"A STUDY ON CUSTOMERS' PERCEPTION TOWARDS THE PERFORMANCE OF SELECT HEALTH INSURANCE COMPANIES"

Author:

[1]**Dr.N.L.Vijaya**, [1]Assistant Professor, [1]Department of Commerce, [1]Government College for Women, [1]Kolar – 563101, India.

[2]**B.Shamala,** [2]Assistant Professor, [2]Department of Economics, [2]Government First Grade college, [2]Vijayanagara, Bangalore, India.

ABSTRACT

A plan that covers or shares the expenses associated with health care can be described as health insurance. These plans fall into commercial health insurance, which is provided by government, private and stand-alone health insurance companies. Health insurance in India typically pays for only inpatient hospitalization and for treatment at hospitals in India. Outpatient services are not payable under health policies in India. The first health policy in India was Mediclaim Policy. In 2000, the Government of India liberalized insurance and allowed private players into the insurance sector. The advent of private insurers in India saw the introduction of many innovative products like family floater plans, critical illness plans, hospital cash and top-up policies. The study focused on analyzing the perception among respondents about the performance of select Health insurance companies.

***Index Terms*: Health insurance, premium, agent, claim, dependent, renewal.**

I INTRODUCTION

The new economic policy was being followed by the Government of India since 1991. With setting up the Insurance Regulatory and Development Authority of India (IRDA) in 1999, the concept for privatization and liberalization of insurance sector in the country had been reaping. Health insurance, which was nothing and underdeveloped, have been developed a lot in its fundamentals, product innovation, premium contribution and management strategies after liberalization.

A health insurance policy is a contract between the insurance company and the policyholder. It is a product that covers expenses related to medication and surgery of an insured which could be an individual, family or a group of people. It is an arrangement where an individual, family or a group purchase health care coverage in advance by payment of a fee called as premium.

There are mainly 3 types of health insurance covers provided by insurance companies in India, which are as follows:

1. **Individual Mediclaim Policy** : It is a policy in which each member is covered for a separate sum insured, yet premium is payable in single amount but it is costlier than floater policy.

2. **Family Floater Policy:** In family floater policy, there is a single sum insured, which can be used by each covered member any number of time but up to the maximum limit of sum insured. The family floater plan's premium is less than individual policies.

3. **Unit Linked Health Insurance Plan**: In market there are some health insurance plans which give security at the time of medical emergency as well as some market returns as per market trend and companies rule known as unit linked health insurance plan.

II HEALTH INSURANCE GLOSSARY:

1. **IRDA** - "Insurance Regulatory and Development Authority" established in 1999 under an act of Parliament, is regulator of the insurance industry in India. Its mission is to protect interest of investors and to promote the insurance industry.
2. **Policy –** is a contract document which has been done between insurers and insured. The policy is duly stamped and explains the benefits and features provided to insured by insurer under the plan he has chosen.
3. **Agent** – is a person or company who is authorized by IRDA by giving license to sell insurance products of one or more insurance company. In return he gets commission from these companies.
4. **Claim** – It is a sum which has to be reimbursed to the insured by an insurer, as per the norms of policy. The claim incurred because of treatment taken by insured for covered disease.
5. **Insurance** – It contains what they covered under the policy and what is not, it describes the benefits and coverage of a policy contract.
6. **Premium** - On yearly/quarterly/six monthly basis an insured has to pay a sum to his insurer as a cost of insurance, is known as premium.
7. **Renewal** – Generally all health insurance policies have term of one year. If customer wants to continue the policy then he can get renewed it with the company by paying renewal premium before expiry date.

