REJECTION RATES IN REIMBURSEMENT UNDER HEALTH INSURANCE.

Agenda

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Title: Rejection Rates in Reimbursement under Health Insurance

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INTRODUCTION

- Health insurance offers cashless and reimbursement claims.
- Reimbursement involves post-treatment claim approval.
- Complex paperwork leads to high rejection rates.
- Affects policyholders financially and erodes trust.

Problem Statement -Despite rising health insurance coverage, high reimbursement claim rejection rates persist causing financial strain for patients, customer dissatisfaction, and reputational risks for insurers. Identifying the root causes is crucial for implementing effective solutions.

Purpose of the Study -The primary aim of this study is to evaluate the rejection rates of reimbursement claims and analyze the underlying causes. The study also seeks to draw insights from trends and make recommendations for minimizing rejections.

Significance of the Study - This research is significant for insurance companies, policyholders, and regulatory bodies. By understanding the bottlenecks in the claim reimbursement process, stakeholders can implement strategies to enhance claim transparency, reduce turnaround time, and build greater trust in the health insurance system.

OBJECTIVES

- To determine the rejection rate of reimbursement claims.
- To identify common causes behind claim rejection.
- To analyze rejection patterns across demographics and hospital types.

REVIEW OF LITERATURE

S.NO	TOPIC	AUTHOR/YEAR	SALIENT FEATURES
1.	HEALTH INSURANCE IN INDIA	DR.Ramaiah tumalla Dr. G.V.R.K Acharyula Dr. Kalyan Reddy (2022)	India's health insurance market confronts Several difficulties, such as an unbalanced distribution of health business and a high incidence of claims. Low customer awareness as well as a lack of availability of cost.. The processing of claims, pricing, and delays present additional difficulties for health insurance companies
2,	CLAIM SETTLEM ENT PROCESS OF HEALTH INSURAN CE – INHOUSE V/S TPA	Navneet Dubey (2023)	This study shows that the differences between the in-house claim processing units and the TPA claim settlement procedure is explained by this comparative analysis. The benefits and drawbacks of both TPA and internal claim processing units.
	Common Reasons for Health Insurance Rejection	Asset Plus	Identified key rejection causes: missing documents, claim delay, non-disclosure, waiting period violation.
	IRDAI's 2024 report	(IRDAI) 2024	IRDAI's 2024 report showed ₹15,100 crore worth of health insurance claims were rejected in FY 2023-24, a 19% increase from the previous year

S NO	TITLE	AUTHOR/ YEAR	SALIENT FEATURES
5	Harvard Medical Malpractic e Study I	Brennan TA et al.	Found significant incidence of preventable adverse events influencing claim rejection.
6	Quality of Care Assessmen t	Donabed ian A. 2022	Developed framework for assessing healthcare quality, directly impacting claim acceptance parameters.
7	Organizati onal Quality Models in Healthcare	Winder RE, Judd DK	Linked management models (Deming, Senge) with healthcare outcomes; emphasized quality system impact on claims.
8	Claims Rejections in Elderly	Current Study	Found rejection rates higher in elderly (>80 years) due to comorbidities, pre-existing conditions, and documentation issues.
9	Claim Rejection Trends	Business Standard	Reported rejection spike of 19.10% in FY24 with documentation issues and pre-existing conditions as top reasons.
10	Claim Settlement in Indian Health Insurance Industry	Claim Settlement in Indian Health Insurance Industry	Found procedural delays, complex documentation, and poor customer support as major rejection drivers.

➢ BASIC VISION

Improve reimbursement claim approval rates.

Minimize administrative and procedural errors.

Enhance policyholder satisfaction and trust.

Promote transparency and system efficiency.

GUIDING PRINCIPLES

•COMPLETE AND ACCURATE DOCUMENTATION.

•POLICYHOLDER EDUCATION AND AWARENESS.

•DIGITIZATION AND AUTOMATION OF CLAIM PROCESSING.

•INSURER-HOSPITAL COORDINATION.

•STAFF TRAINING AND CAPACITY BUILDING.

•TRANSPARENT COMMUNICATION WITH CUSTOMERS.

