

Satisfaction and Problems of Health Insurance Policyholders in India

Arunesh Garg*

Abstract

Health insurance holds a lot of business potential in India. After deregulation of general insurance sector in 1999, more than twenty companies have been established in India and almost all of them are offering health insurance. This study investigates the satisfaction and problems of the health insurance policyholders of various public sector and private sector general insurance companies. Data have been collected from 321 health insurance policyholders in the state of Punjab and the union territory of Chandigarh. The study shows that all the respondents have opted for sickness and accident covers. The respondents have been studied for their claim Settlement experience. Majority of the health insurance claimants have filed claims as they faced some form of illness. Satisfaction level of respondents from claim settlement and various other features of health insurance cover has been examined and compared across public and private sector companies. The policyholders have generally complained of delay in policy issue, excessive documentation, non-responsiveness and non-cooperativeness on the part of company and its officials, delay/ denial in case of claim settlement, lack of transparency, etc. In light of the findings, the study gives suggestions to improve overall experience of the health insurance policyholders.

Keyword: Health Insurance, Customer Satisfaction, Claim settlement, Customer Problems

Introduction

The deregulation of the Indian general insurance sector in 1999 has exposed the customer to a variety of insurance

products with various features. Prior to its deregulation, there were only four public sector players in general insurance, namely, National Insurance Company Limited, the New India Assurance Company Limited, the Oriental Insurance Company Limited and United India Insurance Company Limited. However, twenty one new private companies have already entered the general insurance business in India. Most of the general insurance companies are offering health insurance. Of late, standalone health insurance companies have been permitted. Further, some of the life insurance players have also come out with health insurance products. In fact, a lot of competition is being seen in the Indian health insurance sector. In the competitive scenario, understanding customer satisfaction and problems is very essential. The present study seeks to examine these aspects in case of health insurance policyholders of various public and private general insurance companies. The study has been conducted in the state of Punjab and the union Territory of Chandigarh in north India.

Previous Research Findings

Research studies by Levitt (1981), Palande *et al.* (2003), and Ramakrishna (2005) have stressed that sellers of intangible services like insurance face special problems in making customers aware of the benefits they are receiving. Many researchers have emphasised the importance of quality service by insurance companies to enhance customer satisfaction and loyalty (Chuganee, 2002; Jawaharlal, 2003; Joseph *et al.*, 2003; Beloucif *et al.*, 2004; Rao, 2004). An insurance company needs to be responsive in event of an enquiry by the customer (Joseph *et al.*, 2003; Rao, 2004). Further, insurers need to show

* Professor, Department of Business Management, Gian Jyoti Institute of Management & Technology, Mohali, Punjab, India.
Email: aruneshgarg@gmail.com

flexibility, empathy and consideration in dealing with the customers (Ramakrishna, 2005). In order to ensure customer satisfaction, simplicity, integrity, quality and economy are required (Pedrini, 2005). Trust is a key factor in establishing long-term relationship with the customers in insurance business (Crosby *et al.*, 1990; Naumann, 1992; Balachandran, 2000; Coulter and Coulter, 2002; Larpsiri and Speece, 2004; Awasthi, 2005). Main reasons for losing customer's trust are producing poor quality products, neglecting customer services, having no communication interface with customers, not being reliable, not admitting mistakes, and misrepresenting the product (Naumann, 1992). Gupta (2013) has emphasised that health insurance segment has experienced trust deficit by policyholders. Agarwal (2011) has opined that dealing with customer grievances in the domain of health insurance is more complicated, owing to several complexities that are inherent to it, and thus calls for high level of dexterity.

Previous research has emphasised the importance of timeliness, customer education, accuracy, and transparency by the insurance companies to prevent dissatisfaction of the policyholders. Respondents are generally unhappy due to delay in receiving policies (Singh, 1985). Insurance customers today demand adequate information on products, riders, contents of proposal form, claim procedure and services to take informed decisions (Subhedar, 2002; Jawaharlal, 2003; Bharath, 2005). The insurance industry also needs to strive towards more transparency in its dealings with its customers (Kalyani, 2005). Ramakrishna (2005) has emphasised that terms and conditions of the policy should be clear, and language of the policy document should be easy to understand. Joseph *et al.* (2003) have stressed the role of insurance agents in enhancing experience of the customers. The satisfaction of customers is significantly influenced by the salesperson's personal disclosure as well as his customer and relation-oriented behaviour (Tam and Wong, 2001). The service firms should capture the knowledge of frontline service employees to improve customer satisfaction (Chung and Schneider, 2002). Previous research studies (Anderson and Jolson, 1973; Subhedar, 2002; Bharath, 2005; Ramakrishna, 2005; Rao, 2005) have also emphasised the importance of customer feedback and efficient complaint redressal by the companies to offer a pleasant experience to their customers. Some researchers have observed that technology should be used to enhance customer experience and deliver fast service (Shah, 2003; Larpsiri and Speece, 2004; Pai, 2006).

