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Myth or coverage: experience and expectation of policyholders from health insurance during COVID-19 in the NCR region of India

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Abstract

This study intends to determine whether and to what extent policyholders admitted to the hospital for COVID-19 treatment receive financial support from their health insurance. The researcher interviewed 67 health insurance claimants in the NCR region's several cities—some in Uttar Pradesh, Delhi, Haryana, and Rajasthan. They also interviewed various insurance system participants, including branch managers, agents, and hospital staff, to obtain an overview of policyholder experiences and insurer challenges. For analysis, qualitative research techniques have been used. This research is helpful in various situations when people are hospitalised for planned and unanticipated reasons by recommending what insurance companies should do to protect the interests of their customers. For the Indian insurance industry and regulator/supervisory authorities, the COVID-19 pandemic incidents can be a lesson about their strengths and weaknesses. According to this research, service-level agreement violations, procedural bottlenecks, and lack of clarity and awareness are the problems policyholders face when pursuing claims. The challenges insurers confront in serving their client's needs are maintaining operations in the face of financial stress and changing regulatory compliances, on the one hand, and helping policyholders by resolving their claims and raising awareness, on the other.

Keywords Health insurance, Policyholders, Claim, COVID-19, IRDAI

JEL classification G22, O47

Introduction

Background of the study

The second COVID-19 wave resulted in the hospitalisation of countless people, placing a heavy financial strain on them. If they had health insurance, they won't have to spend all their saving on medical expenses, which would have relieved their financial burden. However, it has been observed during COVID-19 that people with health insurance have unsatisfactory experiences. Receiving cashless care or having claims paid out grew more challenging as there were more COVID-19 cases. Numerous statistics have been reported in the newspaper on the rise in health insurance claims, the flaws in insurance companies' claim settlement procedures, and the difficulties policyholders have in their claims settlement at network medical providers. Consequently, IRDAI and supervisory authorities have released several guidelines on efficiently settling claims and introducing various COVID-specific policies.

In the COVID scenario, health insurance claims increase as a result of a high number of hospitalisations,

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which, on the one hand, strains the resources of health and general insurers and, on the other hand, makes policyholders frustrated with their insurance companies when partial or non-settlement of the claim occurs. According to one article published in Business Standard, the number of COVID-related health insurance claims received by general and health insurers in the financial year 2022 is very high than what they had received in the financial year 2021 (Business Standard, 2021 August 21).

According to the reported insurance settlement ratio of the companies, 90% of reported claims have been settled, which is pretty excellent [14]. Although policyholders claimed that hospitals charged unreasonable rates to insured patients, excluding certain medical expenses and rate caps imposed by the state government and General Insurance Council (GIC) prevented them from receiving a full settlement for their claim amount. All of these factors combined to create a sizable amount of unpaid medical expenses that put a heavy financial burden on them.

Insurance is generally viewed as a medium to ensure financial security, but it is viewed as voluntary, frequently at the more profound levels of an individual's regime of needs [16–18]. The COVID-19 pandemic has changed people's mindset by making them realise that getting infected by the disease has become a distinct possibility. Hence, people now consider that insurance policies are more of a necessity than an alternative. The role of health insurance is highlighted during the pandemic due to rising medical costs; hence, examining the benefit of health insurance to those who have purchased it is the need of the hour.

We examined policyholders' experiences with and expectations from their health insurance during COVID-19. We interviewed 67 health insurance claimants in the NCR region's several cities—some in Uttar Pradesh, Delhi, Haryana, and Rajasthan. We also interviewed various insurance system participants, including branch managers, agents, and hospital staff, to obtain an overview of policyholder experiences and insurer challenges.

This research is crucial not only for COVID-19 but also for determining what the regulator, insurers, and policyholders should do and how they may prepare when any health crisis arises. Before COVID-19, we never anticipated a situation of this nature, but during COVID-19, policyholders encountered several issues due to exclusion, SLA violations, and procedural bottlenecks. Insurance companies also experienced several difficulties due to increased claims, changes in the pattern of claims, remote working, malpractices, and other issues. IRDAI has issued several guidelines and circulars to address the issue, even though policyholders suffered while these regulations were formulated. The results of this study will help us decide what should be done and how to address such crises in the future.

Claim settlement practices of insurance companies: an overview

The settlement of the claim is one of the most significant interactions a current policyholder has with an insurance company. Policyholders expect their insurance providers to be a reliable source of financial relief during pandemics when they have a lot of difficulty obtaining hospital beds and medical facilities. We believe that their experiences of claim settlement with insurance providers will either strengthen or weaken their relationship and affect how they choose to purchase insurance in the future. A positive experience can drive them to make a long-term relationship, while a negative experience can break the trust. The health insurance claim settlement during COVID-19 is depicted below (Fig. 1):

Steps involve in claim handling

Existing policyholders' claims experiences are driven by how they have been treated throughout various claim stages and channels of communication, which begin with the reporting of claims and end with the payment of claims (see Fig. 2).

The following three steps were involved:

- Reporting and documentation of claims by the claimant: Claim reporting and documentation are the initial stage at which the client demands their insurance companies keep their commitments. It covered their experience, such as how long it took to report the claim and receive a response from the company, how claims were reported (offline and online), and how well trained and engaged the staff was with the claimant. There are two ways to settle claims: cashless claims and reimbursement claims. The entire process for a cashless claim is completed at the hospital, and the policyholder is not required to pay any cash. For a reimbursement claim, the policyholder first paid the hospital bill before requesting reimbursement from the insurer.
- Claim settlement: The experience of the claimants can be seen in terms of the amount of the settled claim, the eligibility for settlement, the time it took to resolve the claims, the management structure, the level of personal support, and the reasons the claim was denied or left unpaid. The policyholders had various issues during COVID-19, such as partial settlement of claims, claim denial and other challenges, which fuelled resentment among them.
- Claim dispute resolution: The policyholder may file a complaint if their claim is not adequately settled. The

