A Cross-Sectional Study to Understand the Outcome of Health Insurance Claims At Care Health Insurance, Gurgaon

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TABLE OF CONTENTS

ABSTRACT

INTRODUCTION

TYPES OF INSURANCE

RESEARCH QUESTION

OBJECTIVES

REVIEW OF LITERATURE

METHODOLOGY

RESULTS

CONCLUSION

REFERENCES

ABSTRACT

INTRODUCTION: Health insurance has a key role to play in offering protection against financial costs incurred due to medical treatment. Proper management of claims, especially timely and equitable reimbursement, is imperative to ensure trust and satisfaction among policyholders.

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.

METHODOLOGY: 200 reimbursement claim cases processed at CHIL between April and May 2025. Data processed using EXCEL and SPSS (Chi Square Test)

RESULTS: Many of the claims were approved, with surgical treatments showing significantly higher approval odds (OR = 1.8, $p = 0.02$). The East zone had the highest utilization and approval, though zone-wise differences were not significant ($p > 0.05$). Most cases involved middle-aged and pediatric patients, with cataract and fracture being the most common conditions.

KEY WORDS: Standalone Health Insurance (SAHIS), Indian regulatory and development Authority of India (IRDA), Turnaround time (TAT), Data entry operator (DEO).

INTRODUCTION

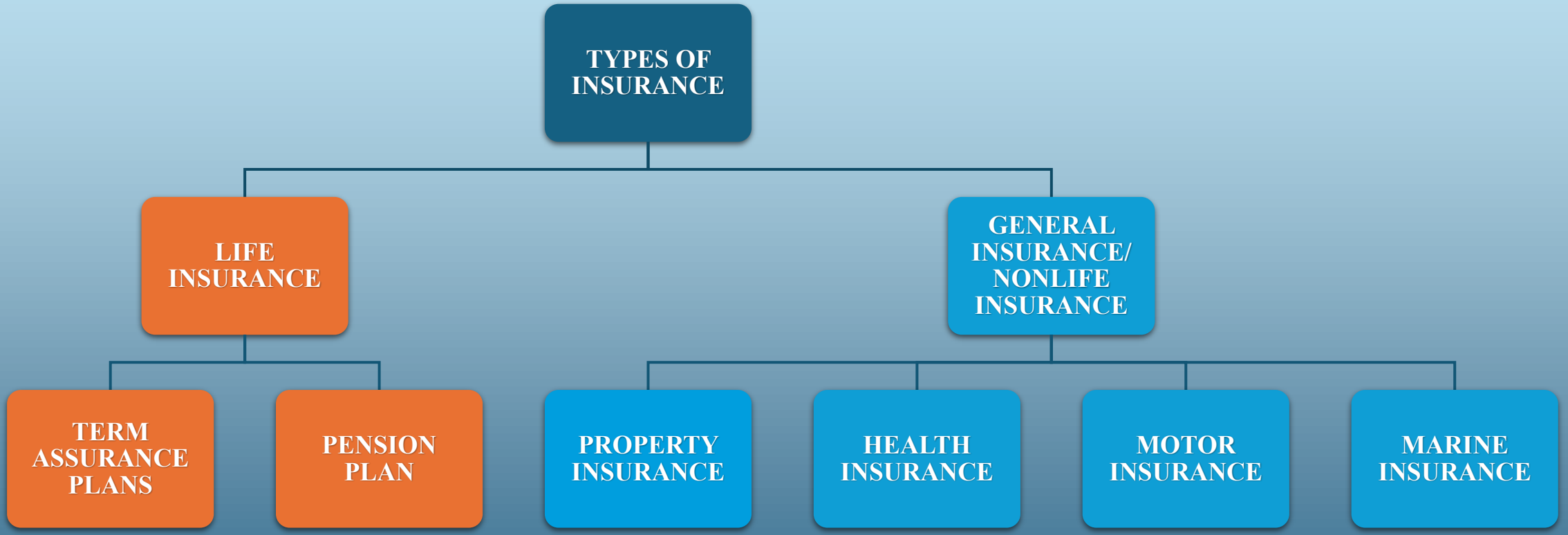
Insurance is a type of financial loss protection in which one party agrees to pay another party in the event of a specific loss, damage, or injury in return for a fee. It is a type of risk management mainly employed to guard against the possibility of an unforeseen or contingent loss**.**

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.

