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Claim settlement excellence: Keys to customer satisfaction in health insurance

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Abstract

The Indian health insurance market is quickly developing, owing to increased healthcare awareness, rising medical expenditures, and government initiatives. However, client satisfaction, particularly in claim settlement, remains a major concern. This study investigated the demographic profile of health insurance policyholders and factors influencing their satisfaction with claim settlement. Analysis revealed an association between efficient claim processing, positive customer service interactions, and overall satisfaction. The study suggests that focusing on these areas can improve policyholder experience.

Keywords: Health insurance, claim settlement, policyholders, customers satisfaction

1. Introduction

The Indian health insurance market has experienced substantial growth in recent years. in the non-life insurance market India ranks 15th in the world [1]. This is driven by increased awareness of health risks, rising healthcare costs, and government initiatives promoting health insurance coverage. With a diverse range of policyholders, from urban to rural populations, the market presents unique challenges and opportunities for insurers.

In the rapidly evolving health insurance industry that is at a CAGR of 24% and rose about 34% in the pandemic time period [2]. The health insurance sector now makes up 37% of the general insurance industry's revenue, making it the largest segment. In FY24, it settled 2.5 crore claims worth ₹. 75,000 crore, resulting in a 25% operating profit. General Insurance Council chairman Tapan Singhel stated that the sector collected nearly ₹. 1,00,000 crore in premiums in FY24, showing a 20% annual growth in recent years. Additionally, more than 50 crore people are now covered by health insurance, which is 38% of the population, up from 37% in FY23 [3].

Health insurance in India is still optional and decentralized, causing many people to pay significantly less on healthcare due to inadequate insurance coverage. The healthcare system is divided into two sectors: public and private, with free services provided by government facilities. Despite this, many people prefer private health insurance for better and faster care. The market is expanding, but distribution is uneven, and the public system receives little funds, making private insurance a more appealing alternative for most people [4].

In this health insurance industry customer satisfaction is paramount. One of the most critical aspects influencing customer satisfaction is the efficiency and effectiveness of the claim settlement process. The ability of health insurance companies to settle claims promptly and accurately can significantly impact their reputation, customer loyalty, and overall success. Despite the growth, the industry faces issues such as complex claim processes, varying levels of customer service, and regulatory changes.

The complaints received from health insurance are more than any other segments of general insurance in India. Specifically, the complaints rose regarding 'claim' settlement of health insurance was highest in numbers as compared to remaining type of complaints (The types of Complaints in Health Insurance claim, Coverage, Others, Policy Related, Premium, Product, Proposal Related and Refund) [5]. This reveals that there is a gap between the

customer experiences with claim settlement and the insurer's role while claim settlement. The Challenges faced ranged from insurance companies rejecting claims by classifying a health condition as a pre-existing condition to only approving a partial amount. 43% health insurance policyholders who filed a claim in the last three years struggled with getting it processed [6].

In a positive move, the IRDAI has implemented many reforms to increase health insurance coverage. These include simplifying the definition of pre-existing conditions, lowering the waiting period to 36 months, and reducing the moratorium term for new policyholders to five years. Additionally, policy renewals are now guaranteed, and individual premium loading based on health status is prohibited. The IRDAI has also clarified coverage specifics and broadened it to encompass contemporary therapies, mental illness, physical disability, and previously excluded diseases [3]. The IRDAI has mandated life and general insurers to extend cover to certain identified Gram Panchayats. the General Insurance Council to identify the Gram Panchayats for extending the health cover [7]. Addressing these challenges is crucial for improving the claim settlement experience and ensuring customer satisfaction in this dynamic and expanding market.

