EVALUATION OF TURNAROUND TIME OF REIMBURSEMENT CLAIM PROCESSING IN INTERNATIONAL CLAIMS AT CARE HEALTH INSURANCE LIMITED

Dissertation submitted to

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

Dr. Ridhima Khandelwal

Under the supervision and guidance of

Dr. Susmit Jain

2023

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled Evaluation of Turnaround Time of non-medical reimbursement claim processing in international claims at Care Health Insurance Limited 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Dr. Ridhima Khandelwal

Date

CERTIFICATE

This is to certify that Dr. Ridhima Khandelwal in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed her/his internship during 10 March- 10 June 19, 2023.

Place: Preceptor/Head of the Organization

Date: Name of the organization

CERTIFICATE

This is to certify that dissertation titled Evaluation of Turnaround Time of non-medical reimbursement claim processing in international claims At Care Health Insurance Limited is a record of the research work undertaken by Dr.Ridhima Khandelwal in partial fulfilment 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 his/her approach to the research study has been sincere, scientific, and analytical.

Dr. Susmit Jain	Dr. (Col) Mahendra Kumar
Faculty Guide	School Dean
IIHMR University, Jaipur	IIHMR University, Jaipur
Date	Date

ABSTRACT

Submitted By: Dr. Ridhima Khandelwal Guided By: Dr. Susmit Jain

Roll No- 1367

Title: Evaluation of Turnaround Time of non-medical reimbursement claim processing in international claims At Care Health Insurance Limited.

The Insurance Regulatory and Development Authority (IRDA), which is in charge of developing and enforcing rules and regulations for the insurance sector, regulates and oversees the insurance industry in India.

India's insurance market is still developing as a result of legal changes, technological improvements, and shifting consumer tastes. It is essential for protecting people and businesses from a variety of hazards and supports the nation's overall economic growth and financial stability.

In India, travellers can purchase travel insurance to guard against unanticipated dangers and costs whether they are travelling domestically or internationally. It provides financial protection and assistance during travel-related emergencies, such as trip cancellations, medical emergencies, lost baggage, or flight delays.

The objectives of this research study are to assess the turnaround time (TAT) for reimbursement claim settlement., to record the process of health insurance reimbursement claims and to identify the factors that lead to the delays and inefficiencies in the process.

The research is descriptive cross-sectional. Study tools used in this study is collecting data from the secondary data of the organization which was analysed using MS Excel. Descriptive and inferential statistics were used as and when required. This study is conducted for three months from 10th march 2023 to 10th June 2023. Sample size is 1000 non-medical claims in which convenience sampling technique was used.

Data gathered and used for analysis was kept confidential and it was only used for research purpose. The final completed report would be submitted to the concerned authority.

RESULT:

In the analysis of a total of 1000 claims, it was found that 412 claims were approved, indicating that the policyholders met the necessary criteria for reimbursement. 393 claims, on the other hand, were denied, indicating that these policyholders did not adhere to the conditions outlined in their insurance plans. A final judgement on the approval or denial of 195 claims was also marked as enquiry raised, indicating that more details or clarification were required. Total of 72.6% claims were handles promptly and met standard TAT as per guidelines whereas 27.4% claims were delayed. It's critical to remember that a variety of factors are responsible for delay in claim processing such as inadequate documentation, complicated cases, or a high number of claims. The study offers a number of important suggestions to boost the effectiveness and client satisfaction of processing reimbursement claims in the international claims department.

Conclusion:

The assessment of the turnaround time for processing reimbursement claims in the International Claims Department offers important insights about various suggestions and challenges. Recommendations were made after identifying the causes of delays. These include implementing digital solutions, automating data entry processes, enhancing communication channels, providing clear guidelines and support to policyholders, conducting regular training and performance evaluation, monitoring and analysing turnaround time, fostering collaboration and knowledge sharing, and conducting periodic reviews and adjustments. The implications include enhanced customer satisfaction and operational efficiency for the insurance organization.

KEY WORDS

"Non-medical reimbursement claims", "Turnaround time", "Efficiency and effectiveness of claims", "customer satisfaction"

ACKNOWLEDGEMENT

I would like to express my sincere gratitude and appreciation to all those who have contributed to the successful completion of this project.

First and foremost, I would like to thank my supervisor/guide for their invaluable guidance, support, and mentorship throughout the duration of this project.

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Finally, I want to thank my family and friends from the bottom of my heart for their constant support, compassion, and inspiration during this quest. They have inspired me with their never-ending encouragement and confidence in my abilities.

I owe a duty of gratitude to everyone who helped with this project, whether they were directly involved in it or not. They have provided excellent assistance, and I sincerely appreciate it their contribution and support.

Dr. Ridhima Khandelwal

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

CHIL- Care Health Insurance Limited

EHR – Electronic Health Records

IPD – Inpatient Department

IRDA – Insurance Regulatory and Development Authority

KPI – Key Performance Indicator

MIS – Management Information System

OPD – Outpatient Department

PED- Pre-existing Disease

TAT – Turnaround Time

INTRODUCTION

Turnaround time for reimbursement claim processing focuses on assessing how long it takes a health insurance company to process and pay out non-medical reimbursement claims, which cover things like trip interruption, trip cancellation, trip delay, delay of checked-in baggage, loss of checked-in baggage, and loss of passport. A crucial performance parameter used to evaluate the effectiveness and efficiency of the claim processing system is turnaround time.

The research intends to quantify the time required, assess the impact of delayed claim processing on customer satisfaction and overall customer experience, and improve the department's capability. It also attempts to uncover any workflow inefficiencies in claim processing that contribute to delays.

The international claims department can assess more about its operational performance and pinpoint problem areas after this research. Some potential problems that are encountered while evaluating are inconsistent data availability, lack of standardized processes, complexity of international claims, limited resources and staffing constraints, integration challenges with external systems, lack of automation and outdated systems, complex or disputed claims, compliance and regulatory requirements, various external factors such as natural disasters, political instability, or global events can disrupt claim processing timelines and contribute to delays.

ADVANTAGES

There are several advantages of taking travel insurance when planning a trip. Here are some key advantages:

1. Trip Cancellation and Interruption Coverage: Travel insurance offers protection against trip cancellation or interruption brought on by unforeseeable events including illness, injury, or the death of the insured person or a family member. This insurance might aid in recouping non-refundable costs such as airline tickets, hotel reservations, and tour reservations.

2. Medical Expense Coverage: Medical expenses incurred while travelling are covered by travel insurance. This can be especially useful when travelling abroad because medical expenses in some nations are very expensive. The cost of emergency medical care, hospitalisation, and medical evacuation may be partially or completely covered by travel insurance as per policy terms and conditions.

3. Emergency Assistance Services: Many travel insurance plans provide different types of emergency assistance services, such as round-the-clock hotline support, cash loans in case of emergencies, and coordination of medical services. These services can be very valuable in unfamiliar situations or during emergencies when immediate help and guidance are required.

4. Loss or Delay of Baggage Coverage: Travel insurance can provide protection against the theft, loss, or damage of bags and other personal belongings. In addition, it might pay back expenses incurred due to baggage delays, such buying basics while waiting.

5. Trip Delay Coverage: Travel insurance can pay for extra expenses incurred during a trip delay, such as hotel, meals, and transportation, as long as the delay was brought on by circumstances beyond your control, such as bad weather, airline strikes etc.

6. Personal Liability Coverage: Your travel insurance may include personal liability coverage, which will defend you in the event that you inadvertently cause harm to someone else or damage to their property while you're on vacation.

7. Peace of Mind: The assurance that travel insurance offers is among its most important benefits. You may unwind and enjoy your travel experience by being confident that you are financially covered against unforeseen circumstances and emergencies while away.

Evaluation of Turnaround Time of non-medical reimbursement claim processing in international claims At Care Health Insurance Limited.