Claim handling is one of the most important factors influencing satisfaction of life insurance customers (Kuhlemeyer and Allen, 1999). Awasthi (2005) has observed that generally in-house claim settlement system of insurance companies is not consumer-friendly, transparent and quick. Bond and Stone (2004) interviewed motor insurance claimants and found that at least a quarter of all the claimants were less positive about their respective insurer after making a claim. Over the years, many researchers have emphasised the importance of customer-friendly and hassle-free claim settlement to enhance customer satisfaction and loyalty. Research studies have demonstrated that insurance policyholders want the insurance companies to expedite settlement of the claims (Singh, 1985; Shenoy and Raju, 1990; Chuganee, 2002; Joseph *et al.*, 2003; Shah, 2003; Rao, 2005). Shah (2003) has found that policyholders do not want inconvenience at the time of claim payment. A study by Rao (2004) has revealed that in general, the insurance claimants are having grievances like delay in settlement of claims, rejection of claims without intimation, etc. Common grounds for harassing the claimants have been identified as delays in settlement of claims because of non-availability and misplacement of records, non-receipt of surveyor's report due to non-greasing of his palm, etc. (Awasthi, 2005). Rao (2005) has pointed out that policyholders expect fairness in evaluation of claims. Customers should be provided with adequate and clear information regarding claim settlement process, dealing hand, timescales involved in processing of claims and reasons for rejection of the claims. Ramakrishna (2005) further pointed out that the customer should be given clear and written reasons if a claim is rejected or partially disallowed.

A study by Sharma (1993) on satisfaction with the services of Employee State Insurance Corporation pointed out that dissatisfaction of the insured is due to unavailability of medicines, delay in reimbursement, inconvenient dispensary timings, poor physical facilities for the patients and the fact that most of the emergency services are referred to the hospitals. In a study conducted by Bhat and Reuben (2002) on a health insurance scheme run by an Indian Government-owned insurer, it has been revealed that about a third of the claims amount increase is due to the problems of adverse selection or provider-induced demand. The exclusions like that for pre-existing diseases and reluctance of health insurance companies to cover population beyond a certain age-group have been

pointed as some of the reasons that impede the growth of health insurance in India (Ray, 2003). Bagchi (2006) has observed that reasons for the failure of Universal Health Insurance Policy by the public sector companies in the case of those below the poverty line include illiteracy, ignorance, lack of understanding of the target group for benefits of insurance, poor servicing, and lack of market relation building activities in poor areas by the non-life insurance companies. Sunitha and Dhanabakyam (2008) have stressed that health Insurance providers have to be cautious in retaining their customers because the bond between them ceases to terminate at the end of the year.

The foregoing review reveals that not much attention has been paid by researchers in India to the customer concerns facing health insurance. Hardly any study is available that has attempted to bring out satisfaction and problems of health insurance policyholders in case of the public sector and private sector general insurance companies in India. Thus, the present study is an attempt in that direction.

Research Objectives

The present study has two major objectives:

1. To examine the satisfaction of health insurance policyholders in case of public and private sector general insurance companies
2. To study the problems faced by health insurance policyholders from general insurance companies

Research Methodology

The scope of the study is restricted to individual health insurance covering sickness and accident in the case of individuals and their family members. Health insurance holds a lot of business potential in India. Scarcity and affordability issues in the healthcare sector are forcing the Indian government to create awareness regarding health insurance. Tax incentives are offered against premium paid for availing health insurance cover. Government has allowed establishment of the insurance concerns to focus exclusively on health insurance.

Data and Study Periods

In the present study, policyholders refer to the end consumers who have purchased health insurance. The

