



International Journal of Multidisciplinary and Scientific Emerging Research (IJMSERH)

Volume 13, Issue 3, July-September 2025

Impact Factor: 9.274



Study of Customer Satisfaction Towards Health Insurance

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ABSTRACT: Health insurance plays a critical role in providing financial security and access to quality healthcare. As the demand for health coverage increases, especially in the post-pandemic era, understanding customer satisfaction has become essential for insurance companies to retain and grow their customer base. This study focuses on evaluating customer satisfaction with health insurance services, examining key factors such as policy benefits, premium affordability, claim settlement processes, customer service quality, and network hospital availability. The research is based on both primary and secondary data. Primary data was gathered using structured questionnaires administered to a diverse group of policyholders. The survey covered various satisfaction dimensions, including transparency of policy terms, ease of purchasing and renewing policies, claim experience, and responsiveness of support teams. Secondary data from industry reports and regulatory sources supported the analysis. Findings reveal that while many customers value cashless hospitalization, online services, and wide network coverage, they also express concerns about high renewal premiums, hidden clauses, and delays in claim settlements. The lack of clear communication and guidance during policy selection was a major issue, especially among senior citizens. In conclusion, this study provides insights into customer expectations and satisfaction levels, helping health insurers enhance their services. A customer-centric approach, supported by transparent and responsive service practices, is vital for long-term success in the health insurance industry.

I. INTRODUCTION

Insurance involves the sharing of losses among individuals exposed to similar risks, where the loss of an asset's value due to an event is termed as risk, and the cause of such an event—like an accident or illness—is called a peril. Premium contributions are pooled to provide financial protection. In today's world, with the rapid spread of diseases and rising health issues such as cardiovascular disease and diabetes—highlighted by experts like Dr. V Mohan and supported by studies from the Indian Council of Medical Research—health insurance is increasingly essential. India has seen a sharp rise in heart-related deaths, especially among younger populations, making medical insurance vital to safeguarding against unpredictable health emergencies. Relying solely on employer-provided group policies can be risky, especially upon retirement, resignation, or job changes, where premiums for individual policies may become unaffordable. Therefore, individuals are strongly advised to maintain personal medical insurance coverage beyond employer policies to ensure continued protection. Ultimately, satisfied customers view the value of such insurance as superior, recognizing its importance in preserving health and financial stability.

NEED FOR STUDY

With the continuous rise in healthcare costs, more individuals are turning to health insurance to safeguard themselves and their families. While both governments and private insurers are actively promoting insurance and public awareness is improving, many policyholders still face dissatisfaction. Common issues include confusion over policy terms, claim processing difficulties, inadequate customer service, and a mismatch between promised and actual coverage. These challenges can result in frustration and erode trust in insurance providers. This study seeks to understand customer perceptions of health insurance—what aspects are effective, what fall short, and what improvements are needed. By capturing real feedback from policyholders, the research aims to help insurers enhance their services, making health insurance more transparent, reliable, and customer-focused.

OBJECTIVES OF THE STUDY

1. To understand what customers expect from their health insurance providers in terms of coverage, support, and services.

2. To explore how satisfied people are with different aspects of their health insurance, such as premium costs, claim processes, network hospitals, and customer service.
3. To find out what common issues or frustrations customers face when dealing with health insurance companies.
4. To identify the gaps between what customers are promised and what they actually experience.
5. To gather suggestions and feedback directly from policyholders on how insurance companies can improve their services.
6. To compare satisfaction levels between different types of insurance providers, such as public vs. private companies, if applicable.

II. REVIEW OF LITERATURE

Rao and Ramesh (2020) discovered that digital services such as mobile apps and online claims have enhanced convenience and improved customer satisfaction, particularly among younger consumers.

Kumar and Rajasekar (2016) found that claim settlement speed and ease are the most critical factors affecting customer satisfaction in the health insurance domain.

Srivastava and Singh (2019) reported that responsiveness to complaints and quality of customer support services are key influencers of satisfaction among policyholders.