CHAPTER 1 – INTRODUCTION

A critical component of the health insurance sector is the assessment of the processing time for non-medical reimbursement claims. Its main objective is to evaluate the effectiveness and efficiency of the system for processing claims for non-medical services, including travel cancellation, delay, baggage loss, and other similar occurrences. The turnaround time is the amount of time taken by insurance company to process and compensate the policyholder for their loss.

Both policyholders and insurance companies place highest significance on prompt and effective claim handling. In order to recover their losses and lessen financial obligations, policyholders anticipate rapid compensation for expenses incurred due to non-medical occurrences. On the other side, insurance companies strive to offer consumers a smooth and satisfying experience while retaining operational efficiency.

Analysis of the various claim processing workflow steps, from claim submission to final pay-out, is required to determine the turnaround time for non-medical reimbursement claims. This assessment aids in locating any potential process bottlenecks, inefficiencies, or delays.

BENEFITS COVERED

Medical benefits

- Hospitalization coverage

  It offers policyholders the assurance that their medical expenses will be taken care of during a hospital stay, reducing the financial burden on them and their families. It ensures access to quality healthcare without having to worry about the exorbitant costs often associated with hospitalization.

- Daily allowance for hospitalization

  Daily allowance for hospitalization is a specific feature offered by some health insurance policies. It provides policyholders with a fixed monetary amount for each day they spend in the hospital as an additional benefit on top of the coverage for medical expenses.

- Dental expenses

  Dental expenses refer to the costs associated with dental care and treatments. It commonly includes routine check-up, periodontal treatment, restoration, extraction, root canal treatment, crown, bridges, dentures, and other dental treatments. In the context of health insurance, coverage for dental expenses can vary in different companies.

- Common carrier accidental death

  Common carrier accidental death refers to a type of coverage provided by insurance policies that protects individuals in the event of accidental death while traveling on a common carrier, such as a plane, train, or bus.

- 2-way compassionate visit

  2-way compassionate visit refers to a type of coverage provided by travel insurance policies that allows for the travel expenses of a family member to be covered when there is a medical emergency or serious illness involving the insured person.

- Accidental death

  It is a type of insurance benefit that provides financial protection in the event of the insured person's death due to an accident.

- Permanent total disability

  In the case of permanent total disability, the coverage pays out a predetermined benefit amount to the insured person if they become permanently and completely disabled due to an accident or illness. Permanent total disability is typically defined as the complete and irreversible loss of bodily functions or the inability to engage in any gainful occupation for the rest of one's life.

- Family option discount

  Family option discount is a benefit offered by some insurance providers that allows families to receive a discounted premium when multiple family members are covered under the same insurance policy.

- Medical evacuation

  It is a crucial benefit provided by travel insurance and some health insurance policies that covers the cost of transporting a policyholder to the nearest suitable medical facility or their home country for medical treatment when faced with a serious illness, injury, or medical emergency while traveling abroad.

- Pre-existing disease cover

  Pre-existing disease cover is a feature offered by some health insurance policies that provides coverage for medical expenses related to pre-existing diseases. PED refers to any illness, injury, or health condition that existed before the insurance policy's effective date.

Non- Medical benefits

- Trip cancellation

  With trip cancellation coverage, policyholders can be reimbursed for their pre-paid and non-refundable expenses if they are unable to embark on their trip due to specific reasons specified in the policy.

- Trip interruption

  Trip interruption coverage is a feature offered by travel insurance policies that provides financial protection to travellers if their trip is interrupted or cut short due to unforeseen circumstances.

- Trip delay

  When a trip is delayed due to covered reasons, such as severe weather conditions, airline strikes, or mechanical failures, travellers may incur extra costs for accommodation, meals, transportation, and other necessary expenses. Trip delay coverage reimburses these additional expenses up to the policy's specified limits.

- Loss of checked-in baggage

  Loss of checked-in baggage coverage is a key feature offered by travel insurance policies to protect travellers in the event that their checked-in baggage is lost.

- Delay of checked-in baggage

  Delay of checked-in baggage refers to a situation where a traveller's checked-in baggage is not delivered to them at their destination within a certain period of time.

- Repatriation of Mortal Remains

  Repatriation of mortal remains refers to the process of transporting a deceased person's body back to their home country or place of origin. It is an important aspect of travel insurance coverage, particularly in the event of a death occurring during international travel.

- Loss of passport

  Travel insurance can provide coverage for the loss of passport, offering assistance and financial support to help the traveller navigate the process of obtaining a new passport.

- Return of minor child

  Return of minor child is a coverage provided by travel insurance policies to assist the safe return of a minor child who is traveling alone or with a covered adult and is left unattended due to the covered adult's injury, illness, or death during the trip.

- Upgradation to business class

  Upgradation to business class refers to a feature or benefit provided by some travel insurance policies that offers the policyholder the option to upgrade their travel accommodations from economy class to business class in certain circumstances.

- Automatic trip extension

  Automatic trip extension is a feature offered by some travel insurance policies that allows the insured individual to extend their trip duration without the need for additional paperwork or policy amendments. This benefit is typically applicable when unforeseen circumstances beyond the traveller's control cause delays or disruptions to their scheduled return.

- Missed flight connection

  Missed flight connection coverage is a benefit provided by some travel insurance policies to protect travellers in the event that they miss a connecting flight during their journey.

- Hijack distress allowance

  Hijack distress allowance is a specific benefit provided by some travel insurance policies to offer coverage and financial assistance in the unfortunate event of a hijacking during a trip.

Process of reimbursement

STEP 1: CLAIM INTIMATION

Member needs to inform the insurance company about expenses incurred member wants to claim with details of incidence on email id and claim advice mentioning complete documentation process will be shared.

STEP 2: DOCUMENTS SUBMISSION

Member needs to submit claim documents as per claim advice shared to member.

STEP 3: CLAIM PROCESSING

Claim documents submitted to insurance company for processing will be reviewed and in case of any further requirement, member will be informed on the pending information and member needs to provide the same.

STEP 4: CLAIM DECISION

Decision on claim will be done on the basis of submitted documents and as per policy terms and conditions. Approved claims will be settled in member's account.

IRDA

The Insurance Regulatory and Development Authority of India (IRDAI) plays a crucial role in regulating and monitoring the insurance industry in India. Here are some key roles and responsibilities of IRDA in relation to insurance companies:

1. Regulation and Licensing: IRDA is responsible for issuing licenses to insurance companies in India. It sets various factors such as eligibility criteria, evaluates applications, and grants licenses to entities that meet the ideal standards and regulations. IRDA also monitors the compliance of insurance companies with the licensing conditions.

2. Policy Formulation: It develops and evaluates laws and rules pertaining to the insurance industry. For different parts of insurance operations, such as product design, pricing, underwriting, and claims resolution, it creates standards and frameworks. These regulations are designed to safeguard policyholder interests and advance ethical business practises.

3. Consumer Protection: By developing rules and regulations that control honest and moral behaviour in the insurance sector, IRDA ensures the protection of policyholders' interests. It looks into customer complaints and grievances against insurers while also keeping an eye on insurance businesses to guarantee compliance with these rules. Additionally, IRDA encourages information sharing to policyholders and openness.

4. Market Conduct and Supervision: To monitor insurance companies' financial viability, regulatory compliance, and adherence to prudential norms, IRDA performs routine inspections and audits of them. It supervises insurers' business practises, making sure that policyholders are treated fairly, preventing fraud, and upholding the integrity of the market. IRDA also establishes standards for insurance companies' solvency and capital sufficiency.

5. . Product permission: Before launching new insurance products or making changes to current ones, insurance companies must receive IRDA permission. The proposed products' characteristics, terms, and conditions are examined by IRDA to make sure they are reasonable, open, and in the policyholders' best interests.