BENEFITS OF INSURANCE TO SOCIETY: Insurance provides social and economic benefits

- ❑ prevents loss
- ❑ reduction of worries and fear
- ❑ employment opportunities
- ❑ Development of the social sector
- ❑ Protects society’s wealth

TYPES OF INSURANCE



In addition to these, there are many other life and general insurance types.

THE PROCESS OF INSURANCE

UNDERWRITING

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.

REVIEW OF LITERATURE

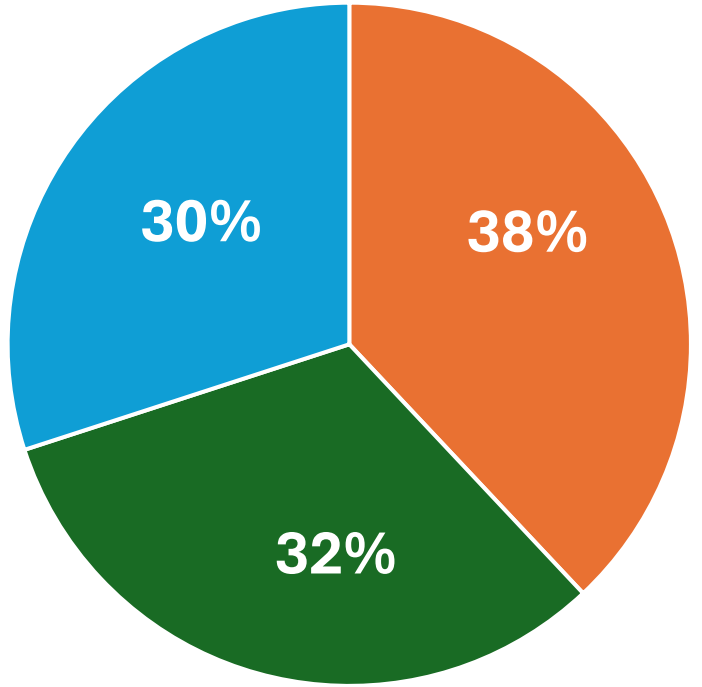
S.NO	TOPIC (YEAR)	AUTHOR	SUMMARY
1.	Leveraging Blockchain for Secure and Transparent Insurance Claim Processing (2022)	Shravan Kumar Joginipalli	• The paper discusses the possibility of blockchain's distributed and unalterable ledger and smart contracts in automating claim approvals, minimizing fraud, and fostering trust among insurers, policyholders, and regulators.
2.	Health Insurance in India – Opportunities and Challenges (2017)	Binny, Dr Meenu Gupta	• 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

4.	Health insurance sector in India: an analysis of its performance (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.
5.	Fraud: A Problem Troubling the Insurance Industry (2016)	Suryakant P. Parwat Aslesha Parwat-Mukadam Dr. Pramod Deo	• 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.

Market Share of Health Insurance Providers

- **MAJOR PLAYERS IN THE HEALTH INSURANCE INDUSTRY**
- Insurance players can be mainly divided into 3 types:
- **PUBLIC SECTOR PROVIDERS (I.E., GOVERNMENT):** Major public sector providers are Oriental Insurance, New India Assurance (NIA), United India Insurance, ETC.
- **PRIVATE SECTOR PROVIDERS:** Private sector health care insurance providers are ICICI Lombard, HDFC ERGO, TATA AIG, Reliance General Insurance, etc. **(4)**
- **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)**

MARKET SHARE OF HEALTH INSURANCE PROVIDERS



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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 insurance company and the hospital 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).

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.

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 filing different original documents.
- It can take weeks for the insurer to approve and settle the claim.
- Chances of rejection are high because of errors or a lack of documents by common man due to lack of knowledge.

DIFFERENT TEAMS ARE WORKING ON REIMBURSEMENT CLAIMS

INWARDS

- Receives courier from the insured, including many documents like discharge summary, investigation documents supporting the diagnosis, bills, ID proof, etc.,
- Scanning and segregation of every document. 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):

- ❑ Check the documents after they are received from the inward team.
- ❑ Cross-verification with policy (which indicates the status of the policyholder).
- ❑ Tag the precise individual who is in the hospital.
- ❑ Verification with discharge summary and other documents.
- ❑ Providers tagging (Hospital details must be entered), type of hospitalization, Type of diagnosis (illness, injury, maternity), and room category type.
- ❑ Bank details of the primary member (in the event of reimbursement).
- ❑ From the final bill, the amounts are classified (room rent, pharmacy, consultation, investigation).

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 internal 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.