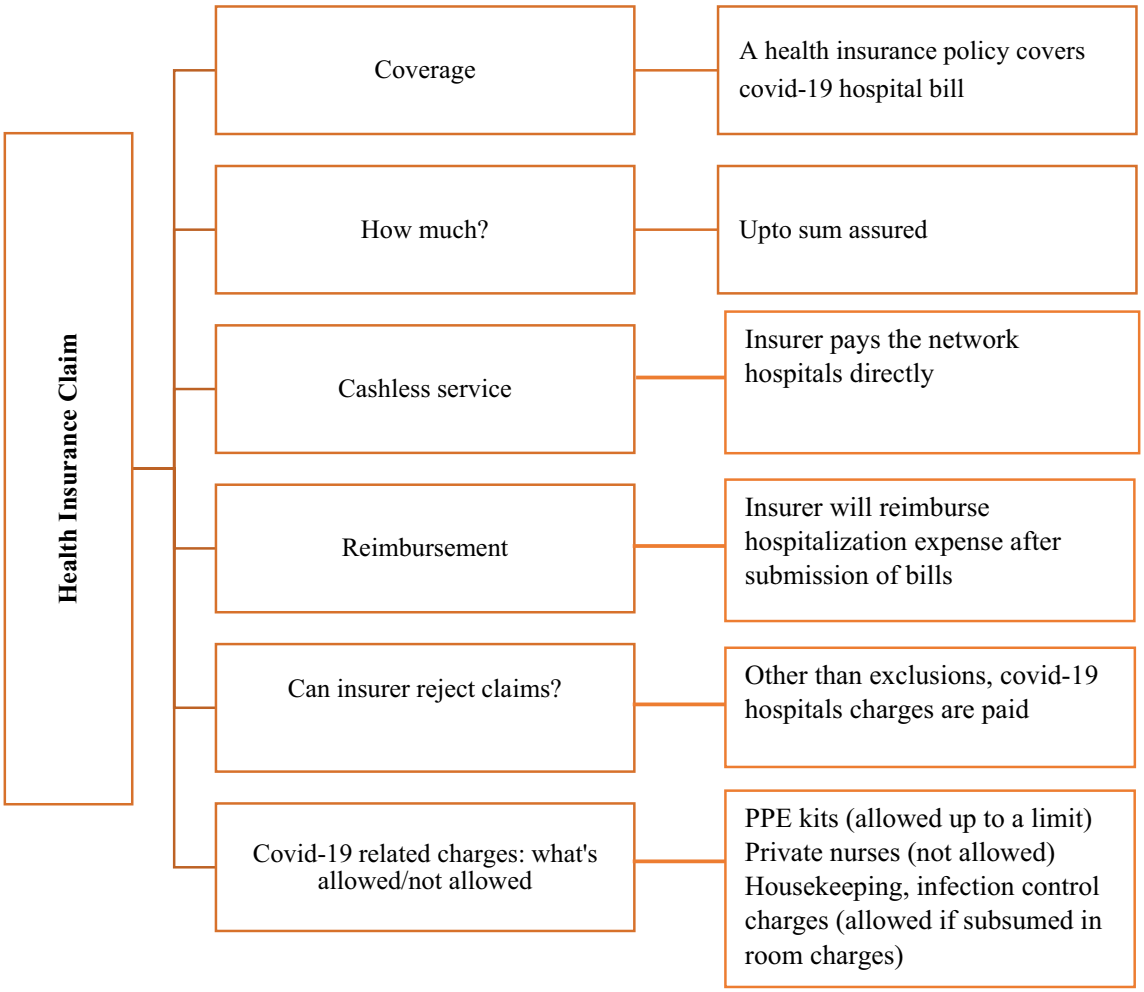

Fig. 1 Health insurance claim settlement mechanism during COVID-19

claim dispute reporting procedure and documentation, the length of the dispute resolution process, the amount ultimately paid, and staff competency and support during the dispute resolution process can all be used to gauge policyholders' experiences in this respect. At the time of COVID, when the claims of many policyholders were partially settled, and they applied for the remaining amount, the time it took to resolve the disagreement ranged from 3 to 18 months. Some policyholders with denied claims have not opted for claim amount reimbursement because the process is cumbersome, while others do so because they are unaware of it or are ignorant of how it works. Suppose someone wants to apply for claim amount reimbursement either due to partial claim settlement or claim denial. In that case, they must file a complaint on the insurer's Grievance Redressal Mechanism as given in the policy document. If insurers do not attend complaint within 15 days of filing, the claimant can use Integrated Grievance Management System (IGMS) to escalate the complaint to IRDAI. Alternatively, complaints can be directly filled through email to complaints@irdai.gov.in or call toll-free No. 155255 or 1800 4254 732 [15] December 26).

Parties involved in health claim settlement

The claimants' experience depends on their interaction with several parties involved in the claim settlement process [19]. Claim settlement is based on the effective handling of the claim by various parties involved (see Fig. 3).

Guidelines for regulating the handling of insurance claims

The supervisory and regulatory authorities have released several guidelines on several domains, as shown in Fig. 4,

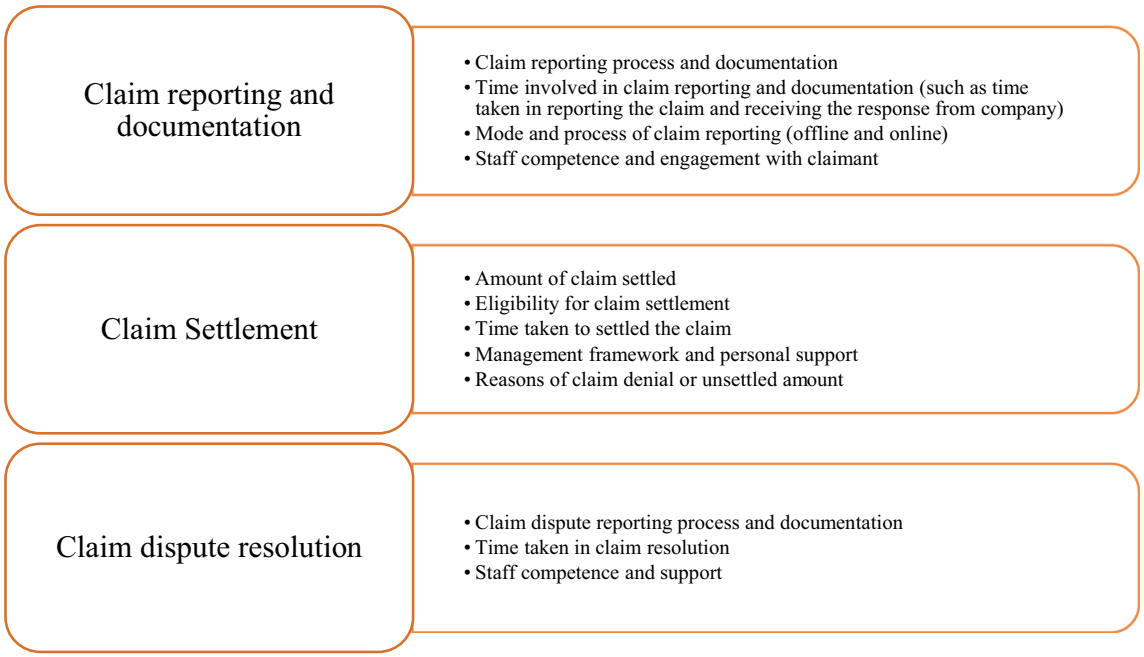

Fig. 2 Steps involved in insurance claim handing

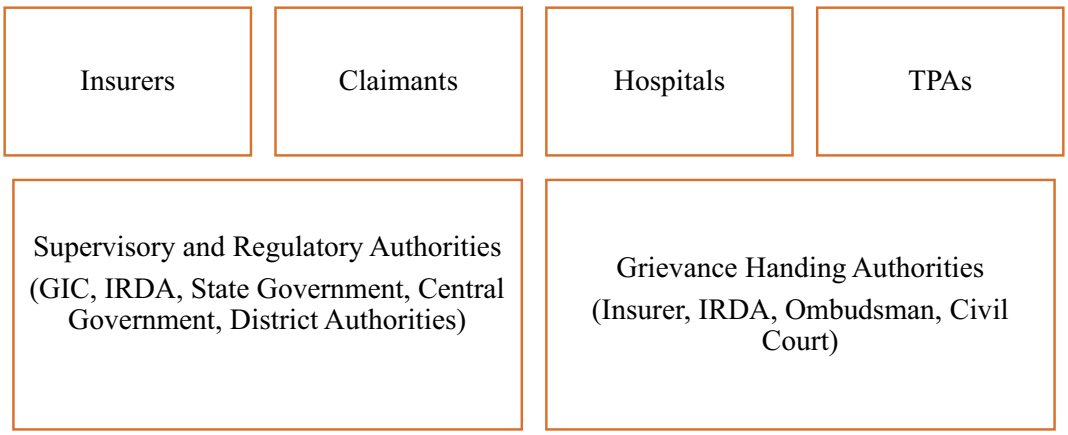

Fig. 3 Parties involved in health claim settlement during COVID 19

to ensure the effectiveness of claim handling during COVID-19.

Cashless claim

The regulator directed that claim shall compensate as per the tariff determined between the parties in compliance with provisions of Regulation 31 of IRDA (Health Insurance) Regulation, 2016 [2–4, 6] January 1). However, the reference rate of GIC can keep in view along with the rate fixed by the state government and union territories. Additionally, the IRDA mandated that the insurers seek to reach a deal with medical professionals regarding the cost of treating COVID-19 in a manner comparable to other conditions for which rate agreements are in existence. It noticed that hospitals have been demanding advance deposits, charging different rates, and refusing cashless treatment during COVID-19. These actions are not only detrimental to the interests of policyholders but may also violate the service-level agreement between the hospitals and the insurance companies [2–4, 6], April 23). The IRDAI, GIC, state governments, and union territories have all issued press releases and circulars to curb these activities (Fig. 4).

