# IDENTIFICATION OF FACTORS AFFECTING TURNAROUND TIME IN REIMBURSEMENT CLAIM PROCESSING IN GROUP HEALTH INSURANCE – A STUDY AT CARE HEALTH INSURANCE, GURGAON

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

**Shalini Singh**

Under the Supervision and Guidance of

**Dr. Sarthak Sengupta**

**2025**

care HEALTH INSURANCE

BEST HEALTH INSURANCE COMPANY IN RURAL SECTOR | CLAIMS SERVICE LEADER OF THE YEAR
INDIA INSURANCE SUMMIT & AWARDS 2024

# CERTIFICATE

This is to certify that **Shalini Singh,** 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.

Place: Gurgaon
Date: 05/06/2025

Barkha

Dr Barkha Gupta
Manager- Claims Adjudication
Care Health Insurance Ltd.

IIHMR UNIVERSITY

# CERTIFICATE

This is to certify that the dissertation titled "**Identification of factors affecting turnaround time in reimbursement claim processing in group health insurance – A Study at Care Health Insurance, Gurgaon**" is a record of the research work undertaken by **Shalini Singh** 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 Sarthak Sengupta
IIHMR University, Jaipur
Date: 12/6/25

School Dean
IIHMR University, Jaipur
Date: 12/6/25

## DECLARATION BY STUDENT

I hereby declare that this dissertation titled "Identification of factors affecting turnaround time in reimbursement claim processing in group health insurance – A Study at Care Health Insurance, Gurgaon" 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Shalini Singh

Name of Student: Shalini Singh

Date: 12-06-2025

## Abstract

**Title:** Identification of factors affecting turnaround time in reimbursement claim processing in group health insurance – A Study at Care Health Insurance, Gurgaon

**Author:** Shalini Singh

**Advisor:** Dr Sarthak Sengupta

**Key words:** Turnaround Time, Reimbursement Claims, Group Health Insurance, Claim Processing

**Background:** This study investigates the underlying reasons for delays in processing group reimbursement claims, a critical aspect of health insurance operations. Reimbursement claims require the insured to pay healthcare expenses upfront and seek repayment by submitting necessary documentation to the insurer. While digitization has streamlined many aspects of claims processing, delays in reimbursement continue to be a major concern affecting customer satisfaction and regulatory compliance.

**Objectives:**

- To understand the different stages of claim processing
- To identify and categorize the factors affecting claim processing TAT.
- To suggest strategies for improving the efficiency of claim adjudication processes.

**Methodology:**

**Research Design:** Descriptive cross-sectional study

**Study Location:** Care Health Insurance, Gurgaon

**Study Population:** Medical adjudicators of the Group reimbursement team

**Research Approach:** Mixed method (Quantitative + Qualitative)

**Sample Size:** A sample of 1000 group reimbursement claim cases and interviews with 20 medical adjudicators

**Sampling Technique:** Convenience sampling

**Study Instruments:**

- **Primary Data**: Interviews with medical adjudicators.
- **Secondary Data**: Analysis of past claim records.

**Data Analysis:**

- Quantitative data- descriptive statistics
- Qualitative data was thematically analyzed

**Results:**

The results revealed that 31% of the claims were processed in more than 3 days, while 35% were processed within 3 days, and the remaining in less than 3 days. The most frequently cited cause for delay was incomplete documentation (23%), followed by late replies to queries (14%), delays in investigation (14%), and inadequate manpower (14%). Other significant factors included increased workload (12%), lack of training (6%), technical errors (6%), and data entry issues (6%). These findings highlight systemic inefficiencies, especially in documentation handling, communication timelines, staffing adequacy, and use of technology.

**Conclusion:**

This research highlights the multifaceted nature of delays in reimbursement claim processing and suggests a comprehensive approach to optimize turnaround times. By addressing both human resource and technological constraints, insurers can significantly enhance their operational efficiency and policyholder satisfaction.

**Acknowledgement**

I express my heartfelt gratitude to all those who have supported me throughout this research and internship journey. This project would not have been possible without the guidance, encouragement, and assistance of many individuals.