REIMBURSMENT CLAIM PROCESS

Inform your insurance provider about your admission to a nonnetwork hospital.

get treated at the hospital

Collect all the documents from the hospital during discharge with proper signs and signatures.

Fill out the pre-authorization form and attach all the listed documents.

The claims processing team reviews all the documents

There are four main documents required for the discharge summary, final bill, payment receipt, ID proof, and bank details.

All the documents are processed as per policy terms and conditions, if any discrepancy is found it is managed accordingly, and if everything is proper the claim gets approved.

After the approval, the insured receives the claimed amount.

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.

HYPOTHESES

HYPOTHESIS 1: Association Between Treatment Type and Claim Approval

- **Null Hypothesis (H_0):**
- There is no difference in health insurance claim approval rates for medical and surgical treatments at Care Health Insurance, Gurgaon.
- **Alternative Hypothesis (H_1):**
- There exists a difference in health insurance claim approval rates for medical and surgical treatments at Care Health Insurance, Gurgaon.

Hypothesis 2: 2. TREATMENT TYPE BY ZONE

- **Null Hypothesis (H_0):**
- There is no association between the zone (East, North, South, West) and the approval rate of health insurance claims.
- **Alternative Hypothesis (H_1):**
- There is an association between the zone (East, North, South, West) and the approval rate of health insurance claims.

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 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. And those 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.

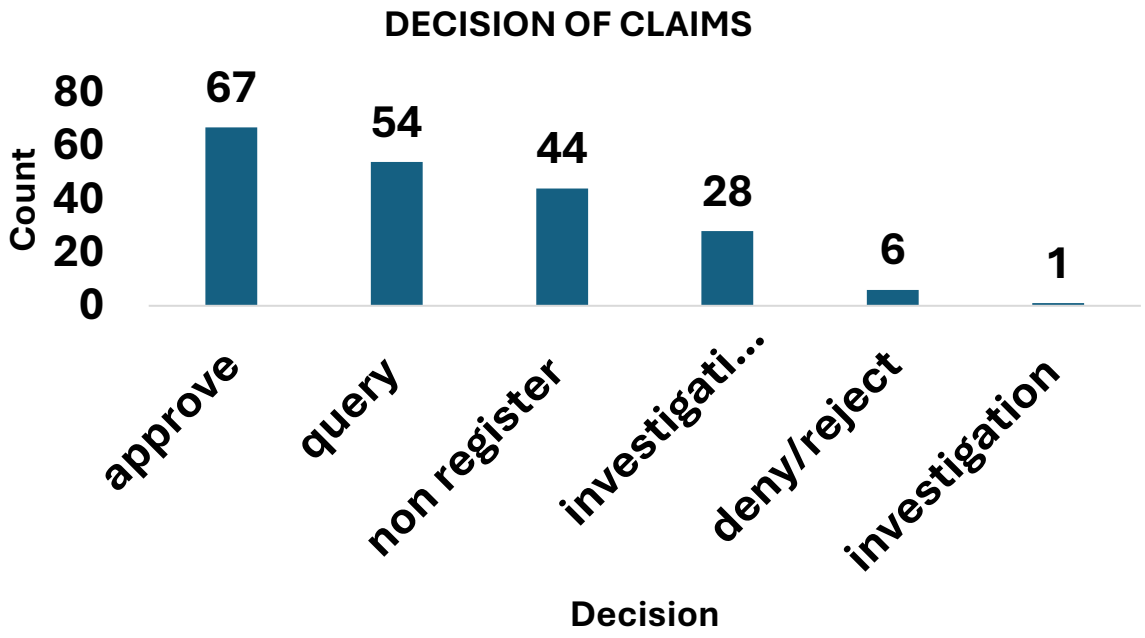
Duration of Study: The research was undertaken over a period of two months, that is, the month of April 2025 through May 2025.

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.

