

Analyzing the Claim Settlement Process and its Impact on Mediciam Policyholder Satisfaction: An Empirical Study in Firozabad City

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ABSTRACT

Purpose: This study examines how operational dimensions of the claim settlement process influence overall satisfaction among Mediciam policyholders in Firozabad City (Uttar Pradesh). **Design/Methodology:** A descriptive-analytical approach was used. Primary data were collected via a structured, pre-tested questionnaire from 200 Mediciam policyholders who had filed at least one claim. SPSS 26.0 was employed for descriptive statistics, Pearson correlation, and multiple linear regression. **Findings:** The model explains 64% of the variance in policyholder satisfaction ($R^2 = 0.64$). Claim settlement time has the largest negative effect ($\beta = -0.42$, $p = 0.001$). Insurer communication, clarity of policy terms, and agent/TPA support are positively associated with satisfaction (all $p < 0.01$). Delays, limited status updates, and unclear exclusions were the most frequent grievances. **Implications:** Improvements in digital claim-tracking, standardized TATs, targeted customer education, and capacity building for agents/TPAs can materially increase policyholder satisfaction and retention. The findings are especially relevant for insurers and regulators in Tier-II Indian cities where digital literacy and awareness vary. **Originality:** Provides recent, region-specific empirical evidence (Firozabad) on claim-process drivers of satisfaction and situates results within the rapidly evolving Indian digital-health and regulatory environment.

Keywords: Mediciam, Claim Settlement, Policyholder Satisfaction, IRDAI, Ayushman Bharat Digital Mission, Firozabad, SPSS.

INTRODUCTION:

Rising healthcare costs, increasing prevalence of non-communicable diseases, and greater public awareness have made health insurance a key financial-protection tool in India. Health insurers settled millions of claims annually in recent years; IRDAI statistics show large volumes of health claim activity and increasing digital adoption across insurers and TPAs. For example, official IRDAI records and annual reporting highlight the large number and monetary magnitude of claims settled by health insurers in FY 2022–23 and FY 2023–24, reflecting both growth and operational pressures in the sector.

While purchase of Mediciam policies provides potential financial protection, policyholder satisfaction depends heavily on the claim settlement experience. International and national literature identify timeliness, transparency, communication, documentation clarity, and frontline support (agents/TPAs) as critical drivers of satisfaction and renewal behavior. Recent digital-health initiatives—most notably the Ayushman Bharat Digital Mission (ABDM)—are changing how claims and health records are processed, tracked, and verified, creating new opportunities and challenges for claim settlement efficiency.

This study focuses on Firozabad, a Tier-II city with mixed levels of insurance awareness and digital penetration. In semi-urban contexts, intermediaries and localized service processes remain central to how policyholders navigate claims. Understanding operational bottlenecks and their effects on satisfaction is essential to inform insurer practice and regulator policy—particularly as India contends with rising costs and plans for enhanced claims oversight. Recent regulatory-discussion and news coverage also indicate moves to strengthen oversight of national claims infrastructure to curb cost escalation, which may influence future claim-settlement practice.

Research Objectives

- To assess policyholders' experiences during Mediciam claim settlement in Firozabad City.
- To identify the primary operational challenges faced by claimants (processing time, documentation, communication).
- To quantify the impact of claim processing time, transparency, insurer communication, and agent/TPA assistance on overall satisfaction.

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- To propose actionable strategies for insurers and regulators to improve claim settlement service quality.

LITERATURE REVIEW

This review prioritizes peer-reviewed studies, regulatory reports, and high-quality sector analyses (2019–2025) that address claim settlement, service quality, and policyholder satisfaction.

IRDAI Annual Reports & National Surveys (2023)

According to the IRDAI Annual Report (2023), over 42% of customer grievances in health insurance pertain to delays or rejection in claim settlement. This aligns with the dissatisfaction expressed in Firozabad, reflecting national trends.

Jain et al. (2022)

Jain et al. (2022) conducted an empirical study across Tier-II cities and found that agent support plays a pivotal role in assisting policyholders during the claim process, especially in semi-urban regions with low digital literacy.

Saxena & Mehta (2021)

Saxena & Mehta (2021) investigated how customer education programs improved understanding of policy terms, leading to smoother claim processing and reduced disputes.

Kumar & Sharma (2021)

In a study on urban and semi-urban health insurance customers, the authors found that claim convenience and agent interaction quality were more predictive of satisfaction than premium cost or coverage limits. Their findings emphasized localized support and procedural transparency.