6. Resolution of Disputes: The IRDA assists in resolving conflicts between policyholders and insurance providers. It gives a venue for fair and unbiased dispute resolution through mediation and arbitration. In addition, the IRDA keeps a grievance procedure in place to handle complaints from policyholders and makes sure insurance providers follow the guidelines on when to resolve claims.

The overall objectives of IRDA in the insurance sector are to safeguard the stable and transparent market environment, protect the interests of policyholders, ensure fair practices among insurers, and maintain the financial soundness of the insurance sector in India. Through its regulatory and supervisory functions, IRDA aims to build trust and confidence in the insurance industry and facilitate the growth and development of the sector.

IRDA GUIDELINES

Guideline has been laid down by The Insurance Regulatory and Development Authority of India (IRDA) for the TAT that is Turnaround Time of non-medical claim reimbursement existing in the insurance sector. The major points regarding guidelines by IRDA for TAT of reimbursement of non-medical claim include:

1. Standard TAT: For the processing and resolution of non-medical claims, IRDA has developed a standard TAT. To ensure that policyholders receive their money in a timely manner, insurance companies are obligated to follow these TAT regulations.

2. Different Categories: The IRDA has divided non-medical claims into various categories, including lost baggage, trip cancellation, and delay. Each category may have a unique TAT for processing claims that is specified.

3. Claim acknowledgment: Insurance firms must acknowledge the receipt of non-medical claims within a predetermined time window, which is often a few days after the claim is submitted.

4. Claim Settlement Time: Depending on the type of the claim, the TAT for claim settlement varies. The maximum time frame for resolving non-medical claims is specified in IRDA guidelines, ensuring that policyholders receive their payouts on schedule.

5. Grievance Redressal: Guidelines of IRDA stresses over the importance of a strong mechanism for grievance redressal. Insurance firms have a deadline by which they must respond to complaints from policyholders and settle any problems with non-medical claim reimbursement.

6. Transparency and Communication: IRDA regulations encourage open and efficient communication between insurance providers and customers. Insurance providers are obligated to tell policyholders in a straightforward manner about the claim procedure, necessary supporting materials, and TAT for reimbursement.

CHAPTER 2: LITERATURE REVIEW

SNO	AUTHOR	TITLE OF STUDY	KEY TAKEAWAYS	SOURCE
1	Vandana Sumbe Aaliya Shaikh Vaishali Mhaske Prof Shital Aher	Intelligent travel and expense claim - ITRAVEL	• iTravel is an intelligent travel and expense claim system that offers a streamlined and automated process for managing travel expenses. It simplifies the entire claim process, from submission to reimbursement. • This feature enhances convenience and eliminates the need for manual paperwork, making it easier for employees to manage their travel expenses. • It offers real-time visibility into travel expenditure, enabling organizations to make informed decisions and control costs more effectively.	INTERNATIONAL JOURNAL OF INNOVATIONS IN ENGINEERING RESEARCH AND TECHNOLOGY [IJIERT]

2	John.D.Allingham	Travel Medical Insurance	• Companies reduce risk either by not covering any pre-existing conditions or, more commonly, by accepting some pre-existing conditions with important qualifications, such as a required period of "stability" and "control." • Physicians are inevitably involved in the claims process and should be aware of the requirements of travel medical coverage and how these affect patients as well as themselves. Any discrepancies between client-supplied information and that provided by the physician will be noted and might adversely affect the claim. • Clarity and transparency are, however, essential to maintaining a good industry reputation and are the best approach to avoid regulatory action.	The official journal of the College of family physicians of Canada

			• Formal identification of the deceased's remains is required and a funeral director must be appointed. Following this, a number of documents prior to providing clearance for burial. • as a travel medicine practitioner, it is prudent to discuss all eventualities, including the possibility of death, during the pre-travel consultation. • Awareness of the procedures involved in this process may ease the burden on the grieving family at a very difficult time in their lives and serve public interests.	
3	Ruairi Conolly Richard Prendiville Denis Cusack Gerard Flaherty	Repatriation of human remains following death in international travellers		International Society of Travel Medicine Oxford Academic

4	Kushal Poddar1 Monika Gupta Jayachandu Bandlamudi Sampath Dechu2	Multidimensional Analysis of Reimbursement Process	• This report leverages existing process mining techniques and implements a set of new techniques to analyze the data from multiple dimensions. • The proposed multidimensional analysis includes loops, bottlenecks, variants, automation amenability, activity centrality, actors' (here, role) profiling, and throughput.	Jawaharlal Nehru University, India

CHAPTER 3: METHODOLOGY

This study was conducted in Care Health Insurance Limited, Gurgaon, Haryana, India.

RESEARCH QUESTION:

- What is the reimbursement process?
- What is the average Turnaround Time of reimbursement process?
- What factors were identified as contributing to delays in reimbursement claim processing, and what recommendations were made for improving efficiency?

AIM:

- Evaluation of Turnaround Time of non-medical reimbursement claim processing in international claims At Care Health Insurance Limited.

OBJECTIVES:

- To assess the turnaround time for reimbursement claim settlement.
- To record the process of health insurance reimbursement claims.
- To identify the factors that contribute to delays and inefficiencies in the process.

HYPOTHESIS

The turnaround time of non-medical reimbursement claim processing in international claims at an insurance company is significantly different from the industry standard average processing time.

STUDY MATERIALS AND METHODS:

Study design is Descriptive cross-sectional while the sampling technique is Convenience Sampling.

STUDY TOOLS:

Study tool used during this study is Collection of data from the secondary data of the organization and Data collection procedure is Direct Observation and Management Information System.

DURATION:

Duration of study is three months (10th Mar-10th June 2023). Sample size of study is 1000 Non-Medical claims (1st April-31st May 20223).

ETHICAL CONSIDERATIONS:

Confidentiality and Privacy:

Ensuring the confidentiality and privacy of participants' personal and sensitive information is essential. Measures should be implemented to protect data and ensure that participants cannot be identified from the published or shared results.

Data Protection:

Adhering to relevant data protection regulations and guidelines is important. Researchers should obtain necessary permissions and approvals to access and analyse data, and take measures to securely store and handle the data throughout the study.

OPERATIONAL DEFINITIONS:

- Reimbursement - Reimbursement is the act of paying back or making up for a previously covered expense. Reimbursement is frequently used in the context of healthcare to describe the payment of medical costs by an insurance company, either to the patient directly or to the healthcare provider on the patient's behalf.

- Cashless - Cashless insurance service is an option offered by insurance providers that enables policyholders to get medical care or services without having to pay up front cash at the healthcare facility. Cashless insurance does away with the requirement for the policyholder to pay out-of-pocket costs at the time of treatment by settling the payment immediately with the healthcare provider.

- Claim processing: Claim processing describes the steps and actions an insurance company takes to assess, confirm, and decide if a policyholder's insurance claim is legitimate. Reviewing the claim's specifics, such as the medical care or services rendered, will help you determine the right amount of compensation that the policyholder is entitled to.

- Trip Cancellation: A claim for trip cancellation is a request for compensation for costs incurred as a result of a scheduled trip being cancelled. These claims could be made for a number of different reasons, including personal illness, family emergencies, or unforeseeable events like natural catastrophes, political turmoil, or aircraft delays.

- Trip Delay: A claim for trip delay is a request for compensation for costs spent as a result of a protracted journey that was originally scheduled. Numerous factors, including those connected to the weather, technical troubles, or other unforeseen events, can result in delays. Trip delays are typically covered by travel insurance packages and protection plans.

- Customer satisfaction - In the context of processing reimbursement claims, customer satisfaction refers to how satisfied an insured is with the submission and reimbursement of services, including the process's simplicity, speed, accuracy, and communication of the claim's status.

- Loss of checked-in baggage is the term used to describe a situation in which a traveler's luggage either does not reach its intended location or is lost in transit.