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I am deeply grateful to my academic guide, **Dr. Sarthak Sengupta**, for his valuable mentorship and unwavering support throughout this dissertation. His critical feedback and thoughtful suggestions have enriched the quality of my research.

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Shalini Singh

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## Abbreviations

CHIL- Care Health Insurance Limited

IRDAI- Insurance Regulatory and Development Authority of India

TAT- Turn Around Time

CMS- Claims Management Software

SOP- Standard Operating Procedures

KPI- Key Performance Indicator

SAHI- Stand Alone Health Insurance

TPA- Third Party Administrator

RPA- Robotic Process Automation

DEO- Data Entry Operator

CSR- Claim Settlement Ratio

# Chapter 1

## Introduction

An insurance contract is an agreement whereby one party assumes the risk of the other in exchange for a monetary payment, known as a "premium," and agrees to compensate the other party in the event of an unforeseen event. Insurance offers the significant benefit of distributing the risk among many individuals who are exposed to comparable risks.

The history of health insurance in India dates to the 1940s with the establishment of the Employees' State Insurance Scheme (ESIS) and later, the Central Government Health Scheme (CGHS). These schemes were designed primarily for organized sector workers and civil servants, respectively. Until the 1990s, the market remained dominated by public-sector insurers and government schemes. The liberalization of the insurance sector in 1999 opened the doors to private players, which brought in competition, innovation, and customer-centricity. According to IRDAI's Annual Report 2022-23, the health insurance segment accounted for nearly 35% of the total non-life insurance premium collected.

**1.1 Types of Insurance:** All insurances can be broadly classified into two main categories:

1. General Insurance

2. Life Insurance

While life insurance provides financial protection against death, a general insurance policy shields you against losses to your non-life assets.

Types of claims in health insurance:

- **Cashless Claims**, where the insurance company directly settles the bill with the network hospital, subject to policy coverage and pre-authorization. This is usually faster and less burdensome for the policyholder.
- **Reimbursement Claims**, where the insured pays out-of-pocket and later submits bills, prescriptions, discharge summaries, and other documents for reimbursement. These are more common in non-network hospitals and often experience delays due to documentation or verification issues.

This study specifically focuses on **Group reimbursement claims**, which are part of group health insurance policies offered by employers to their employees. These claims involve a post-treatment reimbursement mechanism, where the insured pays the hospital or healthcare provider upfront and later seeks repayment from the insurer by submitting all relevant documents. This process takes a long time because it involves scrutinizing documents, ensuring medical necessity, and verifying the policy's terms and conditions.

**1.2 IRDAI:** "The Insurance Regulatory and Development Authority of India (IRDAI) is a statutory body established under the Insurance Regulatory and Development Authority Act, 1999 (IRDA Act, 1999), tasked with overseeing and developing the insurance industry in India.

The Insurance Act of 1938 and the IRDA Act of 1999 both specify the Authority's responsibilities and powers. The main law regulating the insurance industry in India is the Insurance Act of 1938. It gives IRDAI the authority to create regulations that establish the framework for oversight of the organisations involved in the insurance industry. The duties, powers, and functions of the Authority are outlined in Section 14 of the IRDA Act of 1999.

Protection of policyholders' interests, rapid and orderly expansion of the insurance sector, prompt resolution of legitimate claims, an efficient grievance redressal system, encouraging equity, openness, and orderly behaviour in insurance-related financial markets, and prudential regulation while maintaining the insurance market's financial stability are among the main goals of the IRDAI."

**1.3 Claim Process:**

The claims process generally includes the following steps:

1. Claim intimation by the policyholder
2. Submission of required documentation, including bills, reports, and discharge summaries.
3. The review and initial confirmation by the claim processing team.
4. Making decisions and handling queries (if pertinent).
5. Final acceptance or denial by eligibility and policy provisions.
6. Payment distribution or informing the insured of the decision.

