

**QUALITY AND QUANTITY MANAGEMENT IN CLAIM PROCESSING:
ANALYSING THE EFFICIENCY OF GROUP HEALTH INSURANCE
DEPARTMENT (REIMBURSEMENT TEAM) AT CARE HEALTH INSURANCE**

Dissertation Submitted to



The IIHMR University, Jaipur

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Master of Business Administration (MBA)

in

Hospital and Health Management

by

Rutika Ravi Gupta

Under the Supervision and Guidance of

Dr. Deepti Sharma

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CERTIFICATE

This is to certify that **Rutika Ravi Gupta**, 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.

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Self Help Portal:
www.careinsurance.com/self-help-portal.html

Submit Your Queries/Requests:
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CERTIFICATE

This is to certify that dissertation titled **“QUALITY AND QUANTITY MANAGEMENT IN CLAIM PROCESSING: ANALYSING THE EFFICIENCY OF GROUP HEALTH INSURANCE DEPARTMENT (REIMBURSEMENT TEAM) AT CARE HEALTH INSURANCE”** is a record of the research work undertaken by Rutika Ravi Gupta in a 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. Deepti Sharma

Place: IIHMR University, Jaipur

Date: 16.06.2025



School Dean: Dr. Sanjay Gupta

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Date: 16.06.2025

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **Quality and quantity management in claim processing: analysing the efficiency of group health insurance department (reimbursement team) at Care 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.


Rutika Ravi Gupta

Name of Student

Date: 16/6/25

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ABSTRACT

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Title: Quality and quantity management in claim processing: analysing the efficiency of group health insurance department (reimbursement team) at Care Health insurance

The health insurance sector in India has experienced significant growth in recent years, with group health insurance emerging as a crucial segment due to its wide coverage and employee-centric benefits. Within this framework, efficient claim processing—especially under reimbursement models—is vital to ensuring customer trust, regulatory compliance, and financial sustainability. However, insurance companies often face the challenge of balancing **quantity** (the speed and volume of claims processed) with **quality** (accuracy, compliance, and customer satisfaction). An imbalance between the two can lead to delayed settlements, increased errors, dissatisfied policyholders, and even regulatory penalties.

This dissertation focuses on evaluating how the **group health insurance reimbursement team at Care Health Insurance** manages this balance between quality and quantity in claim processing. The study aims to understand the operational dynamics, identify performance gaps, and assess the strategies deployed by the team to ensure efficient processing of high claim volumes without compromising on quality standards. The research explores various Key Performance Indicators (KPIs) such as turnaround time (TAT), claim approval rate, and audit (error) accuracy.

A mixed-method approach is employed, combining **quantitative analysis of internal claims data** with **qualitative insights from interviews with claims officers, managers, and auditors**. The study also examines the impact of technological interventions like automation, and AI-based fraud detection tools on claim efficiency. Additionally, it considers how staff training, process standardization, and regulatory awareness contribute to maintaining quality benchmarks.

The findings reveal that while the reimbursement team at Care Health Insurance demonstrates a strong commitment to both timely and accurate claim processing, there are recurring challenges such as documentation errors, inconsistent communication with hospital billing departments, and periodic surges in workload. The dissertation concludes with actionable recommendations to streamline claim workflows, improve audit readiness, and balance operational throughput with service excellence.

By providing a focused analysis of one of India's leading health insurers, this study aims to contribute valuable insights into improving claim processing practices, ensuring policyholder satisfaction, and enhancing the credibility of group health insurance reimbursement models in India.

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ABOUT CARE HEALTH INSURANCE



Care Health Insurance Ltd (its previous name being Religare Health Insurance, incorporated July 2012) is a dedicated health insurance firm in India. It is a part of the listed diversified financial services group and the promoter and majority shareholder of Religare Enterprises Ltd (REL). Its head office is located in Gurugram, Haryana. Within a short time, it has established a pan-India footprint: by 2024 it had ~260 branches and had around 9,500 employees, covering over 9 crore insured lives and settling ~58 lakh claims till date. Care is well known (industry recognitions and media) as India's second-largest independent health insurer. Its cashless network of providers crosses 21,700 hospitals across India.

Care Health Insurance deals only in the health and wellness business, selling a variety of risk products related to health to retail and corporate clients. Its business model is built around direct and digital distribution, technology-facilitated service, and value-added benefits. All the key offerings – individual/family health, top-up, critical illness, maternity, travel insurance, personal accident, and group health/PA schemes – are developed with "reward for healthy living" benefits and customer-focussed benefits. For instance, Care Ultimate plan singly pays back one year's premium upon five consecutive claim-free years, and offers bonus cover increases. Care focuses its strategy on investment in technology (mobile app, online underwriting, AI-based claims) and high service quality. Consequently, it keeps strong solvency and combined ratios (solvency ~1.74x, combined ratio~95%), which are consistent with REL's governance-backed capital support. It plans to increase its market share by increasing digital and offline reach, taking advantage of REL's distribution network (banks, NBFCs) and deepening penetration in underpenetrated segments (senior citizens, rural).

Chapter 1 - INTRODUCTION

Introduction

Problem statement-

Care Health Insurance processes a high volume of group health reimbursement claims daily, where maintaining speed (quantity) without compromising accuracy (quality) is a constant challenge. Errors, delays, and audit findings can impact customer satisfaction and regulatory compliance. This study addresses the need to evaluate how effectively the organization balances quality and quantity in claim processing and identifies gaps for improvement.

Purpose of the Research

The purpose of this research is to evaluate how effectively the group health insurance reimbursement team at Care Health Insurance manages both the quality and quantity of claim processing. In the context of the health insurance industry, particularly in India's fast-growing healthcare ecosystem, the balance between timely claim resolution (quantity) and accurate, error-free processing (quality) is crucial.

This study intends to assess the current operational efficiency of the reimbursement process, identify challenges faced by the team, and explore the tools and strategies used to maintain optimal performance. Through this analysis, the research will offer practical recommendations for improving processing speed while maintaining high standards of service delivery and compliance. Ultimately, this research contributes to enhancing claim management systems, improving policyholder satisfaction, and strengthening the company's market competitiveness.

The Problem Being Investigated

Health insurance providers, particularly in group policies, face intense pressure to process large volumes of reimbursement claims within a limited timeframe. While the quantity of claims processed determines customer retention and operational productivity, the quality—including accuracy, adherence to regulatory norms (IRDAI, NABH), and minimization of fraudulent claims—determines the organization's credibility and compliance status.

