Analysis of Insurance Process Management to Monitor and Reform the Customer Policy Support

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Abstract.
Good health and supportive insurance is a sustainable combination for both customer and insurance company. Insurance is a domain which provides support to customers in case of emergency. Indian public sector and private sector insurance companies striving to excel in customer facility support in many aspects. Health insurance is almost necessary element for everyone. Motor vehicle insurance, agricultural insurance etc are important sectors which are being opted by customers. In case of private insurance companies, many policy frameworks are available. As a post-pandemic period, many health conditions came which can be included in the health insurance guidelines. However, inconsistent premium submission by clients, fake claim incidences, and fake policy issues arising worldwide. This needs to be evaluated so, this paper presents the analysis for identification of appropriate process evaluation for health insurance.

Keywords: Health insurance, post-pandemic, insurance policy, fake claim, process management, insurance education

Introduction

When monitoring is absent, insurers face a typical moral-hazard problem and a trade-off between risk allocation and incentive provision arises. Policyholders are either partially insured and exert effort or they are fully insured and do not exert effort. Both outcomes are second-best efficient. Perfect monitoring gives the first-best allocation with policyholders being fully insured and exerting effort if it is efficient. If monitoring is imperfect, the first best will usually not be attained [1].Health insurance schemes often include patient copayments to reduce moral hazard the potential overuse of health care when insured. The optimal copayment which reduces moral hazard but still encourages appropriate health care use is likely to differ across individuals depending on their health care needs and capacity to pay. As a result, cost-sharing schemes often include thresholds where copayments change [2].Moral hazard comes from adverse selection in different types of third-party liability claims in automobile insurance policies: that is, those with bodily injury (BI) versus those with only property damage (PD) need to be studied [3].

In contrast, national health insurance schemes typically offer only a single level of coverage. In both contexts, regulation plays a central role in determining the extent of vertical choice, but to date, the economics literature has provided limited guidance to regulators on this topic. In markets with selection, like health insurance markets, this alignment may not be possible [4]. In these markets, costs are inextricably related to private valuations, and asymmetric information prevents prices from reflecting marginal costs the moral hazard problem stems from the fact that insurance companies collect premiums today, while payments on claims are not due until sometime in the future. With this inverted production cycle, competition for premiums may lead insurers to take on excessive risk, especially given their limited liability, a market feature we explore in our theoretical framework of mortgage lending and insurance [5].

All over the world the Covid-19 pandemic and its resulting economic consequences have highlighted social policy shortcomings. One of the most complex issues is the question of how workers who become unemployed can be protected. The theoretical literature on unemployment insurance (UI) in developed countries has long

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recognized its role in terms of both its economic and social value. Terms such as consumption smoothing and job matching are used in line with those related to welfare benefits and analysis [6].Consumer moral hazard refers to an increase in demand for health services or a decrease in preventive care due to insurance coverage. This phenomenon as one of the most evident forms of moral hazard must be reduced and prevented because of its important role in increasing health costs [7].

India has a government health-care infrastructure of sub-centers, primary health centers, and community health centers. There is significant interstate variation in the quality of the infrastructure of these health centers as well as the quality of care provided in them, with the better governed states doing better than the rest. These health centers are almost entirely in the rural areas, where 65% of the population resides [8].

2. Literature Review

Author helped to emphasize the significance of health insurance during the pandemic and analyze the impact on the health insurance industry of COVID-19, covering the challenges faced by health insurance companies and the possible solutions to handle those challenges. This paper does not have a specific purpose; it provides generic and general information regarding the effect of COVID-19 on the health insurance sector of India [9].India's health care suffers from high out-of-pocket medical expenses that lead to a higher financial burden on poor people. To reduce the health cost burden, the government of India has initiated many governments' funded insurance schemes since 2000. Private health insurance also flourished, but the coverage is limited to wealthier households [10].

The most recent nationally representative and publicly available data on health insurance coverage in India were collected in 2015–2016. An investigation of the extent to which place based differences in coverage existed at multiple population levels before ABY implementation would address two gaps in the literature. First, our understanding of drivers of coverage would improve by considering the role of contextual factors in addition to socioeconomic factors [11].

Lack of knowledge about the purpose of insurance and how to use insurance seem likely explanations for the failure rate. Because insurance is a relatively new product, hospitals and beneficiaries may not know how to use it [12].India's healthcare schemes force poorer people to perform complicated valuations of health, wealth, and well-being. How much extra money was it worth spending on Ali's surgery? The answer hinged on many variables: the cost of the surgery, the family's total assets, Ali's earning potential, other household expenses on health, food, education, and maintenance of their land. They had to evaluate if membership in the health scheme was worth it [13].

Strategic social advantage in firms has emerged as a concept that balances the social and fiscal goals of firms. Towards this end, restructuring organizational designs to reduce societal inequalities is gaining prominence. Disruptive technologies are transforming the social and economic context of businesses. Given this background of altered technological, social and economic contexts, a strategic social advantage framework, based on managerial perceptions, has been proposed in this study by integrating the theories of competitive advantage and social orientation of firms [14].

Palliative care is insufficiently integrated in the continuum of care for older people. It is unclear to what extent healthcare policy for older people includes elements of palliative care and thus supports its integration. Palliative care is considered an essential component of continuous, comprehensive care throughout the disease continuum by important inter-governmental organizations, including the World Health Organization, the UN General Assembly on the Prevention and Control of Non-communicable Diseases and the Human Rights Council [15].

