CHAPTER – VI

MEDICLAIM – SETTLEMENT PROCESS AND ISSUES

Cashless policies mean that the health insurance company settles the bill directly with healthcare provider, whether a hospital or a nursing home. This is to reduce the direct financial burden on insured individual at the time of hospitalization. Therefore, whatever bill is raised by the healthcare provider, Insurance Company settles it directly through a Third Party Administrator.

Third Party Administrator (TPAs) is responsible for managing all aspects of claims arising due to health insurance policies. TPAs are licensed by Insurance Regulatory and Development Authority (IRDA) and coordinate with hospitals with respect to treatment and also pass the bills on behalf of the insurance companies. They maintain details of all policies holders and employ medical specialists for assessing need for hospitalization and treatment being given in the hospital. The actual payment, however, is made by the insurance company.

The MEDICLAIM policy holders can avail of the cashless facility at any of the hospitals in the insurance company's network by presenting valid documentation on admission. Cashless facility can be availed in case of planned and emergency hospitalisation and thus help the policy holders with their medical services.

The present chapter is devoted to analyse the settlement process involved in the MEDICLAIM policy. This chapter unfolds information on status of hospitalisation, understanding claim process, understanding claim process by family members, settlement mode, informing TPAs, days from claim to

settlement, room charges claimed and reimbursed, doctor charges claimed and reimbursed, diagnostic charges claimed and reimbursed, medical charges claimed and reimbursed, total amount claimed and reimbursed, sub-limit cases, opinion about hospitalisation charges by TPA networked hospitals, co-payment clause applied, experience with top-up plans, experience with portability, premium loading applied, issues affecting demand for MEDICLAIM insurance and influence of MEDICLAIM policy on stress reduction.

6.1 STATUS OF HOSPITALISATION

Medical treatment can be of two types, planned treatments and unplanned medical emergencies.

In the case of a planned admission, the policy holder would have first consulted a doctor who in turn would have advised him on the probable date of hospitalization.[1]

Emergency hospitalization is a hospitalization which requires immediate admission to the hospital when an insured or covered family member meets with a sudden accident or suffers from about of illness.[2]

The survey has covered 300 MEDICLAIM policy holders. Out of these 300 policy holders, 87 policy holders (29%) have not made any claim during the study period. Planned hospitalisation has been made by 62 policy holders (20.67%). Emergency hospitalisation has been required by 151 policy holders (50.33%).

[1]https://www.uhcpindia.com/web/corporates/ecashless_files/CASHLESS_HOSPITALIZATION.pdf as accessed on January 13, 2013.
[2] http://www.myclaims.in/Faq.aspx as accessed on June 15, 2014.

TABLE – 6.1

STATUS OF HOSPITALISATION

Status of Hospitalisation	No. of Respondents	Percentage
Planned hospitalisation	62	20.67
Emergencies	151	50.33
No claim cases	87	29.00
Total	**300**	**100.00**

Source: Primary Data

It is observed that majority of the MEDICLAIM policy holders (about 50%) has needed emergency hospitalisation while planned hospitalisation has been witnessed in the case of about 21% of the MEDICLAIM insurance policy holders.

6.2 UNDERSTANDING CLAIM PROCESS

The claim procedure in the case of MEDICLAIM policy depends on the type of policies the insured hold. Since these plans are different, the claim procedures differ according to the combination that the policy holder have.[3]

Each aspect of claim processing – from hospitalization notification to the final billing differs in accordance to the type of plan: cashless facility or reimbursement.[4]

[3] http://businesstoday.intoday.in/story/best-way-to-manage-multiple-health-insurance-policies/1/1856 87.html as accessed on July 8, 2012.

[4] http://www.smarterwithmoney.in/Insurance/Health/Articles/Claims_Processing_Procedure_By_Heal th_Insurance_Companies as accessed on April 19, 2013.

The study enquires whether the MEDICLAIM policy holders know the procedure followed by their health insurance providers while processing their claim. Out of 300 MEDICLAIM policy holders surveyed, 126 respondents representing 42% have expressed that they have fully understood the claim process; the rest 174 respondents accounting for 58% have revealed that they have not fully understood the claim process and they have to depend on the insurance agent or the TPA.

TABLE – 6.2

UNDERSTANDING CLAIM PROCESS

Understanding	No. of Respondents	Percentage
Understood	126	42
Not Understood	174	58
Total	**300**	**100**

Source: Primary Data

It is to be noted that considerable number of MEDICLAIM policy holders (58%) had to seek the help of the insurance agent or the TPA to route the claim documents.

6.3 UNDERSTANDING CLAIM PROCESS BY FAMILY MEMBERS

The study enquires whether the family members of the MEDICLAIM policy holders know the procedure followed by their health insurance providers while processing their claim. Out of 300 MEDICLAIM policy holders surveyed, 96 respondents representing 32% have expressed that their family members have fully understood the claim process; the rest 204 respondents accounting for 68%

have revealed that their family members have not fully understood the claim process and they have to depend on the insurance agent or the TPA.