In many insurance companies, including Care Health Insurance, the reimbursement team handles claim post-treatment, often requiring extensive scrutiny of medical documents, hospital bills, discharge summaries, and prescriptions. When documentation is incomplete or ambiguous, delays occur. If errors happen in adjudication or if claims are unfairly rejected or approved without proper verification, it affects both financial outcomes and customer trust. Moreover, manual processing, staff workload fluctuations, lack of standardized practices, and varied hospital formats further compound the problem.

This research investigates how these problems impact the overall efficiency of the reimbursement claim process. It examines whether the current systems and staff practices are adequate for maintaining the required balance between quality and quantity, and where gaps may exist that can be addressed through training, technology, or process redesign.

Context and Importance of the Problem

In the post-pandemic era, with increasing reliance on health insurance, customers have become more aware and sensitive to timely claim settlements. Group health insurance policies, offered by employers, cover large numbers of employees and their families, making the reimbursement team a critical touchpoint for thousands of insured individuals. Care Health Insurance, being a leading health insurance provider, handles a significant volume of group reimbursement claims across India. These claims are not only time-sensitive but also subject to strict audit and compliance standards. Failure to process claims efficiently can result in regulatory scrutiny, reputational damage, and loss of client contracts.

Additionally, with the growing demand for paperless processing and digital transformation, the pressure to improve turnaround time (TAT) without compromising on correctness has never been higher. Understanding how the reimbursement team navigates these challenges is important for organizational growth, enhanced stakeholder satisfaction, and setting industry benchmarks.

The relevance of this research lies in the fact that group claim reimbursement processes directly impact both the insured population and the insurer's sustainability. By focusing on Care Health Insurance as a case study, this research aims to offer actionable insights not only for internal process optimization but also for broader policy-level improvements in claim management systems in India.

Chapter 2 - AIM & OBJECTIVES

Aim-

To analyse and understand the management of both quality and quantity in the claim processing workflow of group health insurance at Care Health Insurance, with a focus on assessing the operational efficiency, accuracy, and effectiveness of claims adjudication.

Objectives-

1. To evaluate the effectiveness of claim processing by analysing the monthly volume of processed claims and identifying the proportion of cases with errors, reopening, or discrepancies as reflected in audit findings.
2. To identify key challenges and operational bottlenecks within the current claim processing system that hinder optimal performance, including workflow inefficiencies, resource allocation issues, and dependency on manual or repetitive processes.
3. To provide practical recommendations for improving the balance between quantity and quality in the claims adjudication process, focusing on reducing dependency on manual intervention, strengthening internal audit mechanisms, and enhancing automation and process standardization.

Chapter 3 - REVIEW OF LITERATURE

Year	Author(s)/Source	Key Insights
2017	Sood et al.	Linked timely claim processing to improved outcomes under public health insurance.
2018	Jain & Mahajan	Identified inefficiencies in manual workflows and lack of process standardization.
2018	Reddy & Rao	Highlighted the need for regulatory and operational improvements in claims handling.
2021	NITI Aayog	Stressed importance of seamless group insurance claims in boosting trust.
2021	Kaur & Kumar	Quantified bottlenecks in claim processing, especially in group health insurance.
2022	FICCI Health Insurance Committee	Called for automation to manage high claim volumes efficiently.
2022	PwC India	Promoted AI and analytics for fraud control and faster claim adjudication.
2022	CAG Audit Report	Revealed irregularities in PSU insurer claim handling; recommended better oversight.
2023	Milliman India	Benchmarked digital insurers with improved claim TAT and fewer errors.
2023	Deloitte India	Demonstrated productivity gains through automated settlement engines.
2023–24	IRDAI	Mandated faster TATs, quality review, and digital transformation via NHCX.
2024	Policy bazaar Health Insights	Reported high approval rates but highlighted issues in payout clarity.
2024	National Health Authority (NHA)	Launched NHCX for real-time, standardized digital claim exchange.
2025	Care Health Insurance (Internal Data)	Audit data showed improved quality and quantity metrics over 3 months.

Group Health Insurance Claim Processing in India

Group health insurance covers employees or associations under a single master policy. It is a major component of India's insurance market – for example, one 2020 survey found that roughly 42% of health insurance claims came from group/employer policies. Claim processing in this segment involves complex workflows: hospitals initiate cashless claims or customers file reimbursement claims, TPAs and insurers verify documents, and approvals or payments are issued. According to industry analysis, efficient claims management is crucial for insurers' viability and competitiveness. Insurers must quickly adjudicate and settle large claim volumes while ensuring accuracy, otherwise fraud, overpayment, or customer complaints can arise. The scale of group portfolios puts pressure on processing quantity (speed of settlement) while also demanding high quality (correctness and compliance).

Operational Efficiency and Workflows

Claims processing typically follows a multi-step workflow: claim intimation, document collection, verification, authorization, and payment. In practice, delays and errors often occur at several stages. For example, manual data entry and incomplete documentation are common bottlenecks: without full digitization, insurers manually key medical bills and reports, leading to errors and lost time. Similarly, pre-authorization (cashless) processes can be unclear, causing back-and-forth queries among hospitals, TPAs, and insurers. These inefficiencies inflate administrative costs and slow turnaround times. Industry experts note that “information gaps, such as incomplete documents, ... delay claims processing and increase costs. Unclear processes ... cause avoidable queries and delays” To optimize throughput, best practices include standardized forms, straight-through processing for routine cases, and parallel-processing of claim sub-tasks. For instance, some insurers use rule-based engines to auto-validate bills, reducing manual review time. These measures help process higher volumes (quantity) while maintaining or improving accuracy (quality).

Quality vs. Quantity Management

Balancing speed with accuracy is a key challenge in claim workflows. Pursuing high quantity (throughput) without quality controls can lead to errors, fraud payouts, and unhappy customers. Conversely, over-emphasis on accuracy and fraud control can slow settlements and frustrate claimants. Insurers therefore employ quality-management practices such as dual-review (maker-checker) systems, exception reporting, and defined service-level agreements (SLAs). IRDAI now mandates that no claim be repudiated without review by a multi-member committee which safeguards quality but can add time. Likewise, performance metrics like *claim settlement ratio* and *average TAT* are tracked at insurer and TPA levels. For example, a recent report notes that 94–97% of health claims were approved, reflecting high throughput, and 86% of customers reported satisfaction. These figures suggest a generally efficient process, but also indicate room to raise payout completeness (currently ~87%) and further reduce rejection reasons (e.g. non-disclosures). In sum, literature emphasizes that streamlining processes (increasing quantity) should be paired with robust controls and reviews (ensuring quality) to optimize overall outcomes.