- Delay of checked-in baggage- A traveler's luggage is considered to be delayed when it takes longer than expected to reach its destination after being checked in.

DATA COLLECTION AS PER TAT

STATUS	0-5 DAYS	6-10 DAYS	10-15 DAYS	15-20 DAYS	30-45 DAYS	50-60 DAYS
TRIP CANCELLATION	95	33	29	8	5	3
APPROVED	27	10	5	4	1	1
REJECTED	46	14	15	3	4	2
UNDER PROCESS	22	9	9	1	0	0
TRIP DELAY	75	52	29	17	18	9
APPROVED	32	19	11	9	11	5
REJECTED	18	10	15	5	5	4
UNDER PROCESS	25	23	3	3	2	0
DELAY IN CHECKED-IN BAGGAGE	198	120	88	45	32	11
APPROVED	72	54	47	19	15	6
REJECTED	84	49	31	25	14	3
UNDER PROCESS	42	17	10	1	3	2
LOSS OF CHECKED-IN BAGGAGE	49	38	16	19	4	7
APPROVED	35	11	5	8	2	3
REJECTED	11	17	7	8	1	2
UNDER PROCESS	3	10	4	3	1	2
GRAND TOTAL	417	243	162	89	59	30

TABLE 4.1 Data collection as per TAT

CHAPTER 4: RESULTS

A total 1000 claims were analysed, and it was discovered that 412 claims were appropriate and approved, proving that the policyholders met the required criteria for reimbursement of insurance claims. On the other side, a total 393 claims were not approved or rejected, indicating that the policyholders failed to fulfil the specified requirements in their claim of insurance policies. Additionally, 195 claims were flagged as having questions, indicating that more details or clarification were required before a decision could be made about whether to approve or reject them. These results emphasise how critical it is to comprehend the policy's terms and conditions, to provide precise paperwork, and to respond to any questions as soon as possible in order to improve the likelihood of a successful refund. The study provides precious insights into the rejection and approval rates of these insurance claims, enabling the company to identify sectors for improvement and modification in their processing procedures of claim and enhance satisfaction of client.

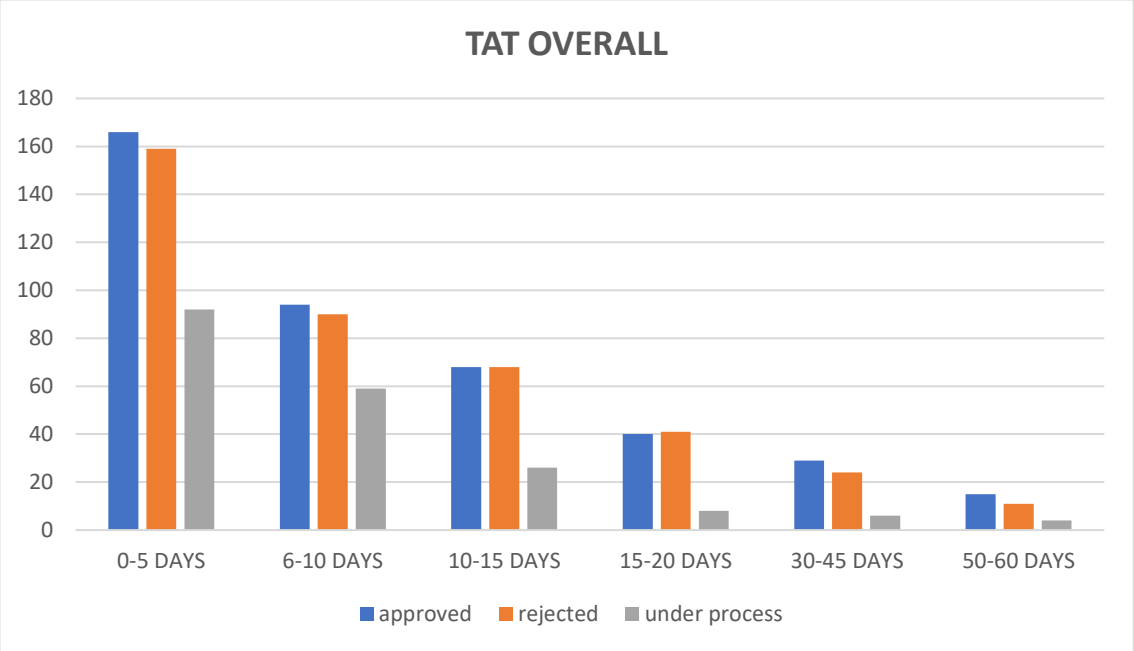

FIGURE 4.1 OVERALL TAT OF CLAIMS

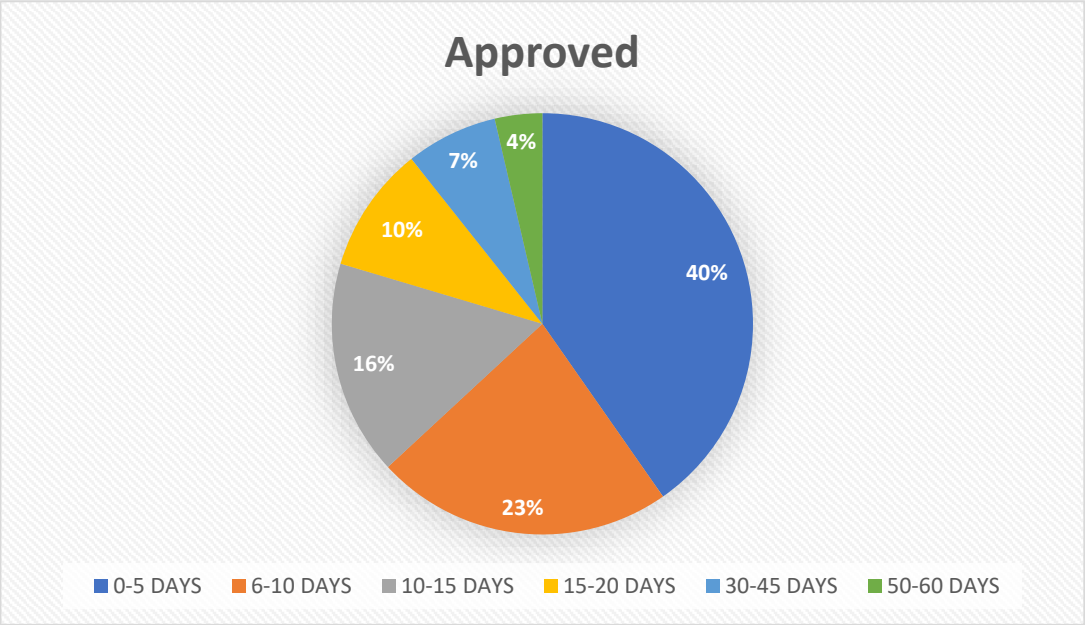

FIGURE 4.2 APPROVED CLAIMS

Out of total 412 approved claims, maximum claims i.e., 162 were approved in first 5 days of processing which is 40% whereas minimum claims i.e., 15 claims were approved in 50-60 days which is 4% of total approved claims.