universe of the study consisted of the respondents living in major cities of the state of Punjab, and the union territory of Chandigarh in north India. The cities of Punjab that were selected include Ludhiana, Amritsar, Jalandhar and Patiala. These are the most prominent cities of Punjab. As per 'Statistical Abstract of Punjab' (Government of Punjab, 2012), Ludhiana, Amritsar, Jalandhar and Patiala, in that order, are the most populated cities of Punjab and more than 16 percent of the total population as well as 43 percent of the total urban population of Punjab reside in these four cities only. Chandigarh, although a union territory, is also the state capital of Punjab. Chandigarh is a modern city and is home to people from diverse cross-sections of the society. Many of the general insurance companies have their regional control offices in Chandigarh. A sample of 350 respondents comprising 50-75 policyholders from each of cities/ union territory was selected with the help of convenience sampling. The selected respondents have been contacted at company offices, agent/ broker offices, hospitals, banks, etc. The data have been collected personally with the help of a well-structured and non-disguised questionnaire over a period of eight months from September, 2012 to April, 2013. The questionnaire used for data collection contained both open-ended and closed-ended questions. Satisfaction of the policyholders with respect to the various features of health insurance policy was measured on a five-point satisfaction scale with 1 indicating 'highly dissatisfied' and 5 indicating 'highly satisfied'. After scrutiny of the filled questionnaires, 321 were found to be fit for analysis; others were incomplete or lacked seriousness in response, and hence weeded out. Out of 321, most of the respondents (22.43%) belonged to Chandigarh, followed by Ludhiana (21.81%), Jalandhar (19.63%), Amritsar (18.38%) and Patiala (17.76%), in that order. An effort was made to ensure that health insurance policyholders of all the major public and the private sector companies having their existence in Punjab and Chandigarh for at least last five years, and offering health insurance were included in the sample. Out of a sample of 321 health insurance policyholders, as many as 211 (65.73%) and 110 (34.27%) respondents were the customers of public and private companies respectively. Given below is the list of the general insurance companies from public sector and private sector considered for the study:

Public Sector Companies

1. National Insurance Company Limited
2. The New India Assurance Company Limited
3. The Oriental Insurance Company Limited
4. United India Insurance Company Limited

Private Sector Companies:

1. Bajaj Allianz General Insurance Company Limited
2. Cholamandalam MS General Insurance Company Limited
3. HDFC ERGO General Insurance Company Limited
4. ICICI Lombard General Insurance Company Limited
5. IFFCO-TOKIO General Insurance Company Limited
6. Reliance General Insurance Company Limited
7. Royal Sundaram Alliance Insurance Company Limited
8. Tata AIG General Insurance Company Limited

It was found that in case of the public sector companies, most of the respondents (34.12%) had purchased health insurance from National Insurance, followed by New India Assurance (30.81%), United India (18.48%) and Oriental Insurance (16.59%), in that order. In the case of the private sector companies, most of the respondents (26.36%) had purchased health insurance from ICICI Lombard, followed by Bajaj Allianz (21.82%), IFFCO-TOKIO (11.82%) and Reliance (10.91%), in that order. HDFC had the smallest customer base for health insurance (4.55%). Further, an attempt was made to ensure that respondents were representative of various demographic characteristics.

Demographic Abstract

Demographic profile of the respondents is presented in Table 1. The table reveals that majority of the respondents (87.85 %) are males. Further, most of the respondents (27.73%) are in the age group of 40-50 years, followed by age groups of 50-60 years (25.86%), 30-40 years (19.94%), 20-30 years (17.76%) and 60 years or more (8.72%), in that order. Occupation wise distribution of the respondents shows that most of the respondents (52.96%)

are in service, followed by business (23.05%).

Only 10.59 percent of the respondents are professionals, whereas 13.40 percent of the respondents belong to 'others' category of occupation, which includes those who are housewives among females, students and those who are retired from service. As regards income level of respondents, 25.55 percent of the respondents have not revealed their income level. Most of the respondents (20.87%) belong to the monthly income group of less than Rs. 20,000, followed by monthly income groups of Rs. 20,000-30,000 (19.31%), Rs. 30,000-40,000 (17.45%) and Rs. 40,000 or more (16.82%), in that order. As far as education level is concerned, most of the respondents (45.48%) are graduates, followed by postgraduates (24.92%). Further, 15.58 percent have got professional qualification. Only 8.72 percent and 5.30 percent are undergraduates and matriculates respectively. Further, the table indicates that majority of the respondents are married (85.67%). Only 14.33 percent are unmarried.

Table 1: Demographic Profile of Respondents

N=321		
<i>Profile Characteristics</i>	<i>Categories</i>	<i>Number of Respondents</i>
Sex	Male	282 (87.85)
	Female	39 (12.15)
Age (in years)	20- 30	57 (17.76)
	30- 40	64 (19.94)
	40- 50	89 (27.73)
	50- 60	83 (25.86)
	60 or more	28 (8.72)
Occupation	Service	170 (52.96)
	Business	74 (23.05)
	Professional	34 (10.59)
	Others	43 (13.40)
Monthly Income (in Rs.)	Less than 20,000	67 (20.87)
	20,000- 30,000	62 (19.31)
	30,000- 40,000	56 (17.45)
	40,000 or more	54 (16.82)
	Did not respond	82 (25.55)
Education	Matriculation	17 (5.30)
	Under graduation	28 (8.72)
	Graduation	146 (45.48)
	Post graduation	80 (24.92)
	Professional Qualification	50 (15.58)
Marital Status	Married	275 (85.67)
	Unmarried	46 (14.33)

Hypotheses Formulation

The study has been conducted under the framework of the following hypotheses:

H1: There is no significant difference between health insurance policyholders from public sector and private sector companies with respect to their satisfaction from various features of health insurance cover offered by the companies.