Process Bottlenecks and Challenges

Multiple factors impede efficient claim processing in India's group insurance:

- **Document and Data Issues:** Claim intimation often lacks accurate policy or member details, especially in large group schemes. IRDAI requires insurers to obtain member data promptly to avoid denials for missing information. Incomplete or non-standardized medical records from hospitals cause rework. Insurers combat this by digitizing forms (OCR-based data capture) and standardizing diagnosis and treatment coding.
- **Third-Party Administrators (TPAs):** Most health claims are adjudicated by TPAs. Variability in TPA performance can slow claims. Audits have found cases where PSU insurers engaged non-empanelled TPAs, violating guidelines, leading to inefficiency. IRDAI now requires insurers to closely monitor TPAs with board-approved criteria (including TATs and service metrics) and even claw back fees for poor performance.
- **Provider Network Limitations:** Limited hospital networks cause routing delays or require ad-hoc reimbursements. A CAG audit noted PSU insurers had only ~2,500 empanelled hospitals (versus ~10,000 for large private insurers), exacerbating processing delays and out-of-network reimbursements. IRDAI urges "common empanelment" so cashless claims can be settled anywhere and pushes inclusion of all hospital categories to expand access.
- **Fraud and Abuse:** Fraudulent claims (faked documents, staged procedures) require scrutiny. While AI and analytics can flag anomalies, manual review is still needed for many cases. Oversights in group underwriting also cause problems: a 2022 CAG report linked PSU insurer losses to underpriced group policies with excessive claims highlighting that suboptimal pricing and oversight of group schemes can indirectly strain claims resources.
- **Multiple Policies and Payments:** Many claimants hold multiple policies (e.g., employer group plus individual cover). Coordination between insurers for co-payment can complicate processing. IRDAI now allows policyholders to choose the primary policy for claim settlement, with the insurer coordinating any balance. This reduces claimant confusion but requires insurers' back-end coordination, which can be a logistical challenge.

Regulatory Framework and Compliance

The IRDAI has issued extensive regulations to improve claim processes and protect policyholders. The May 2024 Master Circular on Health Insurance consolidates earlier norms and mandates strict timelines: insurers must approve cashless authorizations within 1 hour of request and final discharge authorizations within 3 hours of receiving a discharge summary. If insurers delay past these limits, they must bear additional hospital charges. These rules push insurers toward speed (quantity) but also ensure accountability (quality) since undue delays penalize insurers.

Other key IRDAI requirements include: display of clear turnaround times for claims on websites use of Claim Review Committees (CRC) for denials collection of claim documents from providers (not the insured) and mandatory renewal/protection of benefits during a one-month grace period Insurers must empanel all hospitals (to ease cashless claims) and are encouraged to adopt the National Health Claims Exchange (NHCX) gateway. The NHCX, backed by MoHFW and IRDAI, provides a standardized digital platform to exchange claims data among insurers, TPAs, hospitals, and beneficiaries It enforces machine-readable, audit-friendly data exchange for accuracy. As of July 2024, 34 insurers/TPAs and ~300 hospitals were live on NHCX, reflecting regulatory emphasis on interoperability and rapid settlement.

By compliance and governance, IRDAI aims to raise quality. For example, insurers must establish a Board-approved Claims Review Committee (CRC) for repudiation decisions and maintain proper grievance mechanisms. They must also train staff on products, policy terms, and TATs. Periodic audits (both internal and by regulators) scrutinize claims handling – for instance, a recent audit mandated insurers abide by guidelines on third-party administrators and group underwriting (citing heavy losses from non-compliance). In this way, regulatory controls interlock with operational procedures to enforce both efficiency and fairness in claims processing.

Digital Transformation and Automation

Technology is seen as a key enabler of faster, more accurate claims processing. Across the industry, efforts focus on *straight-through processing*. Digital initiatives include end-to-end online portals, mobile apps, and automated adjudication engines. For instance, ICICI Lombard launched an AI-powered claim settlement engine that approved ~60% of group health claims within minutes (up from 31%) On a national level, the NHCX platform ensures standard data exchange for thousands of annual claims

Analysts note that the COVID-19 pandemic accelerated digital adoption. The lack of in-person processes highlighted the need for paperless, tech-driven workflows. A Milliman report observes that “patients want faster claims settlements, which requires automated claims adjudication ... enabled by OCR, AI, and machine learning” OCR (optical character recognition) tools convert hospital bills into electronic data, and AI/ML models apply clinical rules to flag irregularities or expedite routine claims Fraud detection is enhanced by predictive analytics: patterns in data can alert insurers to suspicious claims that need manual review, while clear cases move on automatically.

Machine learning also assists in pre-authorization: algorithms can quickly validate coverage and network status, generating instant approvals for standard procedures. Some insurers deploy chatbots and apps for real-time claim status updates, improving transparency. Overall, the literature indicates that digital transformation helps resolve the quality–quantity dilemma: it allows insurers to process large volumes rapidly *and* reduce human errors. NHCX itself embodies this trend by enforcing machine-readable claim data and enabling standardized checks on every claim

Customer Satisfaction and Service Quality

Customer experience is a central theme in health claims management. Long waiting times, opaque processes, or unexpected rejections can erode trust. Studies and industry surveys show mixed sentiments: while claim approval rates are high, payout delays and claim amounts still fall short for some. A 2024 Policy Bazaar report found ~94% of claims are approved (rising to 97% for online claims), and overall customer satisfaction at 86%. This suggests most customers eventually get paid, reflecting insurer efficiency. However, payout completeness is around 87%, meaning there is scope to improve how much patients receive relative to their bills. Insurers identify common problems (e.g. exclusions, documentation gaps) and try to educate customers and distributors to fill those gaps.

To directly measure service quality, insurers track metrics like claim TAT, Net Promoter Score, and complaint volumes. According to IRDAI data, grievance ratios in health insurance are very low (e.g. ~0.003% of policies), though financial ombudsman cases still arise from claim disputes. High-performing companies (like some private insurers) tout cashless settlements and quick turnarounds in their branding. In practice, satisfying customers means both speed and clarity: explaining claim decisions fully (as now required by IRDAI, providing helplines, and using technology (apps, SMS) to update claimants. The literature emphasizes that “high customer satisfaction levels can give the company a competitive edge”, and timely claims is a key factor

Auditing, Monitoring, and Quality Assurance

Robust audit and oversight systems reinforce claim quality. Insurers typically employ internal audit teams to review claim adjudications, and may implement random audits on settled claims to detect errors or fraud. Regulators also audit insurers; for example, the CAG report cited repeated multiple payouts and policy violations in group claims by PSU insurers. In response, IRDAI now mandates a Claims Review Committee (CRC) – a sub-group of the Policyholders’ Medical Committee – to approve any claim repudiation ensuring that rejections are justified and documented.

