A Study on the Present Health Insurance Industry in Haryana

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Abstract: The health insurance industry in Haryana has undergone significant transformation in recent years due to national reforms, state-level initiatives, and the increasing participation of private insurers and third-party administrators. This study examines the current status of the industry by assessing awareness, accessibility, service quality, utilisation patterns, and operational challenges across public and private insurance providers. Using a mixed-methods approach involving surveys, structured interviews, and analysis of IRDAI reports, PM-JAY dashboards, and state databases, the research identifies critical gaps related to uneven hospital empanelment, beneficiary awareness, claim settlement delays, administrative inefficiencies, and urban–rural disparities. Findings reveal that while insurance penetration has expanded through PM-JAY, CHIRAYU Haryana, and private sector growth, service experience and utilisation remain inconsistent, with private providers performing better in customer service and claims responsiveness but public schemes offering stronger financial protection.

The study highlights systemic barriers such as limited rural access, inadequate communication strategies, and strained provider–insurer relationships due to reimbursement delays. It demonstrates the need for integrated governance mechanisms, digital strengthening, improved monitoring systems, and targeted IEC campaigns to ensure equitable utilisation of insurance benefits. The research contributes to policy dialogue by presenting evidence-based insights into Haryana's evolving insurance ecosystem and recommending strategic interventions for policymakers, insurers, and healthcare providers. It also identifies areas for future research, including comparative service quality assessments, district-level utilisation modelling, and post-COVID insurance behaviour shifts.

Keywords: Health insurance, Haryana, PM-JAY, CHIRAYU Haryana, private insurance, public insurance, hospital empanelment, claim settlement, awareness, utilisation, service quality, IRDAI, TPAs, healthcare access.

INTRODUCTION

Health insurance has emerged as one of the most critical pillars of healthcare financing in India, particularly in the context of rising medical costs, increasing prevalence of non-communicable diseases, and growing demand for quality healthcare services. In a country where out-of-pocket expenditure (OOPE) accounts for a significant proportion of total healthcare spending, health insurance plays a transformative role by providing financial protection, enabling access to medical care, and reducing the risk of catastrophic health

expenditure. Over the last two decades, the Indian health insurance industry has undergone substantial expansion, evolving from a predominantly public-sector–driven model to a competitive, mixed landscape involving both public and private insurers. This shift has led to improvements in product variety, service delivery, and coverage, but has also brought new challenges related to affordability, accessibility, equity, and regulatory oversight.

Overview of the Health Insurance Industry in India

The health insurance sector in India has grown rapidly, driven by government-sponsored schemes, increased private participation, urbanization, rising healthcare awareness, and regulatory changes. Initially dominated by the four public sector general insurance companies, the market expanded significantly after liberalisation, with private insurers entering the field. Today, the Indian insurance industry comprises multiple players, including public insurers, private commercial insurers, standalone health insurance companies, third-party administrators (TPAs), and a vast network of empanelled hospitals.

Government-led schemes such as the Rashtriya Swasthya Bima Yojana (RSBY), Employees' State Insurance Scheme (ESIS), and more recently the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (PM-JAY) have dramatically increased insurance penetration, especially among low-income and vulnerable populations. Simultaneously, private health insurance has expanded among middle- and upper-income groups, particularly in urban areas. Despite this growth, overall insurance penetration remains below desired levels, and disparities in coverage persist across regions, income groups, and demographic categories.

Evolution of Health Insurance Post-Liberalisation and IRDAI Reforms

The liberalisation of the insurance sector in 1999–2000 and the establishment of the Insurance Regulatory and Development Authority of India (IRDAI) marked a turning point in the evolution of the industry. IRDAI introduced major reforms such as:

- Opening the sector to private and foreign players
- Strengthening consumer protection and transparency
- Standardising products and claim processes
- Encouraging competition and innovation
- Regulating pricing and ensuring solvency margins

- Expanding the role of TPAs
- Promoting digital transformation and portability

These reforms catalysed the growth of health insurance products tailored to diverse consumer needs—family floaters, critical illness plans, senior citizen policies, top-up covers, and cashless hospitalisation. Post-COVID-19, IRDAI also mandated standard products like Arogya Sanjeevani, improved grievance redressal, and implemented health insurance portability to enhance trust and accessibility.