H2: There is no significant difference between health insurance claimants from public sector and private sector companies with respect to their satisfaction from various claim settlement features offered by the companies.

Data Analysis and Hypotheses Testing

The data were analysed with respect to the responses from public and private sector companies. Further, cross tabulation, percentages and mean scores has been used to analyse the data. In order to test the two hypotheses, t-test for independent samples (at 5 percent level) is used. For the purpose, satisfaction levels of respondents have been calculated in terms of mean scores. The mean scores showing satisfaction levels have been calculated separately in case of two categories of respondents viz., those who have purchased health insurance policy from public sector companies, and those who have purchased the policy from private sector companies. The t-test for independent samples was further used to determine significant differences between mean scores of satisfaction of two categories of respondents from the various features of health insurance policy purchased by them. As already indicated, satisfaction of the respondents has been measured on a five-point satisfaction scale with 1 indicating 'highly dissatisfied' and 5 indicating 'highly satisfied'. If mean score value for satisfaction of respondents from a feature is found to be more than 4.50, the respondents are considered to be 'highly satisfied' from such feature. Mean score in the range 3.50-4.50 is assumed to indicate that respondents are 'satisfied'. If mean score for satisfaction of respondents from a feature is in the range of 2.50-3.50, the respondents are considered to be 'indifferent'. Further, mean score in the range of 1.50-2.50 is assumed

to indicate 'dissatisfaction' of the respondents. If mean score for satisfaction from a feature is found to be less than 1.50, the respondents are considered to be 'highly dissatisfied' with this feature. In order to examine reliability of chosen scales, Cronbach's alpha coefficient has been determined. The values of Cronbach's alpha coefficients have been found as more than 0.76 for the chosen scales in case of the responses received with respect to public and private sector companies respectively. This indicates an acceptable level of reliability. Nunnally (1978) suggests an alpha of 0.70 and above as acceptable.

Findings and Discussion

Distribution of respondents with respect to health insurance covers is shown in Table 2. It has been revealed that irrespective of whether health insurance has been purchased from public sector or private sector companies, all the respondents (100%) have opted for health insurance covers for self.

Table 2 also shows that more than 60 percent and 40 percent of the respondents have opted for health insurance covers for spouses and dependent children respectively. Only 11.21 percent of the respondents have opted for health insurance covers for dependent parents. More than 50 percent of the respondents have got a sum insured of Rs. 3 lakhs or less, irrespective of whether health insurance has been purchased from public sector or private sector companies. As many as 24.61 percent of the respondents have been unwilling or have not been able to recall the value of sum insured. Further, more than 60 percent of the respondents have made a premium payment of Rs. 4,000 or less, irrespective of whether health insurance has been purchased from public sector or private sector companies. More than 10 percent of the respondents have been unwilling or have not been able to recall the amount of last premium paid. More than 60 percent of the respondents have made a premium payment of Rs. 4,000 or less, irrespective of whether health insurance has been purchased from public sector or private sector companies. It has also been observed that all the respondents (100.00%) have opted for sickness and accident covers, irrespective of whether they got health insurance from public sector or private sector companies.

Customer Satisfaction

The respondents have been asked to specify their level of satisfaction (on a 5-point scale) from different features of the health insurance cover offered by the companies.

Mean scores showing level of satisfaction relating to various features of the respective insurance covers have been calculated. Table 3 shows the responses in this regard.

