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A STUDY ON PROBLEM AND CHALLENGES FACED BY PEOPLE THROUGH HEALTH INSURANCE COMPANIES IN INDIA

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Abstract

Medical insurance is crucial, especially considering the rising expenses of healthcare services in India. As demonstrated by growing healthcare costs, diverse socioeconomic backgrounds, and evolving healthcare systems, medical insurance is an imperative necessity. This study aims to determine the Problems and challenges people face through health insurance companies. The technique used in this study is the Wilcoxon one-sample signed rank test. The findings of the study indicated Rigid procedure of claim settlement, delaying in payment to hospital, Delay in payment of claims, Complex terms in documentation, Billing errors, Coverage disputes and High Co-pay are high problems. Whereas, Delaying in operation in providing services and Lack of 24x7 support are seen to be low problems. Further studies can be conducted using exploratory factor analysis.

Keywords: *Health Insurance, Wilcoxon one-sample signed rank test, Mediclaim Insurance.*

Introduction:

The insurance sector transfers risk from a person or business to an insurance company, protecting the assets of its policyholders. They invest the premiums insurance firms get in exchange for this service as financial intermediaries. The size of an insurance business is often determined by subtracting the sums paid for reinsurance from the premium income, or net premiums issued. Thus, the insurance sector offers defence against monetary losses brought on by various risks. Individuals and businesses can get insurance policies that provide payment for losses resulting from automobile accidents, property theft, fire and storm damage, medical costs, and lost income due to disability or death (Brown & Finkelstein, 2008; Costa-Font, Courbage, & Swartz, 2015). Insurance providers, agencies, and brokerages comprise most of the insurance sector. Large businesses that offer insurance are often considered insurance carriers. Insurance agencies sell insurance policies on behalf of the carriers. Many of these establishments are independent and so free to market the policies of several insurance carriers, even if some are directly connected to one insurer and exclusively offer that carrier's policies. Insurance companies take on the risk connected to policies and annuities and designate premiums that must be paid for the policies. The carrier specifies in the policy the duration and terms of the contract, the specific losses for which it will offer compensation, and the amount that will be granted (Costa-Font, 2010; Fuino & Wagner, 2018). Insurance companies' money in premiums is used to accumulate a portfolio of cash and real estate that generates revenue, which is then available to satisfy any future claims. They can compensate policyholders for their losses as a result. The two primary types of

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insurance providers are reinsurance and direct insurance. Direct carriers handle the original underwriting of insurance policies, whereas reinsurance carriers assume all or a portion of the risk related to the existing insurance policies first underwritten by other insurance carriers. (Sloan & Norton, 1997; Proctor, 2000).

Insurance that covers medical costs is known as health insurance. Occasionally, it is used more generally to refer to insurance that pays for long-term care requirements, nursing homes, or custodial care. Commercial insurance firms offer them or through a social insurance programme supported by the government. Individual customers or groups of consumers may acquire it. In each scenario, the insured people or groups pay taxes or premiums in an effort to guard against unforeseen or excessive medical costs. Government-funded social assistance programs may also offer comparable benefits for medical costs. Employers bear the lion's share of the rising expense of health insurance. (Subhashis 2022). Medicare is health insurance for anyone who is 65 years of age or older. The increasing cost of health insurance is becoming a major issue in today's world. Everybody has the right to get quality medical care. In actuality, health insurance is a must for everyone. However, in addition to the rising expenses of medical treatment, hospital stays, and health maintenance, providers also have to contend with the ongoing challenge of providing excellent coverage. With health insurance plans, policyholders may safeguard their families, themselves, and receive coverage for unexpected illnesses, surgeries, accidents, and other events. In the Indian health insurance market, health insurers encounter a number of problems and challenges. One of the difficulties is meeting the needs of the sizable untapped market in India by creating customer-focused goods and services (Yadav, et al. 2022). Another difficulty is getting commercial health insurance to coincide with universal health care, which necessitates resolving important problems in the insurance market's supply and demand sides (Hasna, et al. 2022). For health insurers, financial reporting and audit provide unique difficulties as well, such as creating supervisory financial reports and guaranteeing adherence to accounting standards (Maia, 2019). Important issues in India's governmental and private insurance systems include oversight, administration, data collection, and monitoring (Partha, et al.). For the health insurance business in India to flourish successfully, challenges with distribution and marketing of health insurance products also need to be solved (Manoj, 2020).

It is extremely important to examine the problems and challenges people have while interacting with health insurance providers. The obstacles individuals face in obtaining healthcare, such exorbitant rates, intricate policies, denials of claims, and restricted coverage, are illuminated. Comprehending these problems facilitates the identification of potential avenues for healthcare system enhancement, with the goal of augmenting accessibility, affordability, and quality of treatment for every individual. Policymakers, insurers, and healthcare providers may use the findings to help them create solutions that tackle these issues, which will eventually enhance the population's overall experience with healthcare.