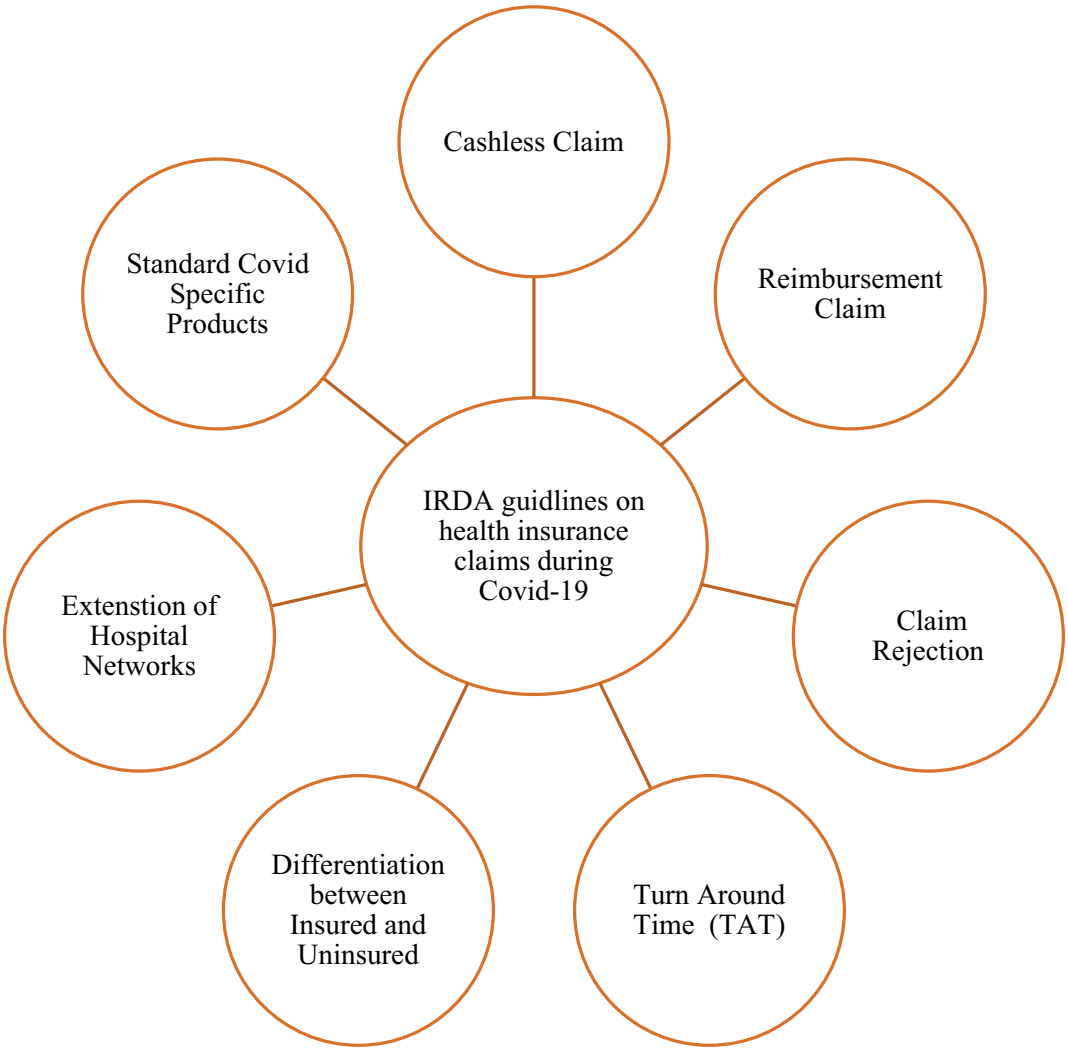

Fig. 4 Guidelines for regulating the handling of insurance claims during COVID 19

Reimbursement claim

Insurance claims must be resolved per the terms and conditions of the relevant policy contract and properly honoured ([2–4, 6] January 1).

Claim rejection

All claims reported under COVID-19 must undergo a comprehensive evaluation by the claim review committee before being rejected, according to an IRDAI ([5], March 4).

Turn around time

Following the second coronavirus outbreak, IRDAI issued guidelines on turnaround times ([2–4, 6], April 29) that state:

(a) The network provider (hospital) must be informed of the decision regarding authorisation for cashless treatment for COVID-19 claims within 60 min of receipt of the authorisation request, along with all necessary hospital requirements.

(b) Within ONE hour of receiving the final bill and all required information from the hospital, decisions on the final discharge of patients covered by COVID-19 claims must be reported to the network provider.

The decision was made to ensure that there would be no delays in patient discharge and that hospital beds wouldn't be unoccupied.

Difference between insured and uninsured

It noticed that some hospitals differentiate between insured and uninsured individuals for admissions and treatment ([2–4, 6], April 23). IRDAI urged hospitals to foster trust and strengthen public confidence in the healthcare system. "Insurers are encouraged to ensure that policyholders have charged according to the rates agreed to by network providers whenever appropriate while examining cashless requests. Additionally, insurers recommended ensuring that hospitals don't charge more than the rates fixed with the insurers for the same treatment.

Extension of hospital network

During COVID-19, IRDAI has released guidelines on the extension of the hospital network that is:

(a) When a policyholder diagnosed as COVID-19 positive is admitted into any make-shift or temporary hospital on the advice of a doctor or appropriate government authorities, notwithstanding the definition of hospital specified in the terms and conditions of the policy contract, the treatment costs shall be covered by insurers.
(b) In cases where a network provider has established a temporary or make-shift hospital, the facility will be treated as an extension of the network provider, and a cashless option will be made accessible ([5], July 16).

Standard COVID specific products

In a press release, IRDAI announced that it had received many complaints stating that certain insurance companies are not providing Corona Kavach and Corona Rakshak policies, despite a mandate that all general and health insurers must provide these plans ([2–4, 6] May 10) (Table 1).

Objectives of the study

The study analyses policyholders' experiences and expectations about their health insurance policies in the NCR. An attempt has been made to examine them to ascertain the reasons behind their positive and negative experiences and the steps various parties must take to live up to policyholders' expectations. Since the insurance penetration is low in India and after COVID 19, the role of insurance is highlighted again and again; this study attempted to determine the actions to be taken by insurers, regulators, and other parties involved to ensure adequate settlement of the claim in every circumstance. The claim is

Table 1 COVID-19 cases in NCR till November 30, 2022

Area covered	States	Cities	Confirmed cases
NCR	Delhi	Central Delhi	184
		East Delhi	38
		New Delhi	37
		North Delhi	60
		North East Delhi	25
		North West Delhi	32
		Shahdara	48
		South Delhi	70
		South East Delhi	130
		South West Delhi	42
		West Delhi	122
	Haryana	Bhiwani	22,394
		Charkhi Dadri	5068
		Faridabad	99,801
		Gurgaon	180,972
		Jhajjar	18,827
		Jind	21,202
		Karnal	39,999
		Mahendragarh	21,687
		Nuh	5010
		Palwal	10,981
		Panipat	31,135
		Rewari	20,304
		Rohtak	25,876
		Sonipat	47,126
	Rajasthan	Alwar	59,652
		Bharatpur	19,590
	Uttar Pradesh	Baghpat	9128
		Bulandshahr	20,201
		Gautam Buddh Nagar	63,228
		Ghaziabad	55,622
		Hapur	12,628
		Meerut	69,420
		Muzaffarnagar	30,999
		Shamli	12,974

Source: Data are retrieved from: https://www.oneindia.com/coronavirus-affected-cities-districts-in-india.html on 2nd December 2022

NCR districts are based on its definition by the National capital region planning board (Ministry of housing and urban affairs, government of India retrieved from https://ncrpb.nic.in/ncrconstituent.html

ultimately the prime consideration for the policyholder while purchasing the policy. Hence, the study stated the following objectives:

(1) To comprehensively assess the claim settlement experience of health insurance policyholders during COVID 19.
(2) To understand the problems insurers encounter in settling their policyholders' claims during COVID-19.
(3) To provide recommendations for policy and practice for adequate settlement of claims.