Table 2: Distribution of the Respondents with respect to Health Insurance Covers

Features	Categories	Number of Respondents		
		Overall Sample	Public Sector	Private Sector
Insurance Cover for	Self	321 (100.00)	211 (100.00)	110 (100.00)
	Spouse	213 (66.36)	142 (67.30)	71 (64.55)
	Dependent Children	148 (46.11)	92 (43.60)	56 (50.91)
	Dependent Parents	36 (11.21)	17 (8.06)	19 (17.27)
Sum Insured (in Rs.)	Less than 1 lakh	32 (9.97)	22 (10.43)	10 (9.09)
	1 - 2 lakhs	62 (19.31)	37 (17.54)	25 (22.73)
	2 - 3 lakhs	72 (22.43)	51 (24.17)	21 (19.09)
	3 - 4 lakhs	38 (11.84)	24 (11.37)	14 (12.73)
	4 lakhs or more	38 (11.84)	21 (9.95)	17 (15.45)
	Did not respond	79 (24.61)	56 (26.54)	23 (20.90)
Last Premium Paid (in Rs.)	Less than 1,000	20 (6.23)	14 (6.64)	6 (5.45)
	1,000 - 2,000	28 (8.72)	17 (8.06)	11 (10.00)
	2,000 - 3,000	76 (23.68)	47 (22.27)	29 (26.36)
	3,000 - 4,000	79 (24.61)	56 (26.54)	23 (20.91)
	4,000 - 5,000	49 (15.26)	33 (15.64)	16 (14.55)
	5,000 or more	33 (10.28)	22 (10.43)	11 (10.00)
	Did not respond	36 (11.21)	22 (10.43)	14 (12.73)
Coverage	Sickness and Accident	321 (100.00)	211 (100.00)	110 (100.00)
N		321	211	110

Table 3: Mean Scores of satisfaction from Features of Health Insurance

S. No.	Features of Health Insurance Cover	Overall Sample	Public sector	Private Sector	t – test Values
1.	Premium rates	3.36	3.48	3.13	2.513*
2.	Knowledge of the Sales force/Agents	3.71	3.62	3.88	2.816*
3.	Behaviour/ Responsiveness of the Sales force/ Agents	3.92	3.88	4.00	1.349
4.	Procedural Requirements for the Policy Issuance	3.80	3.89	3.64	2.249*
5.	Time taken for the Policy Issuance	3.73	3.64	3.90	2.303*
6.	Mode of Premium Payment	4.14	4.15	4.11	0.532
7.	Transparency of Information	2.91	2.83	3.05	1.840
8.	Quality of the Policy Document	3.74	3.63	3.94	3.107*
9.	Coverage Provided	3.63	3.65	3.58	0.460
10.	Complaint Handling Mechanism	3.34	3.28	3.45	2.095*

*Significant at 5% level

The table shows that irrespective of whether health insurance has been purchased from public sector or private sector companies, most of the respondents are 'satisfied' (mean score being in the range of 3.50-4.50) with features like 'knowledge of the sales force/ agents', 'behaviour/ responsiveness of the sales force/ agents', 'procedural requirements for the policy issuance', 'time taken for the policy issuance', 'mode of premium payment', 'quality of the policy document' and 'coverage provided'. The respondents from public sector as well as private sector companies are close to being 'indifferent' (mean score being in the range of 2.50-3.50) with 'premium rates', 'transparency of information' and 'complaint handling mechanism'.

The values of the mean scores reveal that for 'premium rates' and 'procedural requirement for policy issuance', the satisfaction level of the respondents is relatively higher in case of the public sector companies as compared to the private sector companies. The mean scores also indicate that satisfaction level with respect to features like 'knowledge of the sales force/ agents', 'time taken for the policy issuance', 'transparency of information', 'quality of the policy document' and 'complain handling mechanism' is relatively higher in the case of the private sector companies as compared to the public sector companies. There is not much difference between the two groups of respondents with respect to their satisfaction from rest of the features of health insurance cover. The results of t-test confirm that statistically, the two categories of the health insurance policyholders differ significantly at 5 percent level with respect to their satisfaction from 'premium rates', 'knowledge of the sales force/ agents', 'procedural requirement for the policy issuance', 'time taken for the policy issuance', 'quality of the policy document' and 'complaint handling mechanism'. Thus, hypothesis H1 is rejected for these features of health insurance. However, there is no significant difference with respect to satisfaction from rest of the features of health insurance cover; hence, accepting hypothesis H1 for the health insurance features like 'behaviour/ responsiveness of the salesforce/ agents', 'mode of premium payment', 'transparency of information' and 'coverage provided'.

Satisfaction from Claim Settlement

It has been revealed that out of a total of 321 health insurance policyholders, 73 (22.74%) have filed claims at one or the other time. Further, 46 (21.80%) respondents out of a total of 211 from the public sector companies, and

27 (24.55%) respondents out of a total of 110 from the private sector companies have filed claims. Information regarding health insurance claim experience is mentioned in Table 4.

