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Service Utilisation and Patient Satisfaction among Patients Availing Mediclaim Facility in a Multispecialty Hospital: A Descriptive Observational Study

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Abstract

Background: Health insurance in India serves as a critical financial safety net that protects patients from catastrophic out-of-pocket expenditures. Third-party administrators (TPA) facilitate cashless hospitalization at network hospitals, yet evidence evaluating the efficiency of hospital-based insurance desks and patient satisfaction with cashless versus reimbursement modes remains limited. **Objectives:** This study aimed to assess the structure and operational workflow of the health insurance/corporate desk, measure turnaround times (TATs) at each stage of the cashless claim process, and evaluate patient satisfaction among insured inpatients at a multispecialty hospital in Delhi. **Methods:** A descriptive observational study was conducted at a multispecialty hospital accredited under ISO 9001:2000 certification and NABH, and registered with the Directorate of Health Services, Government of the National Capital Territory of Delhi. Ninety patients who availed of cashless hospitalization during the study duration were enrolled consecutively. Data were collected using a structured patient questionnaire and augmented by institutional records maintained at the health insurance/corporate desk. Descriptive statistics were used to report TATs and patient satisfaction ratings. **Results:** All 90 respondents (100%) considered cashless hospitalization superior to reimbursement. 11% favored reimbursement, 22% described it as tedious, and 67% rated it inferior to cashless. Regarding satisfaction with the insurance desk, 22% rated the interaction as very good, 44% as good, and 33% as satisfactory. The most common delay was in transmitting the initial pre-authorization form to the TPA (44.4% of cases took 2–4 h) and in forwarding the discharge summary and final bill (66.7% of cases took 2–4 h). Post-approval patient discharge was efficient, with 88.9% of patients released within 30 min. **Conclusion:** The health insurance/corporate desk operated efficiently relative to comparable facilities; however, specific bottlenecks in documentation turnaround were identified. Targeted operational interventions, including extending working hours, digitizing claim submission, and deploying medically trained personnel, could meaningfully improve efficiency and patient satisfaction.

Keywords: Cashless hospitalization, Health insurance, Hospital management, Patient satisfaction, Third-party administrator, Turnaround time

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Introduction

India's healthcare financing landscape is characterized by a disproportionately high share of private and out-of-pocket expenditure (OOPE). Although India's total health expenditure represents approximately 3–4% of its gross domestic product, public spending constitutes only about 30% of this amount, while the remainder is borne by households through direct OOPE.[1] National health accounts data indicate that OOPE accounted for 47.1% of total health expenditure in 2019–20, representing one of the highest such proportions among middle-income countries.[2] Such excessive reliance on direct household payments creates serious financial risks: Single episodes of serious illness can deplete household savings, push families into poverty, and deter future care-seeking.[3,4]

The consequences of inadequate health financing are well documented. Studies have estimated that an estimated 60–100 million individuals in India are pushed below the poverty line each year by healthcare costs alone, with out-of-pocket health spending exceeding 10% of household consumption expenditure for a substantial proportion of the population, a threshold commonly used to define catastrophic health expenditure (CHE).[3,5] This financial vulnerability disproportionately affects economically marginalized communities and rural populations, exacerbating existing health inequities.

To mitigate this burden, the Government of India and several state governments have pursued health insurance reforms over the past two decades. Government-sponsored schemes such as the Central Government Health Scheme, the Employees' State Insurance Scheme, and, more recently, the Pradhan Mantri Jan Arogya Yojana (PM-JAY) under the Ayushman Bharat initiative, launched in September 2018 with a stated coverage of 500 million individuals, represent significant milestones in expanding financial protection.[6,7] Alongside these, private voluntary health insurance markets have grown substantially, with third-party administrators (TPAs) emerging as key intermediaries between insurers, policyholders, and healthcare providers.

TPAs were formally introduced in India in 2001 through the Insurance Regulatory and Development Authority of India (IRDAI) regulations. They serve as licensed intermediaries that

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perform back-office insurance functions, including health identity card issuance, claims verification and settlement, cashless hospitalization facilitation, and 24-h customer support, on behalf of insurers.[8,9] As of 2022–23, there were approximately 20 licensed TPAs in India, together managing claims worth over INR 70,930 crore, with an average claim settlement of INR 30,087 per patient.[8] Despite their critical operational role, research on TPA functioning from the hospital perspective remains limited.