Understanding what drives broad, system change is fundamental, as societies seek to adapt to challenges. Author highlighted the role that policy entrepreneurs can play as catalysts of such change by linking micro-level strategies and broad, system change which remains understudied. Applying a historical perspective, author analyses the adoption of social health insurance programs in India to identify the role played by policy entrepreneurs in driving the adoption of these programs, even as broader structural and institutional factors established the context for policy change [16].

Health insurance is one of the major contributors of growth of general insurance industry in India. Author depicts an understanding on performance of health insurance sector in India. This study attempts to find out how much claims and commission and management expenses it has to incur to earn certain amount of premium.

Methodology used for the study is regression analysis to establish relationship between dependent variable (Profit/Loss) and independent variable (Health Insurance Premium earned) [17].

n an effort to slow the spread of the novel corona virus (COVID-19) and to lessen its impact on human health and safety in the U.S., many states and municipalities required "non-essential" businesses to cease or limit their operations. These actions had a significant negative impact on the income of firms across many industries, and some businesses are seeking payment for their losses from their business interruption insurance policies. Insurers and insurance industry trade associations claim that these policies were not designed or intended to cover pandemic losses and that policy features preclude coverage for COVID-19 losses. However, some businesses, attorneys and government officials disagree with this stance and contend that insurers should pay COVID-19 business interruption losses, either voluntarily or involuntarily. In this paper, we discuss provisions contained in the commonly used Insurance Services Office (ISO) business income insurance policy, the different ways in which courts have interpreted the policy's language, and how these interpretations can affect whether COVID-19 losses are ultimately covered [18].

Overall, this paper highlights the importance of differences in households' ability to cushion negative income shocks and sheds light on features of effective pandemic-mitigation policy. Our results suggest that, to effectively reduce the negative and uneven consequences of COVID-19 on household welfare, it is important to provide short-term liquidity (as the most affected households also have the lowest means to smooth consumption) and, in the longer term, provide a combination of income and employment support to workers with least flexibility to work from home and in industries with most reduced demand [19].

3. Research Methodology

Proposed research is a quantitative analysis study and data collection accomplished based on the calculated cluster of sample. Domain related primary data is collected from the health insurance clients, professionals and marketing experts from Karnataka state. The secondary data is referred from the research papers, newspapers, magazines, and insurance portals. Closed ended questionnaires are developed and distributed to participants.

Data Sampling Method

We calculated sample size using the randomized linear sampling method.

Table 1: Respondents sample cluster

Respondent/Data	Population	Sample
Health insurance clients, professionals and marketing experts from Karnataka, India.	69,402	400

We collected demographic details of respondents as age, gender, marital status, and insurance status.

Table 2: Age of Respondents

Age of Respondents	Frequency
25-30 years	59
30-35 years	127
35-40 years	204
40 years above	10
Total	400

Table 3: Gender of Respondents

Gender of Respondents	Frequency
Female	197
Male	203
Total	400

Table 4: Marital status of Respondents

Marital status of Respondents	Frequency
Non-married	116
Married	284
Total	400

Table 5: Insurance status of Respondents

Insurance status of Respondents	Frequency
Insurance Purchased	356
Insurance not Purchased	44
Total	400

Based on the geographical data collected, we conducted descriptive statistics as shown in Table 6 below. The identified five elements are analyzed using SPSS software.

Table 6: Descriptive Analysis Execution

Descriptive Statistics					
Elements	N	Minimum	Maximum	Mean	Std. Deviation
Health insurance services	400	23.12	98.04	78.08	0.745
Health insurance customer support	400	41.06	117.45	69.47	0.617
Health insurance claim status	400	36.45	152.44	98.63	0.744
Health insurance maturity model	400	49.54	141.25	101.23	0.628
Health insurance loan against policy	400	36.15	117.47	96.42	0.620

From the descriptive statistics analysis shown in above Table 6, a significant correlation can be seen between health insurance services, health insurance customer support, health insurance claim status, health insurance maturity model, and health insurance loan against policy.

Hypotheses Formulation

H0: The fake insurance claims cannot be controlled.

H1: The fake insurance claims can be controlled.

	df	Mean Square	F	Sig.
Between respondent cluster	2	0.543	1.046	0.002
Within respondent cluster	398	0.571	-	-

Total	400	-	-	-

As significance level is 0.002 the positive hypothesis is accepted.

H0: The health insurance moral hazards cannot be identified.

H1: The health insurance moral hazards can be identified.

	df	Mean Square	F	Sig.
Between respondent cluster	6	1.054	1.042	0.006
Within respondent cluster	394	1.011	-	-
Total	400	-	-	-

As significance level is 0.006 the positive hypothesis is accepted.

As per the hypothesis testing, fake insurance claims can be controlled by means of technology and also health insurance moral hazards can be identified. This needs to be employing as a process in many insurance companies.

5. Conclusions

The proposed study evaluated various health insurance variables which can impacttheoverall customer policy process support. Any health insurance provides risk coverage for policy holder which needs to be with a easy claim process execution. However, as per proposed study the fake claim incidences can hamper the business of insurance management. The moral hazards can be controlled by means of appropriate customer process execution and analysis. The public and private insurance schemes differ in terms of such evaluation processes with which customer needs to be aware.

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