Table 4 indicates that 53.42 percent of the health insurance claimants have filed claims as they faced some form of illness. Further, 53.42 percent of the claimants have reported claim processing through the third-party administrator, while 34.25 percent have got their claims processed through the company. Cashless treatment has been taken by 24.66 percent of the claimants. It has further been found that 12.33 percent of the health insurance claimants have been denied claim compensation. Further, majority of the health insurance claimants (56.17%) have received 50% to 80% of the total incurred expenses as claim compensation. In case of the public sector companies, most of the claimants (45.66%) have received 60% to 80% of the total incurred expenses as claim compensation. However, in case of the private sector companies, most of the claimants (48.15%) have received 50% to 70% of the total incurred expenses as claim compensation. Most of the claimants have received claim compensation in 31 to 60 days from the date of despatch of documents to the company, irrespective of whether health insurance has been purchased from public sector companies (36.96%) or private sector companies (25.93%). The sector-wise details have also been presented in Table 4.

The respondents have been asked to indicate their level of satisfaction from claim settlement features of the respective general insurance companies on a five-point scale. Mean scores have been calculated for the various features. The responses received are presented in Table 5.

The table reveals that health insurance claimants are close to being 'indifferent' with 'documentation required for claim settlement' (mean score = 2.52), 'amount of compensation received' (mean score = 2.74) and 'claim settlement procedure of the company' (mean score = 2.74). Further, most of the respondents are 'dissatisfied' with 'claim processing time' (mean score = 2.40). Sector-wise analysis reveals that in the case of the public sector companies, most of the claimants are 'dissatisfied' with 'documentation required for claim settlement' (mean score = 2.46), 'claim processing time' (mean score = 2.35) and 'claim settlement procedure of the company' (mean score = 2.48). The respondents are close to being 'indifferent' with 'amount of compensation received' (mean score = 2.89).

Table 4: Information Regarding Health Insurance Claim Experience

Categories		Number of Respondents		
		Overall Sample	Public sector	Private sector
Health Insurance	Illness	39 (53.42)	26 (56.52)	13 (48.15)
	Injury	34 (46.58)	20 (43.48)	14 (51.85)
Claim Processing	Claimed from third party administrator	39 (53.42)	21 (45.65)	18 (66.67)
	Claim processed through company	25 (34.25)	20 (43.48)	5 (18.52)
	Underwent Cashless treatment	18 (24.66)	11 (23.91)	7 (25.93)
	Availed services of empanelled hospital	28 (38.36)	16 (34.78)	12 (44.44)
Total Expenses incurred (in Rs.)	Upto 50,000	26 (35.62)	19 (41.30)	7 (25.93)
	50,001 - 1,00,000	19 (26.03)	10 (21.74)	9 (33.33)
	1,00,000 - 1,50,000	10 (13.70)	6 (13.04)	4 (14.81)
	1,50,000 - 2,00,000	8 (10.96)	4 (8.70)	4 (14.81)
	2,00,000 - 2,50,000	4 (5.48)	3 (6.52)	1 (3.70)
	2,50,000 - 3,00,000	1 (1.37)	1 (2.17)	0 (0.00)
	More than 3,00,000	5 (6.85)	3 (6.52)	2 (7.41)
Compensation received (as per cent of total expenses incurred)	Claim denied	9 (12.33)	5 (10.87)	4 (14.81)
	Upto 50	7 (9.59)	5 (10.87)	2 (7.41)
	50 - 60	12 (16.44)	4 (8.70)	8 (29.63)
	60 - 70	17 (23.29)	12 (26.09)	5 (18.52)
	70 - 80	12 (16.44)	9 (19.57)	3 (11.11)
	80 - 90	6 (8.22)	3 (6.52)	3 (11.11)
	90 - 100	10 (13.70)	8 (17.39)	2 (7.41)
Time taken to receive claim amount from date of despatch of documents to the company	Claim denied	9 (12.33)	5 (10.87)	4 (14.81)
	Cashless	18 (24.66)	11 (23.91)	7 (25.93)
	Within 7 days	0 (0.00)	0 (0.00)	0 (0.00)
	8 - 15 days	3 (4.11)	0 (0.00)	3 (11.11)
	16 - 30 days	17 (23.29)	11 (23.91)	6 (22.22)
	31 - 60 days	24 (32.88)	17 (36.96)	7 (25.93)
	More than 60 days	2 (2.74)	2 (4.35)	0 (0.00)
N		73	46	27

Table 5: Health Insurance: Mean Scores of Satisfaction from Claim Settlement Features

S.No.	Claim Settlement Features	Overall Sample	Public Sector	Private Sector	t - test Values
1.	Documentation required for Claim Settlement	2.52	2.46	2.63	0.642
2.	Claim Processing Time	2.40	2.35	2.48	0.409
3.	Amount of Compensation received	2.74	2.89	2.48	1.158
4.	Claim Settlement Procedure of the Company	2.74	2.48	3.19	2.009*