Methodology

This exploratory study examined the experience and expectations of the policyholder from their insurance policies while making claims and the challenges insurers face in settling their clients' claims. The research used a qualitative methodology to attain its objectives. The indicators for claim settlement draw from an extensive literature survey. The literature came from various sources, including print, electronic, and public documents. The target group was surveyed and interviewed, and the transcripts underwent thematic and content analysis to identify the contributing aspects to policyholders' and insurers' experiences.

Policyholders' interviews

Universe of the study

The universe of the study is the policyholders residing in the NCR region. Why NCR? The NCR region was chosen because the number of COVID cases is very high in this area**.** The reason for not taking rural areas of the NCR region is that insurance penetration is low in rural areas, especially for health insurance.

Areas where respondents stay

The respondents mainly hail from the areas such as:

Research design

We interviewed 67 health insurance policyholders from some cities of the NCR region that constituted cities from Uttar Pradesh, Delhi, Haryana, and Rajasthan (see Table 2). NCR region was selected because the number of COVID cases is very high in this area**.** We used snowball sampling for selecting respondents where one source recommends others. Since it is not easy to get data on the people who have been hospitalised due to COVID and also have insurance policies, we have asked the respondents to give the names and contact numbers of acquaintances who were hospitalised due to COVID. Then, we contacted those in our study area for further details. We

Table 2 Areas where respondents stay (Health insurance claimants)

Respondents	Place	City	State
HC1	Ganganagar	Meerut	Uttar Pradesh
HC2	Begum Bagh	Meerut	Uttar Pradesh
HC3	Saket	Meerut	Uttar Pradesh
HC4	Saket	Meerut	Uttar Pradesh
HC5	Lal Kurti	Meerut	Uttar Pradesh
HC6	Kairana	Shamli	Uttar Pradesh
HC7	Subhash nagar	Shamli	Uttar Pradesh
HC8	Kacheri	Hapur	Uttar Pradesh
HC9	Krishna Nagar	Hapur	Uttar Pradesh
HC10	Adarsh Nagar Colony	Hapur	Uttar Pradesh
HC11	New Mandi	Muzaffarnagar	Uttar Pradesh
HC12	New Mandi	Muzaffarnagar	Uttar Pradesh
HC13	Pari Chowk	Gautam Buddh Nagar	Uttar Pradesh
HC14	Beta 2	Gautam Buddh Nagar	Uttar Pradesh
HC15	Kasna	Gautam Buddh Nagar	Uttar Pradesh
HC16	Alpha 2	Gautam Buddh Nagar	Uttar Pradesh
HC17	Awas Vikas Colony	Bulandshahr	Uttar Pradesh
HC18	Jain Mohalla	Baghpat	Uttar Pradesh
HC19	Rajnagar extension	Ghaziabad	Uttar Pradesh
HC20	Sector 19	Faridabad	Haryana
HC21	Sector 16	Faridabad	Haryana
HC22	Sector 14	Faridabad	Haryana
HC23	Sector 11	Faridabad	Haryana
HC24	Sector 17	Faridabad	Haryana
HC25	Sector 19	Faridabad	Haryana
HC26	Sector 17	Gurugram	Haryana
HC27	Sector 17	Gurugram	Haryana
HC28	Sector 53	Gurugram	Haryana
HC29	Sector 53	Gurugram	Haryana
HC30	Lakki Vihar Colony	Palwal	Haryana
HC31	Lakki Vihar Colony	Palwal	Haryana
HC32	Lakki Vihar Colony	Palwal	Haryana
HC33	Bank colony	Shahdara	Delhi
HC34	Bank colony	Shahdara	Delhi
HC35	New Seelampur	New Delhi	Delhi
HC36	Dwarka	New Delhi	Delhi
HC37	Dwarka	New Delhi	Delhi
HC38	Okhla	South East Delhi	Delhi
HC39	Janakpuri	South West Delhi	Delhi
HC40	Janakpuri	South West Delhi	Delhi
HC41	Nagloi	West Delhi	Delhi
HC42	Nagloi	West Delhi	Delhi
HC43	Pitampura	New Delhi	Delhi
HC44	NA	Alwar	Rajasthan
HC45	NA	Alwar	Rajasthan

Table 2 (continued)

Respondents	Place	City	State
HC46	Nagloi	West Delhi	Delhi
HC47	Nagloi	West Delhi	Delhi
HC48	Nagloi	West Delhi	Delhi
HC49	Nagloi	West Delhi	Delhi
HC50	Pitampura	New Delhi	Delhi
HC51	Pitampura	New Delhi	Delhi
HC52	Prabhat Nagar	Meerut	Uttar Pradesh
HC53	Prabhat Nagar	Meerut	Uttar Pradesh
HC54	Prabhat Nagar	Meerut	Uttar Pradesh
HC55	NA	Karnal	Haryana
HC56	NA	Karnal	Haryana
HC57	NAs	Karnal	Haryana
HC58	Beta 2	Gautam Buddh Nagar	Uttar Pradesh
HC59	Beta 2	Gautam Buddh Nagar	Uttar Pradesh
HC60	Beta 2	Gautam Buddh Nagar	Uttar Pradesh
HC61	Beta 2	Gautam Buddh Nagar	Uttar Pradesh
HC62	New Seelampur	New Delhi	Delhi
HC63	New Seelampur	New Delhi	Delhi
HC64	Dwarka	New Delhi	Delhi
HC65	Dwarka	New Delhi	Delhi
HC66	Bank colony	Shahdara	Delhi
HC67	Bank colony	Shahdara	Delhi

interviewed 67 policyholders by contacting them through personal visiting, emailing, and making phone calls. Table 3 provides the number of policyholders and the purpose of the interview:

Based on the literature review, we formed interview questions to elicit policyholders' experiences with (a) claim settlement documentation, amount of claim, staff and system support, and timeliness; (b) claim dispute resolution, and (c) what role regulators should play in protecting policyholders' interests during COVID-19. Open-ended questions based on a semi-structured interview guide by Roulston (2011) were used during the interviews. The interviews lasted between 40 and 50 min. Considering the nature of the study, policyholders were allowed to talk in detail about their opinions (Fig. 5).

Once the data had been collected, transcripts of the interviews' audio recordings were created, after which text codes representing the claimants' perspectives were identified, developed, and cleaned using pattern coding [11]. Consequently, a two-cycle coding technique was used in the study, where a holistic code was created first and subsequently grouped into themes or pattern codes [12]. However, the viewpoints that emphasised sensitive details or occurrences were stated by claimants verbatim.

The authors worked on developing the themes or pattern codes that emerged from the interview transcripts. They compared the holistic codes they had independently developed, and all except two were found to be in accord. To settle this disagreement, the authors looked over the transcripts collectively. After reaching a perfect agreement on the holistic codes, the authors worked together on the pattern codes to categorise the patterns the data showed. Eleven holistic codes are identified based on their highest frequency of occurrence in the coded segments. These codes then converge into five pattern codes for analysis and interpretation of the problems encountered by policyholders. On studying the challenges faced by insurers, two pattern codes made up of five holistic codes were created. Table 6 displays the coding sheet.