TABLE – 6.3

UNDERSTANDING CLAIM PROCESS BY FAMILY MEMBERS

Understanding	No. of Respondents	Percentage
Understood	96	32
Not Understood	204	68
Total	**300**	**100**

Source: Primary Data

It is to be noted that substantial number of MEDICLAIM policy holders (68%) had family members without proper knowledge as to the claim process and had to seek the help of the insurance agent or the TPA to route the claim documents.

6.4 SETTLEMENT MODE

A claim can be made both on cashless or reimbursement basis. Cashless facility is available only for treatments at a network hospital. If the hospital is not in the insurer's network, the policy holder will have to make a claim on reimbursement basis.[5]

Health insurance companies make tie-ups with hospitals after negotiating their rates and checking their quality. These hospitals are called as Network Hospitals. Cashless service is available only in these hospitals. In Cashless health

[5] http://www.livemint.com/Money/B9tbLALwC3F7kk5HXkIOFM/Make-sure-your-health-cover-is-adequate.html as accessed on December 18, 2014.

insurance service, when the MEDICLAIM policy holders get hospitalized with a network hospital, they do not have to settle the bill with the hospital. The Insurance Company represented by the Third Party Administrator, co-ordinates with the hospital and settles the bill.

6.5 STEPS TO CASHLESS CLAIM

Step 1

Select and approach the customer service of the insurer or the TPA helpdesk stationed at the network hospital. It is recommended to submit the request at least 72 hours before the treatment. In case of a planned hospitalization, it needs to be pre-authorised by the insurer. For identification purposes, use Passport, Voters' Card, PAN Card or Driver's Licence along with policy holders' health card provided by the insurer or the policy number. [6]

Step 2

Note down the policy holders' claim intimation number after they have informed the TPA or insurer about the hospitalisation.

Step 3

Fill pre-authorisation form with details of the treatment needed and estimated cost. This form is provided with the policy document. It can also be downloaded.[7]

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[6] www.moneycontrol.com/news/health-insurance/3-steps-to-cashless-hospitalisation-within-hours_996 640.html as accessed on September 22, 2013.

[7] http://economictimes.indiatimes.com/how-to-claim-health-insurance/cashless-claims-planned-hospitalisation/slideshow/9935547.cms as accessed on October 11, 2013.

Step 4

After examining the details, the TPA or insurer will issue an authorisation letter for cashless treatment.

Step 5

Get admitted for treatment and sign all documents, forms and invoices on discharge.

Step 6

At the time of discharge, get photocopies of prescriptions, discharge card, bills and other documents. The hospital will give the originals to the TPA or insurer directly.

In case of an emergency, a policy holder is only required to give the network hospital the cashless treatment card number.

6.6 PROCEDURE FOR REIMBURSEMENT MODE[8]

- Once the medical treatment is over, the policy holder can contact the health insurance company or the third party administrator (TPA), which manages insurance processes on behalf of the insurance provider.
- The policy holder needs to submit medical documents like doctor's prescriptions, pathological reports, hospital bills, discharge summary, pharmacy bills, etc. and details of the expenses incurred.

[8]http://www.smarterwithmoney.in/Insurance/Health/Articles/Claims_Processing_Procedure_By_Health_Insurance_Companies as accessed on October 22, 2013.

- A completed claim form along with all the documents has to be submitted to the insurance provider.
- After verifying the documents and coordinating with the hospital, the insurance company reimburses the total claim amount to the policy holder.

6.7 SETTLEMENT MODE – PLANNED HOSPITALISATION CASES

Of the 62 planned hospitalisation cases, 50 respondents (80.65%) has used cashless mode of settlement of claims and the rest 12 respondents (19.35%) has not opted it; instead, they preferred the reimbursement mode of claim settlement.

TABLE – 6.4

SETTLEMENT MODE – PLANNED HOSPITALISATION CASES

MODE	No. of Respondents	Percentage
Cashless facility	50	80.65
Reimbursement facility	12	19.35
Total	**62**	**100.00**

Source: Primary Data

It is clear that about 81% of the MEDICLAIM policy holders with planned hospitalisation have routed their claim proposal through TPAs.

6.8 INFORMING TPAs – PLANNED HOSPITALISATION CASES

The survey shows that there are 62 planned hospitalisation cases, of which TPA services have been availed in the case of 50 respondents. The time taken by these policy holders in intimating the TPAs was examined. The intimation has been given to the TPA 3 days before hospitalisation by 48% of the policy holders

approaching the TPAs with planned hospitalisation. The intimation has been given to the TPA more than 3 days before hospitalisation by 32% of the policy holders approaching the TPAs with planned hospitalisation. However, in 20% of the cases, the intimation has been given to the TPA in less than 3 days before hospitalisation.

TABLE – 6.5

INFORMING TPAs – PLANNED HOSPITALISATION CASES

When Informed	No. of Respondents	Percentage
3 Days before Hospitalisation	24	48
More than 3 Days before Hospitalisation	16	32
Less than 3 Days before Hospitalisation	10	20
Total	**50**	**100**

Source: Primary Data

It is clear that there is no problem as to the timing of passing the information to the TPAs about the hospitalisation in the case of 80% of the MEDICLAIM policy holders with planned hospitalisation. The time span is short as against the expected norm in 20% of the cases.

