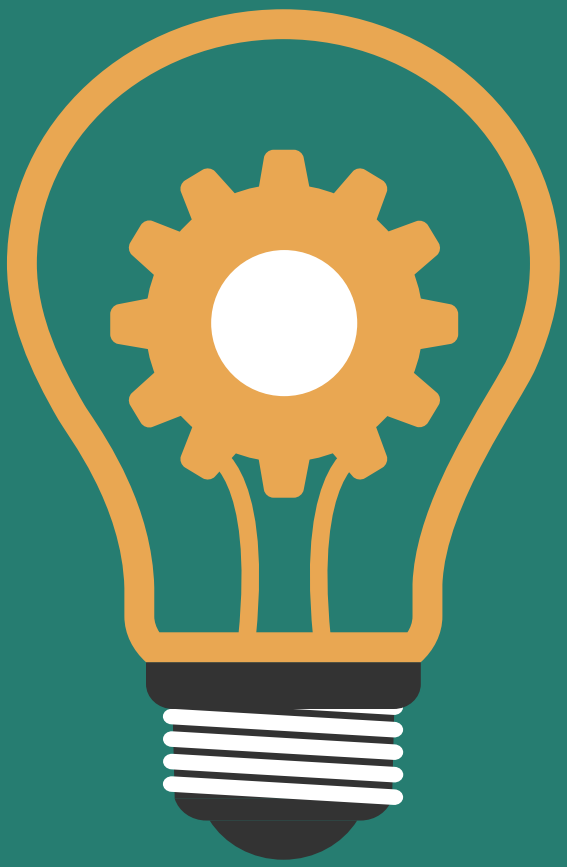


CONSUMER RESEARCH

INDIA HEALTH INSURANCE XP SURVEY - 2020

Beshak

NOTE FROM THE TEAM

Health insurance is an excellent solution with the power to solve serious financial risks for a sizeable population of our country. However, we still see individuals across demographics and educational backgrounds lacking enough confidence to choose a health insurance product. While we have always been cognizant of the gap in health insurance awareness amongst people, and the resulting challenges (some of which we are trying to solve through Beshak), we encountered another problem that made us take a pause, and notice.

When a few of us scanned the social media, and checked with our friends and family about their claims experiences, we sensed that health insurance generally, had a very negative perception. There was a lack of trust and noticeably bad word-of-mouth, specifically around claims. Intrigued by these scattered findings, we decided to dig deeper, and methodically record the gaps across consumer experience in health insurance claims processes.

We, along with our partner **Strategic Caravan** ran a survey within the Beshak community and are presenting our findings in this - India Health Insurance XP Survey - 2020.

We believe that a problem well-stated is a problem half-solved. And this survey is an attempt to objectively analyse and clearly state the extent of one such key problem.

With the India Health Insurance XP Survey 2020, we take the first-step to launch a dialogue and ignite creative minds, to see if operational innovation, technology and the right partnerships can transform this experience for the end-user, and instil trust to adopt health insurance with confidence, in the near future.

Join us, as we set out.

- Team Beshak

WHAT'S INSIDE?

Click on  to come back to this page.

UNDERSTANDING THE LANDSCAPE

Consumer experience and trust go hand in hand

Consumer experience is the cornerstone of any business in general, and the health insurance sector in particular - with thousands of families trusting that their long-term healthcare needs would be financially supported, by this simple investment. With only two touch-points - one, at policy purchase, and two, at the claim stage, a user's trust is built largely on how seamlessly the processes work and how easy the ecosystem makes it for them to purchase a policy and receive a claim. Especially - receive a claim.

It is this second leg of this journey - the health insurance claim experience, that is studied in detail through this report. The objective of this survey is to uncover definitive opportunities for the ecosystem to improve the claims experience and thereby, build trust, loyalty and confidence with every single health insurance customer.

WHY NOW?

Given two decades of privatisation of health insurance and its outstanding growth across the Indian subcontinent, there was a need to pause and take a look at how consumers view their experience interacting with this rapidly evolving industry. The onset and rise of Covid further accelerated this need exposing user challenges that need to be resolved with a sense of urgency.

In this direction, the team at Beshak has taken up this task to evaluate the ground realities of consumer satisfaction and chalk out clear actionables for insurance companies, agents and insurance representatives to improve experience and hence - credibility in this high-impact industry.

Today, most health insurance policies in the country are essentially only ‘hospitalisation insurances’, meaning they pay only when a patient gets admitted to a medical facility for treatment for at least 24 hours.

Providing financial relief in a time of need, this hospitalisation insurance cover ensures that we are able to enjoy high quality healthcare services without crumbling in the financial stress associated with it. All this, for a reasonably low yearly cost.

Major expenses covered by health insurance

Costs leading to the hospitalisation including all tests, doctor consultations etc.

Expenses incurred during the admission and treatment

Medical expenses that follow the admission period, during recovery and follow-up.

Going forward, in the Covid19 aftermath healthcare expenses are only going to rise as was seen from some astonishing media reports in the recent months.

As medical costs soar disproportionately in comparison to income growth, the need for sufficient health insurance becomes urgent, and critical to one's ability to live a high-quality life.

What did we seek to achieve through this survey?

We sought to listen to the pulse of the common man making a health insurance claim. Some of the key objectives include -

Understanding the health insurance consumer sentiment

Understanding pain-points as well as delight-points in their interaction with insurers, agents and TPAs

Empowering the insurance ecosystem through data-driven insights

WHAT STOPS PEOPLE FROM BUYING HEALTH INSURANCE?

While a part of our population is slowly opening up to the case of health insurance, a report by Statista launched in July 2020, on health insurance penetration in India put it at 35% in the year 2018. Of this, a large portion was government-sponsored insurance and the coverage was found to be grossly inadequate in a majority of cases.

So, why is a majority of the population refraining from taking health insurance policies? Here are some reasons we've heard.