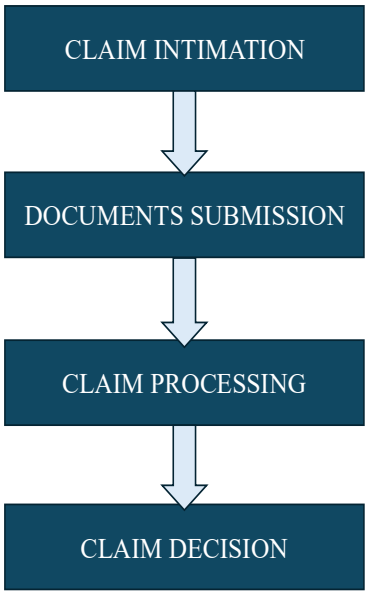


Fig. 1.1: Claim process

**1.4 Turnaround Time:** Turnaround Time (TAT) in health insurance refers to the total time taken from the moment a claim is submitted to the point it is resolved, either approved and paid or denied. It encompasses all intermediate steps, including document verification, medical review, queries, and final adjudication. TAT is a vital Key Performance Indicator (KPI) used by insurers to monitor efficiency, service quality, and compliance with regulatory norms (Sengupta, 2020).

**1.5 About Care Health Insurance:**

Care Health Insurance is a standalone health insurer (SAHI) that offers a wide range of wellness services, group health insurance, and group personal accident insurance for corporates, microinsurance products for the rural market, top-up coverage, personal accident, maternity, international travel insurance, and critical illness insurance in the retail sector. Operating under the guiding principle of "consumer-centricity," the company has continuously made investments in the efficient use of technology to provide superior customer service, innovative products, and cost-effective services. According to an Economic Times report from March 2025, the Claims Settlement ratio for Care Health Insurance is the second highest at 92.77%.

Care Health Insurance was conferred the ‘Overall Achievement Award’ (SAHI category) at the ASSOCHAM 16th Global Insurance Summit & Awards; ‘Smart Insurer’ and ‘Sales Champion’ awards in Health Insurance category at the 11th ET Now Insurance Summit

& Awards 2024; ‘Claims Service Leader for the Year’ & ‘Best Health Insurance Company in Rural Sector’ awards at the India Insurance Summit & Awards 2024, and ‘Best Health Insurance Plan – Care Plus’ at the Global Financial Planner’s Summit 2024.

Some other SAHI-

- Aditya Birla Health Insurance Co. Ltd.
- Manipal Cigna Health Insurance Co. Ltd.
- Niva Bupa Health Insurance Co. Ltd.
- Reliance Health Insurance Ltd.
- Star Health and Allied Insurance Co. Ltd

Like many insurers, it faces challenges in maintaining optimal TAT for reimbursement claims due to increasing claim volumes, variability in case complexity, and logistical hurdles in claim adjudication. Understanding the internal and external factors that influence TAT is crucial for Care Health Insurance to enhance service delivery, reduce customer grievances, and improve overall process efficiency.

Reimbursement claims, although common in group health insurance, are frequently marred by delays, documentation issues, and inefficiencies. In reimbursement claims, unlike cashless claims, the hospital is not involved. It is the responsibility of the insured person to collect all the required documents and submit them to the insurance company. The most common mistakes in this process are missing, unclear, or incomplete documents.

The insurance company then has to carefully check each claim to make sure it is real, medically necessary, and follows the policy rules. This often involves reviewing medical reports, asking questions, and sometimes doing extra research. All of these steps make the claim process more complicated and increase the time it takes to complete it—also known as Turnaround Time (TAT).

**Problem Statement:** When TAT is high, it directly affects how satisfied the policyholder feels and reflects how well the insurance company is functioning. Long TATs can damage the company’s reputation, lead to more complaints, and increase admin costs. On the other hand, shorter TATs help build trust with customers and show strong operations.

Even though technology has helped reduce delays to some extent, issues still remain. Common problems include incomplete documents, delays between departments, limited automation, and unclear communication with hospitals.

This study focuses on understanding these delays in detail, especially in the context of Care Health Insurance's group reimbursement claims. It looks at the technical, system-related, process-related, and staffing issues that cause delays in claim settlements. By identifying these problems, the study aims to find better solutions for faster and smoother claim processing.

**Aim:** To identify the factors for the delay in the claim processing of the Group reimbursement claims

**Objectives:**

- To understand the different stages of claim processing
- To identify and categorize the factors affecting claim processing TAT.
- To suggest strategies for improving the efficiency of claim adjudication processes.

