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

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BACKGROUND

- Care Health Insurance, which initially launched in 2012 as Religare Health Insurance, underwent a strategic rebranding in 2020.
- The company distinguishes itself as a specialized health insurer, offering a comprehensive suite of products that includes top-up coverage, personal accident, maternity, international travel insurance, and critical illness, along with group health insurance and group personal accident insurance for corporates, microinsurance products for the rural market, and a comprehensive set of wellness services.
- Care Health Insurance is committed to a customer-centric approach, leveraging technology to streamline operations and ensure efficient service delivery.
- The company boasts an extensive network of over 21,700 cashless healthcare providers throughout India, facilitating widespread access to medical care for its policyholders.
- According to an Economic times report of March 2025, Claims Settlement ratio for Care Health Insurance is the second highest at 92.77%.

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 a large number of individuals who are exposed to comparable risks.

TYPES OF INSURANCE

GENERAL INSURANCE

LIFE INSURANCE

TYPES OF CLAIMS IN HEALTH INSURANCE

Cashless

- Cashless claims are 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

- Reimbursement claims, where the insured pays out-of-pocket and later submits bills, prescriptions, discharge summaries, and other documents for reimbursement.
- These issues are more common in non-network hospitals and often result in delays due to documentation or verification problems.

•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.

METHODOLOGY

Aim:

To identify the reasons for the delay in the claim processing of the Group reimbursement

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.

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?

- **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
- **Study Instruments:**

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

- **Data Analysis:** Quantitative data analyzed using descriptive statistics. Qualitative data thematically analyzed

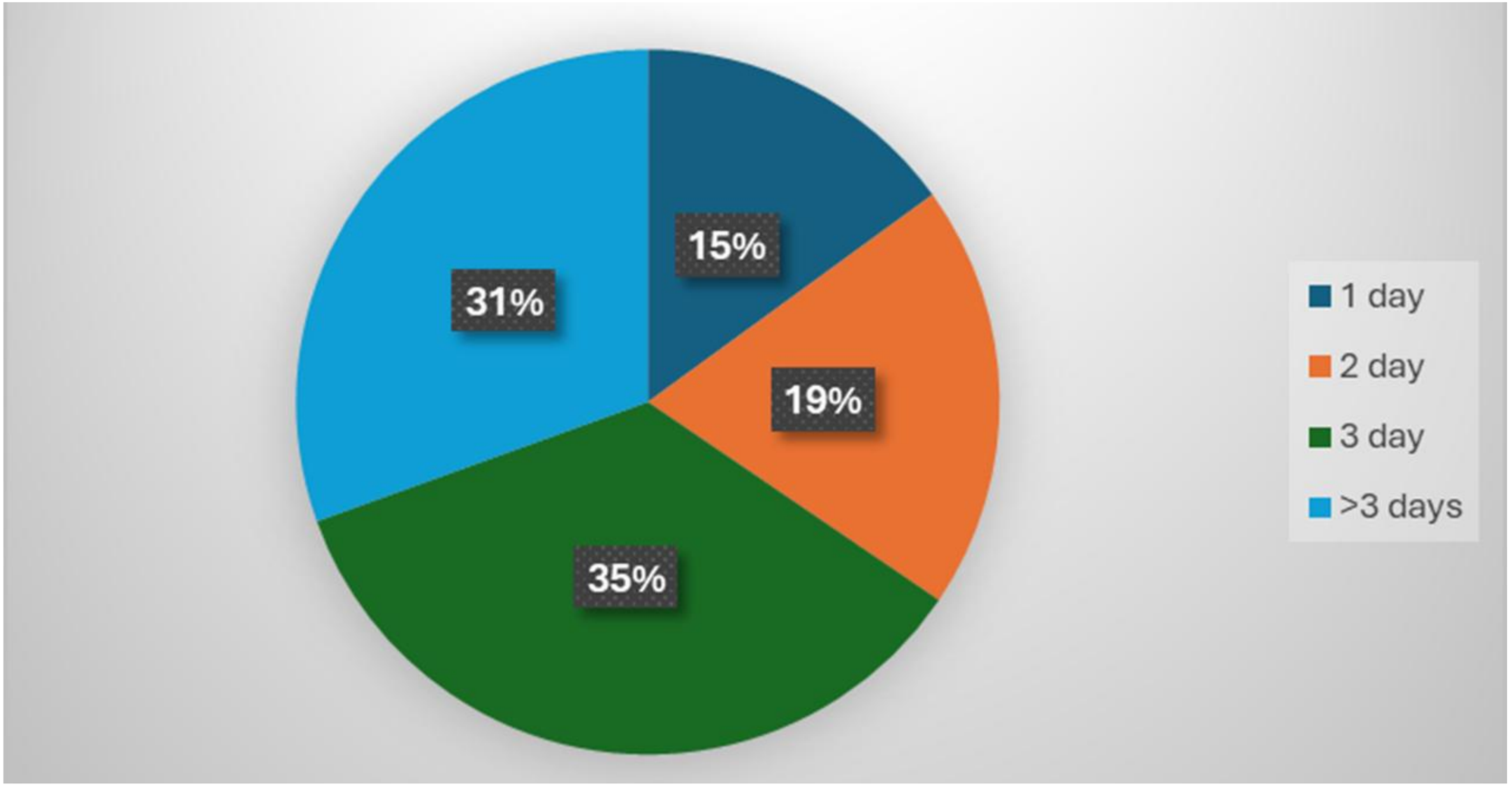
OPERATIONAL DEFINITIONS

- **Turnaround Time (TAT):** The time taken from claim submission to claim settlement.