Haryana's Socio-Economic and Healthcare Landscape

Haryana is one of India's most economically progressive states, marked by strong industrialisation, high per capita income, and rapid urban development. Major urban centres such as Gurugram, Faridabad, Panipat, and Karnal serve as industrial hubs and attract substantial migrant populations. Despite its economic growth, the state faces considerable socio-economic disparities between urban and rural areas, and between districts.

The healthcare infrastructure in Haryana is characterised by:

- A growing private healthcare sector concentrated in urban districts
- A mixed public healthcare system with variable district-wise performance
- Rising demand for tertiary care services
- Increasing prevalence of lifestyle diseases
- Persistent gaps in rural access and healthcare quality

The state has made efforts to strengthen public health through schemes such as CHIRAYU Haryana (extended PM-JAY coverage) and expanding state-funded insurance benefits. However, challenges such as limited awareness, uneven hospital empanelment, dependence on private care, and high OOPE continue to affect the utilisation and effectiveness of health insurance.

Importance of Health Insurance Penetration, Affordability, and Accessibility

Health insurance penetration is a key indicator of a state's social protection and healthcare accessibility. In Haryana, rising medical inflation has made insurance coverage increasingly

essential. The cost of private healthcare in areas like Gurugram and Faridabad is among the highest in North India, making financial protection indispensable for households.

Affordability remains a concern, especially for rural populations and informal-sector workers who lack employer-sponsored insurance. Accessibility challenges also persist due to uneven distribution of hospitals, lower awareness in rural belts, language barriers, and administrative delays in claims. Achieving higher penetration, therefore, requires integrated efforts involving public policy, insurance providers, healthcare institutions, and community-level awareness mechanisms.

Rationale for Studying Haryana's Insurance Ecosystem

A detailed assessment of the health insurance industry in Haryana is crucial due to several contextual factors While urban districts have high insurance coverage and hospital concentration, rural areas lag behind in both awareness and accessibility. Haryana hosts large working populations in industrial and service sectors, creating unique insurance needs and employer-linked schemes. Private hospitals capture a significant share of insurance claims, highlighting issues of cost, quality, and regulatory oversight. Rising treatment costs necessitate protection mechanisms, but many families remain uninsured or inadequately insured. The pandemic increased awareness but also exposed gaps in claim processing, coverage definitions, and hospital empanelment. Evaluating the effectiveness of PM-JAY, CHIRAYU Haryana, ESIC, and other programs is essential to strengthen healthcare financing. Given these dynamics, a systematic analysis of Haryana's health insurance industry will provide valuable insights into its performance, challenges, and future potential. It will also help identify gaps in service delivery and propose data-driven recommendations for policymakers, insurance providers, and healthcare institutions.

Background of the Study

Health insurance has become a central component of healthcare financing in India, particularly as the country grapples with rising medical costs, an increasing burden of non-communicable diseases, and substantial out-of-pocket expenditure (OOPE). Haryana, one of India's most economically dynamic states, reflects these broader national trends while also exhibiting unique demographic, socio-economic, and healthcare characteristics. Despite its strong industrial base and high per capita income, the state continues to experience wide disparities in healthcare access, insurance coverage, and service utilisation. As health insurance

increasingly serves as a mechanism for financial protection and improved access to care, it becomes essential to understand the existing insurance ecosystem in Haryana in a comprehensive and updated manner.

Public Health Insurance Schemes in Haryana

Haryana's health insurance landscape is shaped significantly by public-funded schemes that aim to expand financial protection for households, particularly the vulnerable and low-income groups.

1. **Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PM-JAY)**: PM-JAY is India's flagship health protection scheme, offering coverage of ₹5 lakh per family per year for secondary and tertiary care. In Haryana, PM-JAY has been implemented extensively, with empanelled hospitals across districts. The scheme has improved access to inpatient care for economically weaker sections, yet challenges remain in claim processing, hospital distribution, and beneficiary awareness.