The thematic content analysis makes it simple to identify common themes and trends in qualitative data [13], and it also aids in the explication of more complex patterns in the data. Thematic content analysis served as the primary analytical strategy for this study. For qualitative data, content analysis aids in the identification of overarching themes or pattern codes and makes it easier to relate them to theory. The degree of agreement among claimants was the basis for selecting themes or pattern codes and determining the intensity of the relationship. The word choices made by respondents served as an indicator of the strength of the relationship that assisted in developing the framework for claimants' experiences with claim handling in COVID-19. A theme or pattern code was regarded as highly relevant if more than 60% of claimants agreed with its significance; conversely, it was considered weak if less than 30% did. When the level of agreement fell between more than 30% and less than

Table 3 Number of policyholders and purpose of the interview

Interviewees	Number of in dept interviews (IDIs)	Objectives	Discussion outcome
Health insurance claimants	67	Policyholders' perspectives To get a viewpoint on claim settlement experience during COVID-19 To get an idea about their expectation from insurers	Individual experiences from claim settlement during COVID-19 and their expectation from their insurance providers

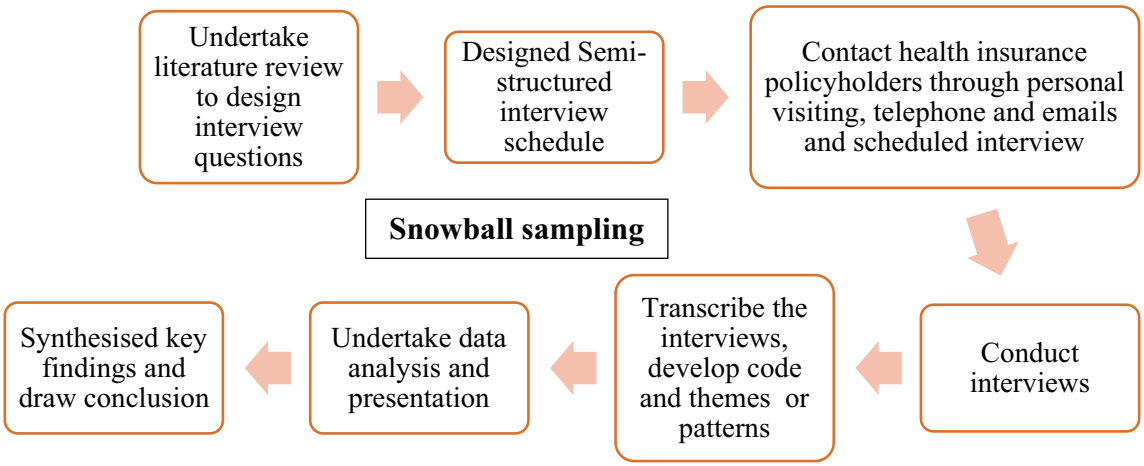

Fig. 5 Methodology for policyholders' interviews

60%, the theme was considered moderately relevant as adopted in the research study of Nayak, Bhattacharyya & Krishnamoorthy [10]

Stakeholders' interviews

Various stakeholders interact directly or indirectly between the insurance company and the policyholders interviewed. To select our interviewees, we used purposive sampling. Then, we contacted them directly by calling, emailing, and visiting them in person. Twenty stakeholders were interviewed, including hospital staff, branch managers, and agents. Table 4 lists the number of each stakeholder and the objectives interview.

The respondents mainly hail from the areas such as:

The objective of the branch managers' interview was to understand more about (i) policyholder awareness of the claim handling process, (ii) the manner of interaction between insurance providers and regulators during the design and execution of policies, (iii) the implementation process, and (iv) their perspectives on the challenges faced by both policyholders and insurers.

Interviews with agents are conducted to learn more about (i) their understanding of the claim policy, (ii) accountability as intermediaries between insurance providers and policyholders, and (iii) perspectives on the issues faced by insurance providers and policyholders. Hospital Staff interviewed to know about (a) the problems faced by policyholders in getting their claim settled, (b) the problems faced by them in dealing with clients and TPA, (c) the steps taken by them to satisfy their clients, and (d) their opinion on the news on overbilling, differential rate and advance deposits of cash and other malpractices (Fig. 6).

Table 4 Number of stakeholders and purpose of the interview

Interviewees	Number of in dept interviews (IDIs)	Objectives	Discussion outcome
Brach managers agents	5 12	Policyholders' perspectives To get their viewpoint on the problems faced by policyholders in getting their claims settled during COVID-19 Corporate perspectives To get their viewpoint on the problems faced by insurance providers in settling their policyholder's claims during COVID-19	Policy creation and implementation approach Claim settlement practices of insurance providers before and after COVID 19 Claim settlement changing practices of insurance providers during COVID 19 Their opinion on the claim settlement experience during COVID 19
Hospital staff	3	Hospital Perspective To get their viewpoint on the problems faced by hospitals in satisfying their patients, especially those whose treatment costs are covered under any health insurance policy	

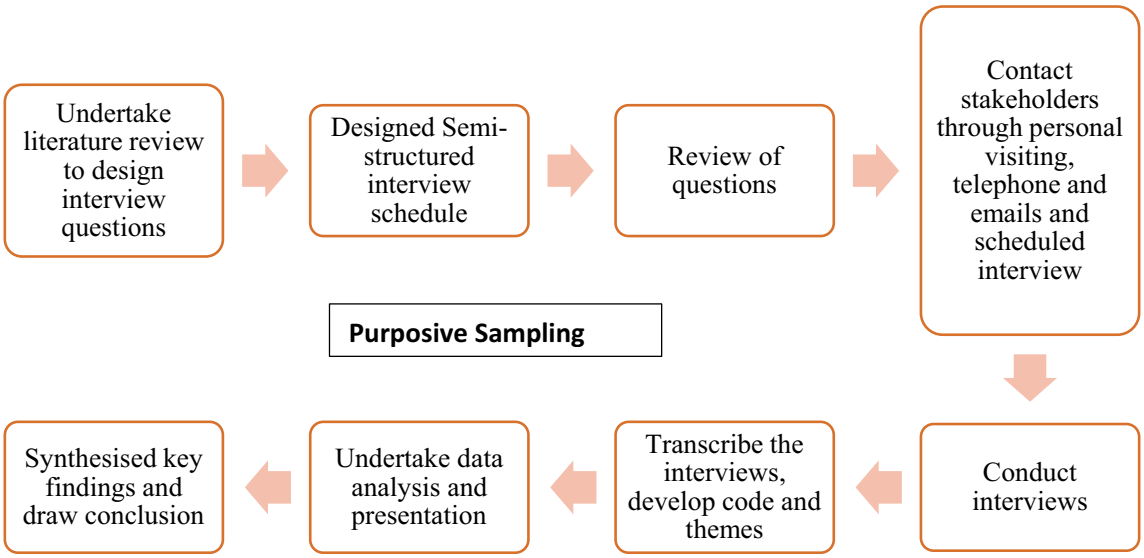

Fig. 6 Methodology for stakeholders' interviews

Table 5 Areas where respondents stay (Stakeholders)

Respondents	City	State
AG1	Gautam Buddh Nagar	Uttar Pradesh
AG2	Gautam Buddh Nagar	Uttar Pradesh
AG3	Bulandshahr	Uttar Pradesh
AG4	Bulandshahr	Uttar Pradesh
AG5	Meerut	Uttar Pradesh
AG6	Hapur	Uttar Pradesh
AG7	Palwal	Haryana
AG8	Gurugram	Haryana
AG9	Faridabad	Haryana
AG10	New Delhi	Delhi
AG11	New Delhi	Delhi
AG12	New Delhi	Delhi
BM1	Meerut	Uttar Pradesh
BM2	Meerut	Uttar Pradesh
BM3	Bulandshahr	Uttar Pradesh
BM4	Hapur	Uttar Pradesh
BM5	Gautam Buddh Nagar	Uttar Pradesh
HS1	Palwal	Haryana
HS2	Meerut	Uttar Pradesh
HS3	Meerut	Uttar Pradesh

Table 6 Data coding for interview transcripts

Holistic code	Pattern code
Challenges faced by policyholders	
Denial of cash-less treatment Differential rates Overbilling	Violation of service-level agreement
Speed of settlement Exclusions Hospital-insurers-regulators tussles Reporting and documentation	Procedural bottlenecks
Lack of clarity and awareness	Lack of clarity and awareness
Emotional and financial stress	Emotional and financial stress
Challenges faced by Insurers	
Managing financial turbulence Regulatory compliances Continuity of services	Continuity of operations
Spread awareness Claim settlement	Supporting policyholders

Results and discussion

Through the interviews, we discovered that the policyholders' experience during COVID-19 comprises several factors that call for additional research and a strategic approach. The findings of this research advise insurance companies and regulatory bodies on the areas that need to be prioritised. Table 5 displays the data coding for the transcripts of the interviews that consist of eleven holistic codes, which were then grouped into five pattern codes on the issues encountered by policyholders. After researching the challenges faced by insurers, a two-pattern code comprised of five holistic codes was created.