6 Reasons Why I Won't Buy Health Insurance

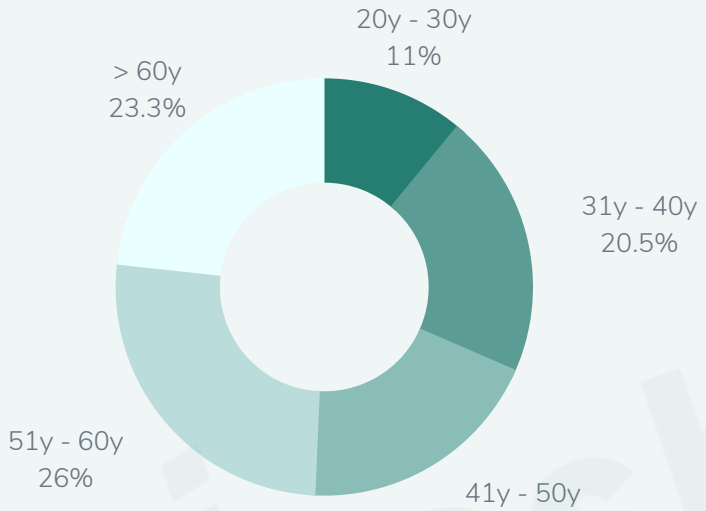
Do not need health insurance right now	Covered by my employer's insurance	Want to build a healthcare fund instead
A lot of individuals that do not invest into health insurance say that they aren't unwell today, and do not need to purchase health insurance.	Individuals still believe that having corporate health insurance is sufficient to protect themselves from the rising costs of healthcare.	Saving up money to come in handy during a healthcare crisis, is viewed as an alternative approach to purchasing health insurance
Cost is too high	**Products are too complex**	**Have limitations because of medical history**
Some consider it unaffordable to invest into health insurance	Individuals want to purchase but dropout during the research journey, as products are too complex and customizations they do not understand	These include willing buyers who cannot purchase as they are considered high-risk individuals as a result of pre-existing medical conditions

SURVEY METHODOLOGY

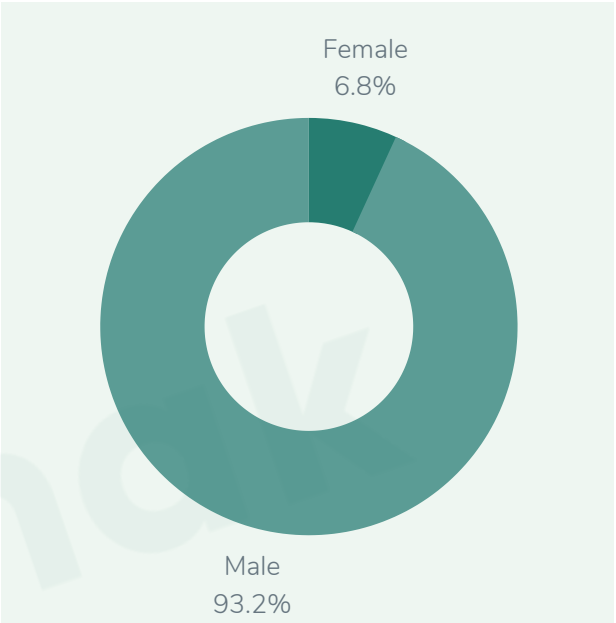
This survey was executed in association with **Strategic Caravan,** our implementation partner.

A total of 530 individuals took an online + telephonic survey and answered questions about their experience with health insurance claims in India.

Respondents profile by age groups



Respondents profile by gender

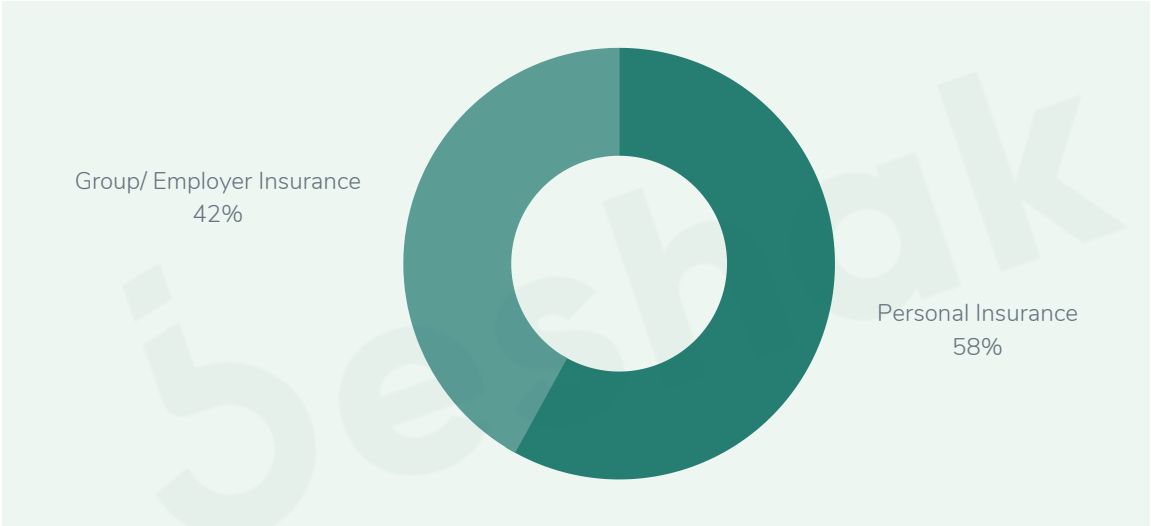


The respondents came from diverse geographies across India including locations such as Ahmedabad, Asansol, Bangalore, Bilaspur, Chandigarh, Chennai, Delhi, Noida, Dhanbad, Mumbai, Goa, Gurgaon, Hyderabad/ Secunderabad, Jamshedpur, Goa, Kolkata, Mathura, Nagpur, Pune, Patna, Ranchi, Sangli, Silvassa and Thane.

