OPERATIONAL BOTTLENECKS: AUTOMATION APPROACH TO ENHANCING GRIEVANCE MANAGEMENT IN HEALTH INSURANCE

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

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Under the Supervision and Guidance of

Dr. Sandesh Kumar Sharma

2025

Aditya Birla Health Insurance Co. Ltd.

ADITYA BIRLA CAPITAL
HEALTH INSURANCE

June 18, 2025

To Whomsoever It May Concern

This letter is to certify that Ms. Vidhi Panchal has successfully completed her Internship with Aditya Birla Health Insurance Co. Ltd., her internship period was from 10th March 2025 to 31st May 2025. During this period, he has worked with Ops - Grievance team and has successfully completed a project – "Automation Opportunities in Grievance Management Process Workflow".

During this period of time, we found her dedicated and a very reliable team member with quick learning ability. We take this opportunity to wish her all the best in his future endeavours.

Thanking You,

Your sincerely,

For **Aditya Birla Health Insurance Company Limited.**

Authorized Signatory

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled **"Operational Bottlenecks: Automation Approach to Enhancing Grievance Management in Health Insurance"** is a record of the research work undertaken by **Dr Vidhi Panchal** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide:
Dr. Sandesh Kumar Sharma
IIHMR University, Jaipur
Date:

School Dean:
IIHMR University, Jaipur

Date:

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **Operational Bottlenecks: Automation Approach to Enhancing Grievance Management in Health Insurance, is** the Bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Vidhi

(Signature)

Dr. Vidhi Panchal

Date: 17/06/25

ABSTRACT

Title: Operational Bottlenecks: Automation Approach to Enhancing Grievance Management in Health Insurance

Background: Grievance redressal is a cornerstone of customer trust and regulatory compliance in the health insurance industry.

The growing volume of customer complaints, coupled with a manual handling process involving tagging, allocation, and resolution, has led to inefficiencies in many organizations. These manual dependencies result in delays, duplications, and workload imbalances.

With the evolving role of technology in healthcare operations, the need to identify automation-ready segments within the grievance process has become critical for improving service efficiency and customer experience.

This study was conducted in the Grievance Department to assess and document current workflows, analyze inefficiencies, and propose areas for automation.

Objective: The objectives of the study are

To analyze the current workflow of the grievance department in health insurance.

To identify key bottlenecks and inefficiencies in the grievance handling process.

To explore areas where automation can be suggested to optimize workflow.

To assess the potential impact of suggested improvements on operational efficiency and customer satisfaction.

Methodology:

This was a descriptive cross-sectional study conducted during a 70-day internship at Aditya Birla Health Insurance in Thane (March 10 to May 31, 2025). A total of 613 grievance cases were reviewed using purposive sampling. Data was gathered through direct process observation, grievance tagging and allocation, key informant interviews, and a review of internal SOPs and MIS tools.

Ethical considerations, such as confidentiality and non-disclosure of sensitive data, were strictly enforced.

Key Results:

Out of the 613 cases handled, 235 were closed, with nearly 48.5% marked as “in-progress” duplicates. From the 363 retrievable created cases, 74% were identified as repeat grievances. Claim-related issues accounted for 55% of cases, predominantly reimbursement claims (94%). Service-related issues (36%) were mainly related to refunds, renewals, and cancellations.

200 IRDAI-regulated grievances were analyzed, of which 70.5% were claims-related, and most (79%) were submitted through the IGMS portal.

The study identified manual touchpoints, such as email-based verification, manual tagging, and allocation planning, as areas with potential for automation.

Conclusions:

This study mapped the grievance workflow in a health insurance setting and identified key inefficiencies. A significant portion of grievances were repeat cases, particularly in reimbursement claims and servicing issues like refunds and renewals. The manual nature of tagging, allocation, and coordination emerged as significant bottlenecks. Implementing automation in these areas can reduce delays, improve accuracy, and increase customer satisfaction. Automation has the potential to make grievance processing faster, more efficient, and accessible to customers.

Keywords: Health Insurance, Grievance Management System, Workflow, IRDAI, Automation.

ACKNOWLEDGEMENT

This dissertation report, titled **"Operational Bottlenecks: Automation Approach to Enhancing Grievance Management in Health Insurance,"** is a study based on direct observations, process mapping, and functional analysis undertaken during my internship.

In accordance with organizational confidentiality and privacy of data regulations, no sensitive policyholder information has been disclosed. As a result, this study does not include any personally identifiable information, such as names, policy numbers, or communication records. To ensure ethical and professional compliance, all examples and insights are concealed or presented in grouped formats.

I'd like to express my heartfelt gratitude to Aditya Birla Health Insurance Co. Ltd. for the opportunity to intern in their Operations-Grievance department. The experience provided valuable insights into the health insurance ecosystem, allowing me to investigate both operational and strategic aspects of grievance handling.

I am especially grateful to **Naveen Chandra sir**, whose guidance and mentorship helped me understand the complexities of grievance workflows and encouraged me to take on this key area for automation as my project. His continuous assistance and constructive feedback were critical in shaping the direction of this project.

I am thankful to my faculty mentor, **Dr. Sandesh Sharma** at IIHMR, whose academic guidance inspired me to pursue this topic.

I am deeply grateful to **Dr. Madhura Rane** and **Dr. Gunjan More** for their invaluable guidance, constant support, and for diligently responding to my questions throughout the study duration and the entire grievance team at Aditya Birla Health Insurance for their cooperation, timely inputs, and allowing me to observe and participate in real-time processes.

Finally, I'd like to express my gratitude to my family and friends for their unwavering support, motivation, and patience throughout this journey.

Table of contents

List of Figures

List of tables

Abbreviations

IRDA	Insurance Regulatory and Development Authority
TPA	Third Party Administrator
MIS	Management Information System
RI	Reimbursement
GRO	Grievance Redressal Officer
RPA	Robotic Process Automation
NLP	Natural Language Processing
IGMS	Integrated Grievance Management System
CPGRAMS	Centralized Public Grievance Redress and Monitoring System
NCH	National Consumer Helpline
TAT	Turnaround Time
BB Portal	Bima Bharosa Portal
SFDC	SalesforceDotcom
CRM	Customer Relationship Management

Chapter 1: Introduction

1.1 Understanding Grievance in Health Insurance

A *grievance* refers to any expression of dissatisfaction raised by a policyholder regarding services, decisions, or conduct of the insurer.

In health insurance, grievances are critical indicators of service quality, compliance, and customer trust. Addressing these grievances in a structured and timely manner is essential for customer satisfaction and a regulatory mandate, especially under the guidelines set by the Insurance Regulatory and Development Authority of India (IRDAI).