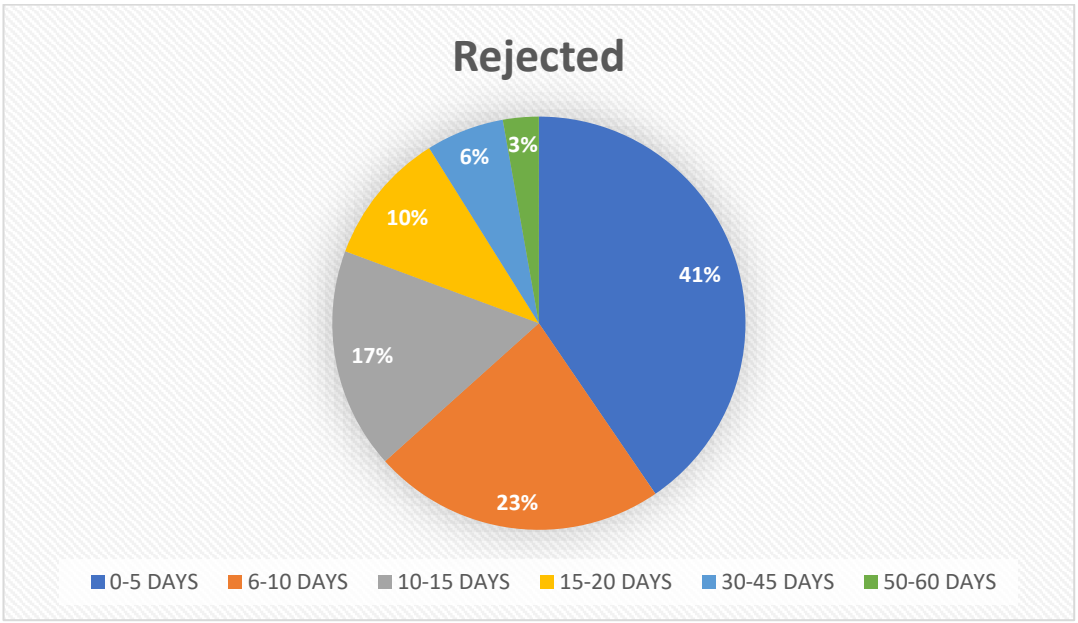

FIGURE 4.3 REJECTED CLAIMS

Out of total 393 rejected claims, maximum claims i.e., 159 were denied in first 5 days of processing which is 41% whereas minimum claims i.e., 11 claims were cancelled in 50-60 days which is 3% of total approved claims.

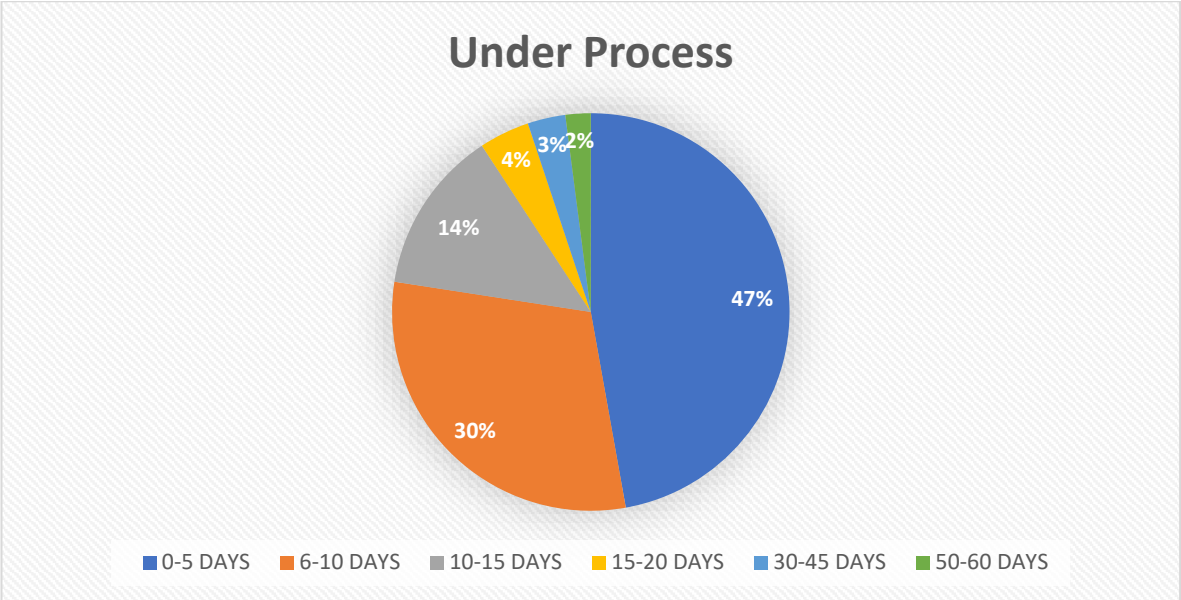

FIGURE 4.4 UNDER PROCESS

Out of total 195 under process claims, maximum queries i.e., 92 were raised in first 5 days of processing which is 47% whereas minimum queries i.e., 4 claims were raised in 50-60 days which is 2% of total approved claims.

TRIP CANCELLATION

STATUS	0-5 DAYS	6-10 DAYS	10-15 DAYS	15-20 DAYS	30-45 DAYS	50-60 DAYS
TRIP CANCELLATION	95	33	29	8	5	3
APPROVED	27	10	5	4	1	1
REJECTED	46	14	15	3	4	2
UNDER PROCESS	22	9	9	1	0	0

TABLE 4.2 TRIP CANCELLATION

Out of a total of 173 claims filed for trip cancellation, the data indicates that 48 claims were approved, signifying that the policyholders met the necessary criteria for reimbursement due to trip cancellation. Conversely, 84 claims were rejected, whereas 41 claims are currently under review, as further information or clarification is needed to determine whether they meet the criteria for approval.

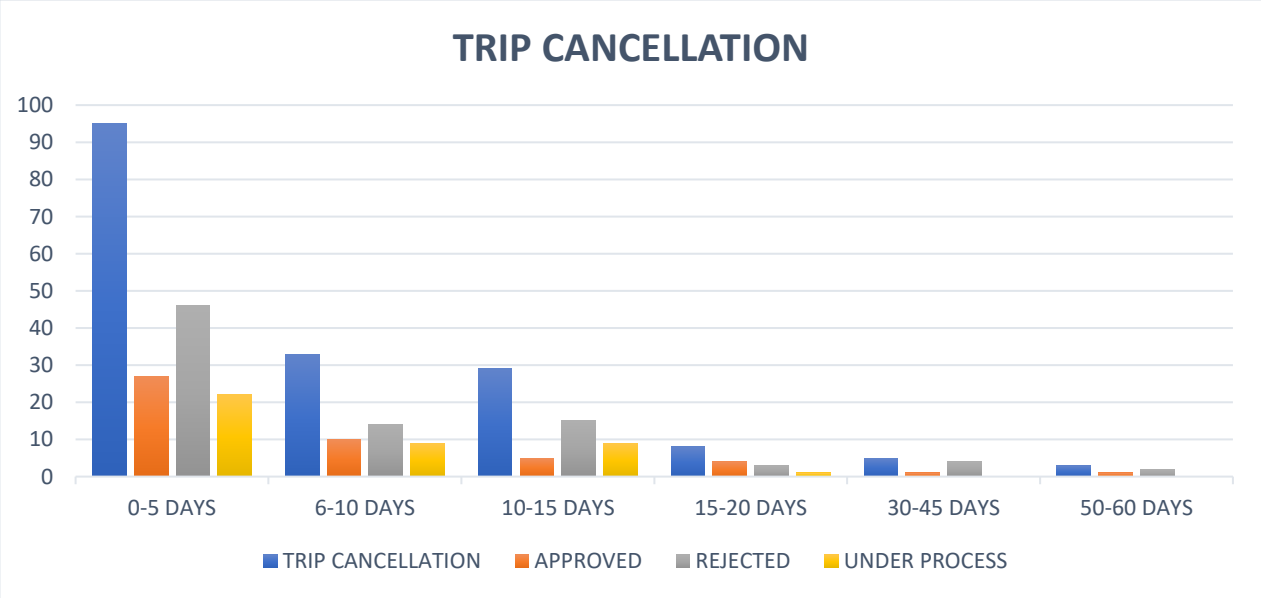

FIGURE 4.5 TRIP CANCELLATION

TRIP DELAY

STATUS	0-5 DAYS	6-10 DAYS	10-15 DAYS	15-20 DAYS	30-45 DAYS	50-60 DAYS
TRIP DELAY	75	52	29	17	18	9
APPROVED	32	19	11	9	11	5
REJECTED	18	10	15	5	5	4
UNDER PROCESS	25	23	3	3	2	0

TABLE 4.3 TRIP DELAY

Among the 200 claims submitted for trip delay, 87 of them were approved, 57 claims were denied and 56 claims were being reviewed, as additional information or clarification is needed to determine their eligibility.