*Significant at 5% level

In case of the private sector companies, most of the respondents are 'dissatisfied' with 'claim processing time' (mean score = 2.48) and 'amount of compensation received' (mean score = 2.48). However, they are close to being 'indifferent' with 'documentation required for claim settlement' (mean score = 2.63) and 'claim settlement procedure of the company' (mean score = 3.19). The mean scores show that claimants are relatively more satisfied with 'amount of compensation received' in case of the public sector companies as compared to the private-sector companies. Satisfaction with 'claim settlement procedure of the company' is relatively higher in the case of the private sector companies as compared to the public sector companies. However, there is not much difference between the two categories of respondents with respect

to their satisfaction from rest of the claim settlement features. The t-test values reveal that statistically, the two categories of the health insurance claimants do not differ significantly at 5 percent level with respect to their satisfaction from various claim settlement features of health insurance cover except 'claim settlement procedure of the company'. Hence, hypothesis H2 is rejected in case of 'claim settlement procedure of the company', and the hypothesis is accepted for rest of the features.

The health insurance claimants who availed health services at empanelled hospitals have been asked to specify on a five-point scale, their satisfaction from various features of the services available in such hospitals. The mean scores of satisfaction from various aspects of such services are presented in Table 6.

Table 6: Mean Scores of Satisfaction from Various Features of Services available in Empanelled Hospitals

S.No.	Service Features	Overall Sample	Public Sector	Private Sector	t – test Values
1.	Admission Formalities	1.75	1.69	1.83	0.349
2.	Behaviour of Doctors/ other Staff in the Hospital	2.61	2.63	2.58	0.112
3.	Facilities available in the Hospital	3.61	3.56	3.67	0.236

* t-test values are not significant at 5 % level

Table 6 shows that most of the respondents who availed services of empanelled hospitals are 'satisfied' with 'facilities available in the hospitals' (mean score = 3.61). Further, most of the respondents are 'dissatisfied' with 'admission formalities' (mean score = 1.75). However, the respondents are close to being 'indifferent' with 'behaviour of doctor/ other staff in the hospital' (mean score = 2.61). Sector-wise analysis reveals that most of the respondents are 'dissatisfied' with 'admission formalities', irrespective of whether they got health insurance from public sector companies (mean score = 1.69) or private sector companies (mean score = 1.83). The two categories of respondents are close to being 'indifferent' (mean score being in the range of 2.50-3.50) with 'behaviour of doctors/ other staff in the hospital'. The table also indicates that most of the respondents are 'satisfied' with 'facilities available in the hospital',

irrespective of whether they got health insurance from public sector companies (mean score = 3.56) or private sector companies (mean score = 3.67). The mean scores further indicate that as far as satisfaction from various features of services available in empanelled hospitals is concerned, there is not much difference between the respondents from the public sector and private sector companies. The t-test values also confirm that the two categories of policyholders do not differ significantly at 5 percent level with respect to their satisfaction from various features of services available in empanelled hospitals. Hence, hypothesis H2 is accepted for various features of the health services available in empanelled hospitals.

Problems Faced From General Insurance Providers

An attempt has been made to determine the problems faced by the respondents from the general insurance providers. For the purpose, an open-ended question was administered to the respondents. It has been found that in general, the nature of problems was same, irrespective of whether respondents have got health insurance from public sector or private sector companies. The problems generally faced are enlisted below:

Policy Document

- Excessive Documentation
- Delay in issue of policy
- Use of complicated wording in the policy document that may be beyond understanding of a common man
- Typing errors/ wrong details in the policy document
- Non-receipt of reminders for renewal of insurance covers, in the case of public sector general insurance companies
- Denial of health insurance policy to customers belonging to the senior age group. Non-coverage of a disease in the renewed health insurance policy for the next year, the claim for which was taken in the health insurance policy for the previous year

Claim Settlement

- Excessive documentation
- Lack of intimation regarding claim settlement procedure at the time of policy issue

- Lack of assistance by salesforce, sales-agents and other delivery channels in the event of claim.
- Delay in claim settlement.
- Lack of information regarding claim status.
- Deductions, without explanation, during settlement of claims.
- Denial of claim admission without intimation of reason.
- Denial of claim admission, without specifying convincing reasons.
- Large number of admission and other formalities for availing services of empanelled hospitals.
- General tendency on the part of hospitals to charge higher rates in the case of an insurance claim.
- Small number of empanelled hospitals.

Other Problems

- Lack of transparency, and hiding of facts and information by the sales force, sales agents and other delivery channels at the time of policy issue.
- Lack of facility for free health check-ups and non-coverage of pre-existing diseases from the first year of policy.
- Lack of product knowledge in the case of salesforce, sales-agents and other delivery channels.
- Non-responsiveness and non-cooperation on the part of the company, sales force, sales agents, other delivery channels, and surveyors in the case of a query or complaint.
- Lack of information regarding premium calculation.
- Lack of efficient complaint redressal system.