Board-level governance is also prescribed: the IRDAI Circular requires insurers to set Board-approved Key Performance Indicators (KPIs) for TPAs and customer servicing. Insurers must collect customer feedback post-claim, and may claw back TPA fees if service levels falter. Every policyholder grievance must be addressed promptly, with clear escalation channels to an ombudsman if needed. Claim settlements must also be compliant with policy terms: auditors check for any unauthorized waivers or breaches of waiting periods. In practice, this means insurers balance the drive for quick settlements with careful documentation. For instance, while new rules push 100% cashless settlement, auditors still verify that all claims meet eligibility criteria and policy conditions.

Staff Training and Organizational Factors

Claim processing is personnel-intensive, and well-trained staff are essential to handle complex cases. Insurers therefore invest in regular training on products, medical coding, and regulatory changes. The IRDAI Master Circular explicitly mandates “periodical training to intermediaries, distribution channels, and employees” on existing/new products, turnaround times, and regulatory updates. Training programs cover topics like recognizing inadmissible claims, fraud red flags, and efficient use of IT systems. Staff

competency affects both speed and quality: experienced examiners can quickly triage standard claims, while knowing when to escalate complicated ones. Companies also emphasize cross-skilling between departments (e.g. between cashless authorizers and reimbursement handlers) to streamline hand-offs.

Organizational factors like incentive structures matter too. Many insurers shifted TPA remuneration away from claim ratios (to avoid bias against claim approvals) Instead, quality metrics, accuracy scores, and customer feedback now influence rewards. Lean and Six Sigma techniques have been adopted by some insurers to identify waste in claims processes. Though academic studies in India are limited, global literature suggests that process mapping and continuous improvement (PDCA cycles) in claims desks can significantly cut turnaround times without raising error rates.

Chapter 4 – METHODOLOGY

Study Design

This research employed a retrospective, descriptive study design. Data were drawn from existing operational records (claims databases and audit reports) without any intervention, allowing examination of performance metrics as they naturally occurred. A descriptive design is appropriate for characterizing the distribution of key variables (such as reopen claims and error rates) without testing causal hypotheses. By retrospectively analysing claims processed from January through March 2025, the study captures current operational efficiency and allows the team's performance on quality (accuracy, error incidence) and quantity (volume, speed) metrics to be described. No experimental or prospective data collection was involved; all analyses are observational.

Study Setting

The study was conducted within the Group Health Insurance Reimbursement department of Care Health Insurance, a major health insurance provider in India. Care Health Insurance processes claims submitted by corporate clients (group policies) and has a dedicated claims team handling reimbursement. The setting includes the insurer's central claims-processing centre and the internal audit unit responsible for quality checks. All relevant data were sourced from the company's internal claims management systems and audit logs. The team's standard operating procedures, claim adjudication workflows, and auditing protocols inform the context for this analysis.

Study Duration

This retrospective analysis covers the first quarter of 2025. Specifically, data were collected for claims processed between January 1, 2025 and March 31, 2025. This three-month window was chosen to provide a clear, recent snapshot of operational performance and to allow month-by-month trend analysis. Covering a full quarter ensures seasonal or cyclical effects (if any) can be observed. The internal audit findings for this same period were also included to correlate quality outcomes with operational metrics.

Study Population (Inclusion and Exclusion Criteria)

- Inclusion Criteria:
 - All health insurance reimbursement claims processed by the group (corporate) health insurance team during Jan–Mar 2025.
 - Claims for which complete processing data were available (e.g. submission date, decision date, approval/rejection status).
 - Claims pertaining to group health insurance policies (e.g. employee group plans) handled by the designated team.
 - Internal audit records corresponding to this period, specifically audit reviews of claims sampled in Jan–Mar 2025.
- Exclusion Criteria:
 - Claims not related to group health insurance (e.g. individual or non-health lines).
 - Any claim records lacking essential data (missing dates or final status) or those that remained pending by March 31, 2025.

- Duplicate or test records (e.g. system tests) that are not genuine reimbursements.
- Audit findings outside the Jan–Mar 2025 period or audits of claims not processed by the group insurance team.

By defining these criteria, the study population consists of all relevant, fully-processed group health claims and corresponding audit results within the selected period. This ensures the analysis focuses on the team’s actual workload and documented quality outcomes.

Sampling Method and Sample Size

Because the study is retrospective and all claim records for the period were accessible, a census approach was used. In other words, *all eligible claims* satisfying the inclusion criteria were included in the analysis, rather than drawing a sample. This complete enumeration maximizes data use and avoids sampling bias. If needed, one could also employ stratified sampling (for example, randomly selecting a fixed percentage of claims from each month) to ensure representativeness; however, the data volume for three months was manageable so the full dataset was analysed.

For reference, similar retrospective studies in health services often rely on complete claim registries for the study period. In practice, the total sample size equalled the number of processed group claims in Jan, Feb, and Mar 2025 combined (as reported by the system) and all audited claims for that quarter. The study did not impose a predetermined numeric sample size; instead, it analysed the entire available population. The internal audit portion of the data typically involved the subset of claims that the quality team selected for review in each month according to standard audit procedures.

Data Collection Tools and Variables Analyzed

Data were extracted from the insurer’s internal information systems and audit documentation using the following tools and variables:

- Data Sources and Tools:
 - Claims Management System: The primary data source was the company’s claims database, which tracks each claim’s submission date, processing steps, and final outcome. Claims data were exported (e.g. as CSV/Excel) for analysis.
 - Internal Audit Reports: The quality/audit team’s reports and checklists for Jan–Mar 2025 were reviewed. These documents record any processing errors, compliance issues, and corrective actions for sampled claims.
 - Documentation: Company policy manuals and claim processing protocols were referenced to understand how metrics are defined (e.g. calculation of turnaround time, error classification).
- Variables and Performance Indicators: The study focused on key operational metrics reflecting both quality and quantity:
 - Claim Approval and Rejection Rates: The counts and percentages of claims approved versus denied (rejected) were computed. This reflects decision accuracy and policy compliance.