Hence, a dedicated Grievance Department is vital for any health insurance provider. It functions as a bridge between customer concerns and institutional accountability, ensuring fair resolution, compliance with timelines, and continuous service improvement.

1.2 Structure of the Grievance Department

The Grievance Department is typically divided into three operational segments:

- MIS Handling: Focused on data reporting, case tracking, and analytics.
- CEO Cases: High-priority cases are escalated to the senior leadership.
- Non-CEO Cases: Regular grievances comprise the majority of case volume.

The department manages grievances raised by both retail and group policyholders and addresses concerns that are categorized under requests and complaints.

While *queries* are informational and often handled by customer support, requests and complaints fall under the direct purview of the grievance team.

1.3 Modes of Grievance Registration

Policyholders can raise grievances through multiple channels, including:

- Email (4 prioritized addresses):
    a. For senior citizens
    b. Grievance Redressal Officer (GRO)

c. Care Health support

d. ABHI Grievance team

- Website portal
- Social media platforms (Facebook, Instagram, LinkedIn, YouTube)
- IRDAI website
- Walk-in requests
- Contact centre calls

Each grievance is formally registered only after verifying the policyholder's identity through predefined security questions to ensure authenticity.

Other external avenues for grievance filing include:

- The insurer's grievance system
- IRDAI's IGMS portal
- Insurance Ombudsman
- Legal proceedings under the Consumer Protection Act, 1986

1.4 Types of Grievances Handled

The grievances received are broadly categorized into three types:

- Claims-related issues
- Service-related issues
- Mis-sell complaints

Each grievance type has a predefined Turnaround Time (TAT) for resolution, as mandated by internal policies and regulatory standards:

Table 1.1

Claims	T + 3 working days
Service	T + 3 working days
Mis-sell	T + 5 working days

1.5 External Sources of IRDAI Complaints

Grievances are also registered through the following three national-level portals:

1. IGMS (Integrated Grievance Management System) – IRDAI's official portal for complaint tracking.
2. CPGRAMS (Centralized Public Grievance Redress and Monitoring System) – A Government of India portal connected to all ministries.
3. NCH (National Consumer Helpline) – Operated by the Department of Consumer Affairs, addresses grievances at the pre-litigation stage.

1.6 Systems and Platforms Used by the Grievance Department

Grievance executives utilize various digital tools to manage and resolve complaints efficiently:

- SFDC (Salesforce CRM): A centralized system for recording and tracking complaints and requests.
- Jarvis: The internal policyholder database for customer identity verification and information retrieval.
- IGMS Portal: For accessing IRDAI-received complaints.
- BB Portal, CPGRAMS, NCH: Additional regulatory portals for external grievance cases.

1.7 Objective of the Grievance Team

The primary goal of the grievance department is to ensure timely resolution of all complaints within the prescribed TAT while maintaining accuracy, empathy, and regulatory compliance. The team plays a pivotal role in safeguarding customer trust and enhancing the overall service quality, ultimately contributing to improved customer satisfaction and brand reputation.

1.8 MIS Handling and Grievance Case Processing

1.8.1 MIS Handling – Key Responsibilities

The MIS team is crucial in supporting the grievance resolution process through several key tasks. They begin by distributing incoming grievance cases for tagging, ensuring that each case is categorized accurately as a claim, service, or mis-sell. Once tagged, these cases are allocated to the appropriate grievance executives based on the nature of the case—for example, service executives handle service-related grievances, while claim-related issues are directed to claim executives to ensure efficient and relevant resolution.

To monitor performance, the MIS team generates a daily productivity report for each executive, detailing the number of cases resolved. Additionally, a separate escalation report is prepared and shared with the CEO. This report highlights the number of cases resolved within and beyond the defined Turnaround Time (TAT), offering insights into overall departmental performance and compliance.

In line with regulatory standards, the MIS team also ensures that acknowledgment emails are sent for all valid complaint cases before the assigned executive begins resolution. Furthermore, they are responsible for reassigning cases that may have been incorrectly routed—such as redirecting a claim-related grievance mistakenly assigned to a service executive—ensuring the case reaches the most appropriate handler for timely and effective resolution.

1.8.2 Case Extraction and Preliminary Filtering

The grievance journey begins with data extraction from the system. In Salesforce (SFDC), the GRT dump report is generated to identify newly received grievances. These cases, especially those categorized as Requests, are reviewed by MIS handlers for further processing.

For complaint cases routed through IRDAI, the MIS handlers refer to the Bima Bharosa portal, which is IRDAI's designated platform to access and manage regulator-received grievances. These cases are downloaded, reviewed, and appropriately tagged in SFDC for further processing.

This step ensures that all incoming grievances, whether internal or externally escalated, are captured and prepared for classification.

1.8.3. Tagging and Case Classification

Tagging refers to the classification of grievances based on the customer's concern. It is a vital part of the grievance lifecycle and is necessary to route the case to the right handler.

The tagging process includes:

- Taking ownership of the case in SFDC, which marks it as *open*.
- Categorizing the case under a relevant type (e.g., Cashless, Reimbursement, etc) and a more detailed subtype (e.g., Claim status).
- Completing a checklist in the system.
- Changing the ownership back to the grievance department, thereby marking the case as *In Progress*.

During tagging, MIS handlers also review the audit history of the case or customer profile. If the same customer has previously raised a similar concern, the case is considered a repeat and is ideally reassigned to the same executive who handled the earlier issue. This step supports continuity, reduces back-and-forth reassignments, and simplifies allocation by retaining ownership within the same workflow chain. This repeat tagging approach improves efficiency while preserving customer context.

Importantly, no new grievance is tagged if there is already an in-progress case from the same customer under review. Additionally, grievances are only tagged if received from the customer’s registered email ID, verified through the internal policyholder database system, Jarvis. If an unregistered email address is used, a standard draft reply is sent requesting the customer to resend the grievance from their registered email ID.

Apart from handling and assigning cases, the MIS team is also responsible for closing non-actionable grievances. These include grievances originating from irrelevant sources such as marketing content, third-party brokers, hospitals, internal organizational communication, and newsletters. If the concern raised by the customer is already under review (i.e., marked as “In Progress”), any duplicate or overlapping case is closed to avoid redundancy.

Only those cases that require active resolution are retained. All others are formally closed in the system.