Cashless hospitalization, wherein a patient receives treatment at a network hospital without making an upfront payment, with the TPA settling the bill directly with the hospital, is widely regarded as the most patient-friendly mode of health insurance utilization. Under this model, the hospital's health insurance/corporate desk functions as the operational interface linking the TPA, the treating clinicians, and the patient. The desk is responsible for pre-authorization form completion, document submission, query resolution, and final bill processing, all within defined turnaround times (TATs). Delays or failures at any of these stages directly impair patient experience and hospital efficiency.

Notwithstanding the recognized importance of this desk function, published evidence evaluating its operational performance and its impact on patient satisfaction remains sparse. Most prior studies have focused on broader insurance coverage metrics, claims ratios, or policyholder awareness rather than the granular, process-level functioning of hospital insurance desks.[10,11] A study by Rane *et al*., on in-house TPA departments at tertiary hospitals, identified patient satisfaction factors, but was conducted with a different scale and methodology.[12]

The present study was conducted with the following specific objectives: (1) to describe the existing structure, workflow, and processes of the health insurance/corporate desk at a multispecialty hospital; (2) to assess operational efficiency through measurement of TATs at each stage of the cashless claim process; (3) to evaluate the quality of counseling provided to patients regarding cashless facility procedures; (4) to elicit the perspectives of both patients and insurance desk staff; and (5) to formulate evidence-based recommendations for improving desk efficiency and patient satisfaction.

Methods

Study Design and Setting

This was a descriptive observational study conducted at a multispecialty secondary-care hospital located in New Delhi, India. The hospital is registered with the Directorate of Health Services, Government of the National Capital Territory of Delhi, and was among the first hospitals in Delhi to receive ISO 9001:2000 certification. The hospital operates a dedicated health insurance/corporate desk that processes Mediclaim cases round the clock during working days.

Study Participants

The study population comprised all patients who availed cashless hospitalization via the insurance desk during this period. A consecutive sampling approach was used; all ninety eligible patients or their accompanying attendants who were available during the study window were included. Informed verbal consent was obtained from each participant before questionnaire administration.

Data Collection

Data were collected using two complementary instruments: (i) a structured patient questionnaire developed specifically for this study, capturing patient preferences (cashless versus reimbursement), satisfaction ratings regarding interaction with the insurance desk (on a four-point scale: Very good, good, satisfactory, or poor), and qualitative comments; and (ii) institutional records maintained at the health insurance/corporate desk, including pre-authorization timestamps, TPA response logs, query registers, and discharge clearance documents. TATs were extracted from time-stamped records to calculate durations at each processing stage.

Variables and Definitions

TAT was defined as the elapsed time between two consecutive process steps in the cashless claim workflow. Five TATs were measured: (i) submission of the initial pre-authorization form to the TPA after admission advice; (ii) receipt of initial approval or query from the TPA; (iii) reply to queries raised by the TPA; (iv) submission of the discharge summary and final bill to the TPA after discharge advice; and (v) patient release after receipt of final approval from the TPA.

Data Analysis

Descriptive statistical analysis was performed. Categorical variables are reported as frequencies and percentages. All data were tabulated to facilitate presentation and interpretation. No inferential statistical testing was applied, given the descriptive nature of the study. Monthly mediclaim volume data were additionally extracted from hospital records covering the last 1 year to contextualize operational scale.

Ethical Considerations

This study was conducted as a hospital management thesis project. Patient participation was voluntary and confidential. No patient identifiers were recorded. Institutional approval was obtained from the hospital administration before commencement.

Results

Operational Structure of the Health Insurance/Corporate Desk

The health insurance/corporate desk operated as a dedicated unit within the hospital, staffed by personnel trained in insurance documentation and claim processing. The standard workflow upon receipt of a treating physician's admission advice was as follows: the patient or attendant submitted all requisite documents (insurance policy, prior approval forms, identity proof) to the desk; trained staff assisted the treating physician in completing the pre-authorization (pre-auth) form; and the completed set of documents was transmitted electronically or physically to the concerned TPA. On receipt of an initial approval or a query from the TPA, the desk notified the patient or attendant accordingly. Queries originating from the patient side (e.g., missing policy documents) were resolved by directing the patient to provide the required information; hospital-side queries were addressed by the desk staff in coordination with the treating clinician. On discharge

advice, the discharge summary and final bill were compiled and submitted to the TPA for full and final approval. After receipt of the final approval letter, all documents were handed over to the patient, and formal discharge clearance was granted.