## Chapter 2

## Review of Literature

1. “In their 2024 study, Hankede and Mwelwa looked at why health insurance claim reimbursements are delayed in Zambia. They used both surveys and interviews, collecting responses from 36 people working at insurance companies and 7 staff members from the Pensions and Insurance Authority (PIA). Although many respondents felt that claims systems are generally working well, the study found several problems that still cause delays. These include unclear rules, weak communication, poor handling of documents, and limited cash availability. To solve these issues, the authors recommend using better digital tools, automated messaging systems, stricter rules for compliance, and clearer documentation processes. These changes could help insurance companies in developing countries process claims faster and keep customers more satisfied.”
2. “Dr. Nikita Singhal’s 2024 study takes a deep look at the different problems that affect how quickly health insurance claims are settled in India. The study found that delays are mainly caused by complicated paperwork, slow admin processes, confusing policy rules, a high number of claims, and outdated technology. It also explains how insurance companies struggle with too much work, old systems, fraud risks, and strict regulations. On the other hand, policyholders face issues like too much paperwork, slow responses from insurers, and not understanding the policies clearly. These delays hurt both the performance of insurance companies and the satisfaction of their customers, and the situation got even worse during the COVID-19 pandemic. To fix these problems, the study suggests making processes simpler, using digital tools, educating customers better, improving teamwork between all parties involved, keeping track of performance, and building stronger, more skilled teams over time.”
3. “Shakeela and Rao (2019) studied the Indian health insurance industry and gave a clear picture of how it's structured, how it's growing, and the problems it faces, especially with claim processing. They found that while more people are getting insured and the total premium collected is increasing, the industry still struggles with settling claims on time, high claim costs, and uneven performance between insurance companies. The study shows that issues like poor documentation and weak coordination between hospitals and insurers cause delays. It also highlights that public and private insurers perform differently when it comes to claim

settlement, financial strength, and customer service. The authors stress the need for strong regulation, smoother claim processes, and better awareness among the public to improve health insurance services. Overall, the study helps explain how system-level problems can slow down reimbursement and affect the quality and speed of service."

4. "Smith and Doe (2020) found that when claims are processed manually, it can take anywhere from a few days to several weeks, depending on how complex the claim is and how efficient the staff are. They also pointed out that using paper documents and multiple different systems makes the process harder and increases the chances of errors and mismatched information."
5. "Vedicherla (2025) talks about how artificial intelligence (AI) is changing the way healthcare claims are handled. The study shows that AI can help reduce human errors, speed up decisions, and make the whole claim process much faster. The article explains how different AI tools are used for things like automating workflows, spotting fraud, predicting claim outcomes, and pulling information from documents. AI can handle repetitive tasks such as checking documents, verifying eligibility, and generating queries, making the process more accurate and less stressful for staff. However, the report also points out some challenges, like the difficulty of combining data from different systems, ethical concerns, and the need for trained people to manage AI tools. Still, Vedicherla believes that using AI in health insurance—especially for reimbursement claims—can reduce delays, improve rule-following, and make customers more satisfied with the service."
6. "Kumar (2022) looked at how using robotic process automation (RPA) in health insurance can help improve admin work and reduce the time it takes to process claims. The study explains that RPA can take care of repetitive tasks like entering data, sorting documents, and checking claims. This helps save time, lowers the chance of mistakes, and cuts down on costs. The research also talks about how RPA can easily handle a large number of claims and work well with older software systems already in use. According to Kumar, using RPA not only speeds up the claim process but also improves accuracy, keeps things consistent, and ensures better compliance with rules. Because of all these benefits, RPA is seen as an important tool for making the health insurance claim process faster and more efficient."

**Limitations in Existing Research Specific to Group Health Insurance Reimbursement:** Although the aforementioned factors are derived from a larger body of research on health insurance claims, there are relatively few studies that thoroughly examine TAT for reimbursement claims in the context of group health insurance. Many studies focus on national health insurance schemes, individual policies, or provider-side claim submissions. The unique dynamics of group policies, such as the role of the employer in intermediation, the impact of policy customization for large groups, and the operations of TPAs dedicated to group schemes, warrant more targeted research to fully understand their specific impact on TAT.