8. **Cashless Claim** – It is the facility, available only in any network hospital, where an insured after having discharged need not to pay cost of treatment to the hospital, such treatment cost is paid by insurer/TPA directly to the hospital.
9. **Reimbursement** – Where an Insured takes treatment in non-network hospital he has to pay the bills, and submit it to the insured/TPA then he get back his money from the company. This is known as reimbursement.
10. **Coverage Amount** – It is also known as sum insured. A company is responsible to pay a claim amount up to the limit of sum insured at the time of claim arises.
11. **Pre-existing Disease** - A disease which is already exist in a person is known as preexisting disease.
12. **Third Party Administrator** (**TPA**) – Some companies hire intermediaries to provide services to the customers known as TPA. TPAs handle various tasks like customer data and claim data management, claim settlement, cashless facilities etc.
13. **Cumulative Bonus** – For each claim free year customer get some increment in his sum insured from the company known as cumulative bonus. It generally ranges from 5% to 10% and for 5 to 10 years.
14. **Exclusions** – The diseases which are not cover under the policy known as permanent exclusion, whereas some diseases are coverable only after some waiting period is known as exclusions with waiting period.
15. **Deductible** – Where at the time of claim as per the policy rule insured pay some percentage of claim amounts by his own is known as deductibles.
16. **Network Hospital** – Insurance companies for giving facility of cashless claim, do tie-up with the hospitals and nursing home, which are known as network hospitals.
17. **No Claim Discount** – If a customer did not file any claim in previous year, he receive No Claim Discount on the renewal premium, which generally ranges from 5% to 25% on basic Premium for every claim free year.
18. **Dependents** - Spouse and/or unmarried children (whether natural, adopted or step) of an insured are known as dependent.

III OBJECTIVES OF THE STUDY

1. To comprehend the concept of health insurance.
2. To analyse the customers' perception towards performance of select health insurance companies.

IV RESEARCH METHODOLOGY

The study is based on primary data.The structured questionnaire administered to the respondents was aimed at eliciting the most essential information and data relating to the objectives. A scrutiny of all the response was done. Data was further tabulated on different characteristics relating to the study. Data was analyzed using a statistical technique of percentages. Charts/ diagram are shown wherever it was felt relevant to understand the clear breakup of the concept.

V SAMPLING METHOD

Convenient sampling method was instituted to select the Health insurance companies. Health insurance companies selected for the study was; ICICI Lombard, Bajaj Alliance, Star Allied, New India Assurance. Simple random sampling method was adopted to select the respondents.

VI SAMPLE SIZE

FIFTY respondents (customers of selected health insurance companies) were chosen for the study, 20 respondents from ICICI Lombard, 10 from Bajaj alliance, 10 from Stat allied and 10 respondents from New India assurance.

VII ANALYSIS AND INTERPRETATION OF THE DATA

Table-1: The insurance companies where respondents avail health insurance policy.

Name of the company	No. of respondents	Percentage
ICICI Lombard	20	40
Bajaj Alliance	10	20
Star Allied	10	20
New India Assurance	10	20
Total	50	100

Table-1 describes that, out of 50 respondents , 40% of the respondents has a Health Insurance Policy in ICICI Lombard, 20% of the respondents has a Health Insurance Policy in Bajaj Alliance, 20% of the respondents has a Health Insurance Policy in Star Allied and remaining 20% of the respondents has a Health Insurance Policy in New India Assurance

Majority of the respondents avail health insurance policy from ICICI Lombard.

Table-2: Annual Health insurance premium paid by the respondents

	INSURANCE COMPANIES			
PREMIUM	ICICI Lombard	Bajaj Alliance	Star Allied	New India Assurance
1000- 5000	12	07	06	08
5001- 10000	04	02	01	01
10001 – 15000	02	01	02	01
ABOVE 15000	02	0	01	00
Total Respondents	20	10	10	10

Table-2: depicts that comparative health insurance premium paid by the customers;

- A majority respondent from ICICI Lombard pays the premium from Rs.1000 to Rs.5000 per annum.
- Majority respondents from Bajaj Alliance pay the premium from Rs.1000 to Rs.5000 per annum.
- Majority respondents from Star Allied pays the premium from Rs.1000 to Rs.5000 per annum.
- Majority respondents from New India Assurance pay the premium from Rs.1000 to Rs.5000 per annum.

Majority respondents from all the select companies pay the premium from Rs.1000 to Rs.5000 per annum.

Table-3: The reasons for the purchase of health insurance plan.