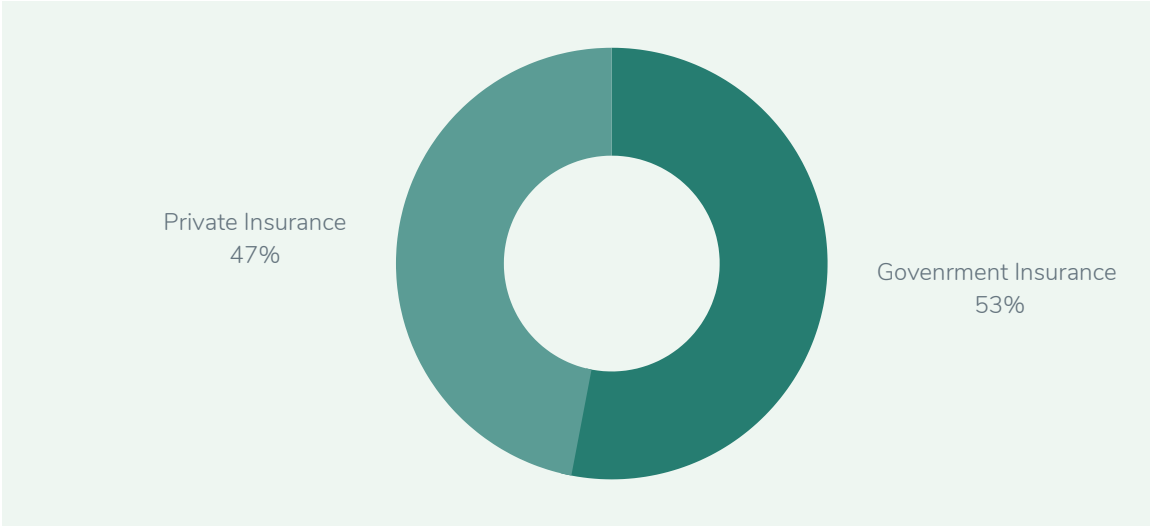
DISTRIBUTION OF RESPONDENTS BY TYPE OF INSURANCE POLICY AND COMPANY

Amongst the respondents of the survey, **58% of the claims were made on personal insurance policies**, while **42% were made on group health insurance policies**. Mostly, group insurance policies were those plans facilitated by employers, but a small fraction also were of policies from banks and other financial organizations offering group insurance schemes. Further, **53% of experience recorded was for Government-backed insurance players**, while the remaining **47% was for private insurance companies.**

What type of insurance plans did the respondents have?



Were the policies from government insurance or private players?



HOW DID INDIVIDUALS GET THEIR CLAIMS?

HOW DID INDIVIDUALS GET THEIR CLAIMS?

There are two ways in which one can get the health insurance claim amount. The first, more traditional approach is to take treatment from the hospital of choice and then submitting the claim form to the insurance company. Called the **reimbursement** process, this could be done either through the agent/ distributor who initially helps in the purchase of the policy, or a neutral third-party (TPA) who will assist the insured person in the claims process.

The more modern type of claim settlement is what is called the **cashless** settlement. In this process the patient takes treatment through one of the insurance company's empanelled list of hospitals.These hospitals have a standing agreement with the insurance company to provide treatment to all their customers on the presentation of the policy document or the cashless card. This process is simpler, and removes the element of anxiety in waiting for the claim approval, that is common in the reimbursement process.

Regardless of which process is followed, the patient/ patient's family will interact with several constituents of the insurance and healthcare ecosystem to get the claim amount delivered to the hospital. Each of these cogs on the insurance wheel, play a part to cumulatively create the insurance claims experience for the user.

So, what is their significance?

4 CONSTITUENTS OF THE HEALTH INSURANCE ECOSYSTEM

AGENT / DISTRIBUTOR

The agent/ distributor is in many cases a family friend or trusted individual who introduces and sells the insurance policy to the user. They often keep in touch with the family and send reminders before the premium due-dates, so the policy remains active and the insured person continues to enjoy the benefits without a disruption.

- Familiarity
- Personal Trust
- Open channel of communication

BRANCH OFFICE OF INSURANCE COMPANY

The branch office of the insurance company is the entity that needs to make all approvals beginning from the issue of the policy itself, to the approval of the claim amount. One can choose to interact with the branch office for their claim settlement as well, if they prefer having a direct conversation without involving a middleman.

- Approval authority
- Single POC

3 TPA / THIRD PARTY ADMINISTRATOR

They are an outsourced agency of the insurance company receiving documents from the user, verifying the authenticity of the claim and approving the claim amount to be released to the hospital's / patient's bank account. They are also responsible for identifying any fraudulent claims and rejecting them, on behalf of the insurance company.

- Document verification
- Claim approval
- Fraud detection

4 HOSPITAL INSURANCE DESK

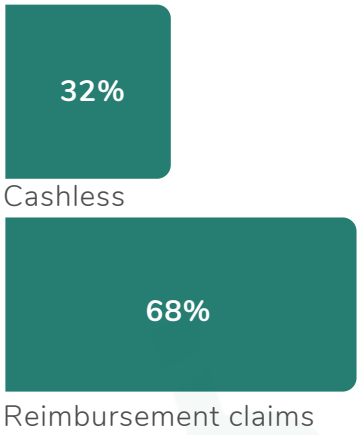
Operated by the hospital administration. It is the interface created by the hospital to facilitate cashless claims - coordinate between hospital billing, customer and TPA/Insurer.This is an extremely convenient option for the patient/ patient's family as they are available at the hospital premises

- Highly convenient
- Documentation on your behalf
- Single POC for cashless claims