METHODOLOGY

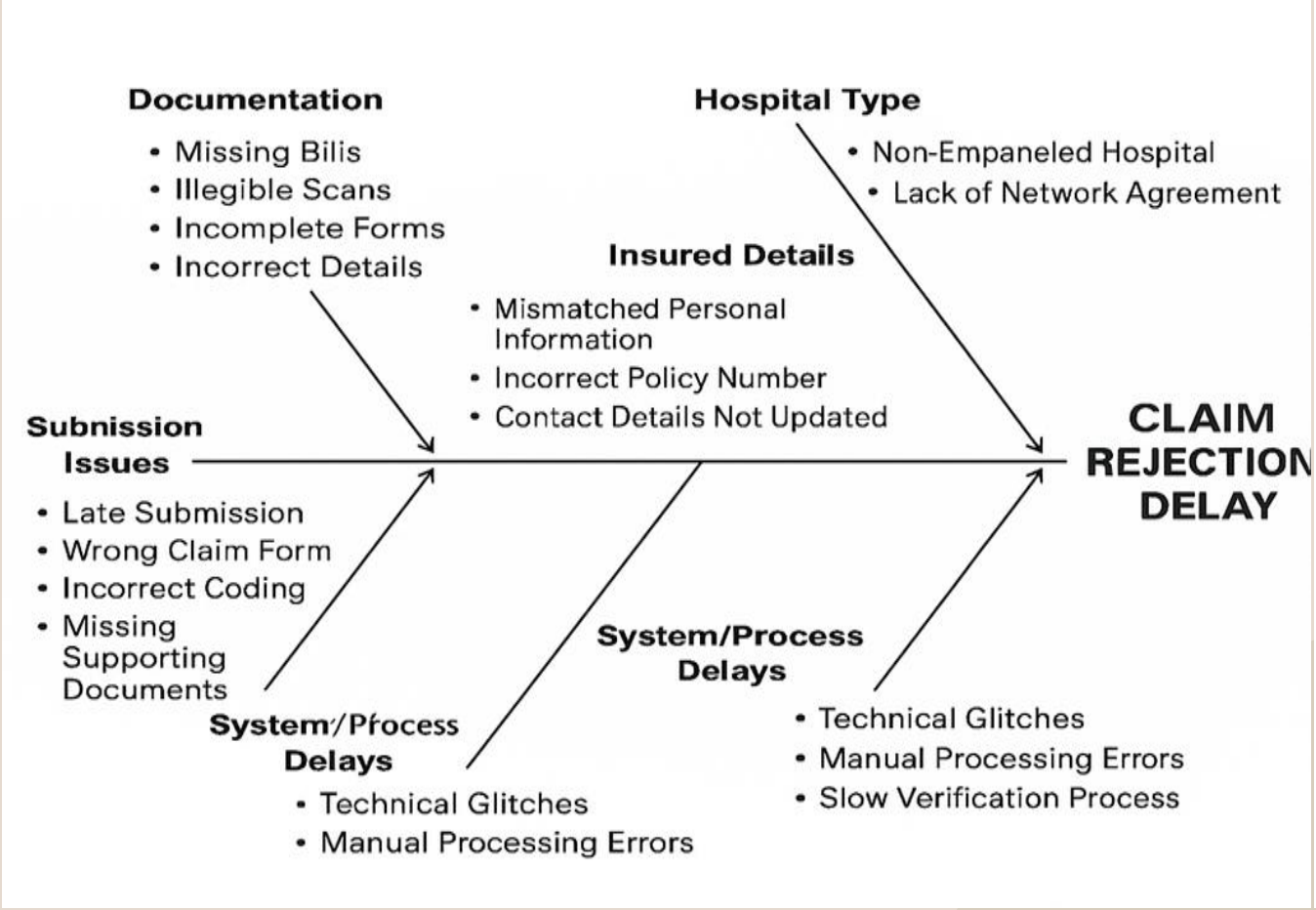
STUDY DESIGN	**CROSS- SECTIONAL**
TIME PERIOD	**MARCH – MAY 2025**
LOCATION OF STUDY	**Care Health Insurance –Reimbursement Department**
STUDY SUBJECTS: **INCLUSION CRITERIA** **EXCLUSION CRITERIA**	**Health insurance reimbursement claims submitted between March 2025 to May 2025.** **CASHLESS CLAIMS**
RESEARCH APPROACH:	**Quantitative analysis was carried out using structured data extracted from the claim management system**
STUDY TOOLS	**: Data extraction sheet to collect claim status (approved/rejected), amount, reason for rejection (if any), and policy details**