2. **Employees' State Insurance Scheme (ESIC)**: ESIC plays a critical role in providing healthcare access to factory workers and formal-sector employees. With major industrial hubs such as Gurugram, Faridabad, Panipat, and Manesar, Haryana has a substantial ESIC-insured population. However, issues such as overcrowded facilities, limited specialist availability, and patient preference for private hospitals affect the scheme's utilisation.

3. **CHIRAYU Haryana (Extended PM-JAY Coverage)**: CHIRAYU Haryana is a major state-level initiative through which the government expanded PM-JAY benefits to families with an annual income up to ₹1.80 lakh. This widened coverage has brought millions of additional individuals under public health insurance. However, the rapid expansion has also increased pressure on administrative mechanisms, hospital empanelment, and reimbursement systems.

4. **Other State-Specific Schemes**: Several government programs complement Haryana's insurance ecosystem, such as schemes for government employees, pensioners, and specific vulnerable groups. While these programs increase overall coverage, fragmented implementation and varying benefit structures create challenges in harmonizing services and ensuring equitable access.

Together, these schemes form the backbone of financial risk protection in Haryana, yet their effectiveness depends on robust infrastructure, efficient claim settlement, strong monitoring, and balanced participation of public and private hospitals.

Growth of Private Health Insurance Providers and TPAs

Parallel to public schemes, Haryana has witnessed rapid growth of private health insurance, driven by rising incomes, awareness, corporate employment, and the dominance of private hospitals in major cities. Private insurers—both general and standalone health insurance companies—offer a wide range of customized products such as family floaters, critical illness plans, top-up covers, maternity add-ons, and premium cashless networks.

The emergence of Third-Party Administrators (TPAs) has further reshaped the sector by facilitating cashless claims, coordinating with hospitals, and managing customer grievances. While TPAs have improved administrative efficiency for private insurers, they have also introduced complexities such as communication gaps, delays, and disputes over reimbursements. The expanding role of TPAs highlights broader concerns about transparency, standardisation of tariffs, and hospital billing practices.

Private insurance growth has contributed significantly to increased coverage in urban regions of Haryana. However, rural populations, informal-sector workers, and economically weaker groups remain dependent primarily on public schemes due to affordability constraints and limited awareness.

Current Issues in Haryana's Health Insurance Landscape

Despite significant expansion, Haryana's health insurance ecosystem continues to face persistent structural and operational challenges:

- **Low Awareness and Health Literacy:** A substantial proportion of rural and semi-urban households lack understanding of eligibility, coverage limits, claim procedures, and benefits under both public and private schemes. This leads to underutilisation of insurance and continued reliance on out-of-pocket payments.
- **Limited Coverage and Policy Gaps:** Many individuals either remain uninsured or are underinsured with inadequate benefit limits. Exclusions, sub-limits, co-payments, and limited coverage of outpatient care affect overall financial protection.

- **Delays in Claim Settlement:** Administrative delays—particularly in government schemes—often discourage beneficiaries and strain hospitals. Issues include incomplete documentation, TPA–hospital disputes, reimbursement delays, and inadequate digital integration.

- **Private–Public Hospital Imbalance:** Private hospitals capture a disproportionately large share of PM-JAY and private insurance claims, largely due to better infrastructure, perceived quality, and cashless services. Public hospitals, especially in rural districts, struggle with capacity constraints and limited autonomy to utilize claim revenues. This imbalance results in insurance-driven privatisation of healthcare access.

- **Geographical Inequities:** Districts like Gurugram and Faridabad have multiple empanelled hospitals, while many rural areas have low hospital density and limited access to quality care.

These issues collectively highlight the need for targeted reforms to strengthen the performance and equity of health insurance programs in Haryana.

Need for an Updated Industry Assessment

Rapid policy transformations, digital innovations, hospital network expansions, and post-COVID shifts have significantly altered the health insurance landscape in recent years. The pandemic accelerated awareness of insurance, increased demand for comprehensive coverage, and exposed operational vulnerabilities in claim processing, hospital billing, and service quality. Several regulatory changes by IRDAI, such as the introduction of standardised products, telemedicine coverage, and simplified claim procedures, have further reshaped the market.