Tagging Challenge: During the tagging stage, cases are expected to be classified accurately based on the customer's concern. However, in several instances, Salesforce (SFDC) fails to automatically detect the customer's registered email ID, which is essential for tagging validation. To overcome this limitation, MIS handlers manually enter the policy number into the system or use the claim number to retrieve the policy details via Jarvis—the internal policyholder information database. Once verified, the handler confirms whether the grievance email matches the registered email ID on file. Only after this validation is complete can the case be considered authentic and appropriately tagged.

This manual verification adds an extra layer of effort, especially in high-volume scenarios, and presents a clear opportunity for process automation.

1.9 Allocation

Allocation relies heavily on manual managerial judgment and the efficiency of the MIS executive. The allocation process follows tagging and is typically completed at the end of the day. The allocation sheet prepared by the MIS team is shared with the grievance executives the following morning. Allocation is done manually but systematically to ensure fair workload distribution among executives. The department manager makes the final decision regarding how many and which cases each executive will handle.

The summary allocation file serves as the starting point for grievance executives to begin their work. This allocation sheet is critical to initiating resolution activities.

Grievance cases are first extracted from the Salesforce (SFDC) dump and then exported into an Excel file. This Excel dump contains multiple columns with customer-related data and case details.

Using this file, the MIS handler manually performs several key actions:

- Assigns grievance executives to New/Fresh cases considering the bifurcation.
- Refers to tagging data to ensure repeat cases are assigned to the same executive who previously handled them
- Performs bifurcation of cases into Claim, Service, and Mis-sell categories based on tagging.
- Highlights the Turnaround Time (TAT) status for each case, indicating how long the case has been open since its registration

The allocation sheet also includes important columns that indicate the nature of the grievance—whether it is a Request or a Complaint—and whether the case is Fresh or Repeat.

To maintain specialization and efficiency:

- Claim executives handle claims and claim-related mis-sell cases.
- Service executives address service and service-related mis-sell grievances.

This summary enables the grievance team to prioritize their workload and proceed with resolutions systematically.

Throughout this MIS-driven workflow, multiple manual touchpoints exist—tagging, allocation, verification, escalation, and closure—all of which involve repetition, dependency on individual accuracy, and potential for delay.

1.10 Grievance Executive Workflow and Case Resolution Process

Once grievance executives receive their daily allocation sheet, they initiate the case-handling process based on the classification of Request or Complaint. Each executive begins by extracting their assigned cases and maintaining an individual tracker to monitor progress. The resolution process varies depending on the type of grievance but broadly follows a standard framework involving evaluation, departmental coordination, and response finalization.

1.10.1. Initial Grievance Evaluation and Internal Coordination

Upon receiving a case, the grievance executive reviews the customer's concern in detail. Based on the nature of the grievance, appropriate internal departments are contacted to provide necessary inputs for resolution. For example:

- If the issue pertains to cashless or reimbursement claims, the Claims Team is involved.
- For renewal-related concerns, the case is forwarded to the Persistency Team.
- If the issue involves alleged mis-selling, the Sales Team is consulted.

Communication with these departments is carried out via email. The subject line of the email typically includes the case number, policy number, claim number, and customer name to ensure traceability and context.

Executives use pre-approved resolution templates or drafts as a base for their responses. These drafts are then customized according to the specifics of each case. Once finalized, the resolution is sent to the customer through Salesforce (SFDC). After the response is delivered, the case is formally closed in the system with resolution comments recorded under the ownership of the grievance executive.

1.10.2. Special Handling of Complaint Cases – IRDA (Regulatory) Complaints

Complaint cases that originate from the Insurance Regulatory and Development Authority (IRDAI) are handled with additional scrutiny and procedural steps. Executives access these cases through the Bima Bharosa Portal using the complaint number. Further grievance details are typically received as an attachment. For clarity on unclear complaints, the customer is contacted directly. In such cases, the claim number is noted, and a thorough case evaluation is carried out.

IRDA complaint handling often requires coordination with other departments, depending on the nature of the issue:

- Claims Team – for rejection or deduction-related matters
- Underwriting Team, FWA (Fraud, Waste & Abuse) – in sensitive or disputed cases

Communication is once again managed through email, with the subject including the IRDA token number, case number, policy number, claim number, and customer details.

Once the IRDA case is resolved, it can be reopened if the customer responds within eight weeks for the same concern. The resolution sent to the customer includes two standard attachments:

1. A document explaining the Ombudsman escalation process.
2. A note stating that any response within eight weeks will be considered for reopening.

Although the regulatory TAT for IRDA complaints is 15 days, the department has internally set a stricter target of 3 days. In practice, however, complex cases often take 7–8 days to resolve.

1.10.3. Common Triggers for Complaints and Resolution Outcomes

Customers typically escalate grievances due to claim rejections, deductions, or delays. The most common reasons for such claim denials include:

- Non-disclosure of pre-existing diseases (PED)
- Discrepancies or documentation lapses
- Misrepresentation of facts
- Incomplete policy waiting periods

Grievance executives evaluate each case on its merit and conclude the resolution outcome as one of the following:

- In Favour of the customer
- Partially In Favour
- Rejected

In rejection cases, all supporting documents and factual evidence justifying denial are compiled and submitted to the Grievance Manager for approval. Only after approval is received is the case closed in SFDC.

For deduction cases, the executive justifies. If the deduction appears unjustified, and the amount involved is small, the executive may independently decide on further action. For larger amounts, the case is escalated to the Head of Department (HOD) and communicated to the Claims and Finance teams. If the deductions are ultimately found justified but challenged by the customer, the case is put on hold and revisited if further escalation occurs.

1.10.4. Departmental Collaboration for Case Resolution

For comprehensive resolution, grievance executives often require inputs from the following departments:

- Sales Team – especially for mis-sell and sales code verifications
- Welcome Call Team – for validating disclosures at policy inception
- PPMC (Pre-Policy Medical Check-up) – for access to telemedical reports
- Persistency Team – for renewal-related complaints

- Cancellation Teams – differentiated for retail and group policies
- Other units – for health returns, endorsements, policy issuance, mobile app issues, and health assessments

Requests to these departments are sent via email with structured subject lines indicating the concern, policy number, and case number.

1.10.5. Mis-sell Case Handling and Market Conduct Escalation

In mis-sell cases, the Sales Team is contacted for inputs and verification. The sales manager code is checked to identify and contact the salesperson involved. Additionally, a soft copy of the policy document is reviewed. If the mis-sell is verified, the case is escalated to the Grievance Manager, who maintains a record. These confirmed mis-sell cases are then forwarded to the Market Conduct Team every week for appropriate disciplinary action against the sales personnel involved.