Institutional records indicated that, of 1647 cases processed during the last year as extracted from records, 1622 cases resulted in successful TPA payment, 25 were pending, and only 1 case was denied payment by the TPA, reflecting a claim settlement rate of 98.5% [Table 1].

Patient Preferences: Cashless Versus Reimbursement

All ninety patients or their attendants (100%) acknowledged the advantages of the cashless hospitalization mode over the reimbursement route. When asked specifically about the reimbursement process, 11% expressed a preference for reimbursement over cashless, 22% found the reimbursement process tedious, and 67% considered cashless hospitalization superior to reimbursement in all respects.

Patient Satisfaction with the Health Insurance/ Corporate Desk

Patient-reported satisfaction with the quality of interaction with the health insurance/corporate desk showed that 22% of respondents rated the experience as very good, 44% as good, and 33% as satisfactory. No respondent rated the experience as poor. Collectively, a satisfaction rate of 66% (very good or good) was observed.

TATs at Each Stage of the Cashless Claim Process

TATs were measured across five critical stages of the cashless claim workflow [Tables 2-6]. The findings are summarized below.

Table 1: Summary of mediclaim cases processed by the hospital (during 1 year period)

Period	*Total cases processed*	*Payment received from TPA (%)*	*Payment under process (%)*	*Payment denied by TPA (%)*
One year	1,647	1,622 (98.5)	25 (1.5)	1 (0.06)

TPA: Third-party administrator

Table 2: Turnaround time for sending initial pre-authorization form to the TPA

Duration	*No. of cases*	*Percentage*
0–1 h	0	0.0
1–2 h	20	22.2
2–4 h	40	44.4
>4 h	30	33.3

TPA: Third-party administrator

Table 3: Turnaround time for receiving initial approval or query from the TPA

Duration	*No. of cases*	*Percentage*
0–1 h	0	0.0
1–2 h	20	22.2
2–4 h	10	11.1
>4 h	60	66.7

TPA: Third-party administrator

Discussion

This study provides granular process-level insights into the functioning of a hospital-based health insurance/corporate desk and its influence on patient satisfaction in the cashless hospitalization context in India. The principal findings are threefold: (i) all patients preferred cashless hospitalization over reimbursement; (ii) overall patient satisfaction with desk interactions was high, with no respondents rating the experience as poor; and (iii) meaningful delays were identified in upstream documentation stages, particularly in pre-auth form submission and discharge documentation.

The universal preference for cashless hospitalization observed in this study is consistent with the broader literature documenting the financial and logistical advantages of cashless claims over reimbursement.[8,9,12] Reimbursement requires patients to make upfront payments, often from household savings or emergency borrowings, and subsequently navigate complex paperwork for claim recovery, a process that may take weeks or months. Against the backdrop of India's persistently high OOPE burden, where healthcare payments push millions of households into poverty annually,[3,5,13,14] cashless hospitalization represents a substantive improvement in financial protection and patient experience.

The high claim settlement rate of 98.5% observed at the study hospital over the preceding 1-year period is noteworthy and likely reflects the desk's systematic approach to pre-authorization documentation. The practice of sending discharge documents to the TPA, accompanied by a structured checklist, was identified as a noteworthy strength during the observation period, which probably minimizes post-submission queries and reduces claim rejection risk. Similar emphasis on documentation quality as a driver of claim success has been highlighted in studies examining TPA performance across India.[9,10]

Nevertheless, the TAT analysis reveals clear operational bottlenecks. The most significant delay was in the receipt of initial approval from the TPA: 66.7% of cases waited more than

Table 4: Turnaround time for replying to queries raised by the TPA

Duration	*No. of cases*	*Percentage*
0–1 h	0	0.0
1–2 h	10	11.1
2–4 h	60	66.7
>4 h	20	22.2

TPA: Third-party administrator

Table 5: Turnaround time for sending discharge summary and final bill to TPA after discharge advice

Duration	*No. of cases*	*Percentage*
0–1 h	0	0.0
1–2 h	0	0.0
2–4 h	60	66.7
>4 h	30	33.3

TPA: Third-Party administrator

Table 6: Turnaround time for patient discharge after receipt of final TPA approval

Duration	*No. of cases*	*Percentage*
0–15 min	40	44.4
15–30 min	40	44.4
30–60 min	10	11.1
>60 min	0	0.0

TPA: Third-party administrator

4 h for the TPA response. This delay, while partially outside the hospital's direct control, has a cascading effect on clinical management, prolonging pre-operative waiting times, occupying beds, and generating patient anxiety. Prior literature has similarly documented delays in TPA approval as a key driver of provider dissatisfaction and increased patient costs, and has called for standardized benchmarks for TPA response times.[9,11] The IRDAI should consider mandating and monitoring such benchmarks to improve system-wide accountability.