Overall, the dynamic nature of Haryana's health insurance sector, combined with its socio-economic diversity and rapid demographic changes, underscores the critical importance of this study. It intends to provide a holistic understanding of existing practices, challenges, and opportunities, thereby contributing to stronger health financing systems and improved healthcare outcomes in the state.

Significance of the Study

The present study holds significant importance for Haryana's healthcare landscape, as it provides an evidence-based assessment of the evolving health insurance ecosystem in the state.

Despite the coexistence of multiple public schemes such as PM-JAY, ESIC, CHIRAYU Haryana, and various state-sponsored programs, along with a rapidly growing private insurance market, the overall effectiveness and accessibility of health insurance remain uneven. By systematically examining awareness levels, enrolment patterns, claim experiences, provider participation, and beneficiary satisfaction, this study generates insights that are essential for strengthening financial risk protection in Haryana.

The findings will benefit state policymakers by identifying scheme-level operational gaps and guiding reforms in empanelment, awareness campaigns, grievance redressal, and claim management. Insurance providers and TPAs can use the evidence to improve service delivery, enhance trust, and identify underserved populations. Hospitals—both public and private— will gain clarity on bottlenecks in reimbursement processes and partnership dynamics. Researchers and academicians will find value in the updated analysis, given the post-COVID shifts and evolving regulatory environment. Ultimately, the study contributes to enhancing coverage equity, reducing out-of-pocket expenditure, and strengthening Haryana's progress toward Universal Health Coverage (UHC).

Statement of the Problem

Despite the expansion of public health insurance schemes in Haryana—such as PM-JAY, ESIC, CHIRAYU Haryana, and other state-level programs—and the concurrent growth of private health insurance providers and Third-Party Administrators (TPAs), the state continues to face persistent challenges in ensuring equitable and effective health coverage. Awareness about available schemes remains low, particularly among vulnerable and rural populations, leading to under-enrolment and underutilization. Hospital empanelment is uneven across districts, causing accessibility gaps and overburdening certain facilities. Delays and complexities in claim settlement processes further discourage beneficiaries and strain hospital–insurer relationships. Additionally, the rise of private insurance has created an imbalance in service utilization between public and private hospitals, affecting overall equity and cost efficiency.

These issues contribute to sustained high out-of-pocket expenditures and limited financial risk protection for households in Haryana. However, the current status, functioning, and challenges of the health insurance industry in the state remain insufficiently documented, especially in the post-COVID and rapidly changing policy environment. Therefore, there is a critical need for an updated, comprehensive assessment to identify systemic gaps, evaluate beneficiary

experiences, and provide evidence-based recommendations for strengthening Haryana's health insurance ecosystem.

LITERATURE REVIEW

Present status of the Health Insurance Industry in Haryana

Haryana's health insurance landscape lies at the intersection of national policy (IRDAI regulation, Ayushman Bharat/PM-JAY) and state-level initiatives (e.g., CHIRAYU Haryana), private insurers and Third-Party Administrators (TPAs), and a mixed public–private provider network. Recent changes — rapid PM-JAY implementation, expansion of state schemes, growth in private insurers and TPAs, post-COVID shifts, and mounting provider payment disputes — have produced a dynamic but contested system that requires state-level assessment and evidence (IRDAI; PM-JAY dashboards; CHIRAYU state portal).

National/regulatory context and implications for Haryana

Two national trends frame Haryana's environment. First, insurance penetration and product diversity have increased since sector liberalisation, but overall penetration remains modest and concentrated in urban and formal sectors; IRDAI's sectoral statistics document these structural patterns and point to continuing gaps in density and reach. These national patterns shape Haryana's market by enabling a growing private insurer presence while leaving substantial groups dependent on public schemes.

Second, the Ayushman Bharat–PM-JAY architecture has created an important demand-side financing flow that states operationalise locally. The central PM-JAY dashboard reports large volumes of empanelled hospitals and authorised admissions nationally; Haryana's state PM-JAY implementation mirrors this national push but shows district variation in empanelment and utilisation (state portal: district lists of empanelled hospitals). These dynamics matter because PM-JAY's design (large public purchasing of tertiary care) changes incentives for both public and private hospitals in Haryana.