Review of Literature:

1. **Seema, Surendran. (2023).** This research aimed to evaluate the efficacy of health insurance schemes offered by the government to low-income persons in India's

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unorganised sector. The research revealed that socioeconomic limitations, gender norms, and the unequal distribution of healthcare resources continue to pose obstacles to getting adequate treatment, even in the face of the attempt to extend health coverage to this group. The government's attempts to close this gap through the implementation of different health insurance measures were emphasized in the report, but it also brought attention to the continued difficulty of setting up and effectively running health insurance programmes, particularly in rural regions.

2. **Udhaya, K. et al. (2023).** The purpose of this study was to evaluate how satisfied and how well-informed health insurance subscribers were about their plans, specifically in the Indian district of Sivagangai. The results showed that a sizable percentage of participants only had a cursory understanding of health insurance plans. In spite of this, most people said they were happy with their health insurance. This demonstrates how strong health insurance policies may reduce stress associated with medical costs during crises, freeing policyholders to concentrate on their treatment rather than worrying about money.

3. **Mayanka, Ambade., et al. (2023).** This study aimed to give an updated evaluation of health insurance coverage at the district level in India, which is essential in order to lower high out-of-pocket medical expenses successfully. The results showed that just 25% of Indian households had at least one member with insurance, and significant regional differences underlined the necessity for significant expansion initiatives. “Employer-provided insurance accounted for 13.2% of coverage, private purchase accounted for 3.3%, national schemes for 15.5%, state health schemes for 47.1%, and other schemes for 25.6%.” Considerable differences were found between “states, districts, and clusters,” which accounted for 30.5%, 2.7%, and 9.5% of the variation in coverage, respectively. “Size, gender, marital status, and head education level of the household” all had a minor impact on insurance coverage. Targeted interventions are required to promote health insurance accessibility and equity across various areas of India, since over 60% of households lacked coverage despite a growth in the population eligible for coverage.

4. **Subhashis, Dey. (2022).** The study aimed to evaluate how different health insurance policy types were perceived and affected people's lives in India's vibrant and fiercely competitive financial sector. Most respondents said they were happy with the life insurance they already had and had no desire to get more. Because of doubts about the durability and dependability of private enterprises, faith in the public sector's Life Insurance Corporation (LIC) persisted despite the rise of private insurers. little knowledge made it difficult for foreign insurance companies to be recognized, and little knowledge of various agents made people dependent only on their own agents for information. Some believed that the details of their coverage needed to be clarified, and many agreed that life insurance was important, but felt that the returns should be higher.

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5. **Puja, Roshani., et al. (2022).** The study's objectives were to determine the degree of consumer knowledge about health insurance in India and the factors influencing the decisions consumers make about their policies. The results showed that customers were knowledgeable about different types of insurance. Furthermore, people's decisions to purchase and hold onto insurance plans were greatly impacted by elements like the advantages and features of the policies. The study emphasized how important these factors are in influencing consumers' choices of health insurance plans.

6. **Poonam, Rani., Payal, Chauhan. (2022).** This study examined the development of health insurance in India, emphasizing how its upfront premium payment system helps to provide access to high-quality medical treatment. The Ministry of Health recommended looking into risk pooling plans to lessen the burden on the poor after the report highlighted greater healthcare expenditures in the private sector. Drawing upon secondary data from WHO, IRDA, research, and review articles, the report underscored the unexplored potential of the Indian health insurance market, namely among the middle-class population, offering significant prospects for industry expansion and advancement.

Objectives of the Study:

1. To evaluate the problems and challenges of people through health insurance companies.

2. To give suggestive measures towards eradication of these problems and challenges.

Hypothesis:

H_0: The problems and challenges by people through health insurance companies is insignificant (Median = 3)

H_1: The problems and challenges by people through health insurance companies is significant (Median $\neq$ 3)

Research Methodology:

A descriptive research design is used for the current study. The sample size selected for the survey is 150 railway commuters in Mumbai Region. The sampling technique used for the present research is non-probability purposive sampling. Both primary and secondary data collection sources have been used. One-sample Wilcoxon signed ranked test has been used using SPSS software.