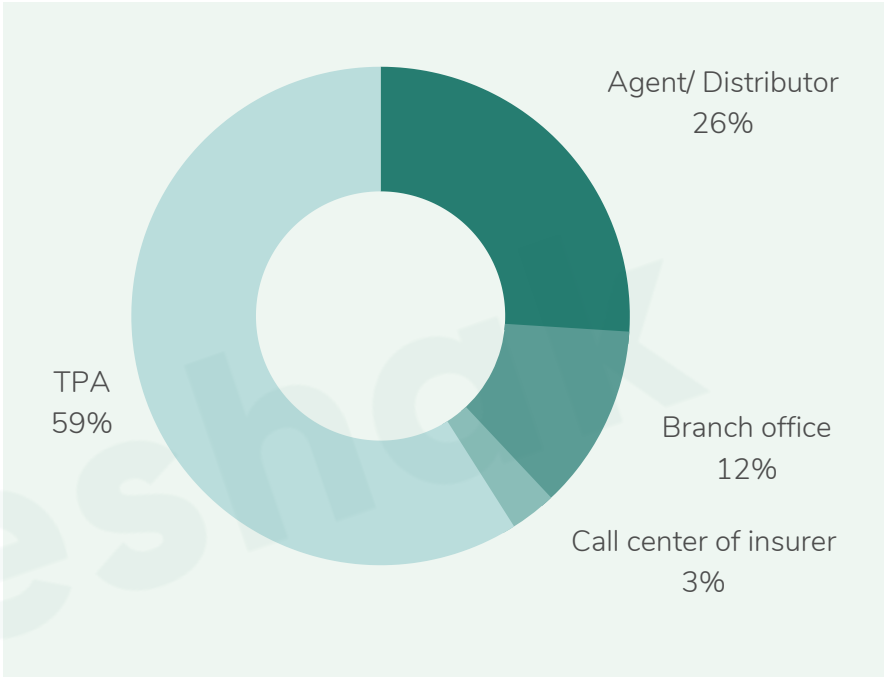
Where did you get your insurance claims serviced?

A large majority of the respondents did not need to connect with their insurance company to get their claims. Here's a view into how they got their claims.

Type of claims



Further Split of Reimbursement claims



SUPPORT AT THE TIME OF NEED

SUPPORT AT THE TIME OF NEED

Health insurance helps you and your family get the medical attention you need, when you need it - without worrying about the money. In addition to providing financial support, having insurance provides emotional relief and peace of mind, that we do not have to compromise on the quality of care we receive.

Based on the type of claim - cashless or reimbursement - you will need to go through a claim settlement process outlined by the insurer. Here's what typical cashless and reimbursement processes would constitute.

How does a cashless claim process look?

A cashless settlement has its advantages.

- The process and documentation happens through the hospital insurance desk. So, you don't have to worry about that putting your papers together.
- If pre-authorisation is approved, you will not need to make a large payment out of your pocket.
- You have a single point of contact the hospital insurance desk - to follow up for any queries.

However, not all hospitals might be on the insurer's empanelled/ networked list of hospitals. In such a case, you might need to go through a reimbursement claim.

What are the steps in a reimbursement claim?

A reimbursement process is suitable when the hospital recommended by your doctor, or preferred by your family isn't on the insurer's empaneled list of partners/ networked hospitals.

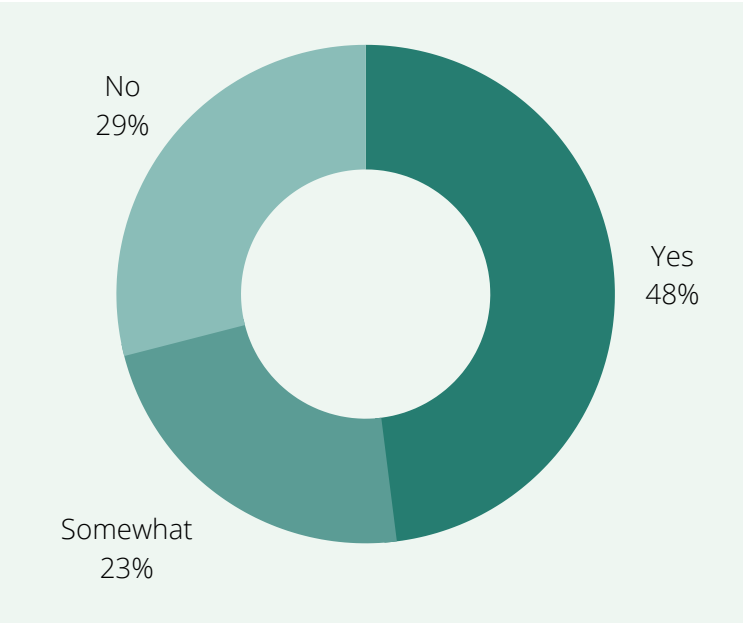
While the processes can be different, consumers need a smooth, seamless flow and ready support from the ecosystem during their insurance claims procedures. But, are they getting that peace of mind that is promised? How well are they supported by the insurance ecosystem in their time of need?

We set out to find out more.

Did you get timely support, while initiating the claims process?

Answering the question, on whether they found it easy or difficult to find support to initiate the claim, over **half the respondents (52%) reported to have faced some hiccups in getting timely support** from the insurer/ TPA in the time of need.

Timely support in claim initiation



Why does it matter?

When you make a health insurance claim, it indicates that you, or a family member is going through a difficult personal time. There is uncertainty with respect to the health condition, anxiety about the recovery, and not to mention a complete disruption of life as usual.

Investing in a health insurance policy is supposed to help you slightly reduce this anxiety - at least about the money matters. While the processes remain riddled with lengthy forms and ambiguous clauses - the onus remains on the ecosystem to provide all the support you need to get your claim as smoothly as possible, so you can focus on what matters most - the treatment, caregiving and recovery.

THE BESHAK TAKE!

How can the ecosystem help the customer?

- **Streamlining claims processes:** Every customer is entitled to a smooth claims process, and it is the insurer's responsibility to ensure that they receive it. From outlining simpler forms, digital integration and building a seamless on-ground support system for claims - it is a long way to go, but what's crucial is we begin somewhere.

- **Customer education at the policy purchase phase:** There is an urgent need to engage customers with educational content - videos, infographics, etc. when the policy is sold to them, as well as making it readily available on the insurer's website for later reference. This will help consumers understand both the policy conditions and the claims process, well before the actual event of hospitalisation.

- **Building a culture of customer-care:** Taking a customer-first approach, as opposed to today's process-first approach requires a change in the basic fabric of how the industry functions and operates. It is important to hire the right people, invest in training, and build a robust customer-care system, to ensure that users do not feel helpless and confused, at the time of the claim.

PROCESS CLARITY AND GUIDANCE

PROCESS CLARITY AND GUIDANCE

As insurance claims involve large sums of money per transaction, and the insurance company wants to ensure that all guidelines are properly adhered to and documentation is immaculate. To them, it becomes second-nature to scrutinise lengthy forms with ease, as it is part of everyday business.

