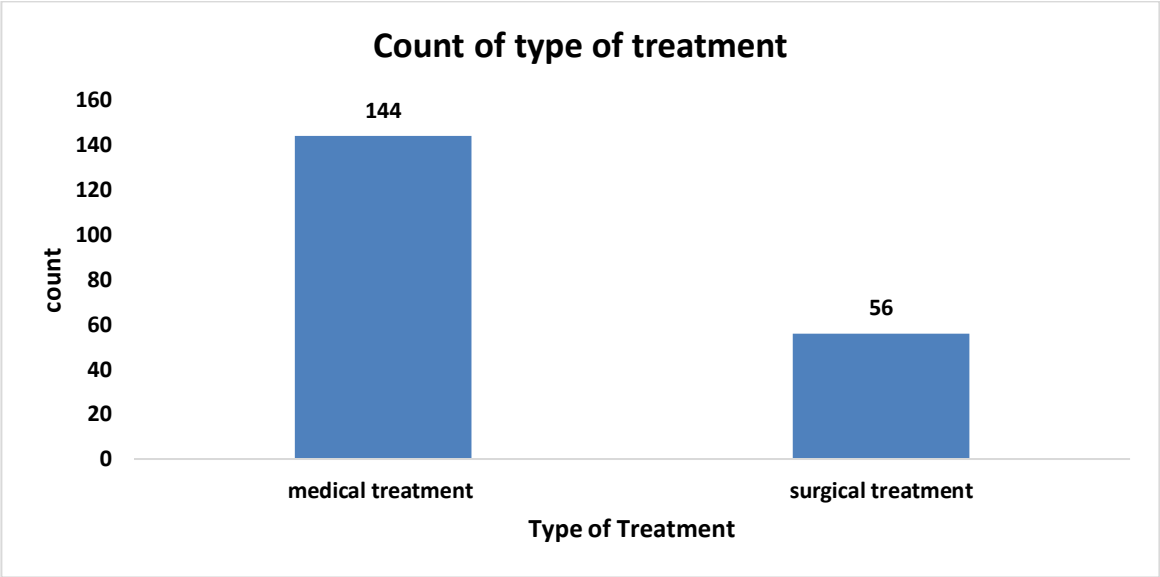


FIGURE 1.5 Distribution of Treatment Type

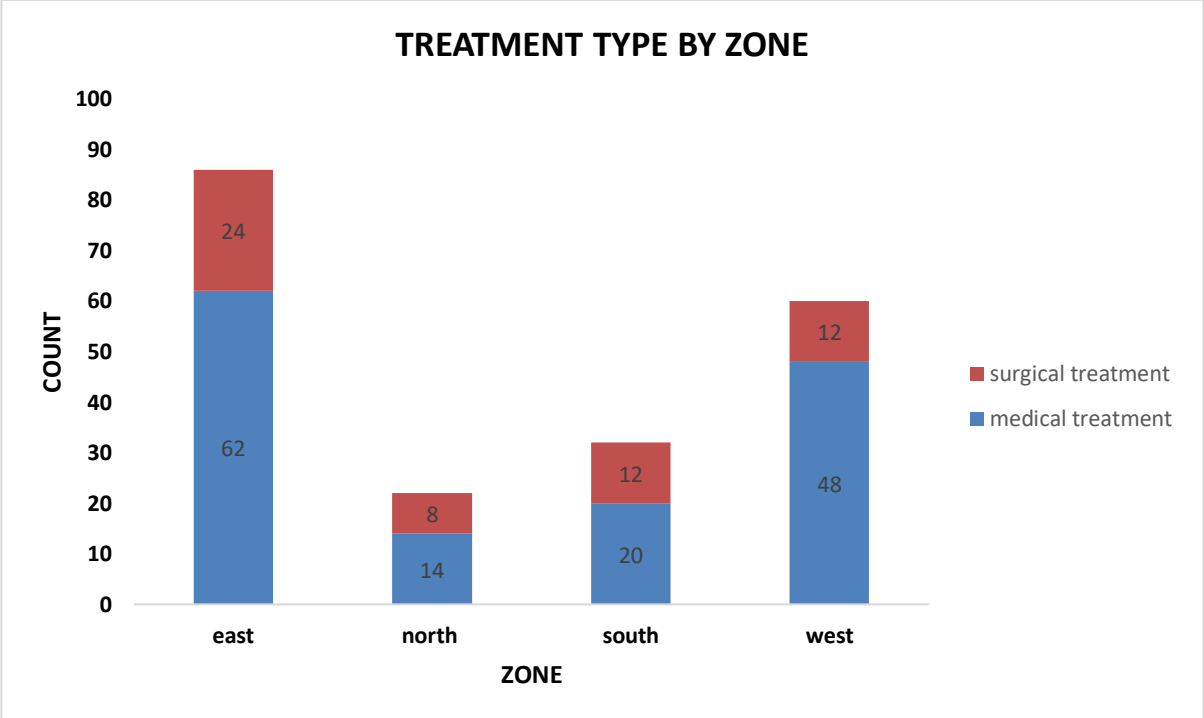


FIGURE 1.6 Surgical vs Medical Treatment by Zones

CHAPTER 6 – CONCLUSION

The findings of this study offer useful perspectives into patterns and processes influencing the outcomes of health insurance claims in the population studied. The data show that most claims are granted, highlighting an overall accommodative and encouraging assessment policy that focuses more on information collection than denial. Interestingly, surgical interventions are approved at a greater rate than medical interventions or treatments, which can either indicate the perceived urgency or the definitive nature of surgical interventions within the claims evaluation process. This is supported by the regression analysis, which discovered that surgical claims have a considerably higher odds ratio for approval. Such results indicate that the existing system might be better suited to simple, procedure-based cases, perhaps at the cost of more complicated medical cases.

Geographically, the East zone appears to be the one with the highest use of healthcare services and a modestly higher approval rate than in other zones. Yet, chi-square analysis discloses no statistically significant variance in approval rates between zones, and thus, regional influences do not necessarily control the outcome of claims. This consistency is an encouraging signal for procedural fairness and standardization, as it implies that the application of assessment criteria is equal across geographic regions. However, the increased service utilization in the East zone may be an area for further study to clarify underlying demographic or administrative reasons.

The prevalence of diseases among claimants further accentuates the predominance of cataract and fracture cases combined, which represent a high percentage of reported conditions. This trend could represent the aging population as well as the incidence of trauma-related events, both of which are typical inducers of health insurance claims. The broad spectrum of other diseases, while less prevalent, highlights the range of health requirements in the population.

This variability is both a problem and an opportunity for insurers to tailor better their coverage policies so that all the conditions are adequately addressed.

