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Quality and Quantity Management in Claim Processing

Care Health Insurance - Group Reimbursement Team

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Introduction

- 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.
- This study addresses the need to evaluate how effectively the organization balances quality and quantity in claim processing and identifies gaps for improvement.
- 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.

Category	Key Statistics
Market Share	Group Health = ~44% of total health insurance market
Coverage	Over 15 crore individuals covered under group policies
Premium FY 2023-24	₹33,000 crore from group health (out of ₹76,500 crore total)
Average Claim Size	₹45,000 – ₹75,000
Top Claim Reasons	Maternity, surgery, general medicine, chronic conditions
Avg TAT (Cashless)	~3 hours (discharge approval)
Avg TAT (Reimbursement)	7–10 working days
Claim Settlement Ratio	>95% for leading private insurers
Digital Adoption	70%+ claims settled digitally
Corporate Coverage	90%+ large companies offer group health plans
New Trends	Mental health, parental cover, wellness benefits

Problem Statement

- How effective are the quality and quantity management practices in the claim processing system of group health insurance at Care Health Insurance?

Purpose & Objectives

Purpose:

Assess operational performance and identify improvement areas

Objectives:

- Evaluate monthly claim trends and error rates
- Identify bottlenecks
- Recommend improvements

Literature Review

- **Group Health Insurance** is a type of health coverage offered by an employer or an organization to a group of individuals—usually employees and their dependents—under a single master policy.
- It provides comprehensive medical benefits including hospitalization, daycare procedures, OPD, maternity, and sometimes preventive care.
- In India, group health insurance is widely adopted by corporate employers as part of employee welfare programs and often includes cashless and reimbursement claim options.
- It plays a key role in providing accessible and affordable healthcare, while also enhancing employee satisfaction and retention.

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.

About Care Health Insurance

- Leading standalone health insurer in India
- 260 branches, 9 crore lives covered, 21,700+ hospital network
- Focus on tech-enabled claims, audit-driven improvements

Achievements & Recognition

- Awarded "**Best Health Insurance Company of the Year**" multiple times by prestigious bodies like FICCI and ASSOCHAM.
- Known for **quick claim settlement**, high **customer satisfaction**, and **innovative health plans** like Care Advantage, Care Plus, and Care Freedom.

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- Offers customized corporate and institutional group health policies.
- Manages both cashless and reimbursement claim processes.
- Strong in-house reimbursement claims team, audit systems, and digital reporting dashboards.

Methodology

- **Study Design**

Type: Retrospective, descriptive, non-interventional

Approach: Observational analysis of claim performance trends (Jan–Mar 2025)

Purpose: Evaluate quality (accuracy, errors) vs. quantity (volume, speed)

- **Study Setting & Duration**

Department: Group Health Insurance Reimbursement, Care Health Insurance

Period Covered: Jan 1 to Mar 31, 2025

Data Points: Claims processing logs, internal audit records, SOPs

- **Study Population & Sampling**

Inclusion: All group reimbursement claims with complete data

Exclusion: Pending, test/demo, individual claims

Sampling: Census method – all eligible claims included (no sampling bias)

- **Data Sources & Tools Used**
- **Systems Accessed:**
  - Claims Management System
  - Internal audit reports & checklists
  - Company SOP & policy manuals
- **Analysis Software:**
  - **MS Excel** (cleaning, tabulation, graphs)

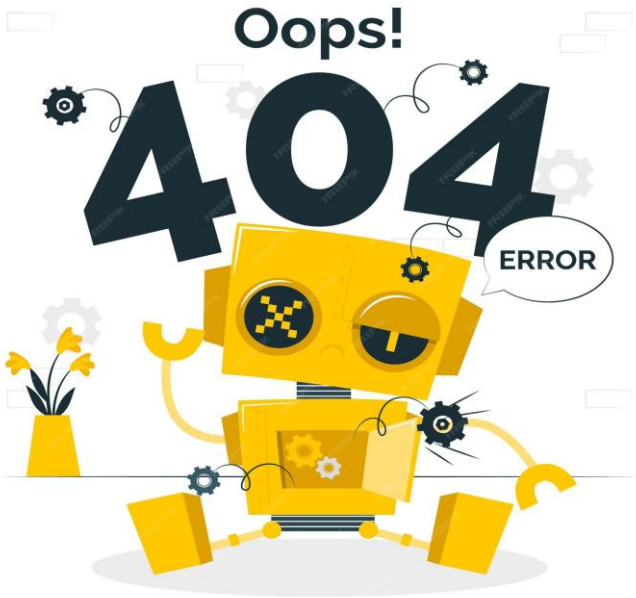
- **Key Variables Analyzed**

Approval vs. Rejection Rates

Audit-Identified Errors

  - Financial (overpayment)
  - Service impact (underpayment)
  - Wrong approvals

- **Monthly claim volumes and error rate trends**
- **Quality compliance scores from audit report**



Key Performance Metrics

- **Total Claims Processed:**
  Monthly and quarterly count of reimbursement claims including IPD, OPD, day care, and pre/post hospitalization cases.
- **Approval vs. Rejection Rate:**
  Percentage of claims approved, partially approved, or rejected. Reflects accuracy in policy interpretation and decision-making.
- **Error Rate:**
  Proportion of audited claims with errors. Categorized as:
  - Financial Error (e.g., overpayment)
  - Service Impact (e.g., underpayment)
  - Wrong Approval (e.g., non-eligible claim passed)

  ➤ Error Rate = (No. of error cases / Total audited cases) × 100

- **Reopen Rate:**
  Percentage of claims reopened after processing due to audit issues, corrections, or grievances. Indicates operational rework.