Consumers on the other hand, would not have the same level of insight into the insurance process. At that juncture, it is important that they are hand-held and provided guidance, so there is no confusion in terms of what is required of them, and what they can expect to receive in return.

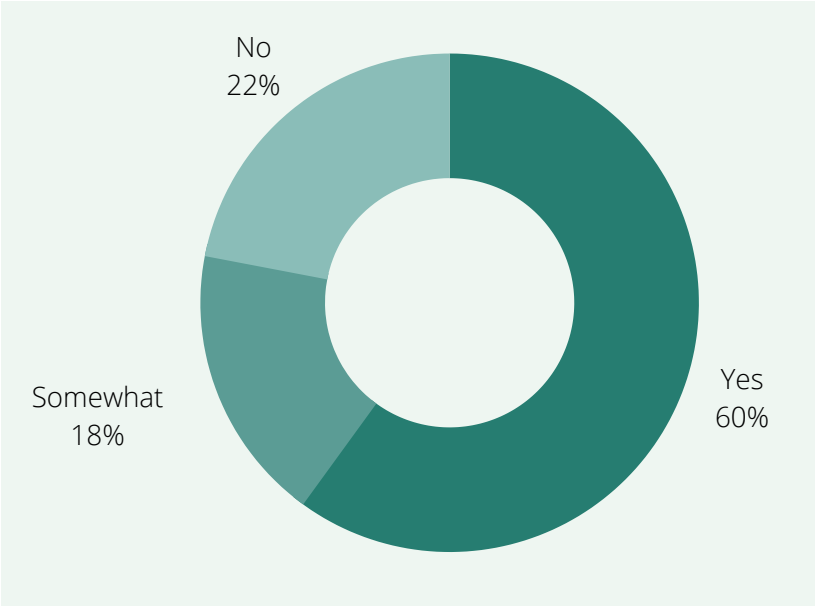
We asked our audience if they were adequately guided through the paperwork and documentation stages.

Did you get clear, step by step guidance on the claim process and paperwork?

We found that 2 out of every 5 respondents did not receive satisfactory step-by-step guidance on the claim settlement process.

On further probing we found that **43% respondents had to repeatedly follow up** during the claim process/approval, and an additional **13% needed to follow up at least a few times** during their claims settlement process.

Guidance for the claim process and paperwork



These results showed that less than half of the total respondents went through the entire claim settlement process confidently, with proper guidance - without the need to follow up with the concerned teams.

BESHAK? WHO?

Beshak is a research platform for users seeking informed guidance on all things insurance. Conceptualised by industry experts with several decades of diverse experience, Beshak is a repository of useful content, guides, tips and calculators that simplify the often complex insurance journey.

We don't sell or advertise insurance plans or companies, and never will.

Jargon-free	**Data-Backed**	**Zero Conflict**
Simple, easy-to-use content, assets & tools	Unbiased, researched data and insights	No Sales. No Calls. No Chasing. Ever.

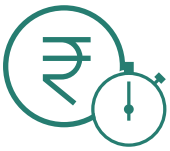
BE PART OF OUR FAST-GROWING COMMUNITY!

Join us, to make insurance simple and trustworthy!

- 1000+ Insurance-aware Twitter Community
- Expert responses on forum within 6-8 Hours
- 2000+ Subscribers

FOLLOW BESHAK

Here's what happens when there is no clear guidance on the process



Claim delays

Delayed discharge

Emotional turmoil

Why is this important?

One of the respondents we spoke to had their father admitted to a hospital for a minor procedure. As it was the first time they were going through a hospitalisation, they did not clearly know how to go about it.

They report that they were extremely confused, worried until the last minute as they did not know whether the claim amount will come through, or not. To add to the worry, the discharge was delayed by a day - as the hospital desk delayed in responding to a query raised by the TPA.

"My father was tired of being at the hospital, and just wanted to go home, and there was nothing I could do," they said.

PAPERWORK AND DOCUMENTATION

PAPERWORK AND DOCUMENTATION

When you have a family member hospitalised and needing your attention, the last thing you want to be doing is lengthy paperwork. We've heard several health insurance users complain about having to answer pages and pages of questions, and sometimes not clearly understanding the intent behind some of them - or the right way to respond. All this, while being worried about the health of a loved one.

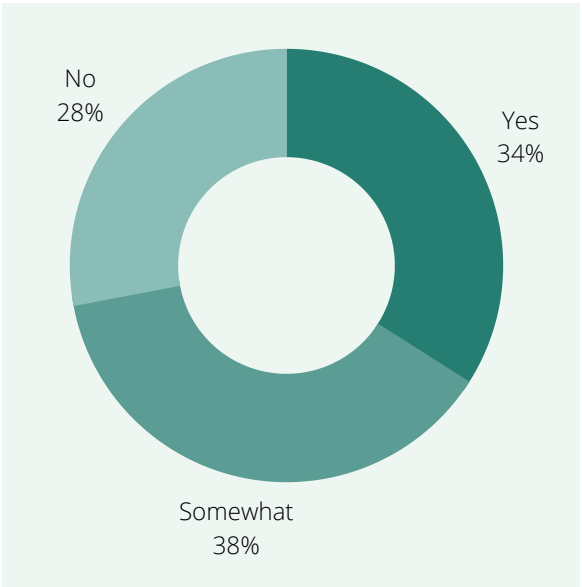
This section of the survey focused on understanding the crux of paperwork and documentation related experiences, and recommending possible remedies.

Did the claim process require a lot of paperwork and back and forth?

From the study, we found that over **72% of the respondents felt that the claims process required more paperwork than they considered ideal**, and did not have a smooth process with respect to the documentation.

When someone is hospitalised, a family member/ attendant needs to be available at the hospital to take care of all the formalities. In addition to providing care of the patient, they will also need to follow up about billing and insurance processes, so it is done on time, and doesn't delay discharge.

Too much paperwork?



The documentation process can get very overwhelming - the TPA raises a query, the hospital desk receives it, coordinates for a response from the nurse's station and doctors. Sometimes, they might have different standards or formats for documentation and this might cause delays.