Within the hospital's sphere of control, the TAT for submitting the initial pre-auth form was also suboptimal: 77.8% of cases required more than 2 h. Prolonged pre-auth preparation typically reflects delays in obtaining the completed form from the treating physician or in assembling attendant-provided documents. Structural interventions, such as integrating pre-auth form completion into the admission workflow and deploying a dedicated medical officer with insurance expertise to coordinate with clinicians, could substantially reduce this delay. The value of clinically trained personnel in insurance desk functions has been recognized in other settings as enabling more precise clinical documentation and facilitating direct communication with TPA medical officers to resolve clinical queries expeditiously.[12]

Similarly, discharge document submission (TAT: 66.7% of cases requiring 2–4 h) merits attention. Delays at discharge affect bed utilization efficiency, a metric of considerable operational importance in high-occupancy multispecialty hospitals. A target of delivering the discharge summary to the insurance desk within 2 h of discharge advice, with escalation protocols if this is not met, would be a practical and achievable standard. The efficiency observed at the post-approval discharge stage (88.9% of patients discharged within 30 min) demonstrates that the desk is capable of rapid turnaround when documentation is complete, confirming that the upstream documentation stages constitute the primary bottleneck.

The patient satisfaction findings, with no respondent rating the desk interaction as poor, suggest that the desk's customer-facing service quality was acceptable. However, the 33% rating of merely satisfactory indicates room for improvement, particularly in proactive communication. Patients and attendants experiencing extended waits for TPA responses reported uncertainty about claim status, a source of anxiety that could be mitigated through standardized, periodic status updates communicated by desk staff. Research on hospitalized patients' information needs consistently identifies timely, transparent communication as a key determinant of overall satisfaction.[12,15]

Several additional operational recommendations emerge from this analysis. The extension of insurance desk operating hours into evening shifts and weekends with appropriate staffing would address the reality that admissions and discharges are not confined to business hours. Adoption of TPA online portals (increasingly available among major Indian TPAs) would accelerate document submission, enable real-time claim tracking, and reduce physical document handling. Standardized color-coding within the hospital information system to distinguish pending, approved, and queried cases would facilitate prioritization and prevent cases from being overlooked. Finally, pre-authorization form completion standards should be enforced, including all required clinical details at the time of initial submission to minimize information-gap queries from TPAs.

This study has several limitations that should be acknowledged. The sample size was small (n = 90), reflecting the small observation window during which all qualifying patients were enrolled. The small sample precludes statistical generalization and may not capture the full variability in desk performance across seasons or different case types. The study was conducted at a single institution, limiting external validity. The study period predates significant developments in India's insurance landscape, including the launch of Ayushman Bharat PM-JAY in 2018, the expansion of TPA digital portals, and post-COVID-19 structural changes in claims processing. Future multisite, prospective studies with larger samples and validated satisfaction instruments are warranted to generate more definitive evidence.

Conclusion

This study provides a detailed operational profile of a hospital-based health insurance/corporate desk and documents patient satisfaction with the cashless hospitalization process in a multispecialty hospital setting in Delhi. The desk demonstrated effective performance in several domains, including a high claim settlement rate, systematic documentation practices, and efficient post-approval discharge, while exhibiting identifiable delays in pre-authorization form submission and discharge document preparation. Patient satisfaction was high overall, with a unanimous preference for cashless over reimbursement hospitalization.

The health insurance/corporate desk occupies a critical position in the hospital ecosystem, functioning as the operational bridge between patients, healthcare providers, and insurance intermediaries. Enhancing its efficiency through structured TAT targets, extended working hours, medically trained personnel, digital document submission, and systematic patient communication protocols would yield measurable improvements in patient experience, bed utilization, and overall hospital performance. These findings have practical implications for hospital administrators seeking to optimize insurance service delivery in an era of expanding health insurance coverage in India.

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