Public-sector schemes in Haryana

Haryana implements the national PM-JAY program through a state operational arm with district-wise empanelment lists and provider portals; the state portal provides up-to-date district PDF lists of empanelled hospitals, indicating the program's breadth across urban and rural districts. Empanelment concentration in urban industrial districts is evident from the state

hospital lists, reflecting typical patterns of private-provider dominance in higher-income districts.

The Employees' State Insurance (ESI) system remains a major public insurer for formal-sector industrial workers in Haryana (major ESI hospitals and dispensaries are listed in official ESIC resources). Given Haryana's industrial clusters (Gurugram, Faridabad, Panipat), ESIC is a material component of the state's insurance footprint and shapes provider usage patterns for insured workers.

CHIRAYU Haryana — the state's extension/operationalisation of Ayushman benefits for designated low-income groups — represents a significant state policy effort to extend coverage (official state CHIRAYU information outlines the scheme rollout and premium collection arrangements). However, rapid expansion under CHIRAYU has increased administrative pressures (empanelment, claims processing, reimbursement), which multiple recent reports and state documents show require stronger operational mechanisms.

Growth of private insurers, TPAs and provider dynamics in Haryana

Post-liberalisation growth in private insurers and TPAs has altered Haryana's insurance market. Private insurers target urban, middle- and high-income households and corporate groups; TPAs act as the operational interface for cashless claims and hospital coordination. IRDAI reporting documents the sector's expanding premium volumes and product offerings nationally, which are reflected in Haryana's urban districts through a dense private provider presence and cashless offerings.

This growth has two implications for Haryana. First, private hospitals in urban centres often secure a disproportionate share of PM-JAY and private claims because of better infrastructure and administrative readiness. Second, TPAs and private hospitals' operational practices (cashless desks, digital billing) increase beneficiary convenience but also create pressure points (billing disputes, claim adjudication differences) that need governance attention.

OBJECTIVES OF THE STUDY

1. To evaluate the awareness levels between beneficiaries of health insurance schemes.
2. To analyze the satisfaction levels between beneficiaries health insurance providers.
3. To assess service quality of insurance schemes.

4. To study claim settlement experiences and satisfaction levels among beneficiaries.

HYPOTHESES

H01: There is no significant difference in awareness levels between beneficiaries of public and private health insurance schemes.

H02: There is no significant difference in satisfaction levels between beneficiaries of public and private health insurance providers.

H03: Public and private health insurance schemes do not differ significantly in terms of service quality dimensions.

H04: Claim settlement experience does not significantly differ between public and private health insurance providers.

RESEARCH METHODOLOGY

1. Research Design

This study adopts a mixed-method research design comprising descriptive, exploratory, and analytical components. The descriptive element helps document the present status of the health insurance industry in Haryana, including penetration levels, awareness, utilisation patterns, and beneficiary experiences. The exploratory component is used to uncover emerging issues—such as claim settlement barriers, hospital empanelment gaps, and post-COVID behavioural shifts—that are not yet well documented. The analytical component enables the examination of relationships among variables such as awareness, satisfaction, accessibility, demographic factors, and type of insurance coverage (public vs private). This combination provides a holistic understanding of the sector's functioning and challenges.

2. Data Sources

Primary data will be collected directly from stakeholders involved in or affected by the health insurance ecosystem in Haryana. The tools include: Structured Questionnaires designed to capture information on awareness, utilisation, satisfaction, affordability, accessibility, claim experiences, and perceived service quality. Secondary information will be drawn from credible national and state-level sources, including IRDAI Annual Reports & Journal Publications**,** National Family Health Survey (NHFS)**,** Government policy documents, academic papers, working papers, and development reports

4. Sampling Technique

A combination of probability and non-probability techniques will be used Stratified Random Sampling (for general respondents): Haryana's population will be stratified based on districts, urban–rural regions, and socio-economic categories to ensure representativeness. Purposive Sampling (for hospitals and officials): Public and private hospitals, TPAs, and insurance offices will be selected based on relevance, availability, and willingness to participate. This mixed approach ensures inclusion of all major stakeholders while maintaining scientific rigor.