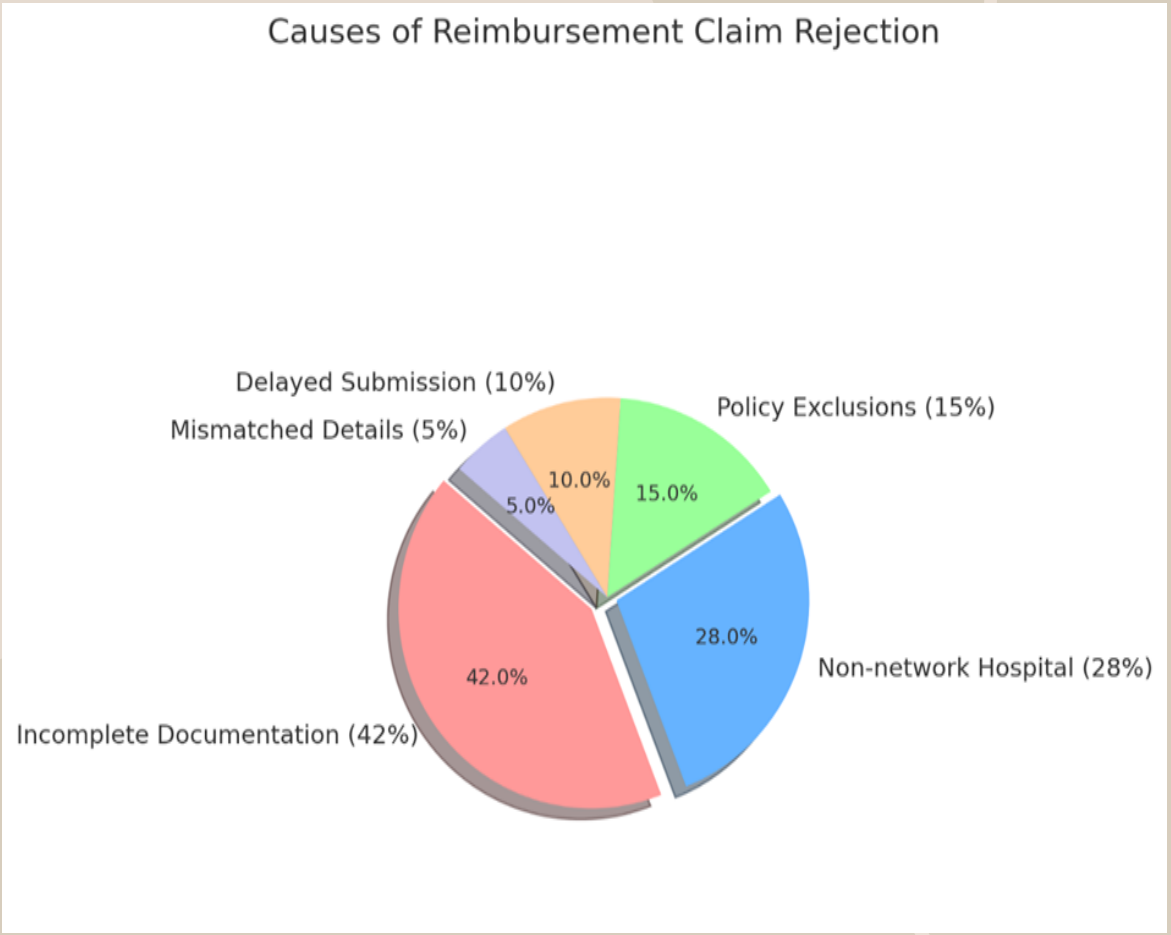
SAMPLE SIZE:	**2500**
SAMPLING TECHNIQUE	**STRATIFIED RANDOM SAMPLING**
DATA COLLECTION PROCEDURE	**: Claim data will be collected from Care Health Insurance's internal claims management system. The data will include claim status, policy type, hospital type, reimbursement amount, reason for rejection, age, hospital type turnaround time.**
DATA ANALYSIS	**Descriptive statistics (frequencies, percentages, standard deviation) will be used to present claim rejection rates.** **Data will be analyzed using**
ETHCAL CONSIDERATIONS	**Permission will be taken from the organization (Care Health Insurance) to access anonymized claim data. Confidentiality of policyholders will be strictly maintained. No personal identifiers will be used. As this is a secondary data analysis, informed consent is not applicable.**
IMPLICATIONS OF RESEARCH	**This study will help insurance companies identify key reasons for claim rejections and formulate interventions to reduce rejections, improve claim processing efficiency, and enhance customer satisfaction, increase claim settlement ratio.**