Policyholders' experience with their health insurance policy

Specific areas of policyholders' concerns and areas for improvement are highlighted in the following sections based on the holistic and pattern codes indicated in Table 6:

Violation of service-level agreement

Insurers enter service-level agreements (SLAs) with healthcare providers, renewed yearly. The SLAs contain details on several treatment options to be provided, preset prices, and cashless insurance. Numerous instances of SLA violations by healthcare providers at the time of COVID compelled insurers to rewrite their SLAs with hospitals. Some SLA violations involve denying cashless treatment to the insured, charging differential rates from the insured and uninsured, asking for advance deposits by the hospital at the time of admission, and overbilling by hospitals.

Denial of cashless treatment

There was a rising concern during COVID 19 that hospitals were rejecting requests of policyholders to settle the claim on a cashless basis despite being part of the network. After seeing this, the finance ministry intervened on April 22, 2022, that COVID-19 claims must be settled on priority. They also imposed that those errant hospitals which refuse to accept cashless claim requests from patients' kin could be removed from the insurers' network.

Despite all these moves, there were many cases of denial of cashless treatment. One of our claimants (H43) said that he had initially paid all the amount in cash because the hospital was not ready to admit him on cashless bases. One of the health insurance policy claimants (H1) said in his case claim was partially settled and that he had been waiting for the funds to return for about 1.5 years. The total amount had not been paid due to exclusion, but at least they arrived close. AG 4 said that reimbursement claims take longer to settle since they require the verification of bills by an outside administrator and subsequently by the insurance company's claims division. Cashless claims are immediate. During COVID-19, when the sum had partially settled in some cases, it took claimants a long time to obtain the remaining sum when they pursued it.

In many instances, insured patients had to deposit some amount before being allowed to admit into the hospital. The advance deposit had made by one of the claimants (HC13), who has diabetes, high blood pressure, and lung congestion. When we asked the reason behind the deposit, he replied that no beds were available at hospitals during COVID, so I preferred the money loss over dying by corona. The insurance company paid Rs. 50,000; the final sum he had to pay in cash was Rs. 8000 because Rs. 8000 was excluded from the Rs. 58,000 total hospital bill. HC43 said that she had moved to a hospital in another city due to the non-availability of beds. She initially paid a small amount at the hospital counter, but that was paid back as the insurance company approved the claim. She had to pay a certain amount in cash because of exclusions, but she did not mind. She said, "At least I was getting treatment despite the serious condition" She was in serious condition because of lung problems and was in ICU for a few days. The advance deposit was asked from many patients by hospitals despite having insurance. One more claimant from Greater Noida (HC58), a financial advisor, said that three family members were suffering from COVID-19 and were not getting a bed in the hospital, and they waited for the entire day for a bed. Ultimately, they get beds in the hospital. The hospital had asked for approximately 20,000 cash for each member on the counter. They deposited without questioning because the situation was critical, and at least they received treatment. However, the amount deposited was settled with the final bill, and the entire bill was settled. He had to pay only 5000 each due for justifiable exclusion. He said I am delighted with my insurance company and the hospital. Another claimant from Karnal, Haryana HC56, said that he went to a hospital where he was asked about the advance deposit that he had made, but later, the amount was adjusted in their medical bill. HC53 was treated in a hospital in Greater Noida, and his hospital bill was Rs. 450,000 due to his 20 days of hospitalisation and severe medical condition. His bill was fully settled except for the exclusion of Rs. 20,000. However, he also mentioned that the hospital told him to arrange oxygen, remdesivir, and other medicine/injections due to the non-availability cost approximately Rs. 400,000 more. He arranged it independently, which was not counted in the medical bill. It was his additional cost of treatment. To quote some of the responses:

HC6: I had admitted to the hospital in June 2021 because of the corona. It was having problems in breathing. My family member was scared because of my age and incidences of misshaping near us. The hospital requested the advance amount, but it returned after claim approval.

HC10: I had asked for an advance deposit before admitting by saying once the claim is approved, we will get the amount back.

HC13, HC17: We had deposited 50,000, but the amount had returned after claim approval from the insurance company.

HC22: Yes, we have asked for a security deposit from the hospital.

HC30, HC31, HC33: Yes, we have deposited the amount because not all hospitals are treating coronavirus, and the availability of beds is less. So, we did what the hospital asked.

HC35: I required medical attention but couldn't find a bed in my city.

HC36: We want treatment rather than consider insurance and other things. We did whatever the hospital asked.

HC36:We choose to worry about medical attention above insurance and other things.

There were certain instances where the patient had not asked for the advance payment. To use some responses:

HC35: I couldn't find a bed in my city, but still needed treatment.

H28: Because of a corona, I was at a hospital in Gurugram. I was fine, but my family sent me to the hospital because of my older age, high blood pressure, and kidney problems. I received medical care without paying with cash. H29: I had not paid any amount. HC 2, HC5, HC7, HC8, HC9, HC12, HC15, HC24, HC66, and HC62 were also not asked for any amount. They had covered under Ex-Servicemen Contributory Health Scheme (ECHS). AG11 said it was a matter of chance that the entire amount paid or no amount deducted because of consumable or exclusion. It might be because the policy cover consumables also.

Differential rates

There were many instances where different rate had charged to insured and uninsured for the same treatment ([1], August 2020) mentioned a patient Mr Bhavtosh Mishra from Delhi, who had been charged Rs. 750 per day in a private hospital as charges for infection control during COVID-19. Though he shared a room with another person (who was uninsured), only Mishra had charged this amount. He had to pay another Rs 10,000 out of pocket as his insurer declined to cover the total amount. Although customers have submitted about 1,27,000 claims for medical expenses associated with COVID-19, hospitals and insurance companies are still at odds over which costs should be paid.

The victims of this blame game between the two parties are the policyholders. Hospitals and insurers were in a constant battle over COVID-19 hospitalisation rates. Hospitals had argued that all patients could not be subject to price caps, and insurers had accused them of not following the General Insurance Council's standard rate.

According to an article by Bathla [7] in The Tribune, Pardeep Sood, a resident of Sector 15 in Panchkula (Haryana), had to pay Rs14.5 lakh out of pocket for his father's 30-day stay at the hospital after his father passed away while undergoing treatment there. "Of the 18.5 lakh rupees in hospital bills, 3 lakh rupees were paid by insurance. Additionally, Rs. 1 lakh was reduced after the insurer's intervention. We ultimately had to pay Rs. 14.5 lakh, though. The average daily expenses came to Rs 61,000 daily, and the 30-day hospital stay of the late Jagdish Chand Sood included 27 chest X-rays.

The amount approved by the insurance company for AG4's client, who was receiving treatment at a renowned hospital in Greater Noida, was approximately 55% of the hospital bill when he inquired with the hospital and spoke with them; however, almost the amount was settled. There are always policy exclusions that the client is responsible for paying in cash and never objects to them. However, they object when patients ask hospitals for the extra amount. AG4 continued, "He was approached about this matter by very few clients, which may be related to pandemic chaos where it was a fortune for you if you got medical treatment at whatever cost".

Overbilling

During COVID-19, inflated billing occurred often. The hospitals had developed comprehensive COVID 19 treatment plans without disclosing to the claimants what the medications would cost them. The amount of the claims had partially settled due to overbilling, and the remaining sum had to pay in cash. Two claimants (H3 and H4) were hospitalised for 5 and 7 days in one of Delhi's renowned hospitals, and their respective hospital bills were Rs. 350,000 and Rs. 540,000. Their bills had settled for 250,000 and 430,000. However, they were unconcerned about them due to their sound financial condition. They claimed, "We were at least tension-free because of the good hospital services".