Desai (2020)

Desai (2020) focused on the role of communication and transparency in claim processing, identifying that most grievances arise due to a lack of awareness regarding exclusions and claim documentation requirements. Bhattacharya & Nair (2020)

In their qualitative study on TPAs, they highlighted systemic inefficiencies such as manual claim processing, delayed approvals, and documentation disputes as major roadblocks to customer trust. This is especially relevant in regions lacking robust digital infrastructure like Firozabad.

Chakraborty & Sengupta (2019)

The authors examined the relationship between digital claim platforms and customer loyalty. They observed a direct correlation between real-time claim updates and repeat policy renewals, suggesting that digitization improves service perceptions.

Kumar & Bansal (2019)

Kumar & Bansal (2019) emphasized that the timeliness of claim processing significantly influences customer

satisfaction, particularly in India's public and private health insurance sectors. Their findings highlight that delays not only reduce satisfaction but also damage insurer credibility.

Kotler & Keller (2016)

The efficiency of the claim settlement process has long been acknowledged as a key determinant of customer satisfaction in the insurance sector. According to Kotler & Keller (2016), service delivery plays a more significant role in customer retention than product features.

Customer Expectation Gap, Gronroos (1994)

Gronroos (1994) proposed the Perceived Service Quality Gap Model, where a mismatch between expected service and actual delivery leads to dissatisfaction. In Mediciam, policyholders often expect seamless claim support, but ground realities diverge—especially in Tier-II and Tier-III cities.

Service Quality Theory, Parasuraman et al. 's (1988)

Parasuraman et al. 's (1988) SERVQUAL framework remains central in analyzing service dimensions, especially in insurance. The five dimensions—reliability, responsiveness, assurance, empathy, and tangibles—directly influence claim service quality. Health insurance falls short primarily in reliability and responsiveness, which are critical during claims.

In semi-urban regions like Firozabad, challenges such as limited awareness, lack of digitization, and dependency on third-party administrators (TPAs) further exacerbate dissatisfaction.

Regulatory and sectoral overviews

IRDAI's recent annual reports and releases document claim volumes, modes of settlement (cashless vs. reimbursement), claim settlement ratios, and growing digitalization trends in insurer operations. These reports show that cashless settlement continues to account for a substantial share of claim transactions, while the average claim amount and overall settlement values have risen—pressuring TPA and insurer processes.

Digital transformation and claim efficiency

The Ayushman Bharat Digital Mission and linked initiatives are accelerating adoption of digital health IDs, health record linkage, and in some cases, streamlined claim verification. Empirical assessments of ABDM report improving awareness and use among urban patients, suggesting digital tools can facilitate claim workflows and status transparency—when adoption and integration are adequate.

Claim settlement and customer satisfaction (empirical studies)

Several India-specific empirical studies (2019–2024) identify claim processing time, communication quality, and clarity of exclusions as major determinants of satisfaction and renewal propensity. Sector reports and recent analyses also show high approval rates in many contexts but persistent gaps in communication and

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grievance redressal that lower perceived fairness and trust. Independent surveys and news analyses through 2024–2025 highlight continuing issues: high approval rates juxtaposed with consumer complaints around delays, hospital billing disputes, and inadequate updates during claim processing.

Role of intermediaries (agents/TPAs)

Studies focused on Tier-II/Tier-III settings emphasize the outsized role agents and TPAs play in assisting claimants—particularly where digital literacy is limited. Where agents actively guide claim filing and documentation, claim convenience and satisfaction improve. Conversely, poor TPA coordination and manual processes (paper-based documentation, repetitive visits) negatively affect experience.

Gaps and motivation for this study

While national-level studies and reports provide broad trends, there is a relative dearth of city-level empirical work from smaller urban centres that integrates operational claim-process measures with satisfaction outcomes using robust multivariate analysis—this study aims to fill that gap for Firozabad (sample $n = 200$).

RESEARCH METHODOLOGY

Study design and location

Descriptive–analytical cross-sectional study conducted in Firozabad City, Uttar Pradesh.

Sample and sampling technique

A total of 200 Mediciam policyholders (who had filed at least one claim) were selected using stratified random sampling. Strata included policy type (individual vs. family floater), insurer category (public vs. private), and duration of policy holding (<2 years, 2–5 years, >5 years) to ensure representativeness.

Data collection instrument

A structured questionnaire (translated/localized in Hindi where appropriate) included: demographic items, claim experience items (processing time, number of follow-ups, cashless vs. reimbursement), Likert-scale items (1–5) measuring insurer communication, clarity of policy terms/exclusions, agent/TPA support, and an overall policyholder satisfaction score. The questionnaire was pre-tested on 20 respondents and validated by two insurance-sector subject-matter experts.