# Chapter 3

# Methodology

## 3.1 Research Questions:

- What are the primary factors contributing to increased turnaround time in group reimbursement claim adjudication?
- How do procedural and systemic inefficiencies affect TAT?

## 3.2 Materials and Methods

**Research Design:** Descriptive cross-sectional study

**Study Setting:** Care Health Insurance, Gurgaon

**Study Population:** Medical adjudicators of the Group reimbursement team

**Research Approach:** Mixed method (Quantitative + Qualitative)

**Sample Size:** A sample of 1000 group reimbursement claim cases and interviews with 20 medical adjudicators

**Sampling Technique:** Convenience sampling

- Inclusion Criteria- Claims submitted under group health insurance policies at Care Health Insurance, Gurgaon. Employees directly involved in claim processing
- Exclusion Criteria- Claims under individual health insurance policies.

**Study Instruments:**

- **Primary Data**: Interviews with medical adjudicators.
  Each interview lasted 20–30 minutes and followed an interview guide exploring:
  - Perceived causes of delay in claims processing
  - Challenges in documentation review
  - Manpower and workload issues
  - Experience with system-related errors
  - Training adequacy and support
  - Suggestions for improvement

- **Secondary Data**: Analysis of past claim records.

**Operational Definitions:**

- Turnaround Time (TAT): The time taken from claim submission to claim settlement.
- Group health insurance: It is a type of Health Insurance plan that covers employees of an organization. Through a contributory or non-contributory version of these policies, employers offer coverage to their employees during their employment tenure. It is a valued benefit for employees & their immediate family members, like spouse, children, and parents, since group health insurance premium costs for employees are significantly lower than individual health insurance plans. Companies also get tax reduction on these, making it advantageous for both the employer and the employee
- **Medical Adjudicator**: An individual responsible for reviewing and approving/rejecting health insurance claims based on policy terms and clinical assessment.
- **Query**: A request for additional information or clarification raised by the adjudicator to the claimant before final decision-making.

**Data Analysis:**

- Quantitative data-

  Descriptive **statistics** were used to determine frequencies, percentages, and averages of TAT and other claim-related parameters.

  **Categorical variables,** such as reasons for delay, were summarized in pie charts

  The data were analyzed using **Microsoft Excel.**

- Qualitative data-

  Thematically analyzed. Codes were assigned to common themes such as “documentation issues,” “system delays,” and “staff shortage.”

**Ethical Considerations:**

- Informed written consent was obtained from participants
- Voluntary participation ensured
- Data confidentiality and security are maintained

## Chapter 4

## Results

The study findings reveal that:

**Quantitative Analysis:**

1. Average turnaround time for group claim processing-

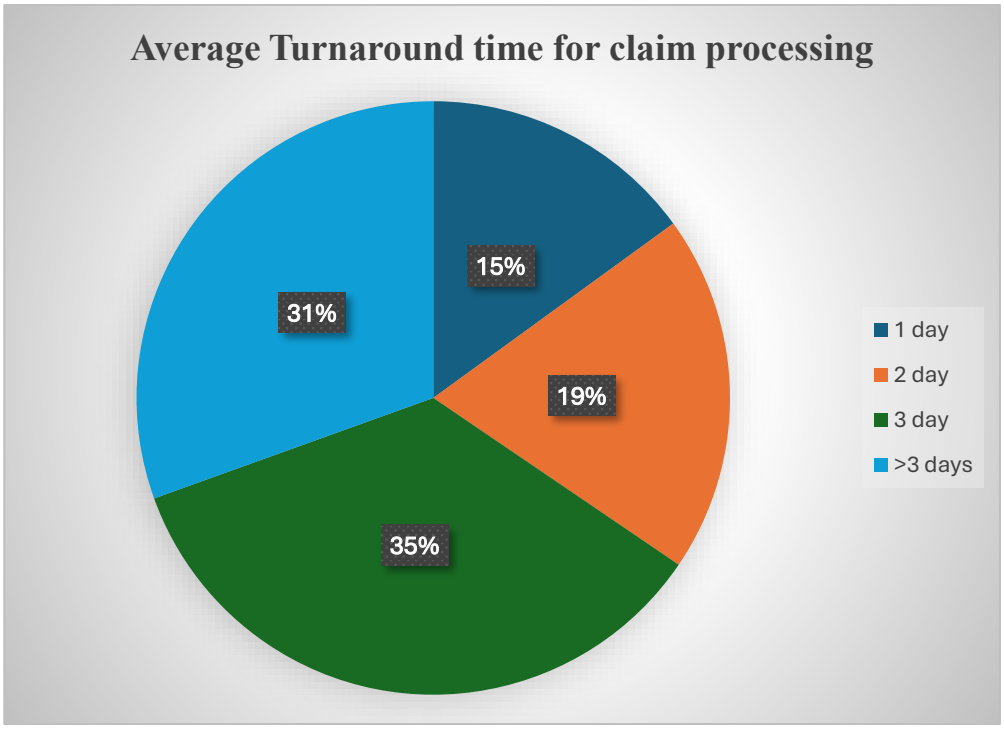


Fig. 4.1: Average turnaround time for claim processing

- **TAT for group reimbursement claim processing:** 31% of the claims were processed in >3 days, while 35% of the claims were processed within 3 days, and the rest were below 3 days.

2. Major reasons for the delay in claim processing-

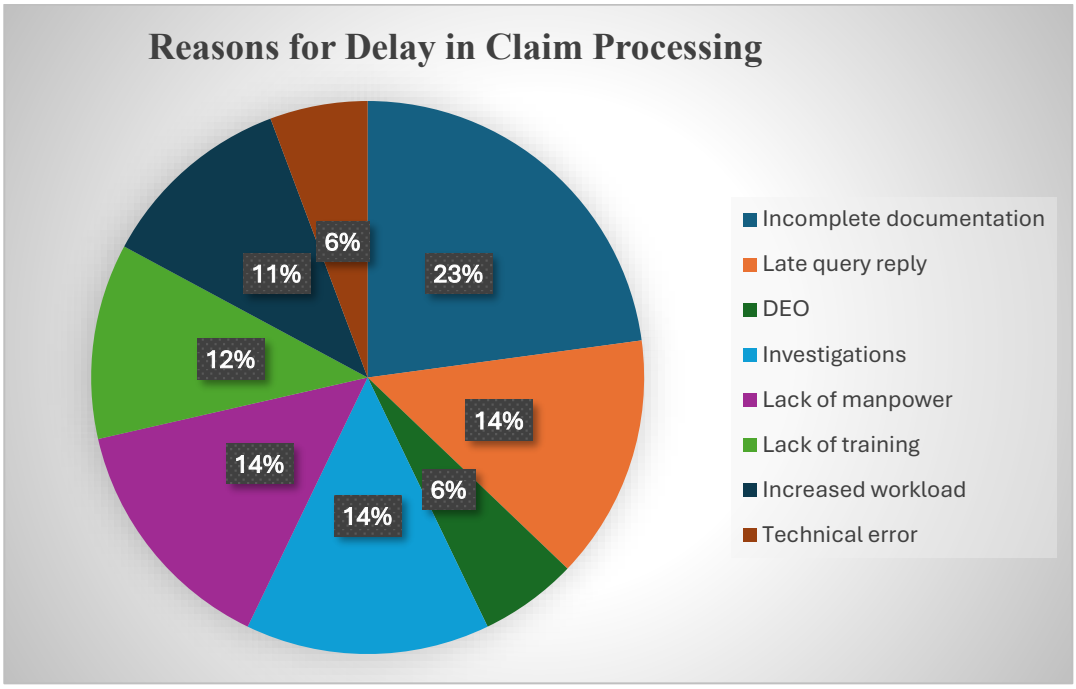


Fig. 4.2: Reasons for Delay in Claim Processing

- **Incomplete documentation** was the most cited reason, accounting for **23%** of the delays. This highlights the need for a standardized documentation checklist and better hospital-insurer coordination.
- **Late query replies** and **investigations** contributed to **14%** of the delays each, showing issues in timely communication and follow-up processes.
- **Lack of manpower** also accounted for **14%**, indicating a need for increased staffing and resource planning.
- **Lack of training** contributed **6%**, which suggests a need for regular training programs to ensure process clarity.
- **Increased workload** was responsible for **12%**, implying a requirement for better workload distribution and automation support.
- **Technical errors** and **DEO (Data Entry Operator) related issues** made up **6%** each, indicating the importance of system reliability and accurate data entry.