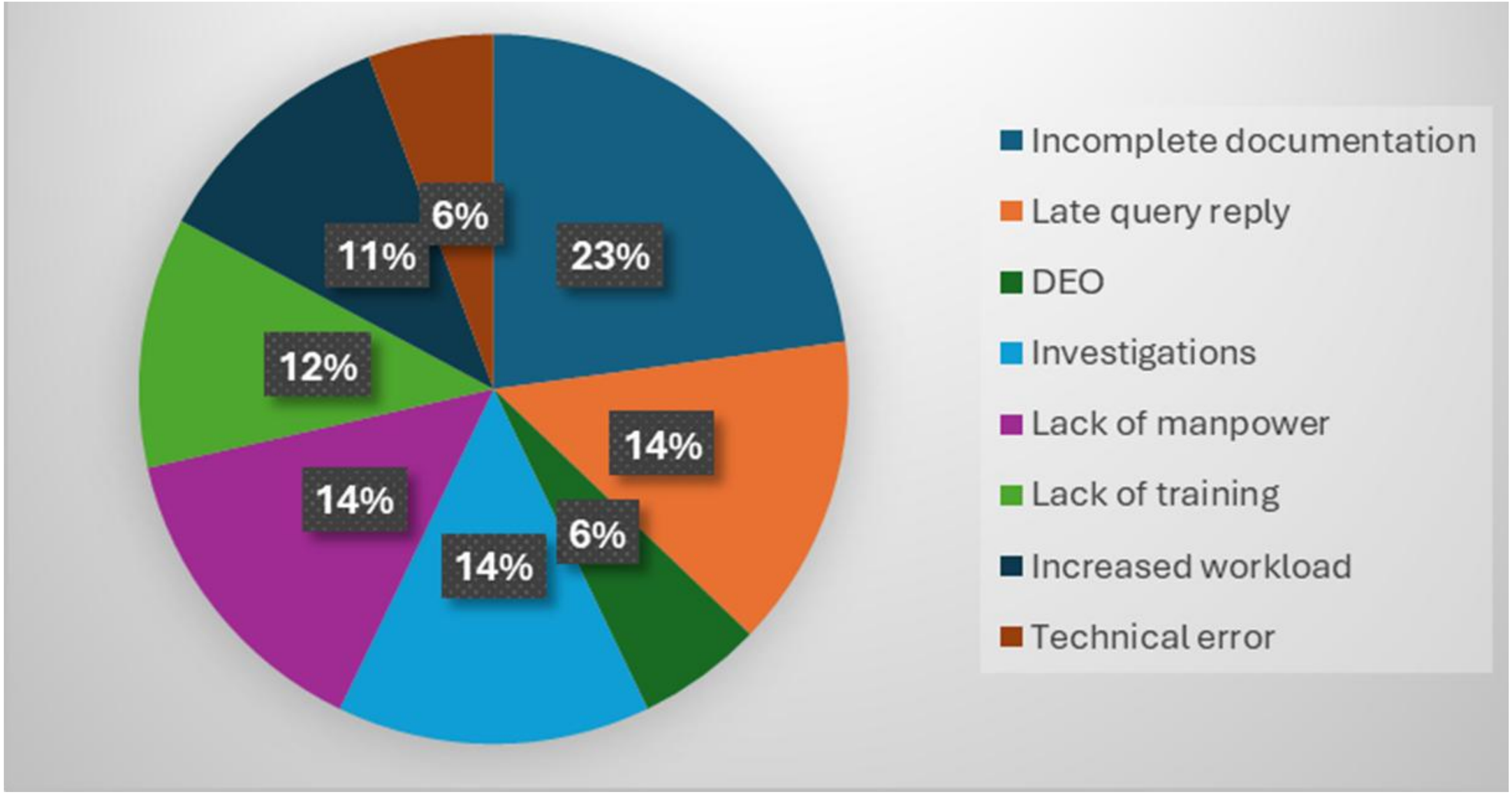
- **Group health insurance:** It is a type of health insurance plan that covers employees of an organization. Through a contributory or non-contributory version of these policies, employers offer coverage to their employees during their employment tenure.


RESULTS

Average turnaround time for group claim processing-



Major reasons for the delay in 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.
- 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.
- Most adjudicators handle more than 65 daily claims, suggesting heavy workloads that may affect decision-making quality and speed.


conclusion

- This research sheds light on the multifaceted reasons behind increased turnaround time in group health insurance reimbursement claims, with a specific focus on Care Health Insurance. The analysis demonstrates that operational inefficiencies such as incomplete documentation, delays in query response, lack of manpower, and inadequate training are key bottlenecks affecting TAT.
- Addressing these challenges requires a multi-pronged approach. First, documentation procedures must be simplified and communicated to both policyholders and hospital administrators. Second, insurers should invest in employee training programs to ensure that claims staff are well-versed in regulatory requirements and internal protocols. Third, digital tools and automation must be leveraged to eliminate repetitive manual tasks, thus improving processing speed and accuracy.


RECOMMENDATION
RECOMMENDATION

- 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.
- Weekly RCA of all claims >3 days to identify and resolve recurring bottlenecks.
- Cross-functional training of all employees so that at the time of increased workload, there can be cross-departmental collaboration.
- Invest in reliable and efficient claim processing software so that IT errors can be minimized.
- Establish a control mechanism that can lead to the early identification of errors and can be resolved in time.

THANK YOU