1.11 Special Consideration: Workflow for CEO-Marked Grievance Cases

Handling CEO-marked cases involves a distinct and high-priority workflow due to the visibility, sensitivity, and potential impact of such grievances. These cases are not received through regular customer service channels alone, but often via direct mentions of the CEO or senior leadership on platforms such as email, social media, or corporate feedback loops.

The workflow for CEO-marked grievances proceeds as follows:

1. Identification of CEO Cases
2. A case is flagged as a CEO case when the customer's communication explicitly references the CEO or senior management, whether through a formal complaint or public post.

a. These may originate from:

b. Emails to leadership

c. Posts or comments on social media platforms (e.g., LinkedIn, Facebook, Twitter)

d. Internal leadership escalation channels

3. Manual Creation of Case in SFDC

4. Once identified, the MIS team manually creates a case in the Salesforce (SFDC) system. If the communication lacks policy details, the team may contact the customer or use basic identifiers (such as name or email) to retrieve the policy number and link it with the case.
5. Prioritization and Assignment
6. CEO-marked cases are few in volume but high in importance. These are assigned to designated grievance executives who are trained to handle escalated or high-scrutiny cases. These executives are responsible for ensuring careful review, follow-ups, and timely updates.
7. Detailed Case Tracking via SharePoint
8. A key differentiator in CEO case handling is the use of a dedicated SharePoint tracker, maintained in parallel to SFDC.
    - This tracker captures every update, departmental interaction, resolution status, and pending action.
    - The tracker is visible to the CEO and senior leadership, enabling real-time monitoring of resolution progress and ensuring top-level accountability.
9. Resolution Drafting
10. The grievance executive prepares a detailed, point-by-point resolution, addressing each aspect of the customer's concern. This often involves multi-departmental coordination (e.g., Claims, Sales, Underwriting) to verify and respond accurately.
11. Response Delivery and Closure
12. The final response is sent to the customer via SFDC, and the case is closed after proper documentation of the resolution comments. The SharePoint tracker is updated simultaneously, ensuring consistency in internal and leadership reporting.

Table 1.2 Grievance Workflow: Step-by-Step Breakdown of Operational Stages

Stage	Step	Description
1. Case Registration	Case Received	Grievance received via SFDC, Email, Portal, or Bima Bharosa (for IRDA cases).
	Case Extraction	MIS Handler extracts case data from SFDC (GRT Dump) or Bima Bharosa for IRDA complaints.
2. Case Tagging	Email ID Verification	Jarvis is used to verify if the grievance came from the registered email ID. Manual intervention if needed.
	Audit History	Reviewing of records to check for fresh/repeat cases.
	Case Tagging	MIS Handler classifies the case into Type and Subtype based on the customer's concern
3. Allocation	Case Allocation	Cases are exported to Excel, categorized, and manually distributed to grievance executives.
	Allocation Summary Sheet	Includes columns for request/complaint, type, fresh/repeat, and TAT – shared with executives daily.
4. Executive Case Handling	Executive Tracker Maintenance	Executives maintain trackers for their assigned cases.
	Grievance Understanding	A detailed analysis of customer concern is conducted.
	Department Coordination	Executives contact Claims, Sales, Persistency, etc., via email for inputs.
5. Resolution and Closure	Drafting and Sending Resolution	Preformed drafts are modified, and the resolution is sent via SFDC.
	Case Closure in SFDC	Resolution comments added, and the case is closed.
6. Special Cases	IRDA Complaint Handling	Viewed via Bima Bharosa portal; evaluated and resolution includes ombudsman note and reopen clause (8-week window).
	Reopen Protocol	IRDA cases may be reopened once if the customer replies within 8 weeks.

Chapter 2-Review of Literature

Authors (Year)	Article /Study Name	Study Location	Sample Size	Sampling Technique	Salient Features
Ramya K. P. (2018) .	Customers' Grievances and Redressal Mechanism in the Indian Health Insurance Industry – An Analysis	India	90 respondents	Random sampling	The study investigates the nature and causes of grievances in India's health insurance sector, particularly focusing on service lapses and unethical practices by insurers. It stresses the need for a strong grievance redressal system integrated with efficient customer relationship management (CRM). The paper recommends better communication, transparency, and awareness-building to improve customer satisfaction and trust in the insurance industry.
Dr. Shubhada Mohan Kulkarni (2019)	Grievance Redressal Mechanism for Insurance	India	205 Policyholders	Convenience sampling	The paper examines the framework of grievance redressal mechanisms as established by the Insurance Regulatory and Development Authority of India (IRDAI). It identifies gaps in policyholder awareness and utilization of redressal platforms such as IGMS (Integrated Grievance Management System) and the Ombudsman. The study emphasizes the importance of strengthening customer education, ensuring transparency in complaint handling, and enhancing responsiveness among private and public insurers.

Mallikarjuna Goda (2021)	A Study on Redressal Mechanism of Health Insurance in India with Reference to IRDA Guidelines	India	200 respondents (policy holder)	Stratified Random Sampling	The study examines the effectiveness and efficiency of grievance redressal mechanisms in the Indian health insurance sector, with a specific focus on IRDA guidelines. The findings show that a majority of policyholders are unaware of the official grievance redressal portals. It also highlights the delay in redressal procedures and the need for digitization and awareness initiatives. The research advocates for policy reforms and enhanced transparency in grievance management systems.
Narendra Maddukuri (2024)	Optimizing Appeals and Grievances Workflows in Healthcare	USA	-	-	This comprehensive article explores the transformation of Appeals and Grievances (A&G) processes in healthcare organizations by implementing advanced technological solutions and workflow optimization strategies. The article examines how artificial intelligence, machine learning, and RPA technologies revolutionize case management, documentation handling, and compliance monitoring in healthcare settings. It investigates the impact of system integration architectures, process optimization methodologies, and quality assurance mechanisms on operational efficiency and patient satisfaction. The article also evaluates the financial implications of implementing modular automated systems and their effect on resource utilization. It also analyses the role of

					change management strategies in successful implementation.
Archana A., Karthik B., Sanjana A. (2024)	Automating Grievance Portal by Automating Central Grievance Redressal System using Artificial Intelligence	India	-	-	This study presents an AI-based centralized grievance portal designed to handle public complaints more efficiently. The system integrates Natural Language Processing (NLP) and machine learning to classify, prioritize, and route grievances automatically. Key findings highlight improved response times, reduced manual effort, and enhanced transparency. The model also supports feedback mechanisms to track satisfaction and system performance.