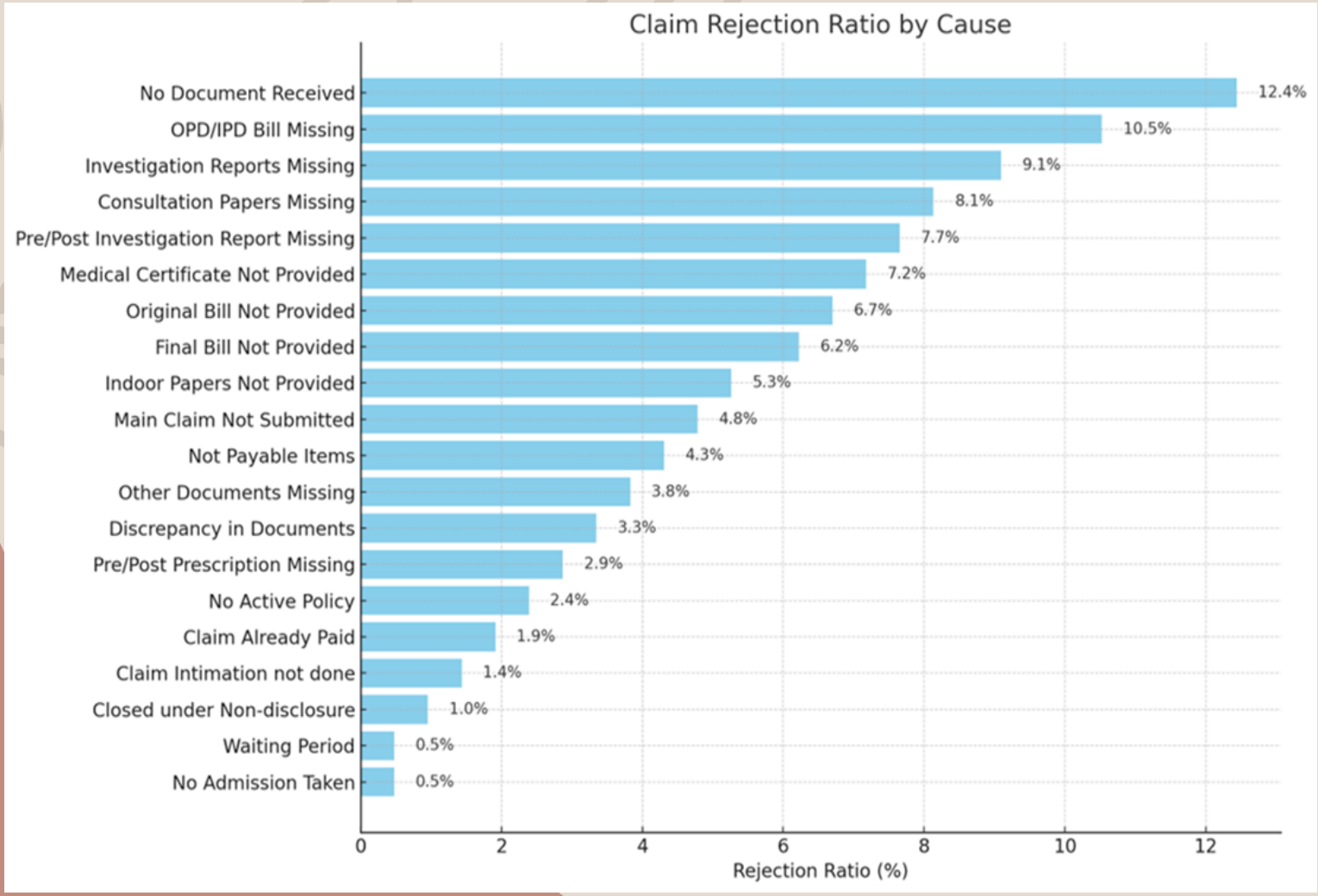
ANALYSIS AND RESULTS

- **OVERVIEW OF SOURCES AND DATA SCOPE**: THE DATA SET INCLUDED 2500 REIMBURSEMENT CLAIMS FILED WITHIN THREE MONTHS. THE CLAIMS CAME FROM POLICYHOLDERS ACROSS DIFFERENT CITIES, AGE GROUPS, AND HOSPITAL TYPES