Turnaround times for the determination of claims are significantly longer for instances involving investigation or further queries. While registered and approved cases are handled more rapidly, information request delays indicate opportunities for process improvement. Simplifying communication and documentation requirements may reduce waiting times, which would enhance customer satisfaction and operational effectiveness. Resolution of these bottlenecks would not only speed up claim resolution but also make the overall experience for policyholders better.

Overall, this research identifies several important trends and areas for improvement within the health insurance claim assessment process. While it is positive that the approval rates are high and treatment is consistent by zone, there is room to further optimize the system, especially in processing complex medical claims and keeping investigation turnaround times lower. Through such understandings, insurers can create a more responsive, fair, and effective claims management system, ultimately benefiting both the organization and its policyholders.

DISCUSSION

The results of the data analysis and literature review identify several interrelated themes in India's health insurance claim processing. Research points to the value of a clear and customer-oriented claims process as the "moment of truth" for customers, which is evident in the fact that most of the claims are approved or queried in the data, suggesting a soft, information-based evaluation strategy. Yet, the higher TAT for investigation claims indicates inefficiency in concert with literature concerns regarding delays impacting customer trust and operational costs. Blockchain technology and smart contracts, as envisioned by Joginipalli (2022), pose a viable solution to automate verification, minimize fraud, and simplify approvals. The findings also reflect a preponderance of older patients among surgical and chronic disease claims, justifying the demand of literature for simplified, senior-oriented insurance products. Treatment utilization of regional differences, particularly increased activity in the East zone, suggests awareness campaigns and policy interventions aimed at specific regions. Additionally, strong claim volumes and ensuing administrative costs validate Dutta's (2020) finding of weak underwriting profitability and reaffirm the importance of embracing technology adoption and efficient cost-cutting strategies. Collectively, these findings imply that for trustworthiness, efficiency, and financial viability, India's health insurance industry needs to adopt innovation, customer-focused design, and regulations.