Analytical techniques

Data were cleaned and analyzed in SPSS 26.0. Techniques used: descriptive statistics, Pearson correlation (Karl Pearson’s r), and multiple linear regression (OLS) with policyholder satisfaction as the dependent variable and four primary independent variables: claim settlement time (measured in working days), insurer communication (Likert index), clarity of policy terms (Likert index), and agent/TPA support (Likert index). Statistical significance was evaluated at standard levels ($p < 0.05$).

Ethical considerations

- Participation was voluntary, responses were anonymized, and informed consent was obtained.
- Data Analysis and Key Findings (Results)
- Claim Settlement Experience (Descriptive Statistics)
- Delay in Settlement: 52% of policyholders experienced claim settlement delays exceeding 15 working days.
- Documentation Hassles: 37% made repeated visits to TPAs or insurers due to incomplete or unclear documentation requirements.
- Policy Exclusion Awareness: 48% were unaware of specific exclusions, indicating a communication gap at the time of policy issuance.
- Post-Submission Status: 43% reported no updates or feedback after claim submission, affecting transparency and trust.
- Correlation Analysis (Using Karl Pearson’s r)

The correlation analysis revealed strong and statistically significant relationships between claim-related factors and overall policyholder satisfaction:

Independent Variable	Karl Pearson’s r	Significance (p-value)
Claim Settlement Time	-0.71	$p < 0.001$ (Highly significant)
Insurer Communication	0.65	$p < 0.001$
Clarity of Policy Terms	0.58	$p = 0.002$
Agent/TPA Support	0.63	$p = 0.003$

Interpretation: Negative r for settlement time indicates that longer processing time reduces satisfaction. Other variables positively influence satisfaction.

Regression Analysis (Multiple Linear Regression)

A multiple linear regression was conducted with Policyholder Satisfaction as the dependent variable and the following independent variables:

- Claim Settlement Time
- Insurer Communication

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- Clarity of Policy Terms
- Agent/TPA Support
- Model Summary:
- $R^2 = 0.64$, Adjusted $R^2 = 0.62$
- F-statistic (4, 195) = 32.18, $p < 0.001$

The model explains 64% of the variance in policyholder satisfaction, which indicates a strong explanatory power. Significant Predictors:

Variable	Unstandardized Coefficient (B)	Standardized Beta (β)	p-value
Claim Settlement Time	-0.45	-0.42	0.001
Insurer Communication	0.34	0.31	0.004
Clarity of Policy Terms	0.29	0.27	0.009
Agent/TPA Support	0.26	0.24	0.013

CONCLUSION:

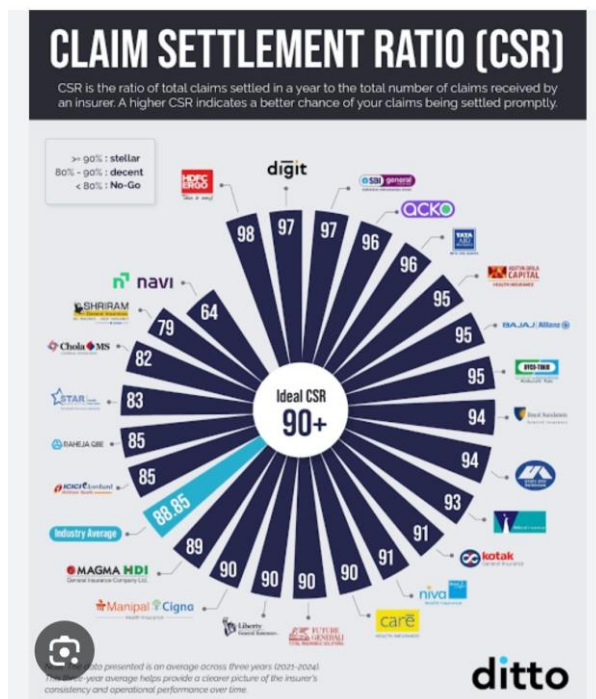
All four predictors significantly affect policyholder satisfaction, with claim settlement time having the most substantial negative impact.