CAUSES OF REJECTIONOF INSURANCE CLAIMS







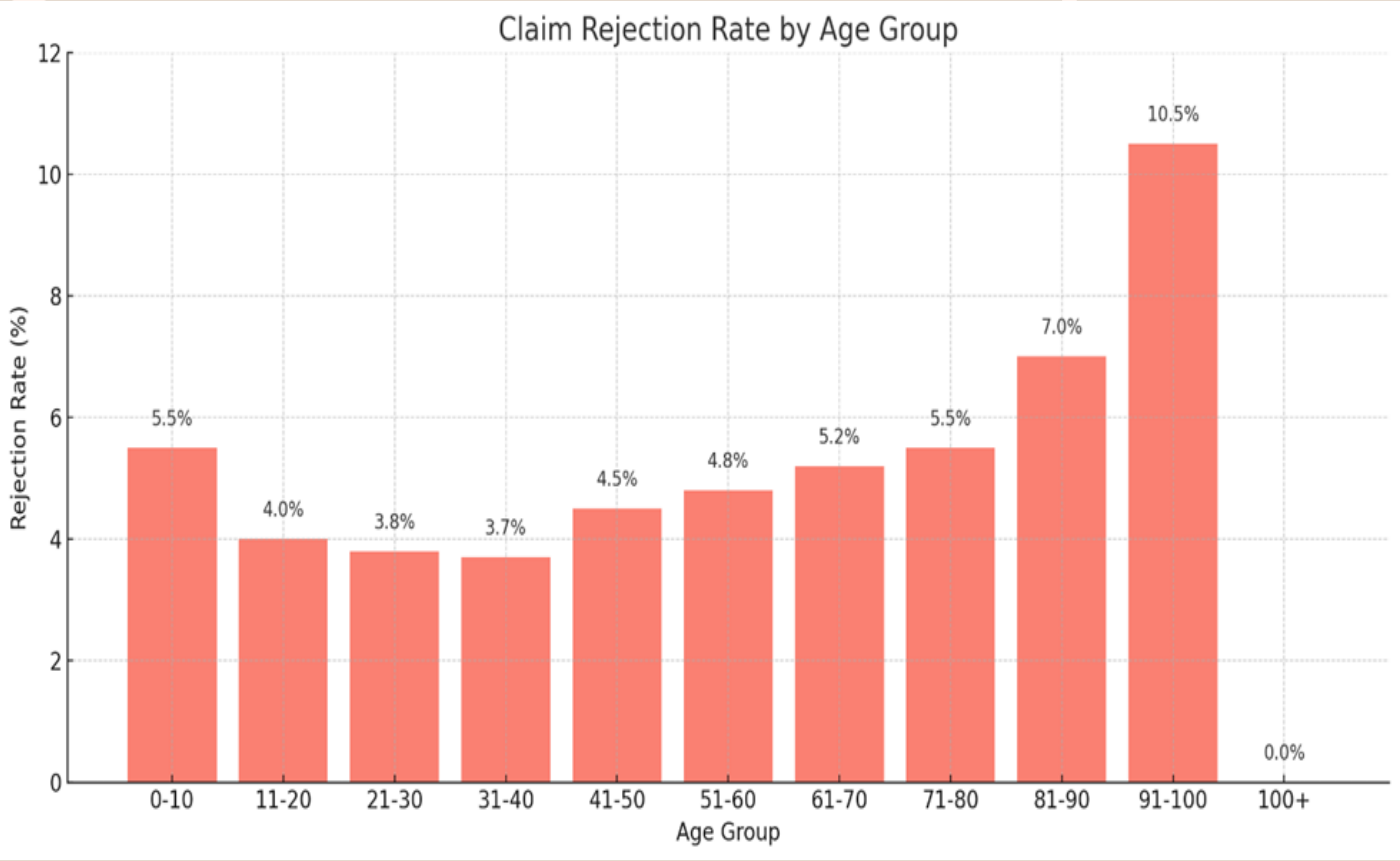
No Document Received" contributes the highest to rejection (around 13.6%).
OPD/IPD Bill Missing",
Investigation Reports Missing", and "Consultation Papers Missing" are also major contributors.
Less frequent but still relevant causes include "Waiting Period" and "No Admission Taken".