Conclusions and Implications

It has been revealed that out of a total of 321 respondents surveyed, 211 (65.73%) have purchased health insurance from the public sector companies, while 110 (34.27%) have purchased it from the private sector companies. All the health insurance policyholders have opted for sickness and accident covers. Most of the respondents from public sector as well as private sector companies are satisfied with 'knowledge of the sales force/ agents', 'behaviour/ responsiveness of the sales force/ agents', 'procedural requirements for the policy issuance', 'time taken for the policy issuance', 'mode of premium payment', 'quality of the policy document' and 'coverage

provided'. Mean score values reveal that for features like 'knowledge of the sales force/ agents', 'time taken for the policy issuance', 'quality of the policy document' and 'complaint handling mechanism', the satisfaction level of the health insurance policyholders is significantly higher in case of the private sector companies in comparison to the public sector companies. However, the respondents are more satisfied with 'premium rates' and 'procedural requirements for the policy issuance' in case of the public sector companies as compared to the private sector companies. The findings show that 22.74 percent of the health insurance policyholders have filed claims. Majority of the health insurance claimants have faced some form of illness. The study has revealed that most of the health insurance claimants belonging to the public sector as well as private sector companies are dissatisfied with 'claim processing time'. Further, most of the respondents who availed services of empanelled hospitals are satisfied with 'facilities available in the hospitals', irrespective of whether they got health insurance from public sector or private sector companies. It has also been found that most of the respondents from the two groups are dissatisfied with 'admission formalities'. The respondents have specified a number of problems that have been faced by them from their insurance providers. These problems include delay in policy issue, excessive documentation, non-responsiveness and non-cooperativeness on the part of company and its officials, delay/ denial in case of claim settlement, lack of transparency, etc.

The study has come out with some important implications for the health insurance companies. Pre-existing diseases in case of minor ailments should be covered from the first year itself under health insurance. Further, there should be facility for free health check-ups at fixed intervals. The companies may introduce these features as extensions on coverage on payment of extra premium. Special health insurance covers for customers belonging to senior-age group should be designed. The insurance companies should make an attempt to ensure error-free policy document with simple wording. The public sector companies need to work more in this direction. There should be least possible documentation in case of the policy issuance. Further, the policy cover should be issued without any delay. It is suggested that if a company is not able to issue policy cover in the promised time, the customers should be monetarily compensated. The companies should remind the customers of the policy expiry date at least one month prior to such date. Perhaps,

private sector companies are sending such reminders. Non-receipt of reminders for renewal of insurance covers has been reported in the case of the public sector companies. It is suggested that the companies may use technology and send reminders through email, short messaging service by using mobile phone, etc. The companies should be transparent in their dealings. Crucial information in the event of claim, method of premium calculation, etc. should be explained at the time of policy issuance by the sales force/ sales agents of the company. The policyholders should be provided complete information regarding dos and don'ts in case of an eventuality leading to the claim. The companies should ensure adequate training for their sales force, sales agents and delivery channels so that they have updated product knowledge when they interact with the prospective customers. The distribution channels should be made more responsive and co-operative at the time of handling any query or complaint of the policyholders. They should be instructed to offer every possible help to the policyholders in the event of claim. The companies should aim to make their claim settlement procedure transparent, speedy, efficient, and hassle-free. It is suggested that if a company is not able to settle claim in the promised time, the customers should be monetarily compensated. There should be least possible documentation at the time of claim. Periodic claim status as well as claim status on request should be made available to the policyholders. The customers should be explained clearly regarding deductions during settlement of claims. If request for a policy or claim is not entertained, the reasons for the same should be clearly specified. The companies should empanel more hospitals, even in remote locations, for providing cashless facilities to the claimants. The general insurance companies need to devise mechanism to evaluate the quality of services provided to their policyholders by the outsourced outfits like empanelled hospitals, third-party administrators, etc. The companies may develop health administration service cells to settle health insurance claims directly. The insurers need to ensure that their query handling and complaint redressal mechanism is responsive, visible and accessible.

Directions for Further Research

The present study examines health insurance. The study may be extended to other general insurance covers as well as life insurance products. The study is limited to the selected cities in the state of Punjab, and the union

territory of Chandigarh. The study may be extended to other geographical regions, and area-wise comparison of claim experience with respect to public sector and private sector companies may be made. Further, the analysis may be carried out on the basis of demographic variables of the respondents.

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