6.9 SETTLEMENT MODE – EMERGENCY HOSPITALISATION CASES

Of the 151 emergency hospitalisation cases, 139 respondents (92.05%) has used cashless mode of settlement of claims and the rest 12 respondents (7.95%) has not opted it; instead, they preferred the reimbursement mode of claim settlement.

TABLE – 6.6

SETTLEMENT MODE – EMERGENCY HOSPITALISATION CASES

MODE	No. of Respondents	Percentage
Cashless facility	139	92.05
Reimbursement facility	12	7.95
Total	**151**	**100.00**

Source: Primary Data

It is clear that about 92% of the MEDICLAIM policy holders with emergency hospitalisation have routed their claim proposal through TPAs.

6.10 INFORMING TPAs – EMERGENCY HOSPITALISATION CASES

The survey shows that there are 151 emergency hospitalisation cases, of which TPA services have been availed in the case of 139 respondents. The time taken by these policy holders in intimating the TPAs was examined. The intimation has been given to the TPA within 2 days of hospitalisation by about 75% of the policy holders approaching the TPAs with emergency hospitalisation. The intimation has been given to the TPA in more than 2 days of hospitalisation by about 25% of the policy holders approaching the TPAs with emergency hospitalisation.

TABLE – 6.7

INFORMING TPAs – EMERGENCY HOSPITALISATION CASES

When Informed	No. of Respondents	Percentage
Within 2 Days of Hospitalisation	104	74.82
More than 2 Days of Hospitalisation	35	25.18
Total	**139**	**100.00**

Source: Primary Data

It is clear that there is no problem as to the timing of passing the information to the TPAs about the hospitalisation in the case of 75% of the MEDICLAIM policy holders with emergency hospitalisation. The time span is short as against the expected norm in 25% of the cases.

6.11 DAYS FROM CLAIM TO SETTLEMENT

There is one sore point with health insurance claimants that Insurance Companies are not following the timeline in the policy wording, regarding settlement of claims. Most policy wordings of Health Insurance products have a timeline of settling claims in 21 days post submission of the documents, which is hardly ever met.[9]

The survey shows that there are 87 cases wherein no claim has been made during the study period. Out of the remaining 213 MEDICLAIM policy holders who have made claim, the claim is settled within 20 days in the case of about 53% of the cases; the claim is settled in one month in the case of about 17% of the

[9] http://www.medimanage.com/health-insurance-experts-blog/post/2012/01/06/IRDA-to-issue-claims-settlement-rules-for-Health-Insurance-Companies.aspx#.VLZbY8kadvM as accessed on January 6, 2012.

cases; the claim is settled in 2 months in the case of about 9% of the cases and the claim is settled in more than 2 months in the case of about 21% of the cases.

TABLE – 6.8

DAYS FROM CLAIM TO SETTLEMENT

Days	No. of Respondents	Percentage
Within 20 Days	113	53.05
One month	37	17.37
2 months	19	8.92
More than 2 months	44	20.66
Total	**213**	**100.00**

Source: Primary Data

The time to settle the claim from the date of submission of claim happens to be more than one month in about 47% of cases of MEDICLAIM policy holders.

6.12 ROOM CHARGES CLAIMED AND REIMBURSED

Room rent is typically restricted to 1% of the Sum Assured in most cases and in some cases it is restricted to 2% of the Sum Assured. There are also policies that do not impose a strict 1% clause, but do determine claim admissible on the basis of type or category of room, thus allowing the room rent to vary based on what different hospitals will charge for the same category. [10]

It is enquired whether the room charges as part of claim in a MEDICLAIM insurance policy are fully allowed to the policy holder. Of the 213 MEDICLAIM

[10] http://www.personalfn.com/knowledge-center/insurance/tutorials/12-06-05/the_one_fact_about_mediclaim_that_your_agent_will_never_tell_you.aspx as accessed on June 5, 2012.

insurance policy holders who have made their claims, about 60% have the claim for room charges sanctioned in full. About 34% of the policy holders have been allowed a lesser amount in respect of claim towards room rent. The rest 6% of the policy holders have felt that the amount sanctioned in respect of room charges is too low.

TABLE – 6.9

ROOM CHARGES CLAIMED AND REIMBURSED

Level Opinion	No. of Respondents	Percentage
Received Fully	128	60.10
Less	72	33.80
Too Low	13	6.10
Total	**213**	**100.00**

Source: Primary Data

It is very clear that as many as 40% of the MEDICLAIM policy holders who have made the claim are not satisfied with regard to the claim money sanctioned towards room charges.

6.13 DOCTOR CHARGES CLAIMED AND REIMBURSED

As a general rule, all of the doctor charges are covered as long as they are medically necessary, unless specifically excluded in the policy. It also depends on which provider the policy holders use.[11]

It is enquired whether the doctor charges as part of claim in a MEDICLAIM insurance policy are fully allowed to the policy holder. Of the 213

[11] http://www.safewaymediclaim.com/faq.aspx as accessed on April 19, 2013.

