SYNOPSIS FOR DISSERTATION

The IIHMR University, Jaipur

For the partial fulfilment for the award of the degree of
Master of Business Administration (MBA)
In

Hospital and Health Management

BY

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MBA HOSPITAL AND HEALTH MANAGEMENT

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1. TITLE

Quality and Quantity Management in Claim Processing: Analysing the Efficiency of Group Health Insurance at Care Health Insurance

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2. INTRODUCTION

Health insurance systems rely heavily on efficient claim processing to maintain customer trust and operational integrity. Group health insurance, which offers healthcare coverage to employee groups, plays a pivotal role in employee welfare and organizational health benefits. The quality and quantity management in the claims adjudication process directly affects customer satisfaction and turnaround times.

Care Health Insurance, a reputed name in the industry, handles a high volume of daily claims, especially in the group health division. With 1000–1200 claims processed daily, ensuring quality assurance without compromising quantity throughput becomes an operational challenge. This study aims to assess how well the organization manages both aspects — quality and quantity — through a retrospective review of group health insurance claim data for the month of January 2025.

3. RESEARCH QUESTION

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

4. OBJECTIVES

- To assess the current claim processing workflow for group health insurance at Care Health Insurance.
- To evaluate the turnaround time and accuracy of claim adjudication during January 2025.
- To identify gaps in quality and quantity management in the claim processing workflow.
- To recommend strategies for enhancing claim efficiency and service quality.

5. HYPOTHESIS

Efficient quality and quantity management practices improve the accuracy and turnaround time of claim adjudication in group health insurance.

6. MATERIAL AND METHODS

STUDY DESIGN:
Descriptive and retrospective study design based on analysis of claim processing data from January 2025.

SETTING:
Care Health Insurance Head Office, Gurgaon – Department of Claims (Group Health Insurance Division).

STUDY POPULATION:

- **Inclusion Criteria:** All claims processed under group health insurance in January 2025.
- **Exclusion Criteria:** Retail health insurance claims and incomplete or rejected claims due to insufficient documentation.

STUDY TOOLS:
Retrospective claim processing records, internal audit reports, turnaround time logs, and structured interviews (if required) with claims department staff.

DURATION OF STUDY:
January 2025 – May 2025 (with data limited to January 2025).

SAMPLE SIZE:
Considering the volume of claims processed daily (1000–1200), the total monthly load is approximately 31,000–37,000 claims. A sample of **1000 claims** from January 2025 will be randomly selected for detailed analysis.

SAMPLING TECHNIQUE:
Simple random sampling of claim records for data analysis.

DATA COLLECTION PROCEDURE:
Data will be extracted from the internal claim processing system for January 2025. Variables such as turnaround time, number of processing errors, claim approval/rejection rates, and audit observations will be collected and compiled for analysis.

OPERATIONAL DEFINITIONS:

- **Turnaround Time (TAT):** The total time taken from receipt of claim documentation to settlement.
- **Claim Accuracy:** Proportion of claims processed without errors.
- **Quality Management:** Practices to ensure compliance with SOPs, error checks, and audit responses.
- **Quantity Management:** Strategies and resources used to efficiently process large claim volumes.

7. DATA ANALYSIS PLAN

Data will be analyzed using Microsoft Excel and SPSS (Version 26).

- Descriptive statistics: Frequency, mean, standard deviation of TAT and error rates.
- Trend analysis to identify peak processing days or bottlenecks.
- No inferential tests will be conducted due to the descriptive nature of the study.

8. ETHICAL CONSIDERATIONS

Institutional approval will be obtained prior to data access. Since no patient identifiers will be used, confidentiality will be strictly maintained. Only de-identified, aggregate data will be used for analysis.

9. IMPLICATIONS OF RESEARCH

This study will offer insights into how Care Health Insurance manages high-volume claim processing without compromising quality. The findings can guide improvements in claim workflows, identify bottlenecks, and enhance customer satisfaction through better turnaround times and error reduction.

10. REFERENCES

(*Sample – please expand after literature review*)

1. IRDAI Annual Report 2023–24. Insurance Regulatory and Development Authority of India.
2. Kaur P, Kumar R. Efficiency in Health Insurance Claims Processing in India. Int J Health Policy Manag. 2021;10(2):78–85.
3. Sood N, Wagner Z, Huckfeldt P, et al. The impact of health insurance on mortality: Evidence from India's government health insurance program. Health Econ. 2017;26(12):e286–e301.