- Error Rate: The proportion of audited claims that contained processing errors. Errors were categorized into procedural (e.g. documentation, authorization mismatches) and financial (e.g. underpayments/overpayments) types, following the internal audit framework. The error rate was calculated as (number of audited claims with any error / total audited claims) $\times$ 100%.
- Audit Outcomes: Details from the audits were analysed, including the total number of findings, types of errors, and severity. This qualitative audit information provides context to error rates and indicates areas needing improvement.
- Claims Volume (Quantity): The total number of claims processed per month was recorded. This measures the workload or throughput.
- Quality Metrics: In addition to error rate, any internal “quality score” or compliance rating assigned during audits was noted. (For example, audits might assign a pass/fail status or a percentage score for each claim’s processing accuracy.)

Each variable was clearly defined and recorded. For example, TAT was measured in calendar days using system timestamps, and error categories were based on the audit checklist. All data collection was performed in a standardized manner to ensure consistency (e.g. cross-checking claim IDs between datasets).

Data Analysis Plan

Data analysis was conducted using descriptive statistical methods and trend visualization:

- Data Preparation: All collected data were compiled into a master dataset (Excel spreadsheet or SPSS file). Data cleaning included removing duplicates, checking for missing values (and excluding incomplete records per criteria), and ensuring consistent coding of variables (e.g. error categories, claim status).
- Descriptive Statistics: For each variable, summary measures were calculated. Continuous variables like TAT were summarized using mean, median, standard deviation (SD) and range. Categorical variables (approval status, error presence) were summarized using frequencies and percentages. For example, the mean and median TAT per month were computed to assess speed of processing, and the percentage of claims approved was calculated for each month. This mirrors approaches in similar retrospective analyses of claims or service data.
- Trend Analysis: Month-to-month trends in the performance indicators were examined. For each metric (TAT, error rate, approval rate, volume), line graphs or bar charts were plotted to visualize changes from January to March. Excel pivot charts or SPSS chart tools were used for this. This visual analysis helped identify any improvement or deterioration over the quarter. In particular, trends in turnaround time and error rate were scrutinized to see if efforts to manage quality impacted throughput, reflecting the study’s focus on balancing quantity and quality.
- Comparative Analysis: Where appropriate, simple comparative statistics were used. For example, ANOVA or Kruskal-Wallis tests could be applied to determine if the mean TAT differed significantly between months. Chi-square tests could compare categorical distributions (e.g. approval vs. rejection) month by month.

However, since the primary aim was descriptive, hypothesis testing was secondary; emphasis remained on reporting observed values and percentages.

- **Software Utilization:** Excel was mainly used for data aggregation, basic calculations, and charting. SPSS (or a similar package) was used to run descriptive statistics and any required statistical tests. All tables and figures (e.g. mean TAT by month, error rate by month) were generated to summarize the findings. The analysis plan followed standard practice for cross-sectional performance data.
- **Interpreting Results:** Finally, the patterns observed were interpreted in the context of operational efficiency. For instance, if TAT increased while error rate decreased, this could indicate a trade-off between quantity and quality. Conversely, improvements in both might suggest process optimization. The analysis explicitly linked quantitative throughput metrics with qualitative audit outcomes to assess overall efficiency.

Ethical Considerations

- **Ethical Approval:** This study involved retrospective analysis of de-identified operational data. Formal approval or exemption was obtained from the appropriate ethics committee or institutional review board prior to data analysis. The research protocol was reviewed to ensure compliance with ethical standards, even though no direct human subjects were involved.
- **Data Confidentiality:** All individual-level data (e.g. policyholder names, personal health information) were not accessed. Claims data were de-identified by claim ID only. No protected health information (PHI) was extracted or reported. The analysis was conducted on aggregate metrics. Any audit findings used were stripped of identifiers so that staff members or clients could not be traced.
- **Informed Consent:** As a retrospective study using existing records, obtaining consent from policyholders was not practicable or required. The data were originally collected for administrative purposes, not research. The ethical review confirmed that individual consent could be waived, given minimal risk and anonymization of data.
- **Data Security:** All data files were stored securely on the company's network with restricted access. Only authorized research team members could view the datasets. Standard data protection practices (password protection, encrypted storage) were followed to prevent unauthorized access.
- **Compliance with Regulations:** The study adhered to relevant laws and company policies on data protection (for example, India's Personal Data Protection Bill provisions and internal privacy policies). The research team also followed professional ethics guidelines for business and healthcare research.

In summary, the methodology ensured that while comprehensive operational data were analysed, all ethical safeguards (approval, de-identification, confidentiality) were in place. This compliance allowed a thorough efficiency assessment without compromising privacy or ethical standards.

Chapter 5 – RESULTS

Results

Results

The retrospective study analysed the efficiency of group health insurance claim processing at Care Health Insurance across a three-month period—January to March 2025. A total of approximately 82,000 reimbursement claims were in

warded during this period, including IPD, OPD, daycare, and pre- and post-

hospitalization claims. The performance was evaluated based on total claims processed and audit-identified errors across three key categories: financial error, service impact, and wrong claim approval.