Reddy and Rani (2017) highlighted the role of agent behavior, finding that the professionalism and honesty of agents greatly affect customers' perception of insurance services.

Das and Panda (2020) stated that after-sales service, including policy updates and renewal reminders, significantly influences long-term satisfaction.

Banerjee and Saha (2016) indicated that urban customers prioritize digital service access, while rural customers value face-to-face interaction and local presence of insurers.

Choudhury and Singh (2021) revealed that family coverage options and cashless treatment facilities are crucial to customer satisfaction in group insurance plans.

Sharma and Verma (2022) investigated post-pandemic consumer behaviour and found that demand for mental health coverage and telemedicine services is growing, influencing satisfaction metrics.

SCOPE OF THE STUDY

This study aims to evaluate customer satisfaction with health insurance services by examining the key factors that influence perceptions, preferences, and satisfaction levels among policyholders. The scope includes assessing awareness and understanding of health insurance products, identifying customer expectations, and measuring satisfaction based on elements such as premium affordability, claim settlement, customer service, network hospitals, policy coverage, and transparency. It also seeks to analyze any gaps between expectations and actual experiences, gather feedback for service improvement, and compare satisfaction levels across different types of insurers, such as public and private providers. The study is limited to health insurance and does not include other insurance types or internal operational strategies. The findings are intended to help insurers enhance service quality and better meet customer needs.

III. RESEARCH METHODOLOGY

To get a clear picture of how people feel about their health insurance, this study takes a hands-on, people-focused approach. The goal is to collect honest feedback from real policyholders and understand their experiences in a straightforward and meaningful way.

RESEARCH DESIGN

This is a **descriptive study**, which means it's designed to observe and describe customer opinions, satisfaction levels, and common issues they face. Instead of testing a theory, this approach helps us better understand the current situation based on what customers actually say.

DATA COLLECTION

Information for this study is gathered using a **simple questionnaire**, which includes both **multiple-choice questions** and a few **open-ended ones** where people can freely share their thoughts. The idea is to keep it easy and comfortable for respondents to express themselves while collecting useful data.

PRIMARY SOURCES

Primary sources of data are the data which need the personal efforts of collect it and which are not readily available. Primary source of data are the other type of source through which the data was collected. The primary data are collected through structured questionnaire

SECONDARY SOURCES

Secondary sources are the other important sources through which the data was collected. These are readily available source of the data where on had need not put much effort to collected, because it is 11 already been collected and part in an elderly manner by some researched experts and special. Secondary data is collected from internet. Journals research paper.

QUESTIONNAIRE

The primary data was collected using structured questionnaire. The structured questionnaires that were framed and designed consists of • Likert 5-point scale • Multiple choice questions • Ranking question.

SAMPLING METHOD

The study uses **convenience sampling**, meaning participants are selected based on availability and willingness to respond. These are everyday people who already have a health insurance policy. The aim is to get a mix of opinions from different age groups, income levels, and backgrounds.

SAMPLE SIZE

The target is to collect responses from around **100 to 200 people**, depending on the level of participation. This number is expected to provide enough insights to understand general customer satisfaction trends.

DATA ANALYSIS

After collecting the responses, the answers will be organized and analyzed using **basic tools** like percentages, charts, and tables. This will help spot patterns in the data. For the open-ended questions, a simple **theme-based analysis** will be done to understand what issues are commonly mentioned and what suggestions people have.

SCOPE AND LIMITATIONS

This study only includes people who already have health insurance. It doesn't cover those who are uninsured or those using other kinds of insurance like life or vehicle insurance. Also, since the participants are chosen based on convenience, the results might not reflect the views of the entire population—but they will still give a useful snapshot of customer experiences.

LIMITATIONS OF THE STUDY

- Limited Sample Size: Small number of respondents may not represent the wider population.
- Geographic Restriction: Findings may not apply to other regions with different policies and standards.
- Subjective Responses: Satisfaction levels vary by individual and may be influenced by temporary emotions.
- Cross-Sectional Design: Data collected at one point in time; cannot track changes or trends over time.