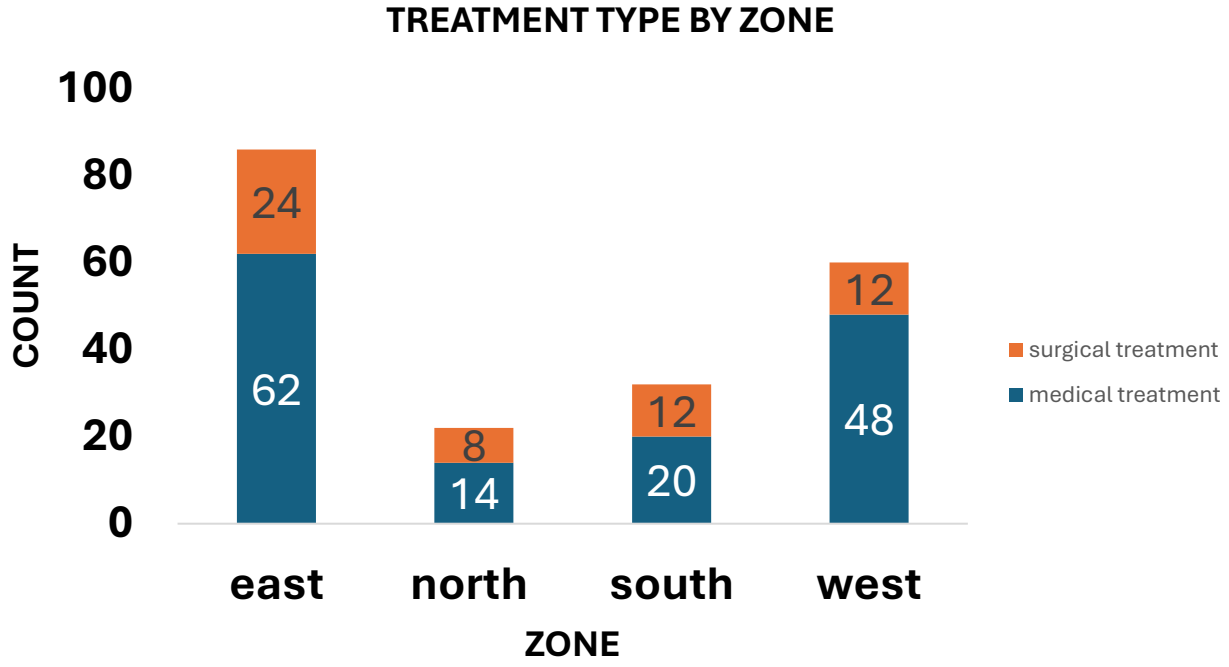
1. DECISION DISTRIBUTION

- ❑ The higher number of claims approved: 67 cases
- ❑ Followed by: Queries (54), Non-registered (44), Investigation + Query (28)
- ❑ Rejected claims were few (6), mostly before responses were received
- ❑ Indicates an information-driven, flexible assessment strategy
- ❑ Surgical claims are more likely to be approved than medical claims (OR = 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%)