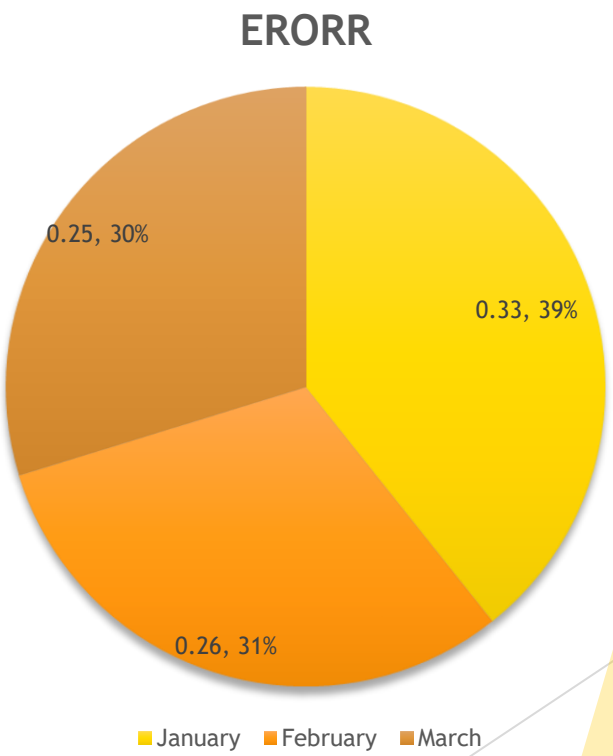
- **Audit Outcomes:**
  Monthly summary of findings from internal audits, including type, frequency, and severity of claim-related errors

Results Snapshot

Month	Total Claims Processed	Total Errors (Audited)	Financial Errors	Service Impact Errors	Wrong Approvals	Error Rate (%)
January	27,000	88	50	23	15	0.33%
February	28,500	74	39	21	14	0.26%
March	26,500	65	30	25	10	0.25%
Total	**82,000**	**227**	**119**	**69**	**39**	-

Error Rate Trends

- • Jan: 0.33%
- • Feb: 0.26%
- • Mar: 0.25%



Discussion Highlights

The findings of this retrospective study reveal key insights into how the Group Health Insurance Reimbursement Team at Care Health Insurance managed both quantity and quality in claim processing during the first quarter of 2025.

- **Volume Management**

Over the span of three months, the team processed approximately **82,000 claims**, averaging around **27,000 claims per month**. This consistently high volume highlights the department's operational capability and process scalability.

- **Declining Error Trend**

A positive decline in error rate was observed over the three months:

January: 0.33%

February: 0.26%

March: 0.25%

This indicates improved quality assurance in claim processing workflows. Audit data showed that most errors in January were related to financial over-approvals, which significantly dropped by March. This decline suggests effective use of internal audits, SOP adherence, and possible training interventions.

- **Error Categorization**

Financial Errors (e.g., overpaid claims) saw a reduction from 50 to 30, indicating better financial oversight.

Wrong Approvals (e.g., non-eligible claims processed) decreased from 15 to 10, showing improved adherence to policy rules.

Service Impact Errors (e.g., underpayments) remained steady, rising slightly in March (25 cases), suggesting the need for **closer attention to benefit calculations**.

- **Operational Implications**

The data reflects a mature claims process that can handle volume efficiently while continuously improving accuracy. The use of audit-driven feedback loops, structured SOPs, and possibly tech-assisted review systems appears to be central to performance improvement.

- **Opportunities for Improvement**

While the overall quality improved, the slight increase in service impact errors in March shows there is still room for fine-tuning. These under-approvals may result from unclear documentation, benefit misinterpretation, or time pressure, and addressing them will improve both fairness and customer satisfaction.

- **Strategic Takeaways**

Efficiency and quality can co-exist when supported by well-structured processes.

Care Health Insurance demonstrated strong internal governance through audits and corrective actions.

Continued focus on automation, audit intelligence, and staff training can further enhance performance

Operational Implications

- Indicates process maturity
- Needs better benefit calculation and audit integration
- Potential for further digitalization

RECOMMENDATIONS

- 1. Automation of Routine Claims Implement AI/ML tools to auto-validate low-risk, high-frequency claims (e.g., OPD, diagnostics).
- 2. Strengthen Internal Training Regular technical workshops on policy interpretation, coding standards, and audit findings.
- 3. Real-time Dashboards & Alerts Use live dashboards to monitor TAT breaches, audit flags, and claim status.
- 4. Enhance Audit Protocols Introduce concurrent audits along with post-claim audits for faster corrections.
- 5. Improve Service Impact Accuracy Focus on underpayments by reviewing benefit caps, exclusions, and documentation gaps.
- 6. Expand Digital Infrastructure Integrate with platforms like NHCX for seamless document exchange with hospitals.
- 7. Stakeholder Engagement Educate HR teams and employees of corporate clients to reduce documentation errors and improve claim clarity.

Conclusion

- The study assessed the balance between quality and quantity in claim processing within the Group Health Insurance Reimbursement Team at Care Health Insurance.
- Over 82,000 claims were processed between January and March 2025, with a consistent decrease in error rate from 0.33% to 0.25%.
- The decline in financial and wrong approval errors indicates effective audit interventions, process adherence, and operational maturity.
- Slight rise in service impact errors (underpayments) highlights the need for improved policy interpretation and benefit calculation.
- Overall, the organization showcased the ability to handle high volume without compromising accuracy, reinforcing the value of internal controls and continuous improvement.
- This study sets a benchmark for process optimization in group health claim processing and provides actionable insights for policy-driven and tech-enabled efficiency.


Thank you!