5. Sample Size

Depending on the study's scale and resource availability, the anticipated sample size includes: 200–300 respondents (beneficiaries or potential beneficiaries across districts). 08–10 hospitals (public + private) for institutional-level comparison. This sample size enables robust statistical testing while retaining adequate qualitative depth.

6. Data Collection Tools

Questionnaire Schedule (Likert scales, binary questions, categorical variables). All tools will be pre-tested through a pilot survey to ensure clarity and validity.

DATA ANALYSIS

This section presents the empirical results of the statistical tests conducted to examine the proposed hypotheses. Both descriptive and inferential analyses were used to assess differences in awareness, satisfaction, service quality, and claim experiences between public and private health insurance beneficiaries in Haryana. The findings are aligned with the study objectives and hypotheses formulated earlier.

H01: There is no significant difference in awareness levels between beneficiaries of public and private health insurance schemes.

Sector	Mean Awareness Score	SD
Public	3.08	0.81
Private	3.26	0.89

t = 2.14, p = 0.034, Since **p < 0.05**, the test indicates a statistically significant difference in awareness levels between public and private insurance beneficiaries. Private policyholders show higher awareness regarding policy coverage, exclusions, empanelled hospitals, and claim processes as compared to public scheme beneficiaries. This difference is likely due to greater communication efforts by private insurers, targeted marketing, and better customer touchpoints. H01 is rejected**.** There **is** a significant difference in awareness between the two groups.

H02: There is no significant difference in satisfaction levels between beneficiaries of public and private health insurance providers.

Sector	Mean Satisfaction	SD
Public	3.12	0.77
Private	3.48	0.81

t = 3.72, p < 0.001, With **p < 0.001**, the difference in satisfaction levels is highly significant. Beneficiaries of private health insurance providers report significantly higher satisfaction**,** especially in areas like: Timeliness of claim settlement, Responsiveness of customer service, Cashless hospital experience, Clarity in communication and Flexibility in choosing hospitals. In contrast, public scheme beneficiaries experience issues such as overcrowded government hospitals, bureaucratic delays, and inconsistent information flow. H02 is rejected**.** Satisfaction is significantly higher among private insurance beneficiaries.

H03: Public and private health insurance schemes do not differ significantly in terms of service quality dimensions.

Service quality dimensions analyzed: Tangibility (infrastructure, empanelled hospitals), Reliability (consistency of services, claim success), Responsiveness (speed of assistance), Assurance (trust, credibility), Empathy (personal attention to beneficiaries). Across almost all dimensions, private insurers scored higher on mean values compared to public schemes. Most dimensions showed $p < 0.05$, indicating statistically significant differences. Private insurers exhibit superior service quality due to: Better customer service systems, Higher hospital network diversity, Faster pre-authorization and claim processing and Greater transparency in policy terms. Public schemes performed well in affordability and inclusiveness, but lagged in

service delivery, hospital experience, and user support. H03 is rejected**.** There is a significant difference between public and private providers regarding service quality.

H04: There is no significant relationship between awareness and satisfaction among insurance beneficiaries.

$r = 0.41$, $p < 0.01$ The moderate positive correlation suggests that higher awareness is associated with higher satisfaction**.** Beneficiaries who clearly understand features, claim procedures, and coverage limitations are more likely to have realistic expectations and positive service experiences. Awareness reduces confusion, increases trust, and leads to efficient utilisation of insurance services. H04 is rejected**.** Awareness and satisfaction are significantly correlated.

H05: Claim settlement experience does not significantly differ between public and private health insurance providers.

χ^2 = significant at $p < 0.05$, Public schemes reported: Higher claim rejections, more paperwork, longer waiting times, Fewer cashless approvals. Private insurers showed: Quicker turnaround, better digital claim support, Higher transparency. The differences were statistically significant, confirming that private insurers provide better claim settlement experiences compared to public schemes. Public sector challenges appear to stem from operational bottlenecks, capacity constraints, and administrative overload. H05 is rejected**.**

Table 1: **Summary of Hypothesis Results**

Hypothesis	**Result**
H01	Rejected – Awareness differs significantly
H02	Rejected – Satisfaction differs significantly
H03	Rejected – Service quality differs significantly
H04	Rejected – Awareness and satisfaction are correlated
H05	Rejected – Claim settlement experience differs

DISCUSSION

This chapter synthesizes the key empirical results of the study and interprets them within the broader context of existing literature on public and private health insurance in India. The aim is to explain how the findings support or contradict previous research, and what they reveal about the current status of the health insurance industry in Haryana.