Chapter 3: Methodology

Research Question

What are the key areas in the grievance redressal process where automation can be suggested to improve efficiency and effectiveness in health insurance?

Implications of Research

This study will provide insights into areas where automation can be suggested to improve workflow, leading to enhanced customer satisfaction, regulatory compliance, and operational efficiency in health insurance grievance handling.

Objectives of the study

- To analyse the current workflow of the grievance department in health insurance.
- To identify key bottlenecks and inefficiencies in the grievance handling process.
- To explore areas where automation can be suggested to optimize workflow.
- To assess the potential impact of automation on operational efficiency and customer satisfaction.

Study Design

This is a descriptive cross-sectional study based on real-time observations to map the current grievance redressal workflow, identify inefficiencies, and suggest automation-ready interventions. The approach is qualitative, with structured observations and analysis of existing operational data.

Study Setting

The study was carried out at the Grievance Department of Aditya Birla Health Insurance, Thane.

Study Population

Inclusion Criteria:

- Policyholders whose grievances were formally logged and processed during the study period.

Exclusion Criteria:

- Grievance cases that are pending legal proceedings or under external regulatory review.

Duration of the study: The study was conducted over 70 days (10th March 2025- 31st May 2025)

Sample size: 613 cases

Sampling techniques: Purposive sampling technique to be used.

Data collection

- Process Observation: Directly monitor the grievance workflow from case intake to resolution.
- Manual Case Tagging: Hands-on involvement in categorizing grievances into predefined case types (claim, service, and mis-sell).
- Key Informant Interviews: Conduct discussions with grievance executives and grievance managers to identify inefficiencies.
- Document reviews, such as SOPs, Daily tagging, and allocation sheets.

Study tools/Instruments

- Observation notes and internal SOPs
- Tagging and allocation data
- Laptop, Excel for data organization and analysis

Operational definitions

TAT- Duration between grievance registration and resolution.

Tagging- The process of manually assigning categories to grievances of customers based on the content of email.

Allocation: Distributing grievance cases to appropriate grievance executives based on case type and load.

Critical request/ complaint

Ethical considerations

- Confidentiality: No sensitive data about policyholders, including names, or policy numbers, was collected or disclosed.
- Data Security: All information accessed during the internship was managed following the privacy policies of the organization and was not kept on an external system
- The grievance team that participated in the study performed voluntarily, free from organizational pressure or coercion.

Chapter 4: RESULTS

Case Volume and Assignment

- A total of **2,821 grievance cases** were recorded for tagging during the study period. Out of these, **613 cases were assigned** for detailed review and processing, forming the working sample for analysis.
- Out of these, **613 cases** were assigned for detailed review.
- The researcher handled **21.7%** of the total tagging volume.

Case Closure Overview

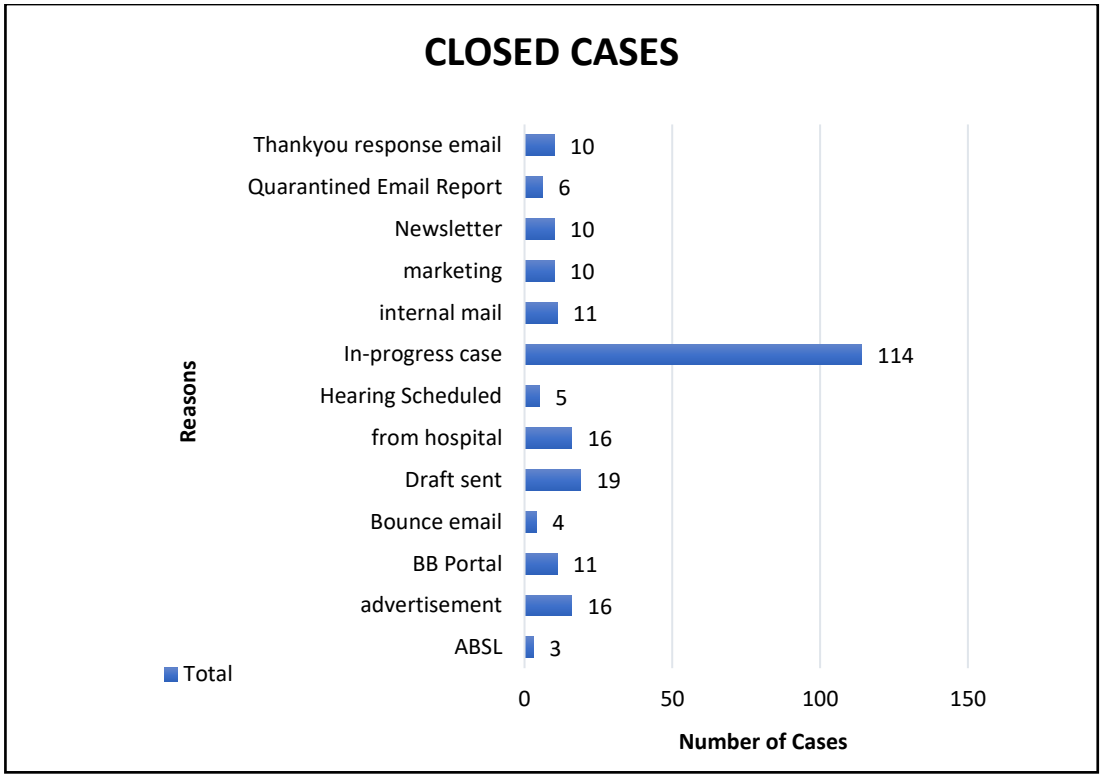

Figure 4.1

- 235 out of 613 assigned cases were closed, amounting to a closure rate of 38.3% during the study period.
- The top reason for case closure (approximately 48.5%) was identification of "In-progress case" (114 cases), indicating that these were duplicates of already ongoing grievances.

Created Cases and Retrieval

- Out of the assigned cases, created 378 cases in the system.
- Due to a system syncing error, only 363 cases were retrievable for analysis at the time of the report.

Fresh vs. Repeat Case Status

The retrieved created cases were further analysed to determine whether they were new or recurring grievances.