1. Monthly Summary of Claims and Errors

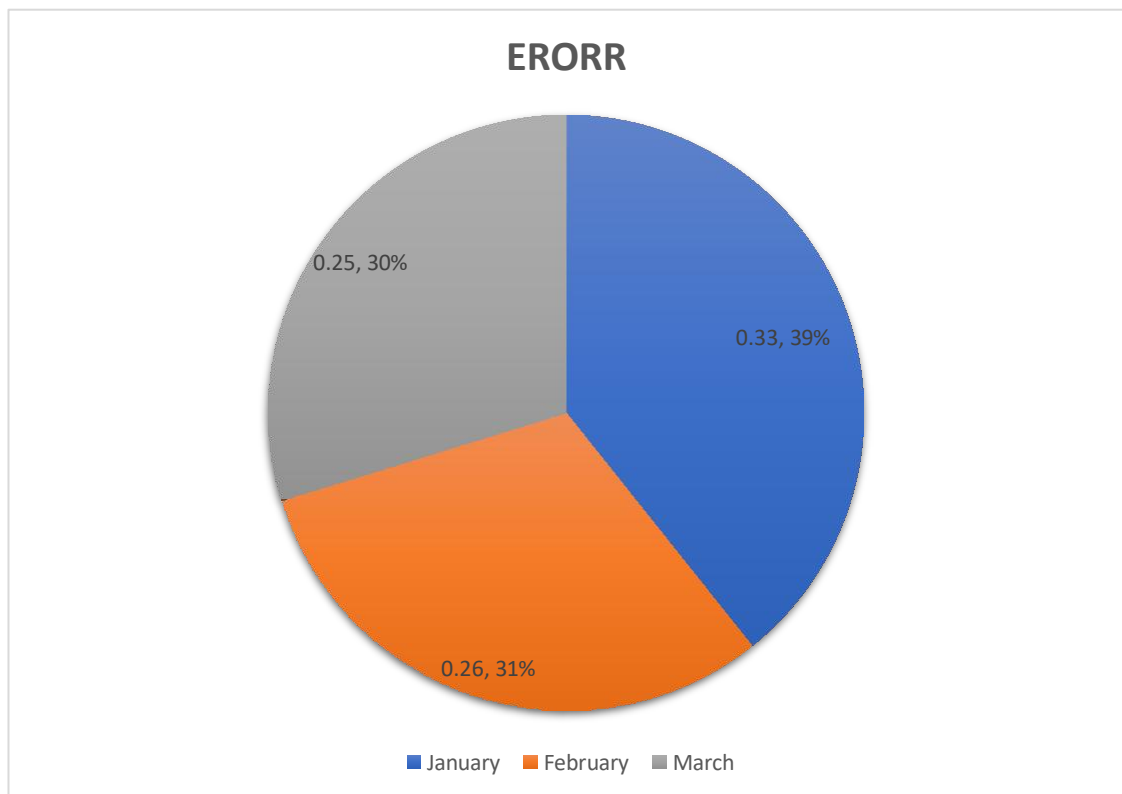
Month	Total Claims Processed	Audited Errors	Financial Error	Service Impact (Underpayment)	Wrong Claim Approval
January	27,000	88	50	23	15
February	28,500	74	39	21	14
March	26,500	65	30	25	10

2. Error Trend Analysis

- Total Errors Decreased over the three months, from 88 errors in January to 65 in March, indicating a potential improvement in quality control mechanisms.
- Financial Errors (overpayment approvals) showed a steady decline:
 - January: 50 cases
 - February: 39 cases
 - March: 30 cases
- Service Impact Cases (underpayment or insufficient approval) remained relatively stable with a minor increase in March (from 23 in January to 25 in March), suggesting a need for improved calculation protocols.
- Wrong Claim Approvals (entirely ineligible claims paid) reduced significantly from 15 in January to just 10 in March, highlighting better verification processes.

3. Error Rate Comparison

Month	Error Rate (%) = (Errors / Total Claims) × 100
January	0.33%
February	0.26%
March	0.25%



The error rate decreased consistently, suggesting improved adherence to SOPs, claim checking protocols, and possible impact of internal audit feedback loops.

4. Visual Representation

A. Total Errors by Category (Stacked Column Chart)

B. Error Rate Trend (Line Graph)

- January: 0.33%
- February: 0.26%
- March: 0.25%

5. Key Observations

- **Quality Improvement Evident:** The decline in total errors over time indicates increasing operational accuracy.
- **Quantity Handled Consistently:** Despite handling over 25,000 claims per month, the team maintained a low error rate.
- **Service Impact Needs Focus:** March saw a slight rise in underpayment cases, which requires root-cause analysis (e.g., mismatched documentation, policy interpretation issues).
- **Audit-Driven Corrections:** The impact of continuous audit review appears positive in reducing wrong claim approvals and financial inaccuracies.

Chapter 6 – DISCUSSIONS

Efficient claim processing lies at the core of customer satisfaction, operational credibility, and financial sustainability in the health insurance sector. In the context of group health insurance—where thousands of employees and their families rely on timely reimbursement for medical expenses—the ability to process large volumes of claims without compromising on quality is both a strategic goal and an operational challenge.

This study was conducted with the objective of evaluating the balance between **quality (accuracy, compliance, error minimization)** and **quantity (throughput, turnaround time)** in the **group health insurance reimbursement team** at Care Health Insurance. By analysing retrospective claim data and internal audit findings from **January to March 2025**, the study aimed to uncover trends, performance gaps, and opportunities for improvement in claim adjudication.

1. Overview of Findings

Over a three-month period, approximately **82,000 claims** were processed by the group reimbursement team, including **IPD, OPD, day-care, and pre-/post-hospitalization claims**. The average **monthly workload exceeded 26,000–28,000 cases**, indicating the department's high operational burden. Despite this, the **error rate consistently remained under 0.35%**, with a **downward trend** observed across the three months.

- In **January 2025**, 88 audited errors were identified (error rate: 0.33%), with the majority being **financial errors (over-approvals)**.
- In **February**, total errors dropped to 74 (error rate: 0.26%).
- By **March**, the department had reduced errors further to 65 (error rate: 0.25%).

This trend highlights an **improvement in quality management**, particularly in areas like financial approval accuracy and verification of claim eligibility. However, the slight increase in **service impact errors** (under-approvals) in March suggests a need to improve precision in benefit calculations.

2. Quality vs. Quantity: Managing the Balance

The central theme of this study was to examine how well the organization manages the **dual goals** of quantity and quality. In many claim processing environments, increasing volume often leads to errors due to time constraints and human fatigue. Conversely, focusing too heavily on detailed scrutiny can delay settlements, leading to customer dissatisfaction and regulatory non-compliance. Care Health Insurance, through its group reimbursement team, demonstrated that **efficient quantity management does not necessarily require a compromise in quality**. Despite handling over 27,000 claims in January alone, the team maintained a high standard of accuracy. The steady reduction in financial and administrative errors over time points to a **well-established operational process**, possibly supported by internal audits, staff training, and workflow refinements. This is consistent with global and Indian studies suggesting that **digitized workflows, SOP adherence, audit feedback loops, and performance monitoring** are effective tools in maintaining quality even under high-volume conditions (Kaur & Kumar, 2021; IRDAI Report, 2023).

3. Trends in Error Categories: Root Cause Interpretation

A detailed analysis of errors reveals the nature of challenges the claims team faces:

- **Financial Errors (Over-approvals):** These represented the highest share of errors in January but declined over time. This indicates that **corrective actions and revalidation protocols**—perhaps implemented following internal audit observations—were effective. Over-approvals can have a direct financial impact on the insurer, making their reduction a key operational priority.
- **Service Impact Errors (Under-approvals):** These errors slightly increased in March. While financially safer for the company, they can result in customer dissatisfaction and complaints. This trend suggests that while financial errors were addressed, **calculation accuracy or benefit alignment** issues persisted. It highlights a need for improved **policy interpretation tools** and possibly better staff understanding of claim entitlements.
- **Wrong Claim Approvals:** These errors (ineligible claims wrongly paid) also decreased over time. This is an important indicator of the effectiveness of **claim validation and rule-based eligibility checks**, possibly assisted by IT systems or AI models. Reducing these types of errors is vital not only for financial accuracy but also for **regulatory compliance**, as IRDAI mandates thorough scrutiny of claim admissibility.