Option	No. of Respondents	Percentage
Health Expenses Recover	30	60
Tax Benefits	10	20
Recover Future Uncertainty	10	20
TOTAL	50	100

Table-3 Describes that majority of the Respondents purchase health insurance plan to recover the health expenses

Table-4: Factors important to respondents in opting health insurance

Factors	No. of Respondents	Percentage
Service Of Insurer	05	10
Network Coverage Of Hospital	10	20
Premium Amount	15	30
Coverage Amount	10	20
Coverage Of Diseases	05	10
Number Of Claims Allowed Per Year	05	10
Total	50	100

Table-4 Describes that the important factors to respondents in opting health insurance were;

- Premium amount (30%)
- Network coverage of hospital (20%)
- Coverage amount (20%)
- Service of insurer (10%)
- Coverage of diseases (10%)
- Number of claims allowed per year (10%)

Table-5: The level of secure thinking of respondents on current health insurance policy covered.

Thinking	No. of respondents	Percentage
Definitely Well - Covered	35	70
Probably Well- Covered	05	10
Not Well- Covered	07	14
Probably Not Well- Covered	03	06
Total	50	100

Table-5 portrays that 70% of the respondents their Current Health Insurance Policy is Definitely well – covered,

Table-6: The most important aspect that every health insurance plan should cover hospital care.

Option	No. of respondents	Percentage
Preventive Care	15	30
Maternity	10	20
Health Specialists	15	30
Choice Of Doctors	10	20
Total	50	100

30% of the respondents says that most important aspect that every health insurance plan should cover Hospital care is preventive care and Health specialists.

Table-7: Respondents opinion on various factors of health insurance companies.

FACTORS	OPINION	HEALTH INSURANCE COMPANIES			
		ICICI Lombard	Bajaj Alliance	Star Allied	New India Assurance
Customer service level of selected health insurance companies.	Excellent	10	06	05	06
	Good	05	03	04	03
	Bad	03	01	00	01
	Poor	02	0	01	0
	Total Respondents	20	10	10	10
Claim refund level by selected health insurance companies	Very Much Satisfied	10	07	06	05
	Satisfied	10	02	02	04
	Not Much Satisfied	00	01	01	01
	Dissatisfied	00	0	01	00
	Total Respondents	20	10	10	10
Complaint addressable system level by selected health insurance companies	Very Much Satisfied	12	05	07	07
	Satisfied	05	04	01	02
	Not Much Satisfied	02	01	01	01
	Dissatisfied	01	00	01	0
	Total Respondents	20	10	10	10
Third party administrator level by selected health insurance companies	Very Much Satisfied	15	05	06	03
	Satisfied	03	03	02	05
	Not Much Satisfied	02	01	00	01
	Dissatisfied	00	01	02	01
	Total Respondents	20	10	10	10

Chart-1: Respondents opinion on various factors of Health Insurance companies.