Table 4.1

Status	No. of Cases	Percentage
Fresh	95	26.2%
Repeat	268	73.8%
Total	**363**	**100%**

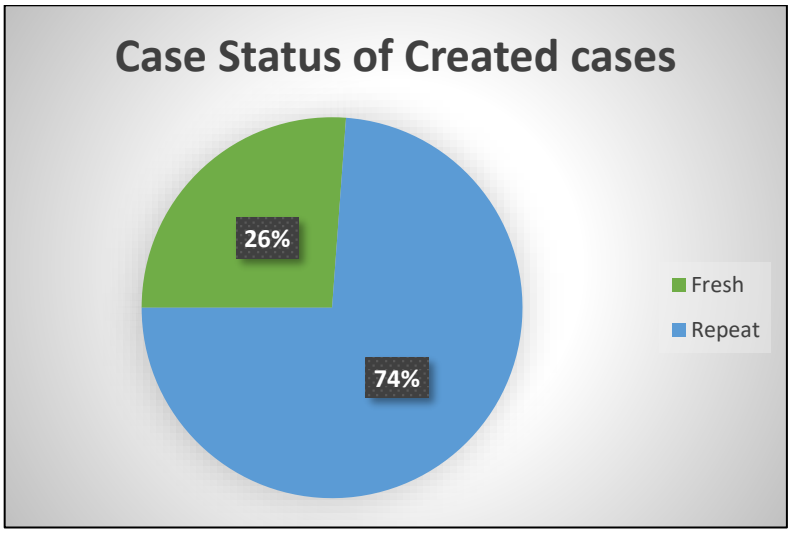

Figure 4.2

- Of the 363 available created cases:
- 268 cases (74%) were identified as repeat grievances.
- 95 cases (26%) were fresh grievances.

Categorization of Created Cases by Type

The Cases created were grouped by the nature of the grievance.

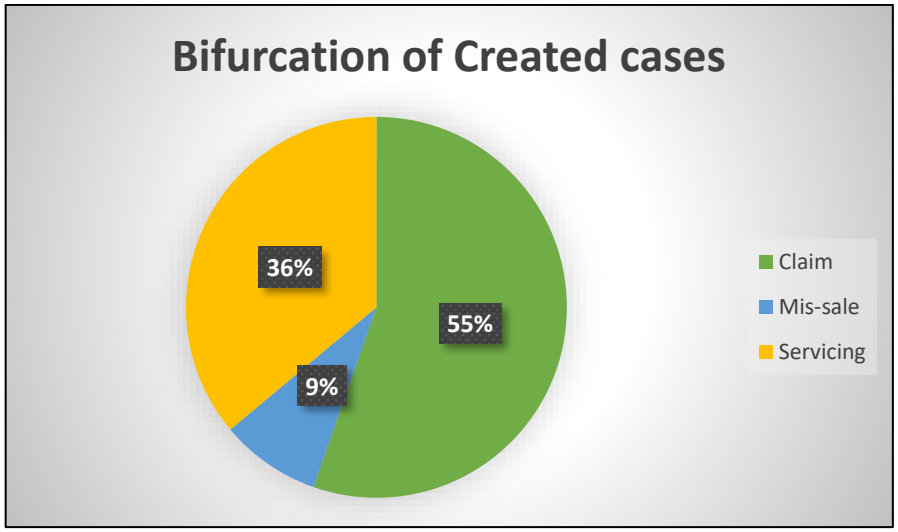

Figure 4.3

Among the 363 created cases:

- Claim-related – 201 cases (55%)
- Servicing-related – 131 cases (36%)
- Mis-sell-related – 31 cases (9%)

Fresh vs. Repeat Cases by Grievance Type

Repeat cases were predominant across all three grievance categories, especially in mis-sell (90%) and servicing (79%). The most fresh cases appeared in the claim category (64 cases), followed by servicing (28 cases).

Table 4.2

Grievance Type	Fresh Cases	Repeat Cases	Total Cases	% Fresh	% Repeat
Claim	64	137	201	31.8%	68.2%
Mis-sell	3	28	31	9.7%	90.3%
Servicing	28	103	131	21.4%	78.6%
Total	**95**	**268**	**363**	**26.2%**	**73.8%**

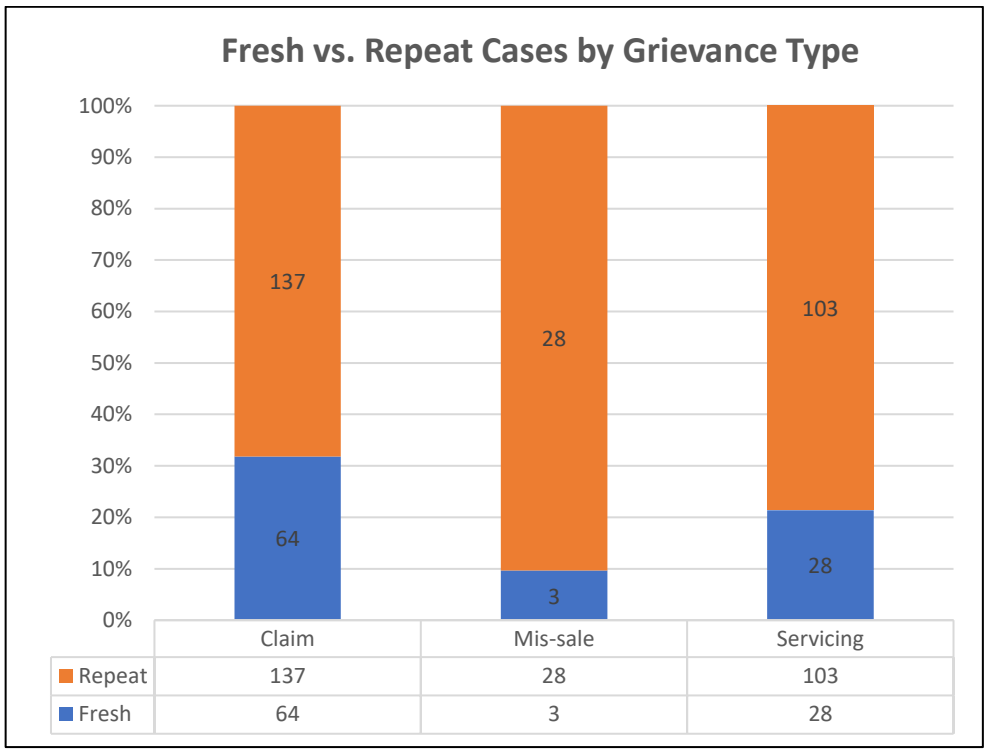

Figure 4.4

- Claim-related grievances had the highest number of fresh cases (64), while still showing a majority of repeat cases (137).
- Mis-sell grievances showed the highest proportion of repeat cases at over 90%, with only 3 fresh entries recorded.
- Servicing-related grievances also showed a high proportion of repeat cases (103) compared to 28 fresh cases.
- The analysis shows that repeat case frequency was notably high across all categories, with the lowest fresh case count observed in mis-sell issues.