Variables	Category	Frequency	Percentage
Gender	Male	87	58.00
	Female	63	42.00
Age	18-25	37	24.67
	26-35	49	32.66

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	36-45	**37**	**24.67**
	46 and above	**24**	**16.00**
How long have you been covered by health insurance?	**Less than 1 year**	**73**	**48.67**
	1-3 years	**45**	**30.00**
	3-5 years	**19**	**12.67**
	5 -10 years	**9**	**6.00**
	10 years and above	**4**	**2.66**

The gathered information displays the demographic distribution of the surveyed Mumbai Region train commuters. Of all the participants, 87 individuals identified as male, making up 58.00% of the sample, while 63 individuals identified as female, making up 42.00%. Regarding age distribution, the largest percentage of respondents (49, or 32.66% of the sample) are in the 26–35 age range. 73 people (48.67%), or almost half, said they had had health insurance for less than a year, which suggests that a sizable percentage of them were relatively new customers. 45 respondents (30.00%), a sizable but smaller proportion, stated that their coverage lasted onedaily Furthermore, 19 individuals (12.67%) reported having coverage for three to five years, indicating a downward tendency in this group of intermediate length. In addition, a tiny percentage of respondents—9 (6.00%) and 4 (2.66%), respectively—reported having health insurance for five to ten years or longer. This suggests that a smaller percentage of respondents had longer-term coverage.

Data Analysis and Interpretation:

Table No: 1 Summary table of One-sample Wilcoxon signed ranked test

Problem and challenges faced by people through health insurance companies	Null hypothesis	Observed Median	P – value	Results
Rigid procedure of claim settlement	The median **Rigid procedure of claim settlement** equals 3	**4**	**0.000**	**Rejected (High problem)**
Delaying in payment to hospital	The median of **Delaying in payment to hospital** equals 3	**4**	**0.000**	**Rejected (High problem)**

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Delaying in operation in providing services	The median of **Delaying in operation in providing services** equals 3	**3**	**0.323**	**Accepted (low problem)**
Delay in payment of claims	The median of **Delay in payment of claims** equals 3	**4**	**0.000**	**Rejected (High problem)**
Complex terms in documentation	The median of **Complex terms In documentation** equals 3	**4**	**0.000**	**Rejected (High problem)**
Billing errors	The median of **Billing errors** equals 3	**4**	**0.213**	**Rejected (High problem)**
Coverage disputes	The median of **Coverage disputes** equals 3	**4**	**0.000**	**Rejected (High problem)**
Lack of 24x7 support	The median of **Lack of 24x7 support** equals 3	**3**	**0.350**	**Accepted (low problem)**
High Co-pay	The median of **High commission charges** equals 3	**4**	**0.000**	**Rejected (high problem)**

Non - parametric one-sample Wilcoxon signed ranked test is applied to evaluate the Problem and challenges faced by people through health insurance companies. It is seen that p-value < 0.05, Rigid procedure of claim settlement, delaying in payment to hospital, Delay in payment of claims, Complex terms in documentation, Billing errors, Coverage disputes and High Co-pay are high problems. It is was further seen that p-value > 0.05, Delaying in operation in providing services and Lack of 24x7 support and were seen to be low problems.

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Conclusion:

The results have revealed several noteworthy obstacles that people with health insurance must overcome. Concerns about rigid procedures of claim settlement, delayed payments to hospitals, delays in payment of claims, complex documentation terms, billing errors, coverage disputes, and high co-payments are among the most common and significant issues that people who deal with health insurance companies face, according to the statistical analysis. On the other hand, suggested that delays in operation in providing services and the lack of 24x7 support were viewed as less significant issues than the previously described difficulties. The health insurance problems that have been uncovered have a substantial impact on people and are indicative of systemic problems that may hinder timely and efficient access to healthcare. Problems pertaining to late payments, intricate paperwork, and disagreements over insurance coverage obstruct access to essential medical care, which may jeopardise people's health results.

Recommendations:

- **Streamline Claim Settlement Procedures:** Guarantee prompt payment to policyholders and healthcare providers, streamline and accelerate the claim settlement procedure.
- **Timely paid:** Take action to guarantee that hospitals and other healthcare institutions get paid on schedule to prevent delays in the delivery of services.
- **Simplify Documentation:** Improve policyholder knowledge and openness about coverage terms and conditions, and use clear, succinct wording in the policy documentation.
- **Billing Error Mitigation:** Invest in systems or technologies that can assist in reducing billing errors can help reduce disputes and inconsistencies in medical bills. This is known as "billing error mitigation."
- **Evaluate Co-payment arrangements:** Reduce the cost of healthcare for policyholders; co-payment arrangements may need to be revised.
- **Enhance Service Delivery:** Respond to issues with operational delays and provide round-the-clock assistance to make sure policyholders have the best possible service experience.
- **Invest in Customer Support:** Upgrade customer service and support systems to give policyholders quick help and direction as they navigate their coverage and claims.
- **Continuous Improvement:** Make sure insurance policies and processes are in the best interests of policyholders, evaluate and modify them regularly in response to feedback and changing healthcare demands.

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Health insurance firms may greatly improve the overall experience for policyholders, improve access to high-quality healthcare, and boost the effectiveness of the insurance system by tackling these issues and putting the required changes into place.

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