MEDICLAIM insurance policy holders who have made their claims, about 69% have the claim for doctor charges sanctioned in full. About 24% of the policy holders have been allowed a lesser amount in respect of claim towards doctor fees. The rest 7% of the policy holders have felt that the amount sanctioned in respect of doctor charges is too low.

TABLE – 6.10

DOCTOR CHARGES CLAIMED AND REIMBURSED

Level Opinion	No. of Respondents	Percentage
Received Fully	147	69.02
Less	51	23.94
Too Low	15	7.04
Total	**213**	**100.00**

Source: Primary Data

It is very clear that as many as 31% of the MEDICLAIM policy holders who have made the claim are not satisfied with regard to the claim money sanctioned towards doctor charges.

6.14 DIAGNOSTIC CHARGES CLAIMED AND REIMBURSED

Health insurance provides cover for all health related expenses. This means that health insurance companies will only pay for hospitalization expenses. Thus, though very expensive, the charges for diagnostic tests like MRI scans, lipid profile, ECG, stress tests are not payable in most of the health insurance policies.[12]

[12] http://www.medimanage.com/my-health-insurance/articles/why-aren%E2%80%99t-diagnostic-tests-covered-in-mediclaim.aspx as accessed on July 23, 2013.

It is enquired whether the diagnostic charges as part of claim in a MEDICLAIM insurance policy are fully allowed to the policy holder. Of the 213 MEDICLAIM insurance policy holders who have made their claims, about 44% have the claim for diagnostic charges sanctioned in full. About 51% of the policy holders have been allowed a lesser amount in respect of claim towards diagnostic charges. The rest 5% of the policy holders have felt that the amount sanctioned in respect of diagnostic charges is too low.

TABLE – 6.11

DIAGNOSTIC CHARGES CLAIMED AND REIMBURSED

Level Opinion	No. of Respondents	Percentage
Received Fully	93	43.67
Less	109	51.17
Too Low	11	5.16
Total	**213**	**100.00**

Source: Primary Data

It is very clear that as many as 56% of the MEDICLAIM policy holders who have made the claim are not satisfied with regard to the claim money sanctioned towards diagnostic charges.

6.15 MEDICAL CHARGES CLAIMED AND REIMBURSED

It is enquired whether the medical charges as part of claim in a MEDICLAIM insurance policy are fully allowed to the policy holder. Of the 213 MEDICLAIM insurance policy holders who have made their claims, about 76% have the claim for medical charges sanctioned in full. About 20% of the policy

holders have been allowed a lesser amount in respect of claim towards medical charges. The rest 4% of the policy holders have felt that the amount sanctioned in respect of medical charges is too low.

TABLE – 6.12

MEDICAL CHARGES CLAIMED AND REIMBURSED

Level Opinion	No. of Respondents	Percentage
Received Fully	162	76.06
Less	43	20.19
Too Low	8	3.75
Total	**213**	**100.00**

Source: Primary Data

It is very clear that as many as 24% of the MEDICLAIM policy holders who have made the claim are not satisfied with regard to the claim money sanctioned towards medical charges.

6.16 TOTAL AMOUNT CLAIMED AND REIMBURSED

It is enquired whether the total amount of claim in a MEDICLAIM insurance policy is fully allowed to the policy holder. Of the 213 MEDICLAIM insurance policy holders who have made their claims, about 69% have the total claim sanctioned in full. About 26% of the policy holders have been allowed a lesser amount in respect of total claim. The rest 5% of the policy holders have felt that the total amount of claim sanctioned is too low.

TABLE – 6.13

TOTAL AMOUNT CLAIMED AND REIMBURSED

Level Opinion	No. of Respondents	Percentage
Received Fully	147	69.01
Less	56	26.30
Too Low	10	4.69
Total	**213**	**100.00**

Source: Primary Data

It is very clear that as many as 31% of the MEDICLAIM policy holders who have made the claim are not satisfied with regard to the total claim money sanctioned to them.

6.17 SUB-LIMIT CASES

There are two kinds of limits that insurers place - on the hospital room rent and the sum assured for specific diseases. The disease-wise capping restricts payment in case of pre-specified diseases.[13]

Usually the medical expenses are associated with the type of room that the MEDICLAIM policy holders take and so they could end up paying the difference for not only the room rent but also all other medical costs should they opt for a higher room category than allowed.[14]

[13] http://www.livemint.com/Money/fWcOIfOroInrC7KtCXZXeN/Sublimits-are-critical-to-evaluate-in-health-insurance.html as accessed on November 26, 2013.
[14] http://www.livemint.com/Money/fg7fQcrwoGyf6lVNgdgC9I/Mediclaim-ratings--Tackling-the-problem-of-plenty.html as accessed on February 9, 2013.