CLAIM CASES

Table 4.3

Claim Type	**Number of Cases**	**Percentage**
RI	188	93.5%
Cashless	13	6.5%
Total	**201**	**100%**

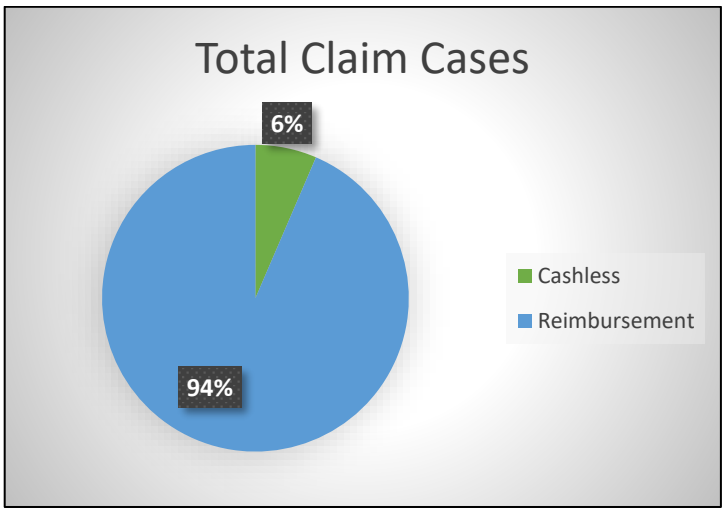

Figure 4.5

- Out of 201 total claim cases, 188 cases (94%) were related to reimbursement claims.
- Cashless claim issues accounted for 13 cases (6%), making them a minor portion of the total claim-related grievances.
- Reimbursement grievances were predominant in the claim category.

SERVICE CASES

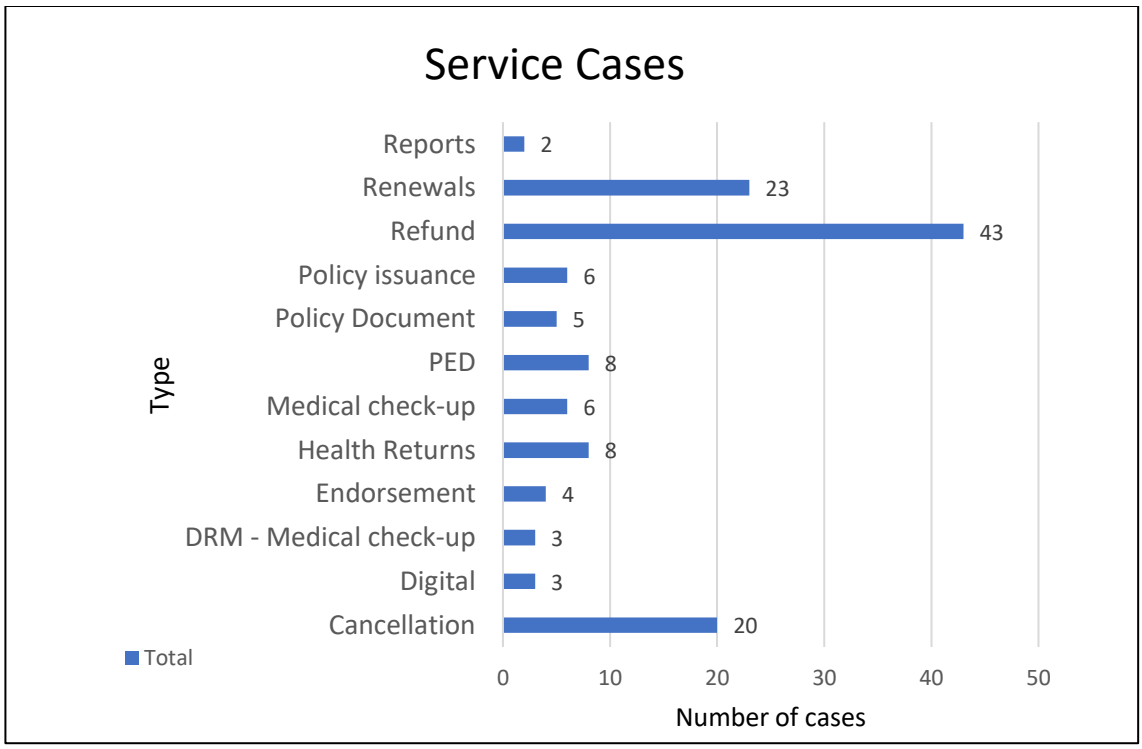

Figure 4.6

- Refund-related cases were the most common, comprising 43 out of 131 cases (32.8%).

- Renewals (23 cases) and Cancellations (20 cases) also contribute significant numbers of servicing-related grievances.
- Other service concerns like PED, health returns, medical check-up, and digital services accounted for smaller proportions.

IRDA Cases

During the study period, 200 fresh grievances were identified as IRDA-regulated complaints.

IRDA-regulated grievances were received through multiple official channels,

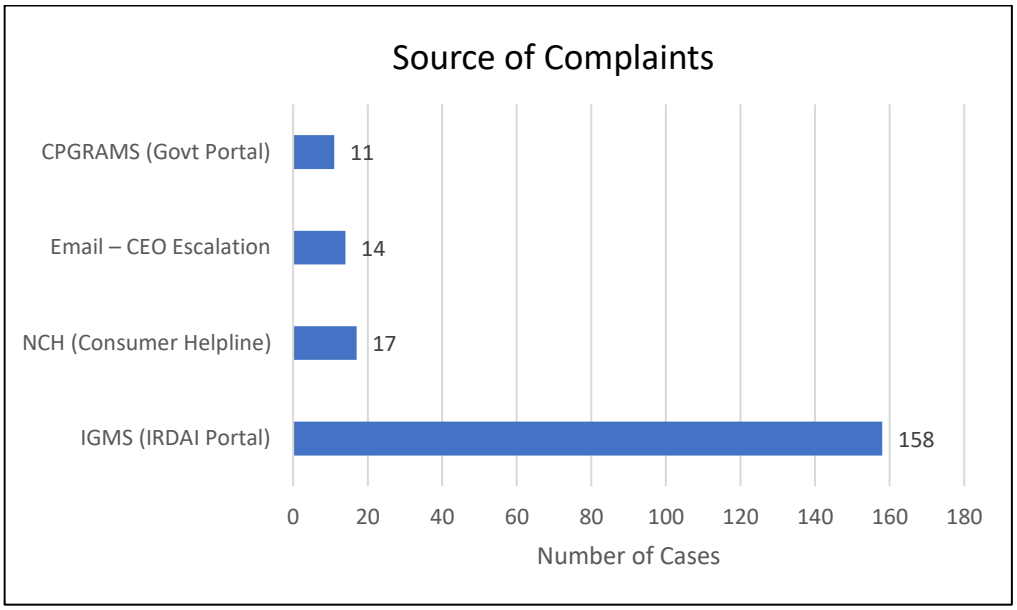

Figure 4.7

- The IGMS portal was the dominant channel, accounting for 158 out of 200 IRDA cases (79%).
- The National Consumer Helpline (NCH) accounted for 17 cases (8.5%).
- Direct escalations to the CEO via email made up 14 cases (7%).
- CPGRAMS, the Government's centralized public grievance portal, accounted for 11 cases (5.5%).