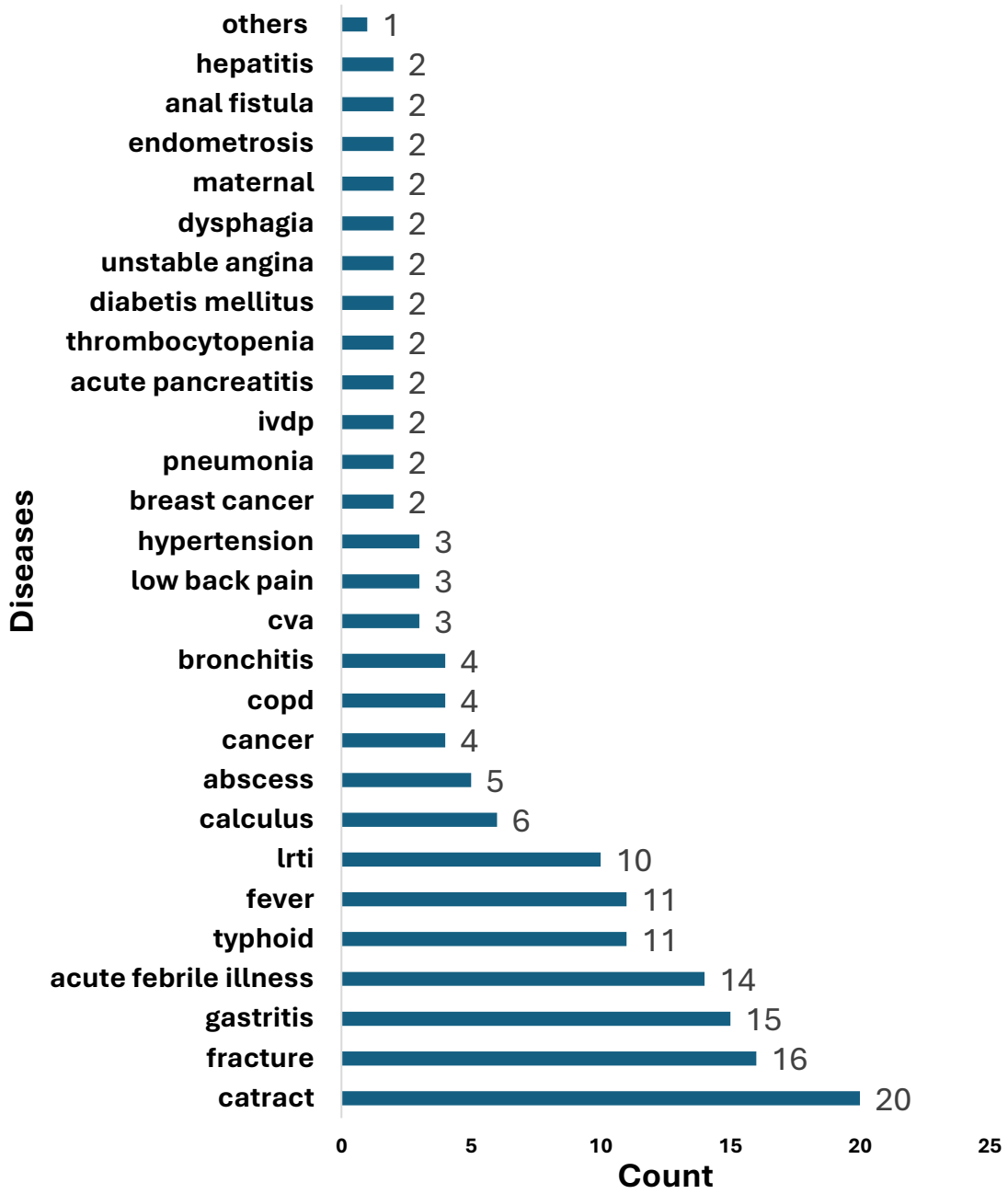


3.. DIFFERENT DISEASES:

- The most common conditions noted are 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).
- 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.

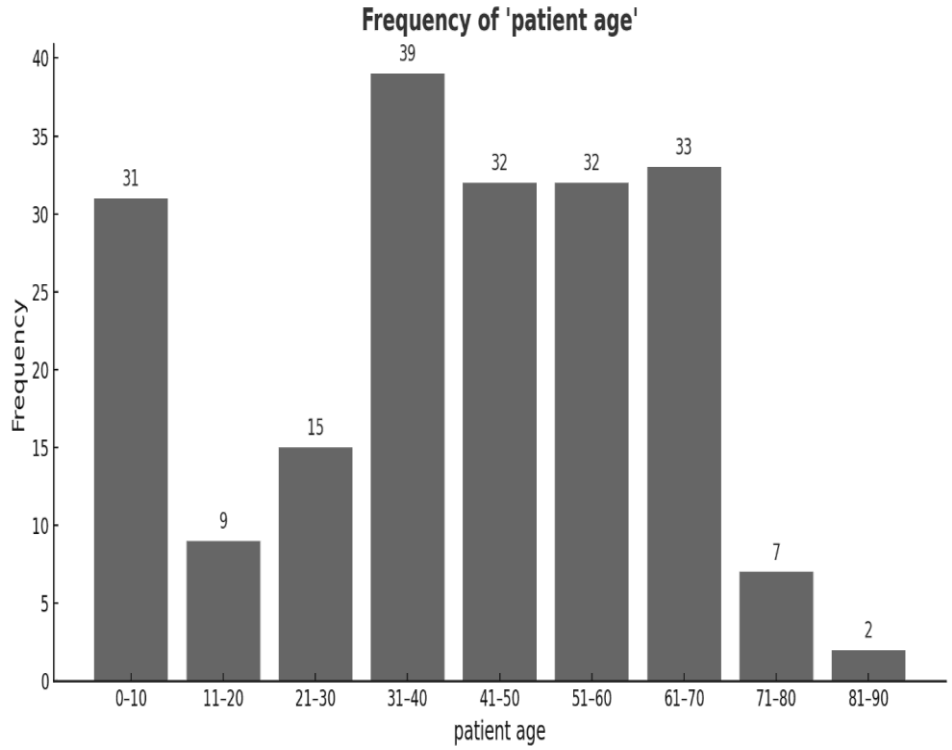
4. TURNAROUND TIME BY DECISION (TATs)

- 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 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



CONCLUSION

- The data show that most claims are granted, highlighting an overall accommodative and encouraging assessment policy focusing 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.

- 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.

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.