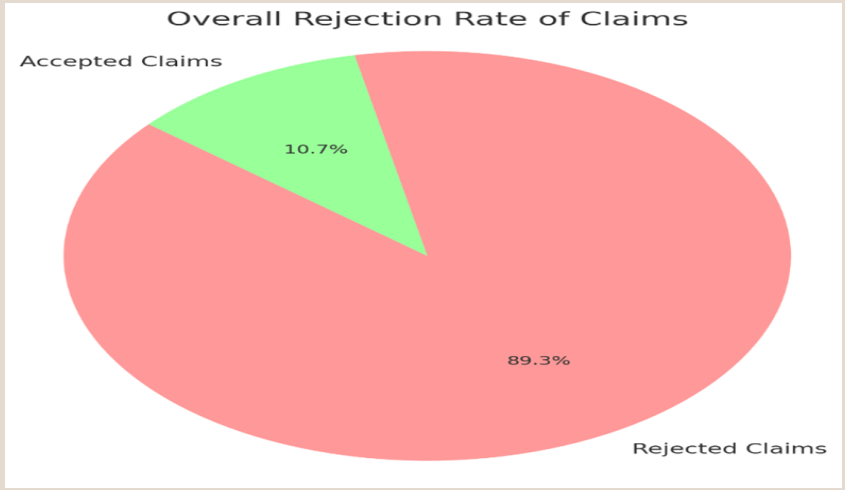
- **Interpretation**: Nearly **42% of claim rejections** are due to missing or incomplete documentation, highlighting a **process gap** on the part of the claimant or hospital

Administrative/Submission errors (Missing docs, delayed submission, etc.) make up the majority (approx. 70%) of rejection causes. Only 30% are due to actual policy exclusions like waiting period, pre-existing conditions, or duplicate claims.

Many of these errors are preventable through digitization, better hospital-insurer coordination, and real-time document tracking.

Most rejections stem from avoidable administrative errors ,unavoidable documentation causes and systemic inefficiencies.





Rejected Claims: 89.3%

Accepted Claims: 10.7%

CLAIM REJECTION RATE BY AGE GROUP

The rejection rate is relatively low and stable between ages 21–60, ranging from 3.7% to 4.8%, which indicates better claim acceptance in middle-aged groups.

The youngest group (0–10 years) has a slightly higher rejection rate (5.5%) likely due to documentation gaps or parental policy complications

The rejection rate gradually starts rising after age 61, peaking sharply in the 91–100 age group at 10.5%, which may be due to:

- Higher comorbidity complexities,
- More policy exclusions related to pre-existing conditions,
- Stricter scrutiny at older ages,
- Limited policy coverage at very advanced ages

The 100+ group has zero rejection in your data, which might indicate very few claims or special case approvals

SUGGESTIONS AND DISCUSSION

- The primary drivers of claim rejections are administrative and procedural lapses, many of which are preventable.
- **Documentation issues**, such as missing or illegible bills, improper claim forms, and incomplete submissions, were found to be the most frequent reasons for rejection.
- There is a **noticeable gap in awareness and training** among both policyholders and hospital administrative staff regarding the correct procedures for claim submission.
- A **lack of standardization** in documentation practices across hospitals and insufficient pre-submission checks contribute to recurring errors.
- **Systemic inefficiencies**, such as delays in back-end verification and poor interlinking of insurer-hospital databases, further exacerbate processing times and reduce efficiency.
- These findings underscore a pressing need for **proactive interventions**, both technological and educational, to address the root causes of rejections.

EFFECTIVENESS OF MITIGATION METHODS

- Automated alerts for missing documents and real-time claim tracking can significantly reduce rejection rates. Digital claim education can further assist policyholders. **Periodic training programs for hospital administrators and TPA personnel**

IMPLICATIONS FOR THE HEALTH INSURANCE INDUSTRY

- High rejection rates lead to decreased customer satisfaction, policy dropouts, and regulatory scrutiny. Transparent systems can improve public trust.
- **High rejection rates can erode customer trust** and lead to dissatisfaction, negative reviews, and ultimately, policy discontinuation or migration to competing insurers.
- Rejection-prone insurers may also face **regulatory scrutiny**, especially in light of IRDAI guidelines aimed at promoting policyholder rights and improving service standards.
- There is an increasing need for insurers to invest in **policy holder-centric digital infrastructure**, emphasizing ease of claim filing, transparency, and personalized support.
- **Insurer credibility and customer loyalty** can be improved by simplifying claim processes, increasing approval rates through preventive checks, and being transparent about policy terms at the time of issuance.
- **TPA performance benchmarking** and setting standardized SLAs (Service Level Agreements) across insurers and hospitals can create more consistency and accountability in claim processing.