Overall, the movement of error trends shows that **audit-driven corrective strategies and performance oversight** played a significant role in improving claim processing quality over the study period.

4. Operational Implications

The results of this study have several implications for both **process improvement** and **strategic planning** within Care Health Insurance:

- **Process Strengths:**
 - The ability to handle over 80,000 claims in a quarter with a consistently low error rate suggests that the **team is operationally mature**, with defined processes and possibly some level of automation in place.
 - The steady reduction in key error categories indicates an effective **feedback mechanism**—likely via internal audits, root cause analysis, and departmental reviews.
- **Areas of Improvement:**
 - **Service impact errors** must be addressed through staff upskilling or the use of decision-support systems that align claim approvals closely with policy entitlements.
 - A more granular audit approach might be needed to detect and prevent **borderline or subjective errors**, such as ambiguous documentation, unclear discharge summaries, or duplicate billing.
- **Technology as a Solution:**
 - The integration of AI/ML tools in claim adjudication can support both **volume management and fraud detection**. For example, Optical Character Recognition (OCR) can automate data extraction, and pattern-recognition tools can flag unusual billing or treatment trends.
 - Enhancing claim software with **real-time policy validation rules**, benefit calculators, and TAT trackers could further reduce service-level issues and manual dependency.

5. Alignment with Regulatory Expectations

The findings also align well with the **IRDAI's recent mandates** emphasizing faster turnaround, customer-centricity, and quality assurance:

- The IRDAI Master Circular (2024) mandates **approval within 1 hour for cashless claims** and **discharge processing within 3 hours**, highlighting the regulator's push for speed.
- Simultaneously, it demands **multi-level review of rejections**, accuracy of documentation, and insurer accountability for any errors or delays.
- The low error rate observed in this study reflects that Care Health Insurance's group reimbursement team is largely compliant with **regulatory quality expectations**, while continuing to meet quantity metrics.

However, the slight uptick in service impact errors may need monitoring to avoid future non-compliance or escalated grievances, as IRDAI also tracks **claim-related complaints and service-level adherence**.

6. Strategic and Customer Impact

From a business perspective, maintaining high standards in both quality and quantity strengthens the organization's position in the competitive group insurance market. Timely and accurate claim processing leads to:

- **Higher corporate client retention**
- **Increased trust among employees covered under group policies**
- **Reduced grievance load and legal disputes**
- **Improved Net Promoter Scores (NPS) and customer loyalty**

The audit findings reinforce the importance of **operational vigilance**. Errors—especially financial over-approvals and wrongful payouts—not only affect profitability but also create **audit risks and compliance liabilities**.

Moreover, reducing under-approvals (service impact) ensures that **customer expectations are met**, which is critical in maintaining a reputation for fairness and transparency.

7. Limitations of the Study

While the study provides valuable insights, certain limitations must be acknowledged:

- It is **limited to one insurer's group health division** and may not reflect practices across the wider industry.
- The analysis is **quantitative and retrospective**, hence lacks direct stakeholder (customer or staff) feedback.
- The **three-month window**, while useful for trend analysis, may not capture seasonal fluctuations or policy changes affecting claims.

Future studies may benefit from including **qualitative interviews** with claims officers, exploring **customer satisfaction surveys**, or benchmarking **performance against industry averages**.

Chapter 7 – RECOMMENDATIONS

Based on the retrospective analysis of three months of claim data and audit findings at Care Health Insurance, the following recommendations aim to enhance the efficiency of group health insurance reimbursement processing. These are structured around five core areas: process improvement, technology integration, workforce development, audit reinforcement, and customer engagement.

1. Process Optimization

Efficient claim processing starts with a streamlined workflow. Although the current system demonstrated low error rates, further refinement can enhance both speed and quality.

- **Standardize Claim Documentation:** Implement uniform templates for hospitals and policyholders to reduce document-related delays and inconsistencies. Use checklists for mandatory items like discharge summaries, prescriptions, and investigation reports.
- **Auto-verification Rules:** Introduce rule-based engines to auto-validate routine claims. For example, fixed benefit amounts for specific procedures can be pre-approved without manual intervention. This reduces turnaround time and human dependency.
- **Segregate Claim Types for Processing Efficiency:** High-complexity claims (e.g., cancer treatment, transplants) should be routed to experienced adjudicators, while low-complexity claims (e.g., daycare cataract, OPD consultation) can be handled through automated workflows. This approach prevents bottlenecks and improves overall throughput.
- **Implement Claim Triage Systems:** Use an initial filter to categorize claims based on risk, volume, and documentation completeness. Claims with insufficient documentation can be rejected or routed back instantly, saving time.

2. Technology Integration

Digital tools are essential for handling high volumes without compromising on accuracy.

- **Adopt AI/ML-Based Claim Review Engines:** These can learn from historical errors and alert adjudicators to potential overpayments, duplications, or unusual charges. For instance, if an MRI is billed on the same day as surgery, AI tools can cross-check standard protocols.
- **OCR (Optical Character Recognition):** Integrate OCR to extract data from scanned bills and medical documents automatically. This reduces manual data entry errors and speeds up data processing.
- **NHCX Platform Utilization:** As mandated by IRDAI, joining the National Health Claims Exchange (NHCX) ensures interoperability and faster communication between providers and insurers. Full integration will reduce documentation delays and fraud risks.

- **Real-Time Dashboards:** Create live dashboards to monitor team performance, TAT breaches, and workload distribution. Managers can use this data for better resource allocation and timely escalations.

3. Workforce Development

Claim processing is people-driven. Even with technology, trained staff remain critical to maintaining quality.

- **Regular Technical Training:** Conduct monthly sessions on policy clauses, IRDAI regulations, coding standards (ICD-10, CPT), and interpreting medical documents.
- **Cross-Departmental Learning:** Claims staff should be exposed to underwriting and customer service processes to better understand the complete policy lifecycle. This reduces misinterpretation of policy terms.
- **Error Feedback Mechanism:** Maintain a system where individuals can review the root causes of errors attributed to them in a constructive, non-punitive way. This builds accountability and learning.
- **Staff Rotation and Job Enrichment:** Rotate employees across tasks (e.g., financial audit, pre-auth review, post-discharge settlement) to prevent burnout and build multi-skill capability.