Turnaround times for the determination of claims are significantly longer for instances involving investigation or further queries. 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, 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

- Data analysis and literature review reveal key themes in India's health insurance claim process.

❑ **A transparent, customer-friendly claims experience is critical, considered the "moment of truth" in health insurance.**

➢ Most claims are approved or queried, reflecting a flexible, information-based evaluation strategy.

➢ High turnaround times (TAT) for investigation-linked claims indicate inefficiencies in current processes.

➢ These delays are consistent with the literature, noting negative impacts on customer trust and operational expenses.

❑ **Joginipalli (2022) suggests blockchain and smart contracts as automation and fraud minimization solutions.**

➢ Implementing these technologies could simplify claim verification and reduce approval delays.

➢ Regional data shows increased claim activity in the East zone, suggesting demographic or outreach disparities.

➢ Targeted health awareness initiatives and localized policy changes may help address this imbalance.

➢ High claim volume also increases administrative costs, stressing insurer resources.

❑ **Dutta (2020) reports low underwriting profitability, reaffirmed by this study's findings.**

➢ Emphasis on customer service and digital ease-of-use is now a strategic imperative.

➢ Automation tools can improve TAT, reduce friction, and boost satisfaction.

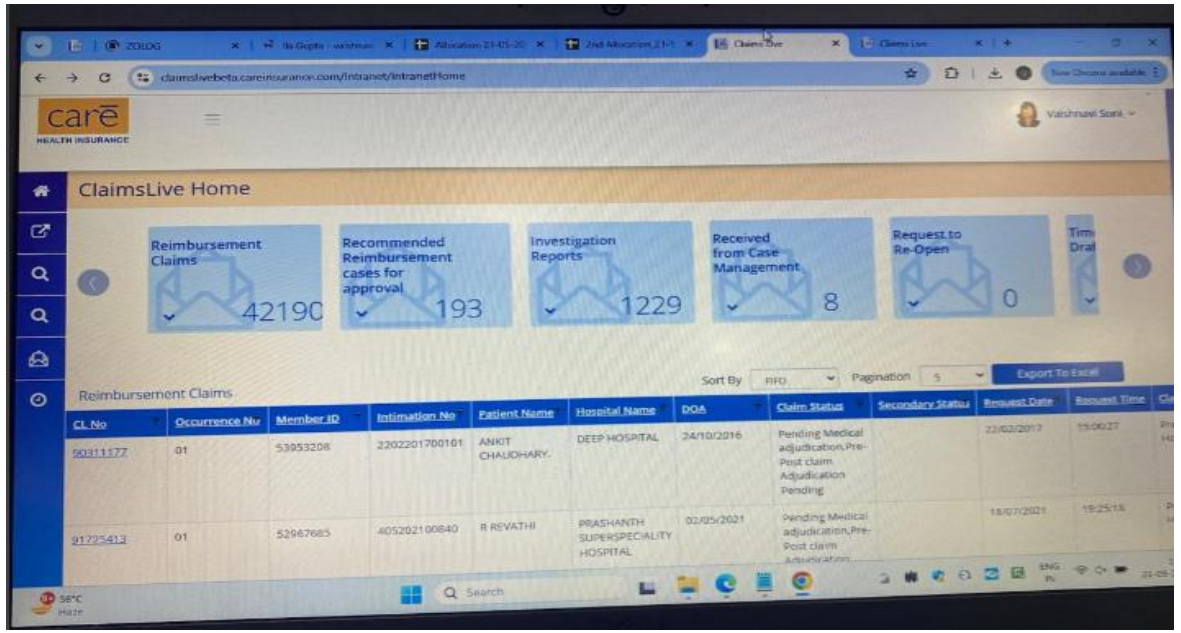
➢ Stronger regulations and process standardization are needed for industry-wide trust.

➢ Data-backed decisions can enhance insurer responsiveness and efficiency.

- 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.



RECOMMENDATION

Provide clear, accessible guidelines to policyholders about required documents and claim procedures during policy issuance and renewal. Consider establishing a dedicated helpline or digital portal for real-time query resolution and status updates

Leverage advanced analytics to monitor claim trends, identify frequent causes of delays or rejections, and predict high-risk cases. Use these insights to inform policy design, risk assessment, and customer service strategies.

Collect the portability policy document from the previous insurer and include it as a separate column. This will help identify the ported policy along with the other submitted documents.

Launch targeted awareness campaigns for senior citizens and their caregivers about the benefits and procedures of health insurance claims. Simplify claim documentation for elderly and pediatric cases to encourage higher utilization

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