Further, there are multiple touch-points, especially in the bigger hospitals with various departments and the attendant/ family member might need to run around, pushing them to complete their part of the fragmented documentation process. In addition to this, they might also need to keep track of the process on the TPAs end.

With 7 out of every 10 customers experiencing dissatisfaction with the amount of paperwork they've to do, this area presents a major opportunity for improving the current processes in favour of the end users.

Such back-and-forth trying to fix minor errors, delays between queries and responses could delay the final insurance approval by hours, even days. On top of this, the hospital desk, TPA and insurance companies might have different working hours and holidays. And all this has to work together, for you to have a seamless experience.

So, the end-user - while on one side has to deal with an ailing family member, on the other are left perplexed with process trivialities.

THE BESHAK TAKE!

- **Solutions such as app-based claims, digital medical records, online consultation records** should become the norm with higher visibility for the insurance company into the patient's medical history as well as their current treatments, so they can make approval decisions with ease.

- Insurance players should take the lead on developing **simpler, streamlined processes for documentation**, as well as keep track of hospitals that consistently deliver smooth experiences. This information can be shared with the customer, helping them make an informed decision about using the services of a hospital, after considering their insurance experience.

- While this might be very challenging to achieve with aggressive medical innovation - it is important to establish **treatment standards across medical facilities** - at least for the most common hospitalisation needs, so insurance procedures for such admissions get automated (or at least well-defined) to a large extent.

COMMUNICATION WITH THE CUSTOMER

COMMUNICATION WITH THE CONSUMER

Effective communication is a true problem-solver. This is especially true in the insurance ecosystem, where every segment is disconnected from the others, and are essentially working across locations.

With a strong communications approach in place, insurance companies, hospitals and the TPA can solve several challenges, in one go, as outlined below -

- Share latest process updates with each other as well as the user
- Identify and resolve issues and gaps effectively
- Save time, while taking decisive action
- Improve visibility and accountability
- Achieve consumer delight

Having said that, we wanted to find out how effective this communications process today is, with specific focus on the claims settlement process.

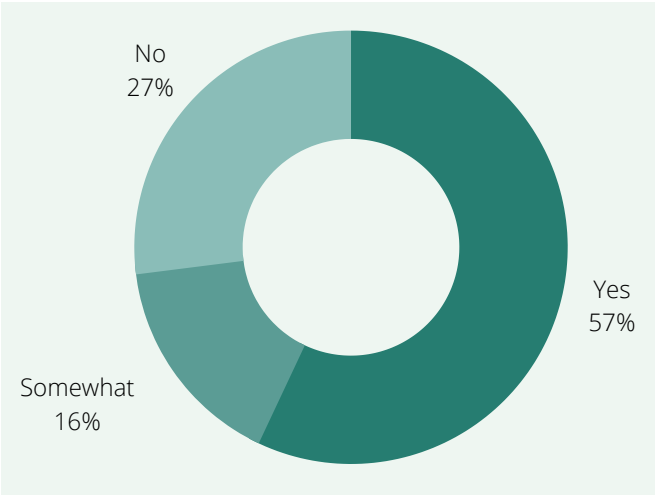
Here's what we found out.

Did you receive clear communication for additional requirements raised by Insurer/TPA?

43% of the respondents reported facing some amount of difficulty in receiving clear communication from the TPA or insurer with respect to additional requirements raised by insurer/TPA.

This clearly shows the lack of a robust process of communication established between the ecosystem and the customer.

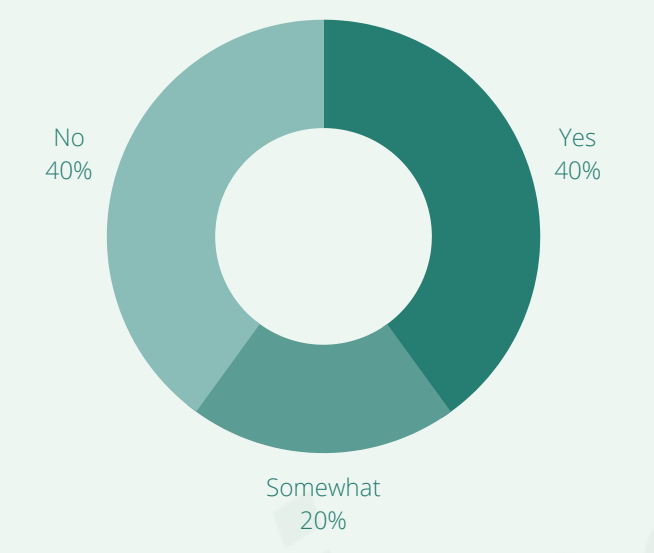
Clear communication was offered



Further, given technology is today, a major enabler of communications across industries including insurance - we asked our respondents if they received regular updates through SMS/Emails/WhatsApp messages to track their claim.

Here's what they had to say.

Could you track your claim through tech?



Of the individuals that took part in our survey, a large majority, **60% of the respondents said that they faced some level of difficulty in tracking their claims through SMS/ Emails/ WhatsApp.**

The claim process can get delayed unnecessarily due to lack of status updates. Better information on additional requirements can result in better action for the customer pushing faster processing of claims.

Without timely updates, The process can become very opaque and hence result in poor experience for the consumer.

THE BESHAK TAKE!

- **Preempting technical glitches:** Most Insurers have built apps, as well as promise to send text notifications through SMS and WhatsApp to customers. As a result - It is very surprising that 60% individuals reported that they did not receive latest updates. It is important to keep track of how well the solutions are working and upgrading them to improve the experience for the end-user. Insurers should consider implementing rigorous periodic tests of their systems to check whether there are any gaps in the delivery of messages.

- **Integrated experience:** The gap in the communication of additional documents or information is also to do with the gap in the systems of the insurance company and the hospital. Many times, the insurance company would have updated their systems but these may not be well integrated with the systems at the hospital. Information lying in such silos, on different island systems is bound to result in a disconnected, broken experience for the user. This too, needs to be fixed with collaborative efforts.