**Qualitative analysis:**

**Theme 1: Documentation Gaps and Variability**

"Almost every second claim has some issue with the documents. Patients don't know the required format, and we have to keep going back and forth."

Most adjudicators emphasized the poor quality or absence of key documents. Although a checklist is shared with policyholders, adherence is inconsistent.

**4.3.2 Theme 2: Delayed Response to Queries**

"Even after raising a query, we sometimes don't get a reply for 2–3 days, which automatically extends the processing time."

Adjudicators indicated that there is no strict follow-up or automated escalation if a claimant does not respond, resulting in passive delays.

**4.3.3 Theme 3: Manpower and Workload Pressure**

"On high-volume days, we barely get time to breathe. We are expected to maintain quality and TAT both, which is not realistic with current staffing."

Multiple adjudicators reported burnout during peak periods and indicated that current staffing levels are not aligned with rising claim volumes.

**4.3.4 Theme 4: System Glitches and Platform Issues**

"Sometimes the system crashes, or we face errors. Re-checking takes time."

Technical issues such as software downtime, lag in loading documents, and data loss were commonly mentioned.

**4.3.5 Theme 5: Training and SOP Awareness**

"We learned most of the processes on the job. There's no structured training or periodic updates."

Several adjudicators pointed out the absence of regular policy training sessions or updates on new disease codes, billing norms, or IRDAI changes.

- Most adjudicators handle more than 65 daily claims, suggesting heavy workloads that may affect decision-making quality and speed.

- Although many claims are processed in 3 days, a substantial number experience longer durations due to unresolved documentation and hospital-side delays.
- Hospitals often provide incomplete data or delay responding to queries, significantly affecting claim processing time.
- In line with workload observations, participants identified a major issue as a shortage of skilled and sufficient labour.
- Respondents brought up the issue of inadequate training, highlighting the necessity of frequent policy revisions and procedural explanations.
- There have occasionally been reported technical problems with claim adjudication systems, which have caused brief but notable delays.
- Standardised document checklists, better hospital coordination, hiring more employees, and improving digital infrastructure were among the recommendations made by respondents.

# Chapter 5

## Discussion

The study findings reveal a number of factors affecting the TAT of group reimbursement claims. It is evident from both the quantitative and qualitative data that procedural inefficiencies, resource constraints, and communication breakdowns are one of the main causes.

Incomplete documentation was the biggest reason for delays, causing 23% of them. This shows that policyholders need clearer information about which documents to submit and how to prepare them properly. A standard checklist could help avoid confusion. This finding matches the study by Shakeela and Rao (2019), who pointed out that good-quality and complete documents are very important for claims to be processed smoothly. When the document requirements aren't clear, people often forget to submit something or send documents in the wrong format. This leads to back-and-forth queries and slows down the process, especially in reimbursement claims, where the responsibility of submitting all documents lies completely with the policyholder. To reduce this problem, insurance companies should create easy-to-use claim submission systems and provide clear guidance on the documents needed.

About 14% of the delays happened because of other issues like not enough staff, slow responses to questions, and long investigations. This shows that delays happen both at the insurance company and the hospital. Hankede and Mwelwa (2024) explain that investigations take longer when investigators don't work well together, case files are confusing, or there are no good methods to prioritize risks. Also, delays can happen when follow-ups and customer support aren't done properly.

Delays in answering requests for clarification can also happen because of poor follow-up and not enough customer education. Using escalation procedures and automated reminders can help fix this.

Technical errors and a lack of training are also big problems. To review claims quickly and correctly, especially in busy corporate settings, it's important to have a well-trained claims team. Singhal (2024) points out that many Indian insurance companies have understaffed claims departments that struggle during busy times and don't have enough backup staff. This shows how important it is to have regular short training sessions to keep staff updated on policy rules, IRDAI guidelines, and how to spot fraud.