Out of 213 claim cases, sub-limit was applied in the case of 85 MEDICLAIM policy holders. The sub-limit has been applied in respect of room rent in the case of 48 MEDICLAIM policy holders (56.47%), in respect of doctor's fees in the case of 12 MEDICLAIM policy holders (14.12%) and in respect of diseases in the case of 25 MEDICLAIM policy holders (29.41%).

TABLE – 6.14

SUB-LIMIT CASES

Sub-limit applied on	No. of Respondents	Percentage
Room rent	48	56.47
Doctor's Fees	12	14.12
Diseases	25	29.41
Total	**85**	**100.00**

Source: Primary Data

It is observed that most of the sub-limit cases (about 86%) are concerned with the caps on the hospital room rent and the sum assured for specific diseases.

6.18 OPINION ABOUT HOSPITALISATION CHARGES BY TPA NETWORKED HOSPITALS

Most insurance claim battles ensue because of one endemic problem: private hospitals, in their quest to generate maximum revenue, encourage patients covered by a medical insurance policy to undergo medical procedures which may

be unnecessary or irrelevant, and health insurers have been known to reject claims saying it was not medically required.[15]

All the 189 MEDICLAIM policy holders who had availed the services of TPA were asked to give their opinion about the hospitalisation charges in the TPA networked hospitals. Out of these 189 MEDICLAIM policy holders, about 29% have revealed that the hospitalisation charges are normal. About 52% of the MEDICLAIM policy holders have rated the hospitalisation charges to be above normal. The rest 19% of them have felt the hospitalisation charges to be very high.

TABLE – 6.15

OPINION ABOUT HOSPITALISATION CHARGES BY

TPA NETWORKED HOSPITALS

Opinion	No. of Respondents	Percentage
Normal	55	29.10
Above Normal	98	51.85
Very High	36	19.05
Total	**189**	**100.00**

Source: Primary Data

It is clear that as many as 71% of the MEDICLAIM policy holders using the cashless services of TPAs are of the view that the hospitalisation charges in TPA networked hospitals have been above normal or very high.

[15] http://articles.economictimes.indiatimes.com/2012-06-25/news/32409038_1_medical-insurance-list-of-network-provider-health-insurance as accessed on December 23, 2013.

6.19 CO-PAYMENT CLAUSE APPLIED

Co-payment is applicable if the insured undergoes treatment in certain metropolitan cities despite paying premiums applicable to smaller cities. Likewise, choosing healthcare facilities that are not part of the insurer's network of hospitals could necessitate co-payment by the insured. Besides, most senior citizen health covers include this clause in their terms, and it is typically applicable to all claims made.[16]

Out of 300 MEDICLAIM insurance policy holders surveyed, co-payment clause is applied in 213 cases. The co-payment condition came into play when the MEDICLAIM insurance policy covers senior citizens and such cases account for about 41%. The co-payment has been insisted when high end hospitals are preferred by the MEDICLAIM insurance policy holders and this accounts for about 48% of the policy holders. The co-payment clause is applied when treatment is taken in out of network hospitals in about 11% of the cases.

TABLE – 6.16

CO-PAYMENT CLAUSE APPLIED

Application of Co-payment Clause	No. of Respondents	Percentage
In the case of senior citizens	87	40.85
When high end hospitals are preferred	102	47.89
When treatment is taken in out of network hospitals	24	11.26
Total	**213**	**100.00**

Source: Primary Data

[16] http://articles.economictimes.indiatimes.com/2012-06-02/news/31984178_1_health-policy-eligible-claim-high-end-hospitals as accessed on January 28, 2013.

It is to be noted that preferring high end hospitals for medical treatment is the main reason for attracting co-payment clause (48%) followed by coverage of MEDICLAIM insurance to senior family members (41%) and preference of treatment in out of network hospitals (11%).

6.20 EXPERIENCE WITH TOP-UP PLANS

The top-up cover that a person buys can only be utilized after or beyond a basic minimum amount – in short, these policies pay his expenses over and above a certain amount. This amount is called the 'deductible' or 'threshold'. Top-up health insurance plans apply the deductible to each and every hospitalization in a year of policy contract and not to the sum total of all the hospitalizations.[17]

It is to be recalled that top-up plans have been used by 84 of the 300 MEDICLAIM policy holders surveyed. Of these 84 policy holders, top-up facility has fetched the full amount of claim in about 51% of the cases. In about 16% of the cases, the top-up cover has not worked at all. About 33% of the MEDICLAIM insurance policy holders who had used top-up plans faced bitter experience in the form of delay in getting claim.

[17] http://www.thewealthwisher.com/2012/08/13/top-up-health-insurance-plans-india/ as accessed on May 5, 2013.

TABLE – 6.17

EXPERIENCE WITH TOP-UP PLANS

Experience	No. of Respondents	Percentage
Received full claim	43	51.19
Top-up not covered	13	15.48
Delay in getting claim	28	33.33
Total	**84**	**100.00**

Source: Primary Data

It is interesting to note that the experience of the MEDICLAIM insurance policy holders using top-up plans is not encouraging as about 49% of the policy holders using top-up plans have either their claim not covered or their claim settled after unnecessary delay.