One of the key concerns is the effect of health insurance portability, as required by the Insurance Regulatory and Development Authority of India (IRDAI). Portability guarantees benefits like waiting period credits continuity, which may influence claim volumes and claim complexity for reimbursement. Because policyholders can migrate policies between insurers, being aware of how claim handling systems accommodate migrated data and claim histories is important. The results of the study could emphasize whether portability imposes processing difficulties or influences the timelines of claim approvals.

Another important point of discussion is the issue of fraud, although fraudulent claims were specifically left out of this study to maintain data integrity, the existence of strict fraud detection processes might bear an underlying impact on genuine claim procedures. For example, over-cautious examination or risk-averse conduct by claim processors can impact turnaround time or customer satisfaction.

Lastly, SAHIs have been observed with their fast growth, owing to customer-centric product innovation and comparatively lower claim ratios. Reimbursement data that have been covered in this study can provide insights about the effect of such innovations on claim approval trends and reimbursement behavior. If reimbursement claim success rates and durations are good, they can support the competitive advantage SAHIs have earned in recent years.

In addition, the research location in an actual insurance work setting and emphasis on reimbursement claims from all over India offer opportunities to examine regional differences in claim trends and processing procedures. It also offers an opportunity to investigate operational efficiencies and shortcomings in existing reimbursement processes.

REFERENCES

1. https://carecloud.com/continuum/how-healthcare-reimbursement-works/

2. Joginipalli S. Leveraging Blockchain for Secure and Transparent Insurance Claim Processing. Journal of Computational [Internet]. 2022 Dec 13 [cited 2025 May 20] https://www.researchgate.net/profile/S-Kumar-Kumar-2/publication/388799092_Leveraging_Blockchain_for_Secure_and_Transparent_Insurance_Claim_Processing/links/67a6625c4c479b26c9d9bb7d/Leveraging-Blockchain-for-Secure-and-Transparent-Insurance-Claim-Processing.pdf

3. Dutta MM. Health insurance sector in India: an analysis of its performance. Vilakshan - XIMB J Manage [Internet]. 2020 May 18;17(1/2):97–109. https://www.emerald.com/insight/content/doi/10.1108/xjm-07-2020-0021/full/htm