4. Strengthening Internal Audit and Quality Review

Audit findings in this study clearly led to error reduction. A stronger, real-time audit process can further ensure compliance and control.

- **Real-Time Concurrent Audit:** In addition to retrospective audits, introduce real-time sampling of claims-in-process for concurrent checks. This allows early correction and reduces post-processing revisions.
- **Quantify Quality Metrics:** Track not just TAT but also “First Pass Resolution Rate” (claims processed correctly the first time), “Financial Error Incidence,” and “Service Impact Score.”
- **Monthly Quality Review Meetings:** Hold monthly meetings with the quality control and claims team to review audit results and implement system-level corrections.
- **Risk-Based Auditing:** Focus more on high-risk categories such as maternity packages, oncology, high-value surgeries, and out-of-network claims.

5. Enhancing Customer Experience and Transparency

Quality in claim processing is incomplete without considering the policyholder's experience.

- **Auto-Communication Tools:** Introduce automated SMS and email updates for every claim milestone—receipt, deficiency, approval, or rejection—with explanations for decisions taken.
- **Claim Tracker Portal:** A secure, mobile-accessible tracker where users can upload missing documents, see TAT expectations, and contact the claims team.
- **Customer Education Drives:** Conduct webinars for HR teams of group clients to explain policy limitations, common rejection reasons, and documentation standards. Better understanding reduces back-and-forth.
- **Feedback Loops:** Post-claim feedback surveys can reveal pain points and areas for service enhancement. These should be tracked and resolved within a time-bound SLA.

6. Strategic and Regulatory Alignment

- **IRDAI Compliance Dashboard:** Maintain a dashboard aligned with IRDAI Master Circular 2024 to monitor turnaround time targets, approval standards, and grievance trends.
- **Prepare for NABH/NABL Collaboration:** With increasing emphasis on hospital empanelment standards, coordinate with quality-accredited hospitals and monitor their documentation quality.
- **Data-Driven Decision-Making:** Use retrospective audit data to predict future bottlenecks and inform process changes in advance.

CHAPTER 8- Conclusion

This dissertation explored one of the most critical functions in the health insurance industry—**claim processing efficiency**, with a particular focus on **group health insurance reimbursement**. In an increasingly competitive and regulated environment, striking a balance between the **speed (quantity)** and **accuracy (quality)** of claim processing is vital to maintaining customer satisfaction, operational integrity, and financial performance.

By evaluating three months of data (January–March 2025) at **Care Health Insurance**, this study aimed to assess how effectively the organization manages both aspects—quality and quantity—in its group health insurance reimbursement team. The results demonstrate strong performance, valuable insights, and lessons applicable to the broader insurance industry.

Summary of Key Findings

Over the study period, the group reimbursement department handled approximately **82,000 claims**. Despite this high volume, the total number of audited errors dropped from **88 in January to 65 in March**, with error rates consistently below **0.35%**.

A more detailed view of errors revealed:

- **Financial Errors (over-approvals):** Reduced significantly from 50 in January to 30 in March.
- **Service Impact Errors (under-approvals):** Slight rise in March indicating room for process refinement.
- **Wrong Claim Approvals:** Reduced steadily, indicating better claim eligibility validation.

These trends indicate a **positive trajectory in quality management**, without compromising the **processing capacity**—a sign of maturing operational systems.

Interpretation of Results

The declining error rates despite consistent workloads suggest that Care Health Insurance's internal strategies—such as internal audits, SOP adherence, workflow discipline, and perhaps use of digital tools—are yielding the desired outcomes. Moreover, the ability to reduce financial and administrative errors without sacrificing claim throughput reflects a culture of **continuous improvement** and **performance accountability**.

The slight increase in service impact errors also acts as a reminder that **accuracy must apply in both directions**: over-approvals hurt the insurer; under-approvals hurt the customer. Both must be addressed with equal rigor.

Implications for the Insurance Industry

In India, where the health insurance market is expanding rapidly and regulations are becoming more stringent, this study highlights the importance of **data-driven operations**. Key implications include:

- **Operational Resilience:** Claim processing teams can manage high volumes effectively if equipped with the right tools, trained personnel, and structured workflows.
- **Compliance Readiness:** IRDAI mandates on TATs, customer transparency, and audit practices are not only regulatory obligations but also performance benchmarks.
- **Technology Adoption:** OCR, AI/ML tools, and integrated platforms like NHCX are transforming the landscape. Early adopters, such as Care Health Insurance, stand to gain from both efficiency and customer trust.
- **Client Retention and Market Competitiveness:** Especially in group insurance, clients value insurers that can demonstrate efficient claim settlement. Organizations with lower error rates and faster TATs can win and retain large corporate contracts.

Reflection on Study Limitations

While the results are promising, the study has certain limitations:

- It focused on a single organization's internal data and may not represent industry-wide practices.
- The approach was quantitative and retrospective, limiting the inclusion of real-time behavioural or customer sentiment data.
- No direct comparisons were made with peer insurers or industry averages.

Nonetheless, these limitations provide opportunities for future research—such as benchmarking studies, qualitative interviews with claim handlers, or customer satisfaction assessments post-claim.

Value of the Study

This dissertation contributes to the growing body of literature on **health insurance operations** in India. By showcasing a successful example of balancing claim quantity with quality, it serves as a reference model for:

- Insurance administrators and quality officers
- Policy-makers seeking to tighten regulatory norms
- Researchers studying healthcare finance and delivery systems

In practical terms, the study's data and recommendations offer a **blueprint for internal process optimization**, especially for insurers handling large group policy portfolios.

Final Thoughts

Healthcare financing is a rapidly evolving domain. In this dynamic environment, **efficiency in claim processing** is not just about minimizing errors—it's about **building trust**. Every delayed or inaccurately adjudicated claim is a potential moment of lost credibility. Conversely, every well-settled claim is a building block in the insurer's reputation.

Care Health Insurance, through its group reimbursement operations, demonstrates that **operational excellence is achievable**, measurable, and sustainable. The trends in error reduction and consistent claim volumes over three months suggest that structured, well-audited, and tech-enabled systems can deliver results. With further investments in automation, training, and customer engagement, even higher standards of performance are within reach.

In conclusion, this study reaffirms the importance of data, discipline, and human oversight in making insurance operations not just functional, but exceptional. The road to excellence in claim processing is continuous—and with the right tools and vision, it's entirely attainable.

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