Insurance works, because people band together to protect themselves from any consequences that may arise. Because insurance helps to achieve the above goal of safeguarding individuals from financial strain, it becomes vital for insurance companies to pay as many claims as they can, as well as offer insurance products that keep up with the needs of potential policyholders [8]. A claim is a payment given by the insurer to the insured or claimant upon the occurrence of the event stated in the contract in exchange for the premiums paid by the insured. This is the ideal time for the insurance to fulfill their promise that they made with the insured in the beginning during the proposal stage [9]. A third-party administrator (TPA) or a health insurance company's internal TPA settles claims. TPAs, established by the IRDAI in 2002, facilitate services for health insurance policyholders by serving as a functional link between insurers and hospitals. They play an important role in coordinating between insurance companies, insured people, and hospitals, offering services like cashless hospitalization and hassle-free claim settlements to improve client service [10].

This Study explores health insurance claim settlement satisfaction. It starts with background information and a literature review (Section 1, 2). Then, it explains the research problem, objectives, and hypotheses (Section 3, 4, 5). The methodology details how the data was collected, analyzed, and which statistical tools were used (Section 6, 7). Results (demographic data, reliability tests, hypothesis testing) and discussion (findings, interpretations) are presented (Section 8, 9, 10, 11). Finally, suggestions for improvement and a conclusion with key takeaways are provided (Section 12, 13, 14). References are listed at the end (Section 15).

2. Review of Literature

The research used Structural Equation Modelling to examine the role of Third-Party Administrators (TPAs) in settling health insurance claims. The conclusion is that the design of the insurance product and how well customers understand it significantly affect their satisfaction with health insurance [9].

The research utilized a Structural Equation Modelling (SEM) approach to explore connections and yielded positive outcomes. The main focus was on investigating how health insurance claim settlement procedures influence customer satisfaction. When considering all the factors collectively, it was found that 'customer aspects' have a noteworthy impact of 0.082 times on the formation of 'TPA Settlement' inclinations. Similarly, 'contextual supports' exhibit a significant impact of 0.208 times, and 'product design knowledge' shows a statistically significant impact of 0.291 times on the development of 'TPA Settlement' inclinations. In simpler terms, this implies that contextual supports and policyholders' understanding of product design have a real impact on how 'TPA Settlement' operates [11].

The study reveals that Insurers haven't really gotten better at settling claims over the years, and it looks like they're not passing on the benefits to the people making claims. If your claim is for a higher amount, it's more likely to either be denied or just left hanging by the insurance company. Also, when Third-Party Administrators (TPAs) take a long time to pay out, it creates a frustrating experience for individuals and gives the whole industry a bad name. This is making people who have insurance policies lose trust in how claims are handled, leading to unhappy customers and fewer people renewing their policies. It's a big problem that needs fixing [12].

The study focused on two important aspects to be considered while buying a Health insurance policy. First one Incurred claim Ratio (ICR) and Claim Settlement Ratio (CSR). Additionally, the paper discusses about the Number of Persons covered under HIC. Results showed Gradual increase in Government sponsored health policy and decline in Individual Health Insurance business. This is concerning. Third-Party Administrators (TPAs) play a crucial role as intermediaries in resolving issues between the insured party and the insurer. Their function involves facilitating communication and addressing concerns to foster resolution in insurance-related matters [13].

The results show that a significant number of people face financial challenges and barriers when trying to get healthcare. However, there are policies in place that can effectively address these issues. The close connection between having insurance and spending less money out-of-pocket highlights how making health insurance more available can make a big difference. Additionally, areas like preventive care, managing chronic diseases, mental health services, and community education are crucial for making positive changes [14].

This study dealt with spotting fake insurance claims by creating features and classifying them. We use a basic dataset with procedure and diagnosis codes due to legal constraints and software discrepancies in richer datasets. We introduce clinical concepts as a new way of understanding claims, assuming each claim is a mix of hidden clinical elements. The MCC model is expanded using Long-Short Term Memory network (MCC + LSTM) and Robust Principal Component Analysis (MCC + RPCA) to filter crucial concepts from claims and determine if they are fraudulent. We see improved accuracy, precision, and recall

scores, with MCC + LSTM achieving 59%, 61%, and 50% on the inpatient dataset and 78%, 83%, and 72% on the outpatient dataset. There's similarity in results between MCC and MCC + RPCA, both using an SVM classifier. We hope this approach will inspire more research in spotting fake insurance claims using essential but limited data [15].