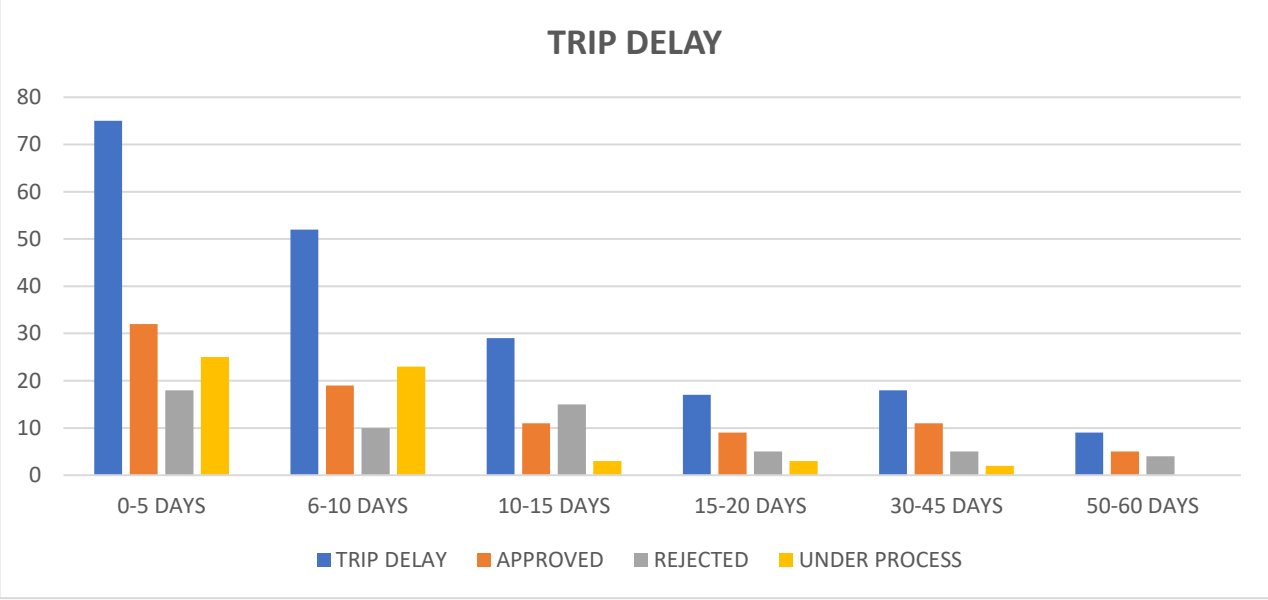

FIGURE 4.6 TRP DELAY

DELAY IN CHECKED-IN BAGGAGE

STATUS	0-5 DAYS	6-10 DAYS	10-15 DAYS	15-20 DAYS	30-45 DAYS	50-60 DAYS
DELAY IN CHECKED-IN BAGGAGE	198	120	88	45	32	11
APPROVED	72	54	47	19	15	6
REJECTED	84	49	31	25	14	3
UNDER PROCESS	42	17	10	1	3	2

TABLE 4.4 DELAY IN CHECKED-IN BAGGAGE

Out of a total of 494 claims related to delayed checked-in baggage, 213 claims were approved, 206 claims were rejected, suggesting that these policyholders did not fulfil the requirements in their insurance policies for reimbursement. Additionally, 75 claims were being reviewed, as further information or clarification is required before a final decision can be made.

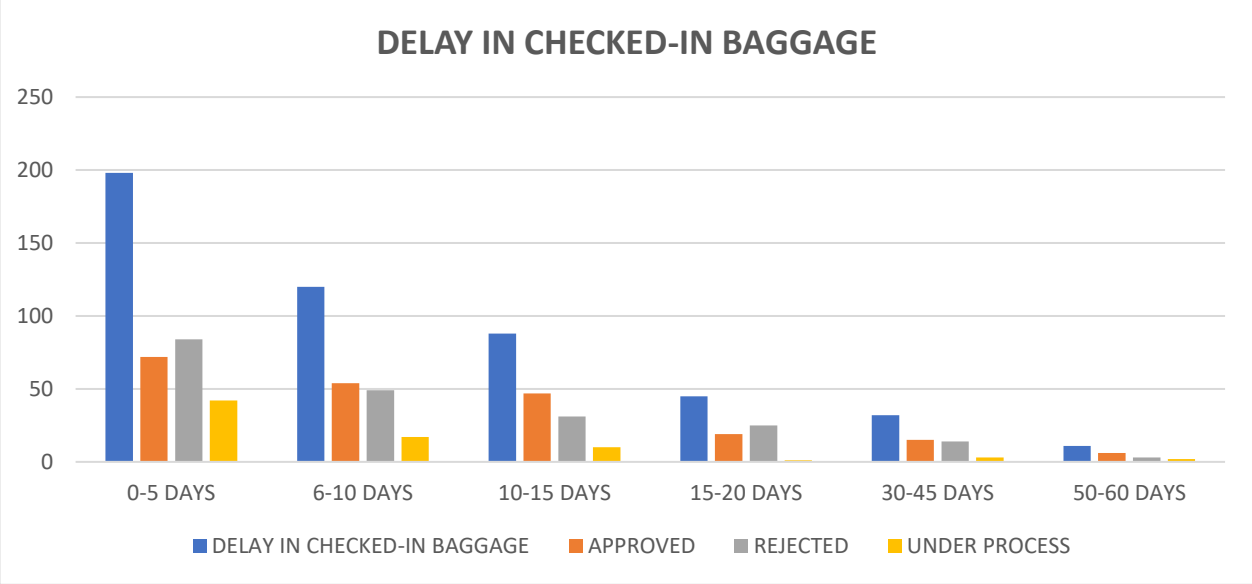

FIGURE4.7 DELAY IN CHECKED-IN BAGGAGE

LOSS OF CHECKED-IN BAGGAGE

STATUS	0-5 DAYS	6-10 DAYS	10-15 DAYS	15-20 DAYS	30-45 DAYS	50-60 DAYS
LOSS OF CHECKED-IN BAGGAGE	49	38	16	19	4	7
APPROVED	35	11	5	8	2	3
REJECTED	11	17	7	8	1	2
UNDER PROCESS	3	10	4	3	1	2

TABLE 4.5 LOSS OF CHECKED-IN BAGGAGE

Out of a total of 133 claims for loss of checked-in baggage, 64 claims were approved, 46 claims were rejected, additionally, 23 claims were under review, as further information or clarification is needed to determine their eligibility for approval.