CLAIM PAYMENT

CLAIM PAYMENT

Today, the claims payment experience is measured largely across two factors.

Speed of claim payout

Transparent evaluation of the claim and deductions

We asked individuals if they were satisfied with the speed of payment, and whether or not they clearly understood what part of their claim was paid, and what was declined.

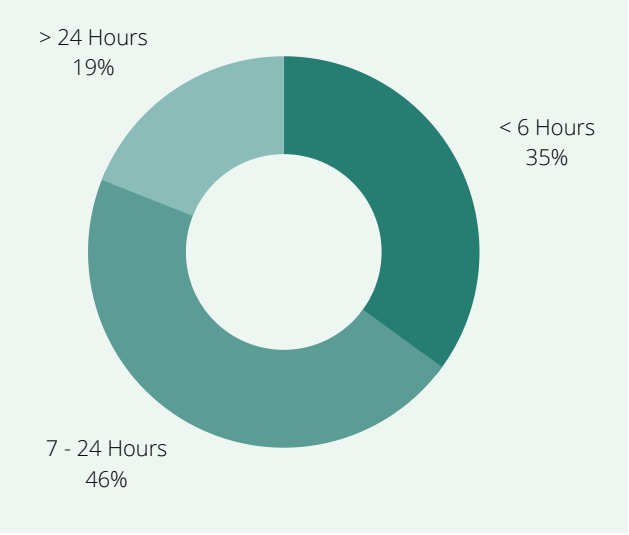
Were you satisfied with the speed of evaluation and payment of your claim?

Depending on whether they went through the cashless process or a reimbursement process, here's how the insurance claim speed fared in our respondents.

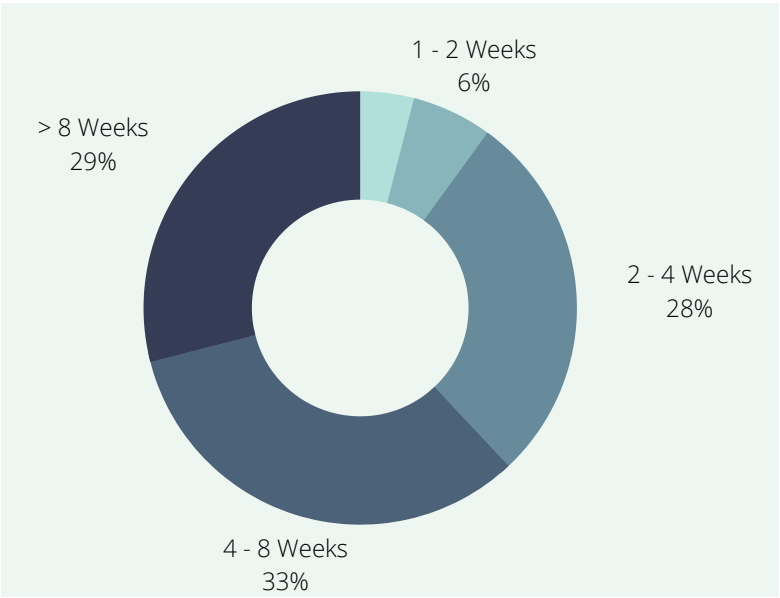
First - cashless claims. According to the results of our survey, out of every five - **19% respondents who got cashless claims took over 24 hours to get their claim settled.**

Then, what about reimbursements?

Speed of payment in cashless claims



Speed of reimbursements



Reimbursement settlements were worse.

62% of respondents who got their claim through reimbursement, waited for over a month, for their payment to be approved and sent to their bank accounts.

This large majority of individuals would have had to pay the hospital out of their savings or taken a loan - and that amount isn't settled for over a month. Further, all that while, they worry wondering whether or not the money will hit their account at all.

Overall, a little over half - 53% of the respondents expressed extreme or mild dissatisfaction with the speed of receiving their claim. (when both cashless and reimbursement claims are taken together)

THE BESHAK TAKE!

- **Insurance companies to lead the change:** This change needs to be driven by insurance companies - who are the people who promise smooth, easy claim settlement in the first place. They need to bring in better technology to complement their processes, and workflows for their TPAs, networked hospitals and users - so the overall burden on the system reduced.

- **Aggressive adoption of digital:** There is immense scope for the insurance industry to benefit from learnings in digital journeys, innovations in other industries, where customers are experiencing smooth tracking and delivery of services. It is about time processes are streamlined online, and visibility improved for users.

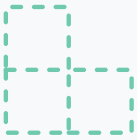
- **Improve accountability:** There is also a need to improve transparency across industry silos to clearly identify bottlenecks- and fix them in time. Opening up digital and social media channels for seamless customer feedback could be a solution.

What about deductions?

Most health insurance claims come with some standard as well as particular deductions that will need to be borne by the patient's family. Deductions often include -

Room rent and other limits

Deductions of Consumables



Deductions due to inadequate documentation

Admin and registration costs

Given the complicated calculations involved, it is often a major challenge for individuals to clearly understand the deductions made in the claim payout.

We asked our respondents the same and the results were as follows.

Were you able to understand all the deductions made?

33% of all respondents said that they were not able to understand the deductions made at all, while another 15% of respondents did not understand at least some of the deductions.

Taken together, that is close to 50% of the respondents who paid money out of their pockets, without clearly understanding why!

Often, waiting at a hospital for long hours after the treatment is completed, following up with the nurses and staff to do the due diligence with respect to discharge formalities, families are stuck between a rock and a hard place.

It is likely that in an attempt to leave the hospital as soon as possible, they do not go through the billing formalities in detail. Remember, these are the same individuals also worrying about their family's state of wellness, while also doing the rounds between the billing counter and the nurse's station and the insurance desk.

While it is their duty to go through the amounts carefully and in detail, the environment doesn't support it.

Why does it matter?

"My 20 years-old son was admitted for an appendicitis surgery, and the doctor said we could go home first thing that morning. After following up several times with the nurse's station and the billing department, our final billing was only completed by 4PM. I knew the TPA would shut shop by 5PM, so I wanted to finish the process in a hurry. But, when I looked at the deductions, I was taken aback by a bill of 45K that I had to pay out of my pocket.