This study aims to understand how policyholders view the claim settlement process handled by third-party administrators (TPAs) using Structural Equation Modelling (SEM). The research reveals significant connections between policyholder perceptions and various factors like how they see the insurance company (0.162), network hospitals (0.182), product design (0.180), insurance agents (0.332), communications (0.114), disclosure (0.122), and internal practices (0.143). Additionally, these factors influence the prospects of claim settlement by TPAs, specifically from the Indian perspective [11].

3. Statement of the Problem

Identifying and understanding the demographic profile of policyholders, as well as the key factors that contribute to excellence in claim settlement, is critical for health insurance providers aiming to improve. Despite advancements in the health insurance sector, many policyholders continue to be dissatisfied with the claim settlement process. Issues like delays, lack of transparency, and perceived unfairness in claim decisions can erode trust and reduce customer loyalty.

4. Objectives of the Study

1. To identify demographic Profile of the policyholders in study area.
2. To examine the customer satisfaction towards claim settlement of health insurance.

5. Hypotheses of the Study

Null Hypothesis (H_{O1}): There is no significant association between Claim Settlement Factors and overall satisfaction of policyholders with the health insurance claim settlement.

6. Research Methodology

6.1 Research Methods

The study is aimed to investigate the factors contributing to customer satisfaction in health insurance claim settlements. For achieving this aim study adopted both descriptive and exploratory research method.

6.2 Population and Sampling Design

To achieve the Objectives of the study, we identified The total numbers of Health Insurance Claims settled in FY 2022-23 is 2,30,814 in Karnataka state alone (IRDAI 2022-23, 2023) to conduct survey. The total numbers of health insurance claims are those of Individual health insurance policies which include Cashless claims, Reimbursement claim and Benefit based claim types (Personal Accident Insurance and Travel Insurance are Excluded).

1. **The Core area of the study:** The study focuses on customer satisfaction with the claim settlement process in the health insurance business.
2. **Geographical Area of the study/Scope of the study:** The study was undertaken in Ballari district, Karnataka State.
3. **Population:** The Total Number of health insurance policyholders who have filed a claim in the year 2022-23.
4. **Sampling Unit:** The individual health insurance policyholder in Ballari district who has had a claim settled in the year 2022-23.
5. **Sampling Frame:** Since we don't have a list of the population, the sampling frame couldn't possible to frame.
6. **Sampling Element:** Each health insurance policyholder who had a claim settled in 2022-23 in Ballari district.
7. **Sampling Method:** Since we don't have a list of the population, a non-probability sampling method is adopted. Under this method convenience sampling is appropriate to survey the policyholders.
8. **Sampling Size:** The sample size for the study is determined as 100, which constitutes of policyholders of health insurance who claimed their policy in study area.

6.3 Source of Data, Data Collection Methods and Procedure

1. **Source of Data and Collection Method:** The study primarily requires to survey policyholders to know their experiences and also requires certain secondary data to frame conceptual aspects. The source of data used for the study is both Primary Data and Secondary. The Primary Data source is collected through structured surveys administered to selected policyholders and Secondary Data source is collected from IRDAI Annual reports, Hand books of IRDAI, Past Research Articles, Web pages and Reports from Various Agency.
2. **Survey Instrument:** A questionnaire designed to capture data on various aspects of claim settlement and customer satisfaction. The survey instrument 'Questionnaire' has divided into 2 Parts; Part A: Personal profile of the Policyholders (Gender, Age, Marital Status, Educational Qualification, Occupation, Monthly Income, type of Family). Part B: Experience of Health Insurance Claims Settlement (Satisfaction level with claims settlement Procedure).
3. **Data Collection Procedure:** The Primary data collected by distributing questionnaire to selected policyholders in person or electronically. While doing so it is ensured that confidentiality and voluntary participation and collected responses over a specified period.