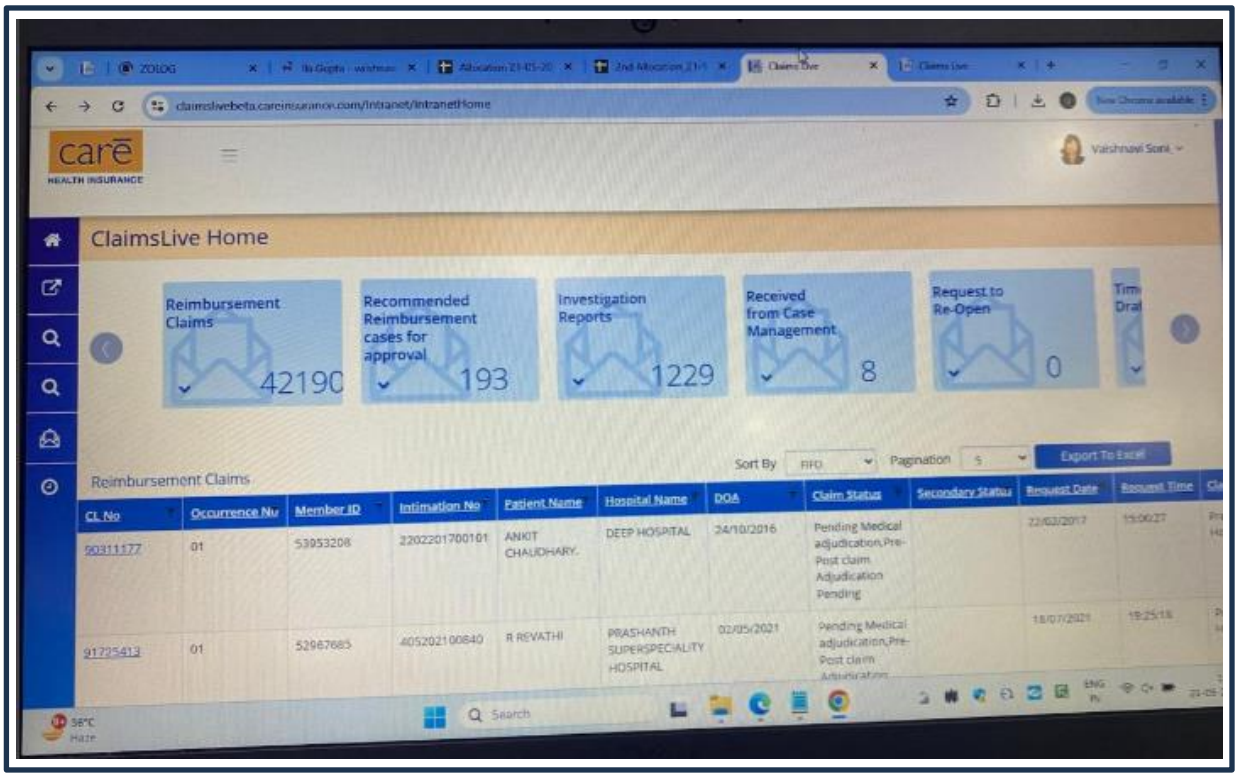
4. Binny, Gupta M. Health Insurance in India – Opportunities and Challenges. Int J Latest Technol Eng Manag Appl Sci. 2017 Aug;6(8):36. https://d1wqtxts1xzle7.cloudfront.net/54636640/36-43-libre.pdf?1507260679=&response-content-disposition=inline%3B+filename%3DHealth_Insurance_in_India_Opportunities.pdf&Expires=1747243385&Signature=fJ086EE2sPfA-XRnu0CVjJnPFF-cr9Wnxr~XQcShJOfSipmMRECaet0lQy6cWwR2ZxvcAe6VrYcfl8B9XunEuNmAJyO0UJ4Ow8Fd953Fb~g7nxEsHW277CX3b0wKcouKhtQjQMJr205Y0-njlZMbtgLcmAnOdS7lZYjC~9lKa9C860qtvyJLH2-1HS0hMxjzbs9w1tbK1YwNOlQBWKauTWunXuW40T~xrgq6aXtLyoEg~jFlZn7FehagZJDkFnxG8THtEpJtOTP7GEEw4Za6O2~IzrRRRy3T~dwcuguZMYm5cZ0hlCTrmoGOzu4gnAdu8rUD0iBgThtMB0qTXxawMg__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA