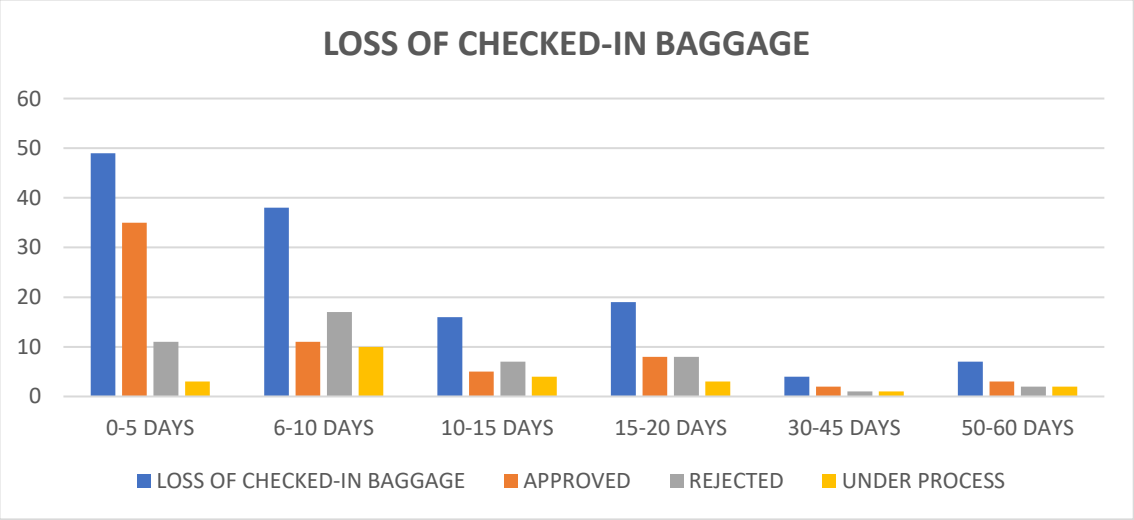

FIGURE 4.8 LOSS OF CHECKED-IN BAGGAGE

TAT EVALUATION

CLAIM STATUS	NO. OF CLAIMS
Within tat	726
Outside tat	274

TABLE 4.6 TAT EVALUATION

Out of the total 1000 claims analysed, 726 claims were processed and settled within the specified TAT. This indicates that the majority of the claims (72.6%) were handled promptly and efficiently by the insurance company, meeting the expected timeline for reimbursement.

However, there were also 274 claims that fell outside the TAT. These claims took longer than the expected time to be processed and settled. It's important to note that delays in claim processing can occur due to various reasons, such as incomplete documentation, complex cases, or a high volume of claims.

By streamlining processes, enhancing communication with policyholders, and implementing measures to reduce delays, the insurance company can work towards improving the overall TAT performance and ensuring a higher percentage of claims are settled within the expected timeframe.

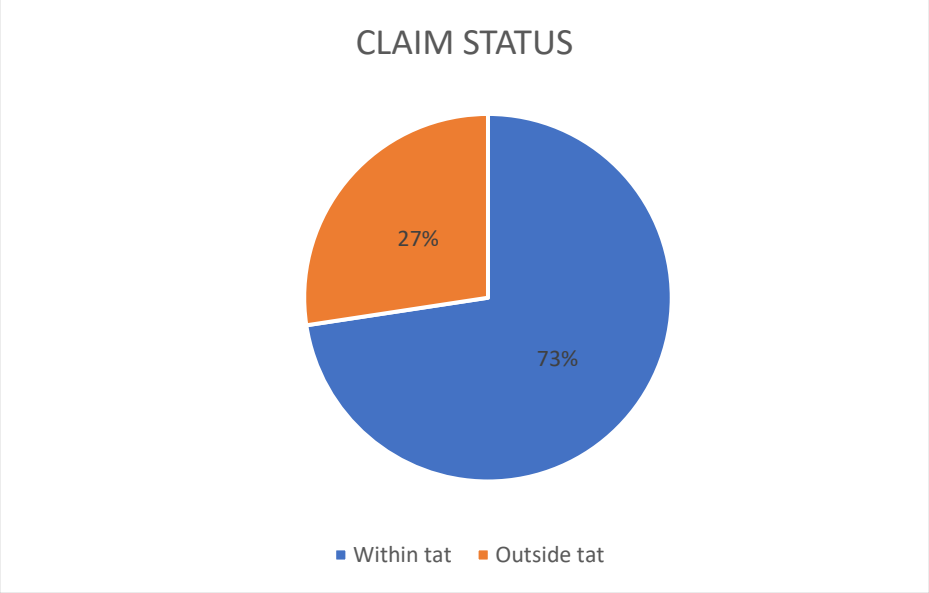

FIGURE 4.9 TAT EVALUATION

CHAPTER 5: DISCUSSION

INTERPRETATION

The study of 1000 claims helped in discovering interesting patterns in the process and criteria for approval, query rates and rejection. A sizable percentage (40%) of the 412 accepted claims were approved within the first five days of processing, demonstrating a timely response from the insurance provider. However, a lesser fraction (4%) of granted claims took 50–60 days to be approved, indicating a possible opportunity for processing efficiency improvement.

Among the claims that were rejected, a considerable number (41%) were rejected within the first five days of the process, implying that some policyholders failed to meet the requirements or gave insufficient information and supporting documents. However, just a small number (3% of denied claims) required 50–60 days for rejection, suggesting that careful consideration went into the decision before it was made.

When it comes to the queries raised by clients, a significant percentage (47%) were raised within the first five days, suggesting a positive approach in seeking or gathering additional information about issues. On the other hand, only a small proportion (2%) of were raised by clients in the 50–60-day time period, indicating that almost queries were addressed and solved early in the whole process.

These results highlight the value of quick response, precise documentation, and efficient interaction between policyholders and the insurance provider. Policyholders can improve their chances of a successful reimbursement by responding to questions and offering thorough and timely information. In order to improve customer happiness and streamline the entire reimbursement process, the insurance company can use the analysis to pinpoint areas where their claim processing practises need to be improved.

LIMITATIONS

This study's evaluation of the turnaround time for processing reimbursement claims in the international claims department has a number of drawbacks. These restrictions consist of:

1. Sample Size: The study's findings and interpretations are predicated on a small sample size, which might not accurately reflect the diversity of the organisation or the total population. Results would be more reliable and trustworthy with a bigger sample size.

2. Generalizability: The study focuses exclusively on an insurance company's foreign claims division, which can have distinctive traits and procedures. The results might not therefore directly apply to other insurance firms or departments.

3. Time Restrictions: The time restrictions of study may have affected the extent and depth of the data collection and its analysis. Lack of time may prevent a thorough analysis of every aspect affecting turnaround time and the implementation of comprehensive recommendations.

4. External Factors: The study might not have taken changes in rules, unforeseen circumstances, or shifts in workload into consideration as external factors that could impact the processing time for reimbursement claims. The validity and generalizability of the study's findings may be impacted by these variables.

5. Data Accuracy: The study depends on the data that were gathered through direct observation and the Management Information System to be accurate and complete. Any mistakes, discrepancies, or gaps in the information that was gathered could bring biases or inaccuracies into the study.

6. Single Methodology: The study mainly makes use of direct observation and a MIS to collect data. While these techniques offer insightful information, other research techniques, such as interviews or surveys, might provide a more thorough knowledge of the causes of delays and relevant remediation techniques.

STRENGTHS

This study's evaluation of the turnaround time for processing reimbursement claims in the foreign claims department has a number of strengths. These strengths include:

1. Real-Time Data: Since the study relies on direct observation, real-time data on the claim processing processes can be gathered. This helps in the identification of reasons resulting in delays and gives a detailed and accurate understanding of the real TAT.

2. Using Management Information System (MIS): For gathering and analysing quantitative data about claim processing, the study uses MIS. It is a computer-based system which offers a well-organized and trustworthy source of data, along with ensuring accuracy and consistency in data gathering and analysis.

3. Emphasis on Non-Medical Reimbursement Claims: The study particularly emphasises on non-medical reimbursement claims, including those for baggage loss, trip cancellation, and delay. This customized strategy enables a more in-depth examination of the turnaround time and the variables affecting the processing of various non-medical claims.

4. Implications for Real-World Practise: The study after completion provided various suggestions for enhancing effectiveness and efficiency in claim processing. The study can provide practical insights that the International claims department might use to improve its procedures by identifying the causes of delays and inefficiencies.