The Secondary data collected with proper causations by visiting websites and through deep study of reports of IRDAI. To cite the work of the other authors in the core area of the study we adopted software application called Mendeley Reference Manager.

7. Statistical Tools and Software used for data analysis

7.1 Statistical Tools

1. In order to analyze the significant association between Claim Settlement Factors and Overall satisfaction policyholders with the health insurance claim settlement the researcher has applied the Pearson Chi-Square Test.

2. Cronbach's Alpha Reliability test used to know the consistency and stability of research instrument and measures.

7.2 Software tools for data analysis

The researcher, Descriptive statistical analyses and inferential statistical analyses were performed using IBM SPSS Statistics Version 25. Mendeley Reference Manager (Version 2.115.0) was utilized for bibliographic management.

8. Data collection and analysis

Table 1: Policyholders details

	Percentage of Respondents	Frequency of Respondents
Gender		
Male	68%	68
Female	32%	32
Age in Years		
25 to 35 years	60%	60
36 to 45 years	26%	26
46 to 60 years	14%	14
Marital Status		
Married	87%	87
Unmarried	13%	13
Educational Qualification	19%	
Below PUC		19
Graduation	63%	63
Post-Graduation	18%	18
Occupation		
Salaried Employee	64%	64
Professional	9%	9
Non-working	15%	15
Business	8%	8
Agriculture	4%	4
Monthly income		
Less than Rs. 10000	19%	19
Rs. 10000 to Rs. 25000	24%	24
Rs. 25000 to Rs. 50000	33%	33
More than Rs. 50000	24%	24
Type of Family		
Joint Family	42%	42
Nuclear Family	54%	54
Extended Family	4%	4

***Source*:** Compiled from primary survey data

The demographic analysis of policyholders provides important insights into policyholder characteristics and the potential implications for satisfaction with health insurance claim settlements in Table 1. Men outweigh women (68% to 32%). The dominant age group is 25-35 (60%), followed by 36-45 (26%). This shows a greater emphasis on health insurance among young individuals. Married people (87%) are much more likely to have insurance than unmarried people (13%). Higher education appears to correspond with insurance, with graduates (63%) constituting the largest group. Salaried employees (64%) are the most common policyholders, followed by non-workers (15%). The income distribution varies, with the Rs. 25,000-Rs. 50,000 monthly group accounting for the highest share (33%). Nuclear families (54%) are the most prevalent, followed by combined families (42%). These demographics offer vital insights into policyholder behavior.

9. Reliability test

Table 2: Reliability Test

Reliability Statistic	
Cronbach's Alpha	N of Items
.883	20

Cronbach's Alpha reliability analysis of the survey instrument results in a coefficient of 0.883 (Table 2) versus a standardized 0.60. Strong internal consistency among the 20 assessed items is indicated by this high result, which supports the validity of the data that was gathered.

Table 3: List of Variables

Sl. No	Variables	Codes
1	Claim application process	CPT1
2	Claim settlement period	CPT2
3	Time taken to Acknowledge the claim, Process the claim and Disburse the claim amount	CPT3
4	Formalities in claim settlement	CPT4
5	Claim settlement terms and conditions	CPT5
6	Cooperation of insurance executives	IEC1
7	Knowledge of insurance executive in claim settlement	IEC2
8	Clarity about the information provided about the claim process	IEC3
9	Behavior of insurance executives	IEC4
10	Helpfulness and responsiveness of the customer service	IEC5
11	Insurer communication during and claim settlement process	CSE1
12	Claim fully settled	CSE2
13	Satisfaction with Previous claim settlement	CSE3
14	Satisfaction with Current claim settlement	CSE4
15	TPA's support and concern in claim settlement	CSE5
16	Hospital admission procedures	HMP1
17	Provision of room's allotment	HMP2
18	Medical expenses/Charges covered	HMP3
19	List of Non-Network Hospitals	HMP4
20	Reimbursement Facility	HMP5

***Source*:** Compiled by Authors from Various literatures.

10. Hypothesis Testing

H_{O2}: There is no significant association between Claim Settlement Factors and overall satisfaction of policyholders with the health insurance claim settlement.