6.21 EXPERIENCE WITH PORTABILITY

Portability allows customers to carry forward continuity benefits accrued on their previous policy. The premium and policy benefits may differ from the existing policy of the policy holder. It will depend on the product plan he wants to port to.

Insurance companies have an escape route by way of the premium loading. The other issue is No-Claim Bonus (NCB) where the net effect may deplete the bonus. The new insurer can port the Sum Insured (SI) on an existing policy inclusive of the NCB that has accrued on it. However, the premium charged will

be on the higher sum which is inclusive of the bonus. This effectively erodes the effect of the NCB itself.[18]

The survey reports 47 cases of portability of MEDICLAIM insurance. Of these cases, there has been no problem in 12 cases (about 26%) of portability. Unpleasant experience has been noticed in the form of high premium in about 19% of the cases, in the form of difference in terms and conditions in about 17% of the cases and in the form of loss of no claim bonus in about 38% of the cases.

TABLE – 6.18

EXPERIENCE WITH PORTABILITY

Experience	No. of Respondents	Percentage
Higher premium	9	19.15
Difference in terms and conditions	8	17.02
No claim bonus lost	18	38.30
No problems	12	25.53
Total	**47**	**100.00**

Source: Primary Data

Thus, portability has resulted in bitter experience in terms of high premium, change in terms and conditions of the policy and loss of no claim bonus in the case of 74% of the portability occurrences.

[18] http://www.moneylife.in/article/mediclaim-portability-guidelines-of-irda-ndash-true-portability-may-remain-a-wish/19709.html as accessed on September 13, 2011.

6.22 PREMIUM LOADING APPLIED

A loading is an added premium that is placed on the MEDICLAIM insurance policy if the policy holders are seen to present a very high risk of claiming benefits in the future. Loadings are typically placed on MEDICLAIM insurance policies if the policy holders carry a pre-existing health condition or have a family history of serious illness that is significant enough to warrant an extra premium. Certain life style factors such as smoking, obesity, high stress jobs that result in hypertension, as well as high-blood pressure may also attract loadings on the MEDICLAIM insurance policy.[19]

The survey explores the circumstances where the premium loading has been applied. Of the 300 MEDICLAIM policy holders surveyed, 31% has expressed that the premium is hiked even when a claim is made for small amount. 54% of the policy holders have expressed that the premium is hiked only when a claim is made for huge amount and 15% has revealed that the premium is hiked in the case of chronic ailments.

TABLE – 6.19

PREMIUM LOADING APPLIED

Application of Premium Loading	No. of Respondents	Percentage
Even when Claim is made for small amount	93	31
Only when Claim is made for huge amount	162	54
In the case of chronic ailments	45	15
Total	**300**	**100**

Source: Primary Data

[19] http://www.lifeinsurancefinder.com.au/post/cover-types/life-cover-death-benefit/loadings-exclusions-and-indexing-in-life-insurance-policies/ as accessed on November 20, 2014.

It is clear that 31% of the MEDICLAIM policy holders in the study area are dissatisfied with the premium loading as it is done even when claim is made for small amount.

6.23 ISSUES AFFECTING DEMAND FOR MEDICLAIM INSURANCE

There are numerous reasons for unpopularity of MEDICLAIM insurance i.e. there are number of factors which act as barrier in the subscription of MEDICLAIM insurance. All these reasons were taken in the form of variables and all the MEDICLAIM policy holders were asked to give their responses on five point Likert Scale ranging from Strongly Agree to Strongly Disagree. The rank 1 signifies Strongly Agree, 2 signifies Agree, 3 signifies Neutral, 4 signifies Not Agree and 5 signifies Strongly Disagree. Thereafter, factor analysis was done in order to reduce the variables. All these factors along with their description are shown in the following table.

List of Variables Along with their Description

Variable	Description
V1	Not aware of MEDICLAIM policy features
V2	Lot of conditions in the policy document
V3	Lack of comprehensive coverage
V4	Hidden cost is involved
V5	Complex process for claims
V6	Difficult to approach insurance agent
V7	Insurance agents are not well aware of policies
V8	Behaviour of insurance agent was not satisfactory
V9	No proper guidance to select MEDICLAIM policy

V10	More deductible applicable
V11	Negative feedback about health insurance claim process
V12	Employer contribution will make MEDICLAIM cost cheaper
V13	MEDICLAIM insurance should be available with least formalities
V14	All diseases are not covered
V15	All hospitals are not covered

Before the application of factor analysis the reliability of scale items were tested by applying cronbach's alpha. The value came out to be .798, which states that scale is reliable and appropriate.

The data adequacy is checked by applying Kaiser-Meyer-Olin (KMO) measure of sampling adequacy. Here, the KMO measure is 0.672. It is >0.5. So factor analysis is justified.

Moreover, the overall significance of correlation matrices has been tested with Bartlett Test. Bartlett's Test of Sphericity is a static that tests whether the correlation matrix is an identity matrix. In this analysis, the value against sig. is 0.000. A value less than 0.05 indicate that the data in hand do not produce an identity matrix. It means that there exists a significant relationship among the variables taken for the factor analysis. Thus, factor analysis is justified.