IV. STATISTICAL ANALYSIS

ONE WAY ANOVA

The one-way analysis of variance (ANOVA) is used to determine whether there are any significant differences between the means of the three or more independent (unrelated) groups.

This guide will provide a brief introduction to the one-way ANOVA, including the assumptions of the test and when you should use this test.

ONE-WAY ANOVA REPORT**Hypothesis**

H_0 (Null Hypothesis): There is no significant difference in the perception of premium charges among different income groups.

H_1 (Alternative Hypothesis): There is a significant difference in the perception of premium charges among different income groups.

TABLE 4.1– ANOVA CLASSIFICATION

Source of Variation	SS (Sum of Squares)	df (Degrees of Freedom)	MS (Mean Square)	F Value	P-value
Between Groups	204.045	3	68.015	68.47	0.0000
Within Groups	59.686	60	0.995		
Total	263.731	63			

Since the p-value is less than 0.05, we reject the null hypothesis. This indicates that there is a statistically significant difference in how people from different income groups perceive the premium charges of health insurance.

Chi square

It is a statistical method used to analyse categorical data. It helps determine if there's a significant association between two or more categorical variables or if observed frequencies differ significantly from expected frequencies. In essence, it compares observed data with expected data to assess if the observed frequencies are likely due to chance or a real relationship.

CHI-SQUARE TEST RESULTS

At a 0.05 significance level, the **critical value** for $df = 1$ is **3.841**

Since **64 > 3.841**, we reject the null hypothesis

The Chi-Square value is far above the critical threshold. This clearly shows a **strong association** between ease of claiming and customer recommendation.

In simple words, when customers find the claim process easy, they are significantly more likely to recommend the insurance service. On the other hand, those who face claim difficulties do not recommend it.

FINDINGS

- A total of 50 individuals participated in the study, with 70% being male and most aged between 31 to 35 years. The majority were well-educated, married, and primarily employed in the private sector, with a balanced range of income levels.
- Out of 32 insured respondents, only 12 had filed a claim, and just 5 reported successful outcomes. Additionally, 58% found the claims process difficult, highlighting a key area for improvement by insurance providers.
- Around 75% of respondents found their insurance premium affordable, with many describing it as “cheap” or “very cheap.” However, ANOVA analysis showed that affordability perception varied significantly across income groups.

SUGGESTIONS

Simplify the Claim Process: Since customers who found the claim process easy are more likely to recommend their insurance provider, companies should focus on making the process more user-friendly.

Invest in Digital Solutions: Insurance companies should develop user-friendly mobile apps and websites that allow customers to file and track claims easily. By incorporating automation and digital documentation, insurers can reduce human errors, speed up processes, and enhance overall customer experience.

Enhance Customer Support During Claims Insurance companies should assign dedicated claim support representatives to guide policyholders through the process. Provide real-time updates and prompt communication via SMS, email, or app notifications.

Improve Transparency Companies should clearly communicate claim eligibility, documentation requirements, and settlement timelines. Transparency builds trust and reduces dissatisfaction due to misunderstandings or false expectations.

V. CONCLUSION

Though many insurance companies offer a wide range of policies tailored to different age groups and sectors, there is no standardized guideline or universal template for determining premiums and coverage. This lack of consistency often leaves policy seekers confused and overwhelmed by the varying details. To enhance transparency, insurers should publish quarterly newsletters that include claim statistics and reimbursement success rates. The study also found that faster claim settlement is a key driver of customer satisfaction and word-of-mouth recommendations. In conclusion, this research highlights several critical factors influencing satisfaction in the health insurance sector—particularly policy features, customer demographics like education, occupation, and income, and the perceived quality of the policy. Insurers aiming to stay competitive must adopt a customer-centric approach by customizing products and services to meet diverse expectations. These insights can help insurance providers improve customer experience and build long-term trust.

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International Journal of Multidisciplinary and Scientific Emerging Research (IJMSE RH)

Impact Factor: 9.274