Rejection Rates in Reimbursement under Health Insurance.

TITLE

Rejection Rates in Reimbursement under Health Insurance.

INTRODUCTION

Health insurance aims to provide financial protection by covering medical expenses, yet policyholders often face claim rejections during reimbursement. Reimbursement-based insurance claims are particularly sensitive due to the complexity of documentation, timelines, and medical validation. The approval or rejection of such claims has a direct impact on customer satisfaction, financial burden, and trust in the health insurance system. This study investigates the rate and reasons for claim approval and rejection in reimbursement-based health insurance claims to understand patterns and propose strategies for improved claim management.

RESEARCH QUESTION

What is the rejection rate of reimbursement claims in health insurance, and what are the key reasons for claim rejection?

OBJECTIVES

1. To determine rejection rates of reimbursement claims in health insurance.
2. To identify the major reasons behind claim rejections.
3. To analyse the trends and patterns associated with rejected claims (e.g., by age group, hospital type, documentation issues).

HYPOTHESIS

A significant proportion of reimbursement claims are rejected due to avoidable factors, such as incomplete documentation or the type of hospital, T and C of company

MATERIAL AND METHODS

STUDY DESIGN:

Descriptive cross-sectional study

SETTING: Care Health Insurance – Reimbursement Claims Department, Gurgaon

STUDY POPULATION

Inclusion Criteria:

Health insurance reimbursement claims submitted between 15 March 2025 to 30 May 2025

Exclusion Criteria:

Cashless claims

STUDY TOOLS:

Data extraction sheet to collect claim status (approved/rejected), amount, reason for rejection (if any), policy details.

DURATION OF STUDY:

March 2025 to June 2025 (3 months)

SAMPLE SIZE:

2500 reimbursement claim records

SAMPLING TECHNIQUE:

Convenience sampling based on available reimbursement claims processed during the selected period

DATA COLLECTION PROCEDURE:

Claim data will be collected from the internal claims management system of Care Health Insurance. The data will include claim status, policy type, hospital type, reimbursement amount, reason for rejection (if applicable), and turnaround time.

OPERATIONAL DEFINITIONS:

Claim Approval: A claim that is fully or partially paid after evaluation.

Claim Rejection: A claim that is denied due to reasons like policy exclusions, incomplete documentation

Reimbursement Claim: A claim where the policyholder pays for services first and is reimbursed later by the insurer.

DATA ANALYSIS PLAN:

Data will be analysed using Microsoft Excel. Descriptive statistics (frequencies, percentages) will be used to present claim approval and rejection rates. Chi-square test or logistic regression may be used to assess associations between claim rejection and variables like age, type of hospital, and documentation completeness. A p-value <0.05 will be considered significant.

ETHICAL 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.

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