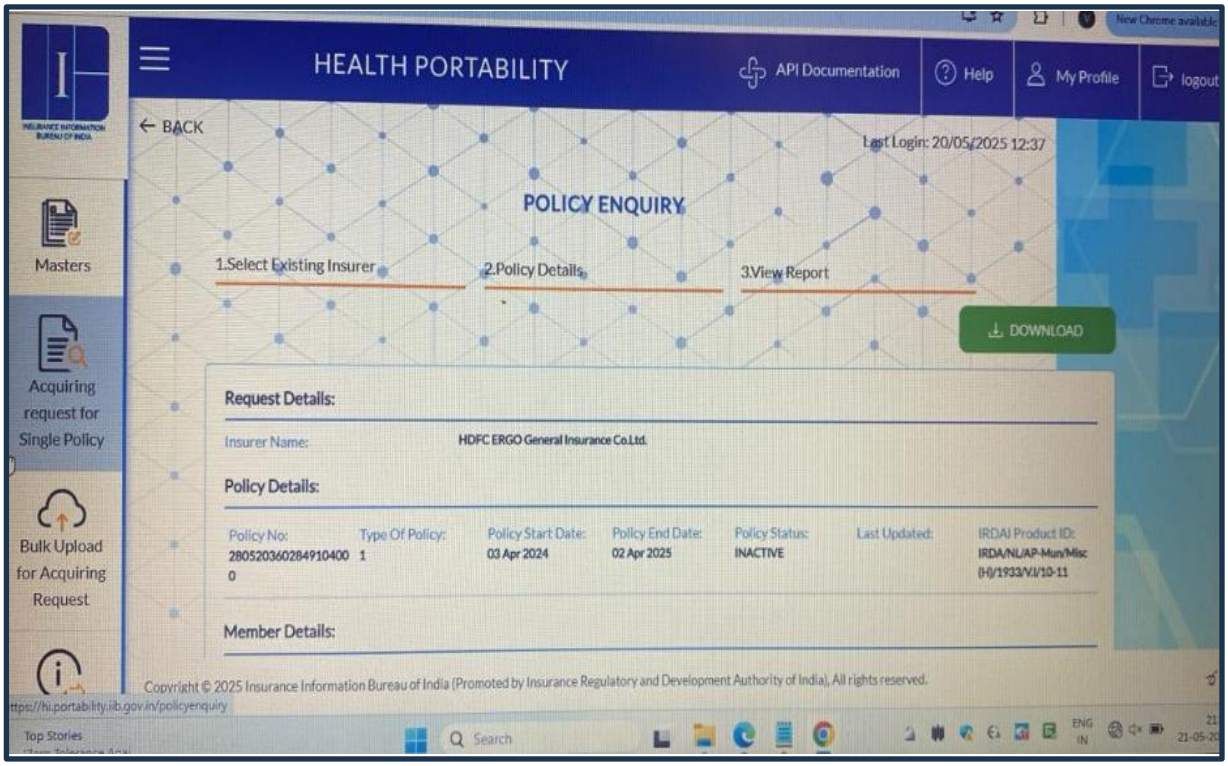
5. Ghadai S. Claim Settlement: The Moment of Truth in Health Insurance [Internet]. 2019 [cited 2025 May 20]. https://www.researchgate.net/profile/Sanjaya-Ghadai/publication/337905601_Claim_Settlement_The_Moment_of_Truth_in_Health_Insurance/links/5df1e6fd4585159aa4767382/Claim-Settlement-The-Moment-of-Truth-in-Health-Insurance.pdf

6.https://policyholder.gov.in/portability-of-health-insurance

7. Parwat SP, Parwat-Mukadam A, Deo P. Fraud: A problem troubling the insurance industry. *Indian J Appl Res.* 2016 Jul;6(7):592–3. Available from: https://www.worldwidejournals.com/indian-journal-of-applied-research-(IJAR)/recent_issues_pdf/2016/July/July_2016_1468996886__187.pdf

8. **Kumar S, Singh H.** A growth analysis of standalone health insurance companies. *Journal of Xi'an University of Architecture & Technology*. 2020;12(6):8575–86. Available from: https://d1wqtxts1xzle7.cloudfront.net/63631103/8575.pdf20200615-46208-1a3rxvu-libre.pdf




HEALTH PORTABILITY
API Documentation
Help
My Profile
logout
BACK
Last Login: 20/05/2025 12:37
POLICY ENQUIRY
1.Select Existing Insurer
2.Policy Details
3.View Report
DOWNLOAD
Masters
Acquiring request for Single Policy
Bulk Upload for Acquiring Request
Request Details:
Insurer Name:
HDFC ERGO General Insurance Co.Ltd.
Policy Details:
Policy No:
280520360284910400 0
Type Of Policy:
1
Policy Start Date:
03 Apr 2024
Policy End Date:
02 Apr 2025
Policy Status:
INACTIVE
Last Updated:
IRDAI Product ID:
IRDA/NL/AP-Mun/Misc (H)/1933/V1/10-11
Member Details:
Copyright © 2025 Insurance Information Bureau of India (Promoted by Insurance Regulatory and Development Authority of India), All rights reserved.
https://hi.portability.iib.gov.in/policyenquiry
Top Stories
Search