The result of factor analysis over 15 factors revealed that there are five key factors, which were determined by clubbing the similar variables most affecting barriers in the subscription of MEDICLAIM insurance and ignoring the rest. The following table shows the respective percentage of variance of all these factors derived from factor analysis.

The Total Variance Explained by Various Factors

Component	Initial Eigen Values			Extraction Sums of Squared Loadings			Rotation sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.007	26.716	26.716	4.007	26.716	26.716	2.518	16.787	16.787
2	2.052	13.679	40.395	2.052	13.679	40.395	2.130	14.200	30.986
3	1.634	10.893	51.288	1.634	10.893	51.288	1.874	12.492	43.478
4	1.250	8.333	59.621	1.250	8.333	59.621	1.769	11.790	55.268
5	1.056	7.037	66.658	1.056	7.037	66.658	1.708	11.390	66.658
6	.971	6.473	73.131						
7	.688	4.588	77.719						

8	.630	4.202	81.921						
9	.571	3.806	85.727						
10	.548	3.651	89.378						
11	.471	3.143	92.521						
12	.388	2.585	95.106						
13	.342	2.279	97.385						
14	.228	1.518	98.903						
15	.165	1.097	100.000						

It is observed from the above table that there are only five factors which have Eigen value more than 1 and the variance explained by these 5 factors is 26.716%, 13.679%, 10.893%, 8.333% 7.037% respectively and cumulative variance explained by all these six factors is 66.658%. Rest of the variance is due to other factors which are beyond the scope of study.

Rotated Component Matrix indicates the degree of relationship between a particular factor and the particular variable.

The Rotated Component Matrix of Factor Analysis

Variables	Component				
	1	2	3	4	5
Not aware of MEDICLAIM policy features	.245	-.085	-.125	**.796**	.044
Lot of conditions in the policy document	**.649**	-.092	.045	-.423	.075
Lack of comprehensive coverage	**.763**	.251	.033	.040	.054
Hidden cost is involved	**.736**	.105	.238	.073	.107
Complex process for claims	**.614**	.245	.223	.023	.295
Difficult to approach insurance agent	.048	**.755**	-.003	.289	.381
Insurance agents are not well aware of policies	.158	**.684**	.173	-.300	.053
Behaviour of insurance agent was not satisfactory	.182	**.790**	.169	-.195	-.197
No proper guidance to select MEDICLAIM policy	-.315	-.146	.010	**.769**	-.048
More deductible applicable	.181	.048	.083	.310	**.684**
Negative feedback about health insurance claim process	.020	.117	.153	-.175	**.815**
Employer contribution will make	.256	-.109	.015	-.081	.345

MEDICLAIM cost cheaper					
MEDICLAIM insurance should be available with least formalities	.464	-.403	.430	.043	.346
All diseases are not covered	.122	.031	**.897**	-.078	.201
All hospitals are not covered	.214	.325	**.819**	-.066	.003

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

The above table shows that each statement corresponding to the highlighted factor loading is correlated with the factor corresponding to that factor loading. Higher the factor loading, stronger is the correlation between the factors and statement.

Factor 1 consists of "Lot of conditions in the policy document, Lack of comprehensive coverage, Hidden cost is involved and Complex process for claims". Hence, factor 1 can be named as "Formality Bottleneck".

Factor 2 consists of the variable "Difficult to approach insurance agent, Insurance agents are not well aware of policies and Behaviour of insurance agent was not satisfactory". Thus, factor 2 can be named as "Agent Related Problem".

Factor 3 consists of "All diseases are not covered and All hospitals are not covered." Hence, factor 3 can be named as "Coverage Issues".

Factor 4 consists of the variable "Not aware of MEDICLAIM policy features and No proper guidance to select MEDICLAIM policy". Thus, factor 4 can be named as "Lack of Awareness".

Factor 5 consists of the variable "More deductible applicable and Negative feedback about health insurance claim process". Thus, factor 5 can be named as "Negative Feedback".

On the basis of rotated component matrix, the factor extraction table has been prepared which is given below.

Factors Extracted Percentage of Variance and Loading on the Variables

Factor	% Variance	Factor Interpretation	Variables included in the factors	Loading
F1	26.716	Formality Bottleneck	Lot of conditions in the policy document	0.649
			Lack of comprehensive coverage	.763
			Hidden cost is involved	.736
			Complex process for claims	.614
F2	13.679	Agent Related Problem	Difficult to approach insurance agent	.755
			Insurance agents are not well aware of policies	.684
			Behaviour of insurance agent was not satisfactory	.790
F3	10.893	Coverage Issues	All disease are not covered	.897
			All hospitals are not covered	.819
F4	8.333	Lack of Awareness	Not aware of MEDICLAIM policy features	.796
			No proper guidance to select MEDICLAIM policy	.769

F5	7.074	Negative Feedback	More deductible applicable	.684
			Negative feedback about health insurance claim process	.815

The above stated factors are in the order of degree of importance i.e. factor 1 is more important than factor 2; factor 2 is more important than factor 3 and so on. The factor 1 has 26.716% of variance which is the highest variance as compared with factor 2, 3, 4, and 5 where percentage of variance is 13.679, 10.893, 8.333, 7.074 respectively.