In another instance, three claimants from Delhi (HC38, HC39, and HC 40) stated that the insurance company only partially covered the bills, with the balance being paid in cash. The hospital could not explain when they inquired why and instead stated that the company had only honoured this amount. "It was all due to overbilling of the hospitals; the medication and injection it has shown on the bill was not given to him", H38 said. He continued, "They were also asked for a deposit in advance, but that was acceptable to him because during COVID-19, at least he was getting the bed and treatment. But the latter scenario, with its excessive bill, unexplained items, and out-of-pocket expenditures, was unacceptable. He asked, "What is the benefit of insurance when they have to cover the medical costs on their own, and do they believe hospitals which are always supposed to be their safe place when they confront any medical issue?" "Everyone was exploiting the predicament or other people's helplessness", he continued. The Government, insurance, and medical facilities saved the people. One more claimant from HC52 from Meerut said that he was admitted to a hospital that was not in the panel of his insurer, and his total amount of bill was approximately Rs. 300,000, and he was taking treatment on a cash basis. He said that

he was not concerned about the bill. He was only concerned about the treatment, and when he was discharged from the hospital after 7 days, he provided documents for claim filling. But, He left his entire amount and didn't go for the reimbursement; when asked why he said that I was not in a position to take more pain of documentation and procedure.

H39 said that she had shifted to another hospital in Delhi because of her deteriorating health condition and lack of trust in the previous hospital. Bill from the shifted hospital was 50,000, and it was cashless. She had not asked for any advance deposit in shifted hospitals. She said, "Some hospitals have followed their morale standards while others have not", One more claimant from Gautam Buddh Nagar (H16) said that his entire treatment was cashless, and insurance was corporate insurance.

Procedural bottlenecks

Speed of settlement

The insurance regulator had issued several press releases and circulars on the swift resolution of the COVID-related claim. Still, several cases have been delayed, especially when reimbursement mode was adopted due to partial claim settlement.

We encountered two instances when claimants chose the reimbursement mode because the claim was partially settled at the hospital. "My amount had cleared for Rs. 40,000 while my bill was Rs. 90,000", the respondent (HC1) stated. I received Rs. 28,000 after follow-up, although it took three months to do so. Respondent (HC18) stated, "My hospital bill was for Rs. 150,000, but it was settled for Rs. 90,000. I chose the reimbursement route and received almost the entire amount, although it took almost a year". "I was supported by a friend who worked in a hospital and sent emails to several authorities because I didn't know the procedures", the claimant said. But in some instances (HC3, HC4, HC27), the respondent chose not to pursue the unpaid balance because they didn't want to deal with the accompanying procedures.

Exclusions

Exclusions apply to every health insurance policy. These are the costs that will not be covered under the insurance policy. Therefore, even if your hospital has levied such fees, your insurer will fail to cover them, leaving you responsible for that portion of the costs. All health insurers must abide by the comprehensive list of exclusions the insurance regulator IRDAI has standardised. Despite this, during the COVID-19 crisis, policyholders were forced to pay a sizable sum out of their pockets as hospitals and insurers fought over 'unreasonable' and 'excessive' hospital fees. One of the respondents (HC32) revealed that he had charged for 3 PPE kits in a day. The Government has allowed PPE kits, but up to a specific limit. Multiple PPE kits are not covered in a day, while the hospital charges for multiple kits. Most insurance companies paid for one PPE kit per day or cost up to 1200–2000 per day. HC34, HC41, HC42, HC44, and HC45 said there are many exclusions during COVID-19 due to consumables; hence they have paid a considerable amount in cash.

The contention in the early days was also over the PPE kits. However, insurers started covering these costs, but certain restrictions continue. "PPE kits have become a sizable portion of the hospital bill, and any excess use beyond the considered limit has been disallowed", says BM2 and BM4.

The emphasis on hygienic measures has significantly increased by COVID-19, which led to higher costs passed on to patients. Insurance providers, however, have opposed the separate invoicing of these costs. Nevertheless, this practice persisted. Similarly, some insurers do not pay for sanitisation and biomedical waste expenditures if invoiced separately. A few more expenses not covered by insurance include those nebuliser kits, steam inhalers, thermometers, private nurses, and attendant fees. The policyholders only received 55% to 85% of the total medical expenses because of all these exclusions. However, in certain instances, we have observed that the patient has made no payment, as in the case of HC16 with corporate insurance coverage. Similarly, HC1, HC2, HC3, HC4, HC5, HC7, HC8, HC9, HC12, HC15, and HC24 claimed they had not paid any amount in cash.

Hospital–insurers–regulators tussles

The General Council developed an indicative rate chart outlining the tariff for paying claims in June 2020. It recommended that insurers pay claims following the rate specified by the state government or, if this was not applicable, under the indicative rate chart. However, the policyholders were left with a problem due to a lack of regulation enforcement. When a Greater Noida resident (HC14) had admitted to a private hospital for COVID 19 treatment, he found himself in a difficult situation. The insurer agreed to pay only Rs. 1 lakh, citing the UP government ceiling, despite the hospitalisation bill being Rs. 1.9 lakhs.

There are several instances where neither the reason for rejection nor the claimant's pursuit of the remaining funds was told. In some cases, insurers refused to pay these charges in full, citing state government caps. If the insurers believe the hospital overcharged, they should hold it liable. They should compel the hospital to limit their billing to what is reasonable. When insurers authorise a cashless pre-authorisation, the claimant trusts the business to control pricing through its cashless

network relationship with the hospital, says HC23. Why was the claimant penalised by the insurance providers? According to HS1, hospitals must handle COVID-related infection-control measures during COVID-19, including testing in-patients and staff, PPEs for healthcare workers, social distancing protocols, and human resource expenditures. As a result, invoices will increase by a specific amount over standard rates.

"Our expenses have increased because of new hygiene standards, including needing PPE kits, masks, ventilators, oxygen, and other injections due to increased COVID cases. The insurer is responsible for covering these expenses", HS2 and HS3 said. BM1 said their company paid out the whole sum following the policy terms.

AG2 and AG10 said that policyholders had not contacted them about the partial payment of the bill amount or any other such practices. They have said if any policyholder ever contacted them, then they help them at that time. AG10 said that one claimant had contacted him for a reimbursement claim for which he has been guided. The amount was settled as per policy, he continued. AG12 said that amount was deducted because the insurance policy did not cover consumables.

> *"Consumable was very high, passing costs to the patient, AG1 said" According to AG12, "There should be a regulating agency for managing the expense of treatment. Previously the procedure, which cost Rs. 15,000, now costs Rs. 100,000. All of this resulted in a rise in insurance premiums".*

Reporting and documentation

In the case of a cashless claim, reporting and documentation are simple, and hospital staff handles all the work. The claimant is the only one who works when using the reimbursement mode. When you choose the reimbursement mode for any reason, the claim can be rejected for two reasons. First, the necessary documents are unavailable; second, treatment does not adhere to accepted protocols. HC14 said they are unaware of the cause of the partial settlement of his claim. According to BM3 and BM5, insurance companies have made it very simple to file paperwork, making it much easier to resolve claims quickly. The amount will be settled if the appropriate paperwork has been done. Before sending the final hospital bill to insurers, hospital staff first submit the anticipated cost of treatment, for which the insurance has granted consent up to a specified sum. According to AG9, the hospital can also influence the amount of approval.

Lack of clarity

Policyholders are concerned about how their insurance will react regarding coverage during COVID-19. IRDAI, however, has clarified it in a press release and asked the insurers to inform their clients. As a result, several insurance companies have issued statements outlining the expenses and losses that insurance will (and will not) cover. Still, several policyholders were unaware of COVID-related exclusions such as PPE costs and room rent and their capping in bills.

Additionally, consumables are not covered, which policyholders know at the time of settlement of medical bills at the discharge. According to AG8, if a patient looks over and finds that they asked to pay for services they did not receive, they may contact the hospital. Sometimes awareness among policyholders matters the most. However, in some instances, the patient chose not to apply for the unpaid amount to the insurer because they were unaware of the process. Many customers were unaware of deductions, reporting and documentation procedures, and government guidelines. BM5 said that his company issued FAQs and messages to the client on coverage. Awareness among policyholders can save them from their financial loss. AG5 said that IRDAI intervened in the situation and encouraged people to contact their insurer or an ombudsperson in the event of an unfair settlement.

As with the insurance industry, insurance market, and banking industry, hospitals should be governed by a regulatory agency, according to AG6 and AG1. Inflated bills are a problem not just during COVID; they were present before COVID but also worsened during COVID-19. AG1 says he will undoubtedly assist if the policyholder contacts him. So, if the hospital erred, you can complain and get the bill amount reduced. But issues arise when customers are uninformed.