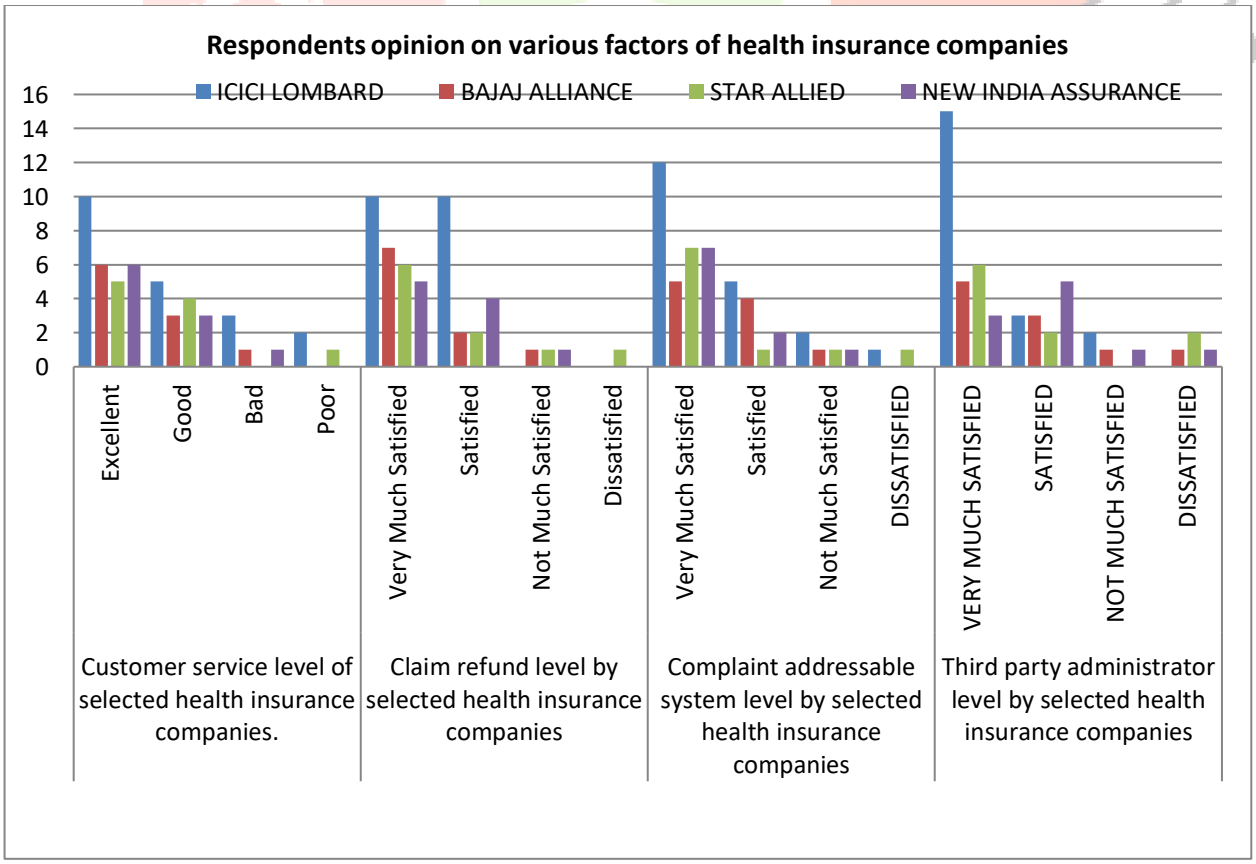

Table -7 and Chart -1 explains that;

- Majority of the respondents i.e, 10 in ICICI Lombard, 6 in Bajaj alliance and New India Assurance and Majority of 5 respondents in Star allied opined that the customer service provided is excellent.
- ICICI Lombard: 10 respondents, Bajaj Alliance: 7 respondents, Star Allied: 6 respondents and New India Assurance: 05 respondents are very much satisfied with the Claims refund
- Majority of the respondents from all the four selected health insurance companies are satisfied with the Complain Addressable System
- Majority of the respondents from all the four selected health insurance companies are satisfied with the with Role of TPA[Third Party Administrator]

VIII CONCLUSION

The study found that, the perception of the respondents were in favour of the select health insurance companies, they should restructure or reorganize their health insurance business. With the liberalization, privatization and globalization of the economy, the market place has become highly competitive. In this competitive world, quality of the service rendered is of paramount importance not only to grow but also to ensure sustainability and future development of the health insurance programmes. The insurance industry in particular is bound to grow by leaps and bounds because of rise in standard of living and health consciousness of the people. Thus the management of insurance sector, backed by IRDA regulations, the insurance ombudsman would contribute to not only better management of the insurance and Third Party Administrator (TPA) functioning but enable in achieving a competitive advantage for the all the stakeholders in the health sector. Thus, there is a need for intensive effort by all stakeholders of all Health Insurance Industry to collaborate and pave the road ahead for the Indian Health Industry. Moreover, due to fast increasing competition their position is gradually taken over by the competitors. So, in order to stay in health insurance business they have to comply with the strategies adopted.

BIBLIOGRAPHY:

1. IRDA Annual reports.
2. Ahuja, R. Insurance: Over the Transition. Economic and Political Weekly: 2004;39(32):3569-71.
3. Ahuja, R. Health Insurance for the Poor in India: An analytical Study. Indian Council for Research on International Economic Relations. 2005.
4. Amponsah E.N., Hiemenz U. Determinants of Consumer Satisfaction of Health Care in Ghana: Does Choice of Health Care Provider Matter?. Global Journal of Health Science, 2009;1 (2).
5. Anand S., Ravallion M. Human Development in Poor Countries: On the Role of Private Incomes and Public Services. Journal of Economic Perspectives: 1993;7(1):133-50.
6. Asoh D.A., Rivers P.A. A Research Model of HealthCare Competition and Customer Satisfaction. Health Services Management Research:2007