From above, it can be concluded that Formalities bottlenecks, Agent related problems, Coverage Issues, Lack of Awareness, Negative feedback are main issues in the selection and monitoring of MEDICLAIM insurance.

6.24 STRESS AND MEDICLAIM POLICY

The foremost advantage of MEDICLAIM policy is perceived to be psychological stress relief and reduced burden on medical expenses in the case of any bitter medical eventuality.

6.24.1 MEDICLAIM AND PSYCHOLOGICAL STRESS RELIEF OF THE POLICY HOLDERS

Being policy holders in the MEDICLAIM insurance, the policy holders take a shield in the policy which reduces the psychological stress level in the minds of MEDICLAIM policy holders to face any eventuality in life.

The survey showed that before taking the MEDICLAIM policy, the psychological stress was felt by 247 respondents (82.33%) out of 300 respondents surveyed. However, after taking the MEDICLAIM policy, 77 respondents

(25.67%) have felt to be in psychological stress. This meant that the psychological stress level get decreased in the case of majority of the MEDICLAIM policy holders. In fact, about 74% of the MEDICLAIM policy holders had stated that they did not have psychological stress after taking MEDICLAIM policy.

TABLE – 6.20

MEDICLAIM AND PSYCHOLOGICAL STRESS RELIEF OF THE POLICY HOLDERS

Type of Change	Before taking MEDICLAIM	After taking MEDICLAIM
Stress	247 (82.33%)	77 (25.67%)
No Stress	53 (17.66%)	223 (74.33%)
Total	**300**	**300**

Source: Primary Data

It is seen from the above table that out of the 300 respondents, only 53 respondents (17.66%) had no psychological stress even before taking the MEDICLAIM policy but 223 respondents (74.33 per cent) had no psychological stress after taking the MEDICLAIM policy. Thus, purchase of the MEDICLAIM policies permeates a sizeable cross section of policy holders with no psychological stress level.

6.24.2 BURDEN ON MEDICAL EXPENSES OF THE POLICY HOLDERS

The Survey revealed that before taking the MEDICLAIM policy, the medical bill commitment was felt to be very high by 249 respondents (83%) out of

300 respondents surveyed. However, after taking the MEDICLAIM policy, only 79 MEDICLAIM policy holders (26.33%) have felt the medical bill commitment to be very high. This meant that the burdensome commitment to medical bill had decreased in the case of majority of the MEDICLAIM policy holders. In fact, about 74% of the MEDICLAIM policy holders had expressed that they experienced the lesser commitment to medical bill after taking MEDICLAIM policies.

TABLE – 6.21

BURDEN ON MEDICAL EXPENSES OF THE POLICY HOLDERS

Type of Change	Before taking MEDICLAIM	After taking MEDICLAIM
Commitment	249 (83%)	79 (26.33%)
Lesser Commitment	51 (17%)	221 (73.67%)
Total	**300**	**300**

Source: Primary Data

It is observed that out of the 300 respondents surveyed, only 51 respondents (17%) had lesser commitment to medical bill even before taking the MEDICLAIM policies but 221 respondents (73.67%) had lesser commitment to medical bill after taking the MEDICLAIM policies. Thus, purchase of the MEDICLAIM policies pervades a substantial cross section of policy holders with lesser commitment to Medical bill.

6.24.3 PSYCHOLOGICAL AND FINANCIAL STRESS: AN ANALYSIS USING *Mc Nemar Test*

In order to test whether there is any significant difference in psychological and financial stress among the sample members before and after taking the policies, the following null hypotheses were framed and tested using Mc Nemar test setting the level of significance at 5% (i.e., 0.05).

1. There is no significant difference in psychological stress level among the sample members before and after taking the MEDICLAIM policies.
2. There is no significant difference in commitment to medical bill among the sample members before and after taking the MEDICLAIM policies.

The P value method is used to identify a region of rejection. The P values are found out and the results of the Mc Nemar Test are given in the following table.

PSYCHOLOGICAL AND FINANCIAL STRESS

- AN ANALYSIS USING *Mc Nemar Test*

Stress	P value	Level of Significance	Remarks
Psychological Stress Level	0.035297	0.05	H_0 Rejected
Commitment to Medical bill	0.014059	0.05	H_0 Rejected

It is clear from the above table that remarkable positive response is noticed after taking MEDICLAIM policies in two variables governing stress**:** psychological stress level and Commitment to medical bill. In both the cases, the

P value is less than the level of significance and hence, the null hypotheses are rejected implying that there is a considerable positive response in respect of these variables as a result of taking the MEDICLAIM policies.

To conclude, the MEDICLAIM policy holders must take some steps to ensure a smooth claim settlement process — while buying the policy and at claim intimation stage. Closely monitored by IRDA, insurers are fully committed to pay all genuine claims, as it not only impacts the credibility and reputation of the company but entire industry.