Emotional and financial stress

People were under a lot of emotional and financial strain during COVID. As there were no hospital beds, people had to rely on recommendations to obtain treatment; they were unaware of the treatments given to the patients and the costs. The final hospital bill resulted in significant out-of-pocket expenses. All of these have disturbed people emotionally and financially. Health insurance is primarily thought of as relieving financial and emotional stress because you need not pay anything besides the exclusions listed in the policy. But insured people must pay the amount due for any reason, including partial payment, advance deposit, etc.

Challenges faced by insurers during COVID 19

Continuity of operations

Maintaining the continuity of business activities during COVID-19 is one of the major issues for insurers. Insurance companies must make sure that policyholders can access insurance coverage. But, due to financial instability

brought on by a high number of claims, various regulatory compliances, the redefining of service-level agreements, the offering of standard COVID policies, the extension of the hospital network, and malpractice by parties, the insurers faced numerous difficulties in providing services to policyholders and carrying out their business operations in a continuous manner.

Managing financial turbulence

COVID-19 has significantly influenced the financial health of insurance companies. The liabilities of insurers have been affected by shifting claim structures. For example, while claims in some business lines, like property and auto insurance, declined, the claims in other business areas, like health and life insurance, increased. BM2 said that "COVID-19 has not been priced under active policies; hence, these claims may place an additional financial strain on the insurers. However, the claims from other business lines have decreased, which has reduced the additional strain brought on by health insurance claims. "The increase in COVID related health insurance claims has not affected insurers as much because the number of planned procedures goes down at the moment", BM5 said.

Because of the lockdown, motor claims are down for general insurers, which means their loss ratio is also lower [8]. Eventually, planned surgeries will take place, and claims may increase at that time. However, it's also crucial to consider that the low COVID-19 claims are due to the low number of persons with health insurance. Consequently, the industry has been less affected by the increased claims in this sector ([9], June 17).

Regulatory compliances

Insurance companies must adhere to regulatory and supervisory requirements during the COVID-19 period regarding TAT, expanding network providers, defining service-level agreements, and standard COVID-related policies. Governing bodies issued numerous circulars addressing issues faced by policyholders. According to BM4, "the norms and circulars from the IRDAI were continually being updated, which sometimes puts strain on the insurers and necessitates proactive action. For instance, during COVID-19, the turnaround time was shortened, which made it difficult for insurers to comply with it due to staff and facility limitations brought on by COVID-related restrictions such as lockdowns, social distancing, and others.

Continuity of services

Working with less staff and remote working are the main challenges insurers face in providing regular services. According to BM3, "Regulators have urged insurers to embrace the digital channels in policy issuing and claim adjustment. Insurers have adopted digital service solutions and encouraged clients to use them. However, doing so is not always easy for the customer or the insurer, especially when working on a non-digital pattern is a practice. COVID-19 has altered the way of business, yet acceptance of any new technology is challenging, BM3 continued. "In India, face-to-face communication is more respected than remote or digital methods of communication. By having a personal conversation, anyone can quickly grasp something that is otherwise inconceivable owing to numerous restrictions, according to BM2.

Supporting policyholders

Spread awareness

Insurance companies are finding it challenging to keep their customers informed during COVID-19 because insurance offices have been working with limited resources, and there are many questions about the coverage and terms of policies. According to AG7, "I've gotten a few calls from my clients asking if their policy covered COVID or not because, as we all know, in the beginning, everyone was unsure as to whether COVID has covered under the existing policy or not". The regulator did, however, clarify that it is covered. Insurance companies have published FAQs and sent SMS and emails to raise awareness. However, there were many instances where policyholders were unaware of coverage, procedure, paperwork, and exclusions.

The customer might have suffered due to a lack of awareness, AG7 said. For instance, several policyholders decide not to seek due to a lack of understanding of the processes and how to challenge them. They are unsure what their coverage covers or doesn't cover because the COVID-19 pandemic is new to everyone and is rife with uncertainty, which constantly causes revisions to policies. Here, the responsibility of insurance companies and agents arises. Keeping their consumers updated at all times and assisting them during difficult times have been the responsibilities of insurers and agents.

Claim settlement

Insurance coverage has not been developed specifically for the associated costs and losses incurred during COVID. The insurance industry was experiencing a high volume of claims at the time of COVID and shifting regulations on claims handling, exclusions, coverage, and turnaround times. Additionally, disagreements over treatment costs periodically flare between insurers and hospitals. Working in the best interest of policyholders is a concern to tackle at that time. A branch manager of a private health insurance provider in Meerut, the respondent (BM2), stated, "Despite all hurdles, his

company has honoured all claims if they were filled out properly".

Conclusion

Health insurance is often considered a mandatory risk cover. Even still, a sizable portion of the population in our nation lacks adequate health insurance. As medical costs rise, you must have coverage for yourself and your family. However, during the COVID-19 pandemic, there have been multiple instances when people have had to pay significant sums out of pocket despite having insurance coverage. It may be because they were insufficiently covered, parties acted improperly, they were not clear and aware, or for other reasons. Health insurance is always essential due to rising medical expenditures, but insurers and regulators/supervisors must follow several measures for policyholders to receive its benefits.

Overbilling and differential rates have been a typical occurrence in private hospitals. Unfortunately, not only has this pattern persisted throughout the COVID-19 pandemic, it may have been worse as private hospitals used the outbreak as a cloak to hide these practices. Hospital raises prices at will in the absence of transparent billing. The COVID-19 pandemic serves the Indian insurance sector and regulators a valuable lesson to take serious measures to avoid overbilling and differential rates. This study recommended insurers design their agreement with hospitals to specify the cost of treatment with the upper band so that cases of overbilling and differential rates can be controlled. Medical costs are very high nowadays, which, on the one hand, encourages people to buy health insurance to avoid out-of-pocket expenditure, which can be observed from the hike in the purchase of health insurance policies.

On the other hand, after COVID 19 pandemic, we have seen an exorbitant hike in the premium of health insurance, which has passed an additional burden on the pocket of people who want to secure their families from medical emergencies financially. The reason for this hike is the rising costs of treatment. Hence, this study recommended that as the insurance sector is regulated, private hospitals must also come under a specific regulator for their prices. Regulatory bodies in the hospitals will bring down the cost of treatment, which will benefit both who are taking it under an insurance policy or without it. During COVID-19, IRDAI has issued several circulars on various practices of insurance companies, as mentioned in Sect. "Guidelines for regulating the handling of insurance claims", which clarify various aspects related to insurance, such as coverage of COVID-19 in existing policy, reduction in turnaround time, COVID specific products etc. Similarly, the regulatory body over the hospital will control the cost of medical treatment.

Although this study is the first to be conducted in India to evaluate policyholder experiences during COVID-19, it has a few limitations. Due to limited physical mobility to other places, the study initially only covers the NCR region, where COVID cases are relatively high. Moreover, other aspects of insurance underwriting are not covered. The current study creates a base for future scholars in insurance to investigate the experience of policyholders from different lines of the insurance business, which will help to validate that insurance increases the financial well-being of people. This study helps us to understand the course of actions to be taken by insurers to improve the experience of people from insurance.

Abbreviations

NCR	National Capital Region
IRDAI	Insurance Regulatory and Development Authority of India
GIC	General Insurance Council
FY	Financial year
SLA	Service-level agreements
TPA	Third-party administrators
ICU	Intensive care unit
ECHS	Ex-servicemen Contributory Health Scheme
TAT	Turn around time
FAQ	Frequently asked questions

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Author contributions

NS led the research, drafted the paper, research methodology, conducted the data analysis, drafted the results, and discussed the manuscript. AS is a co-author responsible for the research framework and the concluding remarks of the draft. SG has collected the data. Furthermore, all authors have read and approved the manuscript.

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Availability of data and materials
The datasets used during the current study are available from the corresponding author on reasonable request.

Declarations

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The researchers provide the consent form to the participants in the data collection procedure. The participants gave their full consent and the researchers collected the primary data.

Consent for publication
We are with this giving our consent for publication.

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