Workload increases (about 11%) make things worse, showing a need for more staff and possibly using automation for repetitive tasks. These issues could be improved by using flexible staffing methods and training teams to handle multiple roles.

The reliance on reliable IT systems and accurate data is highlighted by technical errors and DEO-related problems (6% each). A claim may be delayed by a day or longer due to even small software errors or data entry errors. Such preventable lags could be decreased by investing in real-time system monitoring and claim platforms that are integrated with OCR.

Claims efficiency in developing markets is severely hampered by manual workflows, a lack of system interoperability, and a lack of training investment, according to Smith and Doe (2020). In contrast to digitally advanced insurance ecosystems where straight-through processing is typical, the group reimbursement industry in India still mainly depends on reactive query handling, manual checks, and physical document scanning.

According to information obtained from the questionnaire given to medical adjudicators, delays are frequently institutional in addition to being technical. Inadequate interdepartmental coordination, overlapping responsibilities, and bureaucratic bottlenecks were commonly mentioned. This demonstrates the necessity of a simplified framework for claims management backed by reliable IT systems.

Many developed insurance markets have fully embraced digitization, which has resulted in a significant reduction in TAT when compared to global benchmarks. Although the insurance industry in India is moving in that direction, considerable process reengineering investment is still needed to attain similar results.

The use of both quantitative and qualitative methods, as well as the direct participation of adjudicators, is among the study's strengths. Generalizability may be limited by a small sample size and data from a single organisation.

# Chapter 6

## Conclusion

Within the context of Care Health Insurance, Gurgaon, this study sought to determine and examine the factors influencing the longer turnaround time (TAT) in group health insurance reimbursement claims. The study offers a data-driven understanding of the difficulties present in the current claims adjudication process through the use of a mixed-methods approach that includes the review of 1,000 claim records and interviews with 20 medical adjudicators. This study explains the different reasons why it takes longer to process group health insurance reimbursement claims. It found that the main issues causing delays include poor processes, not enough staff, delays in answering queries, and a lack of proper training.

To solve the above-mentioned problems, we need to take several steps. First, policyholders should be educated about the documents they need to submit. Insurance companies should train their employees to make them understand the rules and the handling of claims properly. To speed up the process, slow and manual repetitive tasks should be eliminated using digital tools and automation.

Longer TAT can have adverse effects. It can lead to unhappy customers, increased complaints, marring of the company's reputation, and penalties. It can also put pressure on staff, backlog accumulation, and reduce service quality.

That is the reason why decreasing TAT is not just for customers, it is also important for the company's success. IRDAI plays a crucial role in ensuring timely claim processing, insurers also need to improve their internal systems. By focusing on continuous improvement and aligning their operations with IRDAI's guidelines, insurers can provide better service and run more efficiently.

## Recommendations

- Provide a **simple, multilingual checklist** on the website, app, and physical claim forms with examples of acceptable documents (e.g., bill formats, discharge summary, etc.).
- Add a **document upload interface** in the mobile app/portal that flags missing or low-quality uploads in real time.
- Implement a bot that guides customers through document submission and FAQs on claim requirements
- When a query is raised, inform the customer about **potential delays if not responded to within 2 days** — this psychologically triggers faster action.
- Set internal TAT standards (e.g., 2 working days) for investigator responses, with escalation protocols.
- Short 15-minute e-learning videos or quizzes on new issues, fraud indicators, and documentation best practices.
- Pair new processors with experienced staff during onboarding for practical learning.
- Internal bulletins summarizing product and process changes in a simplified format.
- Every week, all claims longer than three days undergo RCA to find and fix recurring bottlenecks.
- Cross-functional training for all staff members to facilitate cross-departmental cooperation during periods of increased workload.
- Invest in reliable and efficient claim processing software so that IT errors can be minimised.
- Establish a control mechanism that can lead to the early identification of errors and can be resolved in time.

These steps can contribute to faster and more accurate claim adjudication, improving overall customer satisfaction and procedural efficiency.

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