I did not have the time or patience to argue or understand with my son insisting we get back home. But, I'm not sure what someone without enough money in hand could do in that situation!" said one of our respondents.

THE BESHAK TAKE!

- **Open communication with the customer:** Most of the communication right now, is extremely technical, loaded with jargon, and not focussed on giving the customer a transparent experience - even in rejections and deductions. Alternatively, if customers were educated on these details in common language, they would appreciate the effort and understand how the system works - instead of remaining disgruntled and blaming it.

- **Customer-care training:** Customer-care should include well-trained representatives who understand the product, technicalities and jargon (including medical jargon). At the same time, they should speak the language of a common user with no knowledge of insurance, so they can effectively bridge the communication gap.

- **Root cause analysis on grievances:** There should be an RCA implemented for each grievance, to identify areas that existing customers don't have clarity about. New customers can be educated better in these areas, hence minimising future grievances.

- **Help customers understand possible deductions:** Each deduction can be explained well on the insurer's website: Customers can look up the deduction code or the rejection heading on its website to understand the reasons for deductions better.


CLOSING

A LONG WAY TO GO...

In the two decades since the privatisation of insurance in India, the industry has come a long way. We have seen excellent innovation of product offerings, technology integrations with core operational components and streamlining of processes - especially during the purchase phase. We have also seen several regulatory changes that directly and positively improve the financial security families enjoy in the long-term.

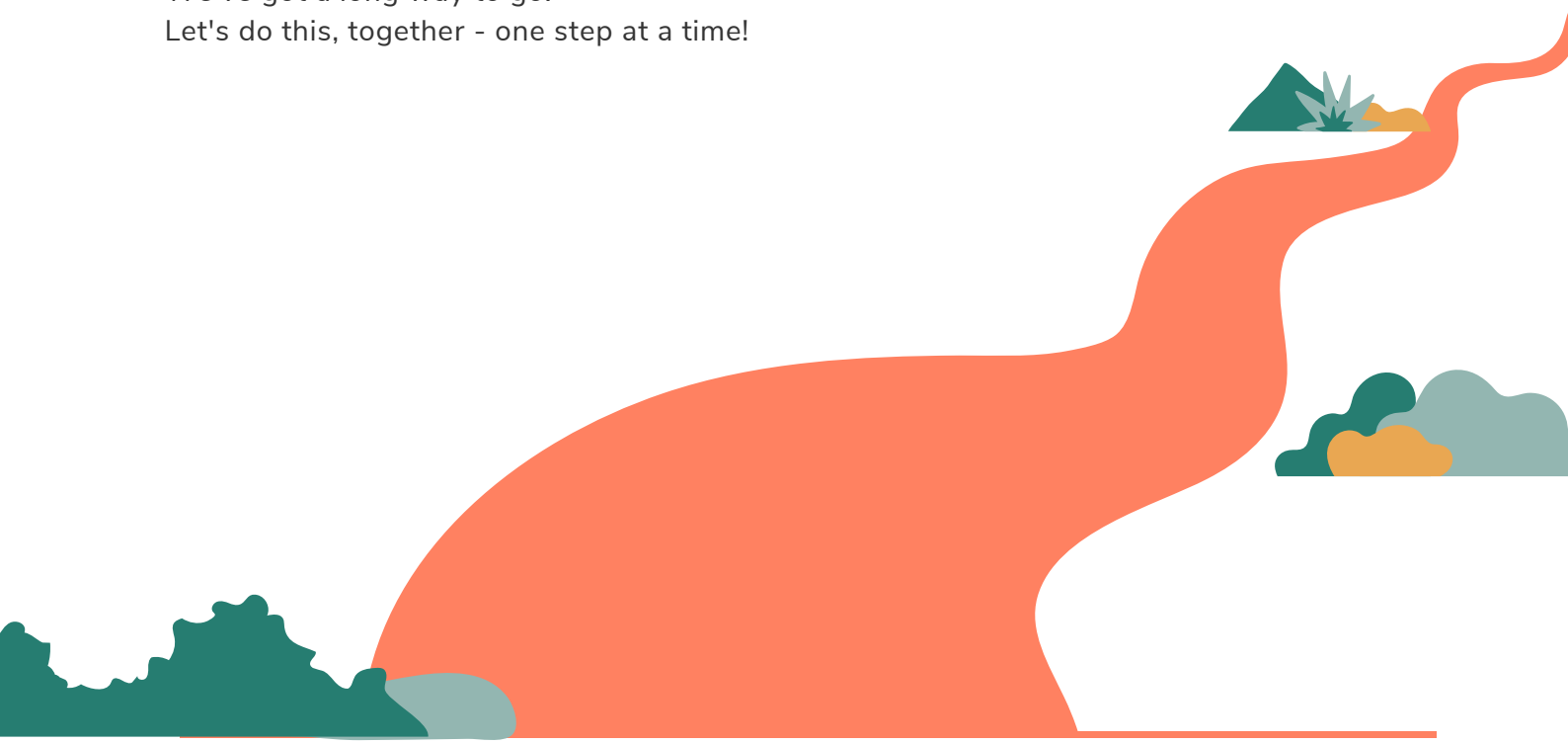
Having said that, we learn from the report that there is immense scope for improving the user experience, especially concerning the claims journey. Across touch-points - we observe that the overall sentiment is mediocre at best.

Across most parameters such as process simplicity, customer support and communication - we see that around half of the respondents were satisfied with their interactions - while the other half remarked that their experience was sub-par.

In the recent times, we have seen technology-powered innovations solve operational, engagement, and communication challenges across industries. Empowering seamless integration between traditional brick-and-mortar models and their novel digitally-present businesses across education, F&B, entertainment, travel, and more, technology has transformed customer experience and thereby, improved trust.

The challenges unraveled from this study, and NITI Ayog's Health Stack, integrating the healthcare ecosystem - including health insurance claims - present a similar opportunity to disrupt and reimagine consumer experience, making it truly seamless - and thereby, solving for the perception problem - before bringing trust back to the ecosystem.

We've got a long way to go.
Let's do this, together - one step at a time!



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