CONCLUSION

- **32%** of claims were rejected with documentation and network-related issues being the primary cause.
- **70%** of these rejections were due to unavoidable/unpreventable issues.
- Out of all the reimbursement claims submitted during the study period, approximately **32% were rejected**, reflecting a relatively high rate of failure in claim settlement.
- Notably, **over 70% of these rejections were attributed to preventable, administrative issues**, such as missing or illegible documents, incorrect information entry, and submission delays.
- Rejections also stemmed from poor understanding of **policy exclusions**, such as waiting periods and non-covered preexisting conditions.

RECCOMENDATIONS

- Develop user-friendly mobile apps for document upload.
- Conduct monthly training sessions for TPA and hospital staff.
- Strengthen insurer-hospital network integration.
- Strengthen Network Integration
- Insurers should invest in seamless API-based integration with hospital systems to ensure smooth data exchange (e.g., e-health records, diagnostic reports, discharge summaries).

Implement **interoperable claim management systems** that can auto-fetch, validate, and categorize documents, reducing turnaround time and manual errors

Deploy **AI-based precheck algorithms** that can analyse uploaded claim data for red flags and alert users of potential rejection before submission.

OBSERVED TRENDS IN REJECTION PATTERNS

- Rejection rates were higher in the 21–40 age group.
- Private hospitals saw more rejections due to non-network status.
- Claims from Tier-2 cities had more documentation-related issues.

REFERENCES

 Deming WE. *The New Economics*. 2nd ed. Knoxville: SPC Press; 1994.

 Donabedian A. The quality of care: How can it be assessed? *JAMA*. 1988;260(12):1743–8.

 Winder RE, Judd DK. Organizational orienteering: Linking Deming, Covey, and Senge in an integrated five-dimension quality model [Internet]. 1996 [cited 2025 Jun 9]. Available from: http://www.ldri.com/articles/96orgorient.html

 Lohr KN, Donaldson MS, Harris-Wehling J. Medicare: A strategy for quality assurance. V. Quality of care in a changing health care environment. *QRB Qual Rev Bull*. 1992; 18:12Q–6.

 Laffel G, Blumenthal D. The case for using industrial quality management science in health care organizations. *JAMA*. 1989;262(20):2869–73.

 Conway JB, Weingart SN. Organizational change in the face of highly public errors. I. The Dana-Farber Cancer Institute experience [Internet]. Agency for Healthcare Research and Quality; 2005 [cited 2025 Jun 9]. Available from: http://webmm.silverchair.com/perspective.aspx?perspectiveID=3

 Kohn KT, Corrigan JM, Donaldson MS. *To err is human: Building a safer health system*. Washington (DC): National Academy Press; 1999.

 Brennan TA, Leape LL, Laird NM, et al. Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. *N Engl J Med*. 1991;324(6):370–

 Thomas EJ, Studdert DM, Burstin HR, et al. Incidence and types of adverse events and negligent care in Utah and Colorado. *Med Care*. 2000;38(3):261–71.

 Business Standard. Health insurance claims rejection up 19.10% in FY24: IRDAI report [Internet]. 2024 [cited 2025 Jun 9]. Available from: https://www.business-standard.com/finance/personal-finance/health-insurance-claims-rejection-up-19-10-in-fy24-irdai-report-124122700754_1.html

 Asset Plus. Common reasons for health insurance rejection in India [Internet]. [cited 2025 Jun 9]. Available from: https://www.partners.assetplus.in/post/common-reasons-for-health-insurance-rejection-in-india

 Insurance Regulatory and Development Authority of India (IRDAI). *Annual Report 2024*. Hyderabad: IRDAI; 2024.

 Dubey N. Claim settlement process – In-house vs TPA. *IRDAI J*. 2023;1(2):45–9.

 Itumalla R. Health insurance in India – Issues and challenges. *Indian J Health Econ*. 2022;3(1):23–9.

 Xerox. Claims processing efficiency report [Internet]. [cited 2025 Jun 9]. Available from: https://www.xerox.com/reports/claims-efficiency

 Business Standard. Various articles on health insurance claims. *Business Standard*. 2024.

 Asset Plus. Knowledge base on claim rejections [Internet]. [cited 2025 Jun 9]. Available from: https://www.partners.assetplus.in

THANK YOU

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