Table 4: Chi-Square Test

Sl. No	Claim Settlement Factors	Chi-Square	Degree of Freedom	P-Value	Accept or Reject (Ho1)
1	Claim Process and Timelines (CPT)	18.722	10	.044	Rejected
2	Insurance Executive and Customer Service (IEC)	20.046	9	.018	Rejected
3	Hospital and Medical Procedures (HMP)	14.865	10	.137	Accepted
4	Claim Settlement Experience (CSE)	13.148	11	.284	Accepted

***Source*:** Primary Survey and Calculated by Authors using SPSS 25.

11. Results and Discussion

The relationship between claim settlement parameters and overall policyholder satisfaction with health insurance claim settlement was examined in Table 4. Four factors were taken into account in the analysis. Specifically, Hospital and Medical Procedures (HMP), Insurance Executive and Customer Service (IEC), Claim Process and Timelines (CPT), and Claim Settlement Experience (CSE).

- **Claim Process and Timelines (CPT):** A p-value of 0.044 was obtained with a chi-square value of 18.722 with 10 degrees of freedom. Overall satisfaction may be correlated with the claim procedure and timeliness, according to this statistically significant conclusion (p-value < 0.05).
- **Insurance Executive and Customer Service (IEC):** A p-value of 0.018 was obtained from the chi-square value of 20.046 with 9 degrees of freedom for IEC. As with CPT, a significant correlation between the interaction between the insurance executive and the customer service representative and overall satisfaction is shown by a p-value less than 0.05.
- **Hospital and Medical Procedures (HMP):** 14.865 with 10 degrees of freedom was the result of the chi-square test for HMP. The related p-value was higher than 0.05, at 0.137. This implies that there is no meaningful correlation between hospital and medical procedure and overall satisfaction, indicating that the null hypothesis (HO) is not rejected.
- **Claim Settlement Experience (CSE):** With 11 degrees of freedom, the CSE chi-square value was 13.148, yielding a p-value of 0.284. We are unable to reject the null hypothesis because the p-value is greater than 0.05, suggesting that there is no meaningful correlation between the experience of claim settlement and overall satisfaction.

12. Findings

The findings show that policyholder satisfaction with health insurance claim settlement is substantially correlated with the claim procedure and timeliness (CPT) as well as the insurance executive and customer service (IEC). This implies that prompt communication, effective handling of claims, and satisfying encounters with customer care agents all have a big impact on customers' level of happiness. The results, however, do not demonstrate a statistically significant correlation between overall satisfaction and hospital and medical procedures (HMP) or claim settlement experience (CSE). The subjectivity of claim settlement experience or the insurance company's limited control over hospitals and medical procedures could be the cause of this.

13. Suggestions

1. **Simplify claim procedures and timelines:** To reduce processing time and delays, put in place clear and effective procedures.
2. **Improve communication with customers:** To ensure that reps are helpful, informed, and professional during the claim settlement process, provide them with training.
3. **Boost communication:** Inform policyholders at every stage of the procedure and give them concise, timely information on the status of their claims.
4. **Take into account providing rewards for satisfying claim experiences:** To promote loyalty, give policyholders rewards for a seamless claim settlement process.

13. Conclusion

The results of this study showed that policyholder satisfaction with health insurance claim settlement is highly influenced by the effectiveness of the claim procedure, prompt communication, and positive interactions with customer service. Hospital procedures and other elements that are not under the insurers' direct control, however, appear to have less of an impact.

14. Competing Interest: The authors declare that they have no competing of interest.

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