Categorisation of grievance In the IRDA case

Table 4.4

Grievance Type	No. of Cases	Percentage
Claim	141	70.5%
Servicing	53	26.5%
Mis-sell	6	3.0%
Total	**200**	**100%**

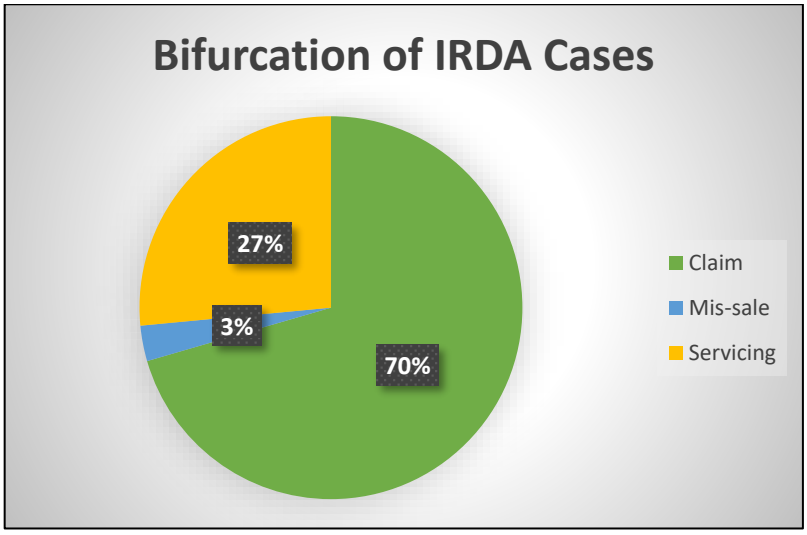

Figure 4.8

Chapter 5: DISCUSSION

The analysis of grievance tagging and resolution activities in the health insurance sector revealed several operational characteristics of the current system. The study spanned 17 days and covered 613 assigned cases, out of which 235 were closed. The most prevalent reason for closure—accounting for nearly 48.5%—was that the grievance was already being addressed under an existing case ("in-progress"), indicating multiple entries of the same issue by customers.

Further, the analysis of created cases showed that 74% were repeat grievances, while only 26% were fresh. This pattern was consistent across all grievance categories—claim, mis-sell, and servicing, with mis-sell grievances showing the highest repeat ratio (90.3%). This high incidence of repeat cases suggests a recurring behaviour pattern in how grievances are registered and highlights the need for clear documentation and streamlined communication with customers.

Within claim-related grievances, reimbursement claims dominated the volume (94%), while cashless claim issues were minimal (6%). This indicates that customers are more likely to escalate issues after treatment, possibly due to dissatisfaction with reimbursements or delayed settlements.

In the servicing category (n = 131), the most frequently raised concerns were related to refunds (43 cases), policy renewals (23 cases), and policy cancellations (20 cases)—all of which are critical to policyholder retention and customer experience perspective.

Further, 200 IRDA-regulated grievances were analysed, with claim-related issues accounting for 70%, followed by servicing (27%) and mis-sell (3%). Among the channels through which IRDA grievances were received, the Integrated Grievance Management System (IGMS) emerged as the dominant platform, contributing 79% of cases. Other sources included the National Consumer Helpline (NCH), CPGRAMS, and CEO email escalations

The study provided a detailed snapshot of the grievance process flow, highlighting volume trends, category distributions, and submission patterns. The structured tagging and allocation of cases offered valuable insights into the operations of grievance department.

Chapter 6: Conclusion

This research aimed to map the existing grievance redressal process in the health insurance and to identify recurring patterns in case categorization and closure. Over the course of the study, 613 cases were systematically reviewed and analysed. The findings demonstrated that a significant proportion of grievances were repeat submissions and that reimbursement claim issues formed the bulk of escalations.

The analysis of servicing-related complaints highlighted key areas of customer concern, particularly related to financial refunds, renewals, and cancellations. In addition, the review of IRDA cases confirmed the predominance of the IGMS portal as the preferred channel for external grievance escalation, with claim-related concerns again taking precedence.

Through structured tagging, allocation, and closure tracking, the study documented the grievance team's functioning and the types of cases typically encountered. The results contribute to a broader understanding of health insurance providers' operational workload and grievance characteristics.

Recommendations:

1. Automation of Case Tagging Using Natural Language Processing (NLP)

Challenge: Manual tagging is time-consuming and inconsistent.
Recommendation: Integrating an NLP in SFDC to auto-classify cases by reading grievance text (claim/service/mis-sell, subtypes). This will improve accuracy and speed up triage (1,2).

2. Deployment of a Rule-Based Auto Allocation Engine

Challenge: Manual end-of-day allocation can lead to delays.
Recommendation: Implementation of RPA bot in SFDC for real-time case distribution based on executive expertise and workload, ensuring TAT compliance (3).

3. Integration with Bima Bharosa and Jarvis Systems for Document Retrieval

Challenge: Executives switch between portals for IRDA complaints and document verification.
Recommendation: An API-based integration between SFDC, the Bima Bharosa portal,

and Jarvis is recommended. This connector should enable auto-fetching of IRDAI complaint data and supporting documents (medical reports, policy details, previous correspondence) linked to the case file. A connector in SFDC to auto-fetch IRDA details and link with Jarvis for supporting documents (4,5).

4. Implementation of a Decision Support System (DSS) for Resolution Outcomes

Challenge: The current approach to grievance resolution relies heavily on executive judgment.

Recommendation: A data-driven Decision Support System (DSS) should be embedded into the SFDC platform. This engine would analyze historical data, underwriting notes, and decision patterns to recommend case outcomes (e.g., approval, rejection with reason, partial settlement). Incorporating such a DSS can reduce subjectivity, improve regulatory compliance, and boost executive productivity (6,7).

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