Source: <https://www.google.com/imgres?imgurl=https%3A%2F%2Fstat.joinditto.in%2Fimage%2F2024%2F12%2F1734348818553.jpeg&tbid=P9YeqRvtXRn-iM&vet=1&imgrefurl=https%3A%2F%2Fjoinditto.in%2Farticles%2Fhealth-insurance%2Fhow-to-choose-the-best-health-insurance-providers-in-india-in-2025%2F&docid=furj1ha3pgssgM&w=1280&h=1600&hl=en-US&source=sh%2F%2Fim%2Fm1%2F4&kgs=deedb3147c64eb0a>

DISCUSSION

The analyses confirm the central role of operational claim-process variables in shaping policyholder satisfaction in Firozabad—consistent with national-level findings and service-quality frameworks (SERVQUAL and Grönroos gap model). The magnitude of the



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negative association for settlement time ($\beta = -0.42$) indicates that operational speed remains the most critical single factor influencing customers, echoing earlier Indian studies that highlight TAT as a major determinant of perceived fairness and retention.

Communication & Transparency: The positive effect of insurer communication ($\beta = 0.31$) and clarity of policy terms ($\beta = 0.27$) underscores that proactive, plain-language communication can mitigate dissatisfaction even when some delays are unavoidable. Where claimants receive frequent, clear updates, perceived reliability and responsiveness increase—this aligns with SERVQUAL dimensions and recent sector analyses showing real-time updates (digital or SMS) improve customer perceptions.

Role of agents/TPAs: Agent/TPA support positively influences satisfaction ($\beta = 0.24$). In semi-urban contexts like Firozabad, intermediaries often bridge gaps in policy literacy and digital ability; well-trained agents can expedite documentation and reduce repeated visits, thereby improving outcomes. Conversely, fragmented TPA practices and manual paperwork were commonly cited complaints, consistent with prior qualitative work.

Digital transformation & policy environment: The ABDM and insurer-led digital platforms create opportunity for improved verification, faster approvals, and better status transparency—however, adoption barriers (digital literacy, integration gaps) must be addressed. Moreover, policymakers have been actively examining national claims infrastructure and oversight to control costs and improve integrity of claims exchanges—moves that will likely reshape claim settlement protocols and bargaining between insurers and hospitals in 2025 and beyond. Such systemic changes are likely to influence how operational improvements translate into customer satisfaction.

Practical implication: For insurers operating in Tier-II cities, investments in streamlined claim workflows, digital claim trackers (with fallbacks like SMS and agent-assisted status checks), agent training, and simplified policy-documentation at issuance can materially improve satisfaction and renewals.

Recommendations

Based on findings and sector context, the following actionable recommendations are proposed:

End-to-end digital claim tracking (with multi-channel updates): Implement mobile/web claim trackers plus SMS alerts and an agent-mediated hotline for digitally excluded customers. Real-time updates reduce uncertainty and perceived service gaps. (Link with ABDM where possible to leverage interoperable IDs.)

Standardize TAT benchmarks: Insurers (and IRDAI guidance) should establish clear acknowledgement and settlement timeframes (e.g., claim acknowledgement within 48 hours; provisional decision within X days), publish them in policy documents, and monitor adherence.

Simplify and clarify policy documents: Use plain language for common exclusions and claim-document checklists at the time of issuance—include a one-page “claim readiness” sheet in Hindi/Urdu to match local literacy.

Agent/TPA capacity building: Structured training and certification for agents and TPA claim-support staff focused on documentation, empathy, and escalation pathways will reduce repeat visits and errors.

Local outreach & literacy programs: Conduct periodic local camps in Firozabad (and similar cities) to educate policyholders on claim types, preauthorization steps (cashless), and required documentation.

Integrate grievance & feedback loops: Provide easy feedback channels and publish periodic service-quality scorecards; tie internal KPIs to customer satisfaction metrics.

Regulatory coordination for claims portals: Support coordinated oversight of national claims exchanges to reduce pricing distortions and standardize coding and claims adjudication, complementing government moves to tighten claims-portal oversight.

LIMITATIONS AND FUTURE RESEARCH

Limitations: Cross-sectional design limits causal inference. The sample is limited to Firozabad City ($n = 200$), so generalization to other regions should be cautious. Self-reported measures may carry recall bias.

Future research: Larger multi-city comparative studies, longitudinal tracking of claimers’ experience across multiple claims, and experimental evaluations of digital-tracking interventions (RCTs) would strengthen causal evidence. Investigation into hospital–insurer price dynamics and their effect on claim settlement behavior would also be valuable given rising healthcare costs.

CONCLUSION

This empirical study demonstrates that claim settlement time, insurer communication, clarity of policy terms, and agent/TPA support significantly affect Medclaim policyholder satisfaction in Firozabad. Operational improvements—particularly around speed, transparency, and agent support—can meaningfully increase satisfaction, retention, and trust. Against a backdrop of digital health initiatives and calls for stronger oversight of national claims infrastructure, insurers and regulators have an opportunity to redesign claim processes to be faster, more transparent, and more user-friendly—especially for semi-urban populations.

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