5. Relevance to the International Claims Department: By concentrating on the international claims department, the study offers insights that are especially suited to the special difficulties and complexities involved in handling foreign claims. This improves the study's findings' capacity to be applied practically in the context of the department.

6. Possibility of Industry Insights: The study's conclusions and suggestions could benefit the larger insurance and claim processing industries. The study can help other insurance firms and departments looking to improve their reimbursement claim processing operations by highlighting best practises and efficiency-improving measures.

GAPS

This study's examination of the turnaround time of reimbursement claim processing in the foreign claims department may include a number of flaws. These gaps consist of:

1. Lack of Comparative Analysis: The study might not compare its findings to those of other departments or insurance firms. Assessing the scope of the discovered delays or inefficiencies may be difficult without benchmarking against industry norms or contrasting the performance of several departments.

2. Limited Scope: The study's main focus is the processing time for claims for non-medical reimbursement. It might ignore other crucial components of the claim processing system, like client happiness, the accuracy of claims evaluation, or compliance with legal requirements. A broader study's focus might offer a more thorough insight of the complete claim processing procedure.

3. An incomplete understanding of the viewpoints of the many stakeholders in claim processing, such as policyholders, claims assessors, or management, may be present in the study. Their perspectives and experiences may be a significant source of knowledge on the problems and potential fixes for increasing productivity.

4. Lack of Long-term Assessment: The study's emphasis on a particular time frame can make it more difficult to identify long-term patterns or gauge how sustainable the suggested solutions are. The effectiveness of the implemented recommendations could be better understood by conducting a longer review spanning several time periods.

5. Limited External Validity: Due to the study's reliance on the particular setting of the International Claims Department at one insurance firm, its conclusions may only have limited external validity. The results might not apply to insurance firms or departments that follow different procedures, structures, or laws.

6. Possibility of Observer Bias or Data Entry Errors: The study's dependence on direct observation and a MIS for data collection presents this risk. These biases or mistakes could affect the reliability and accuracy of the data that was gathered, which would then affect the study's conclusions and suggestions.

IMPLICATIONS

The implications of this study on the evaluation of the turnaround time of reimbursement claim processing in the international claims department are significant for various stakeholders, including the insurance company, policyholders, and the broader insurance industry. Some of the key implications include:

1. Increased Customer satisfaction: This study can increase customer happiness by identifying the causes of claim processing delays and making suggestions for improvement. For policyholders, prompt and effective claim processing is essential since it reduces financial strains and offers the anticipated assistance for non-medical situations. The study's recommendations can lead to quicker claim resolutions, easier communication, and a more satisfying experience for policyholders overall.

2. Operational Effectiveness: The study's suggestions for reducing the claim processing steps can greatly increase the international claims department's operational effectiveness. The department can decrease manual errors, get rid of unnecessary work, and maximise resource allocation by deploying digital solutions, automating data input procedures, and improving communication channels. This increased effectiveness can result in cost savings, quicker processing times, and greater employee and technological utilisation.

3. Competitive Advantage: The insurance business may be able to gain market share through the use of a simplified and effective claim processing system. The business can stand out from rivals and draw in new policyholders by enhancing turnaround time and customer satisfaction. A high level of efficiency can also support favourable word-of-mouth referrals and bolster the business's standing as a dependable and client-focused insurer.

4. Regulatory Compliance: The study's conclusions and suggestions can help the insurance provider make sure that regulatory standards are being followed. The company can better fulfil governing body expectations by streamlining claim processing methods, keeping correct records, and following industry standards. In turn, this can assist the business in avoiding fines, disputes with the law, and harm to its reputation.

5. Industry Best Practices: The study's insights and recommendations can contribute to the development of industry best practices for reimbursement claim processing. The insurance industry as a whole can benefit from understanding the factors that contribute to delays and inefficiencies and implementing strategies to improve efficiency and customer satisfaction. The study's findings can be shared with other insurance companies, industry associations, and regulatory bodies to drive positive changes and enhance the overall quality of claim processing across the industry.

CHAPTER 6: RECOMMENDATIONS

On the basis of the evaluation of the TAT of claim reimbursement processing in the department of international claims, the below mentioned recommendations are advised to improve efficiency and client satisfaction:

1. Implement Digital Solutions: Introduce digital platforms or mobile applications that enable policyholders to electronically submit claim documents. This will decrease the need for paper documents, reduce human error, and shorten the processing time for claims.

2. Automate Data Entry Procedures: Investigate the utilisation of automated data entry programmes, such as optical character recognition (OCR) technology, to wring out pertinent data from claim papers. This will quicken data entry, lower the chance of mistakes, and streamline the entire workflow for processing claims.

3. Enhance Communication Channels: Create effective and responsive channels of contact between policyholders and claims examiners. Use email, SMS, or a dedicated online portal to send policyholders timely updates on the status of their claims, ask them for more details if necessary, and respond to any questions or concerns they may have.

4. Offer Support and Clearly Defined Guidelines: Create thorough rules and uniform templates for claim submissions. These recommendations should be very specific about the paperwork that is needed and the procedure for filing claims. Additionally, give policyholders assistance with claim submission and answer any questions through helplines or specialised customer care professionals.

5. Regularly conduct training and performance reviews: To improve claims assessors' knowledge and abilities in handling non-medical reimbursement claims, hold frequent training sessions for them. Utilise performance evaluation tools to evaluate employee and departmental performance, pinpoint areas for development, and create incentives for timely and accurate claim processing.

6. Track and examine Turnaround Time: Track and examine the turnaround time for processing reimbursement claims. Use key performance indicators (KPIs) to measure the department's performance against industry standards on a regular basis to spot opportunities for improvement and guarantee consistency.

7. Encourage collaboration and knowledge exchange among claims assessors, underwriters, and other pertinent parties. Foster a culture of continual improvement within the department by facilitating frequent meetings or forums where experiences, difficulties, and best practises can be discussed.

8. Periodic Review and Adjustment: Conduct timely evaluations of the recommendations that have been put into practise to determine their efficacy. To further increase the effectiveness of claim processing, locate any bottlenecks or potential improvement areas that may have gone unnoticed and make the appropriate corrections.

CHAPTER 7: CONCLUSION

Following a review of the foreign claims department's turnaround time for processing reimbursement claims, the following conclusions can be made:

1. Analysis of Turnaround Times: The study sheds light on the typical turnaround time for non-medical reimbursement claim processing in the international claims department. By studying the data, it was discovered that the processing times for various types of claims differed, highlighting the need for focused measures to increase effectiveness.

2. Delay-Producing causes: The study highlights a number of delay-producing causes, including inadequate paperwork, human data entry errors, communication breakdowns, and complicated cross-border transactions. For the purpose of streamlining the claim processing procedure, it is essential to comprehend these elements.

3. Recommendations for Improvement: The study makes suggestions to increase the effectiveness of processing reimbursement claims based on its findings. In order to ensure correct and prompt claim filings, these recommendations call for establishing digital solutions for document submission, automating data entry procedures, improving channels of contact with policyholders, and offering clear instructions and support.

4. Importance of Stakeholder Collaboration: The significance of stakeholder participation, including that of policyholders, claims examiners, and management, is highlighted in the study. The speed of claim processing can be greatly improved, and client satisfaction can be raised through streamlining procedures, proactive stakeholder participation, and effective communication.

5. Implications for the Insurance Organization: Both the international claims department and the insurance organisation as a whole will be significantly impacted by the study's findings. Enhancing the turnaround time for processing reimbursement claims can increase client happiness, boost a company's brand, provide cost savings, and improve operational effectiveness.

6. Further Research Opportunities: The study identifies a number of areas for additional investigation, including examining the results of putting the suggested fixes into practise, evaluating the long-term viability of enhanced procedures, and carrying out comparisons with other insurance firms or departments. These study options could support existing initiatives to streamline the claim processing process.

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