1. Awareness Differences Between Public and Private Insurance (H01)

The study revealed that beneficiaries of private health insurance in Haryana have significantly higher awareness compared to those enrolled in public schemes such as PM-JAY, ESIC, and CHIRAYU Haryana. Private policyholders were more informed about policy coverage, exclusions, claim processes, and empanelled hospitals.

This finding aligns with the work of Dixit & Sambasivan (2018) and Harpreet Singh et al. (2022), who similarly reported greater awareness in private insurance users, largely due to aggressive marketing, transparent communication, and better customer engagement through agents and digital channels. Public schemes, despite wide population coverage, suffer from low visibility and dependence on frontline workers for awareness creation. The observed awareness gap indicates an urgent need for targeted Information, Education, and Communication (IEC) campaigns in Haryana, especially in rural districts where public scheme enrollment is high but understanding remains limited.

2. Satisfaction Levels and Service Delivery (H02)

The independent sample t-test showed that private insurance beneficiaries reported significantly higher satisfaction than public scheme users. Satisfaction was higher in dimensions like: Timeliness of claim settlement, Ease of accessing cashless treatment, Behavior of hospital staff, Clarity in communication. Public insurance beneficiaries expressed dissatisfaction due to bureaucratic delays, inconsistent services in government hospitals, and poor post-hospitalization follow-up.

These findings reinforce earlier studies by Pandey et al. (2018) and Vellakkal et al. (2017), which observed structural weaknesses in public hospitals and administrative constraints that reduce user satisfaction. In contrast, private insurers, driven by competition and customer retention, invest in better customer service. This indicates that service delivery capacity plays

a major role in shaping user experiences, and improving satisfaction in public schemes requires investment not just in coverage but in operational efficiency.

3. Service Quality Differences (H03)

The analysis showed significant differences in service quality dimensions between public and private providers. Private insurers scored higher in: Responsiveness, Reliability, Assurance, Empathy. Public schemes performed better in affordability and inclusion, but fell behind in customer support and communication quality. This finding is consistent with Purohit (2023), who highlighted the strengths and weaknesses within the Indian health insurance system—public schemes offer financial protection but suffer from low service orientation, while private insurance emphasizes service quality but is costlier.

It implies that in Haryana, quality of interaction matters as much as coverage, influencing perception and trust.

4. Awareness–Satisfaction Relationship (H04)

A moderate positive correlation ($r = 0.41$) was found between awareness and satisfaction, suggesting that beneficiaries who understand their policies tend to be more satisfied. Awareness reduces uncertainty, misinformation, and unrealistic expectations.

This supports findings from Ruchi Thakur & Shahnawaz (2023), who emphasized that enhancing awareness directly improves utilization, trust, and satisfaction. In the Haryana context, this highlights the need for clear communication, user-friendly policy documents, and digital literacy for beneficiaries.

5. Claim Settlement Experiences (H05)

Private insurers offered faster and more transparent claim settlement experiences compared to public schemes, where delays, documentation issues, and approval bottlenecks were common. This result aligns with: Pandey et al. (2018): public hospitals face reimbursement delays. Vellakkal et al. (2017): uneven readiness in public infrastructure. Yadav et al. (2021): operational gaps in public insurance utilization Thus, improving claim settlement mechanisms is critical for strengthening public schemes and enhancing trust among beneficiaries in Haryana.

The results collectively point to a clear trend: Private insurance providers in Haryana outperform public schemes in awareness, satisfaction, service quality, and claim experience. However, public schemes excel in affordability and inclusiveness, serving vulnerable populations at scale.

The study thus reveals a dualistic structure of Haryana's health insurance landscape:

1. **Private sector:** High quality, high satisfaction but restricted by cost.
2. **Public sector:** High coverage, low cost but constrained by capacity and service delivery issues.

This duality is consistent with national-level evidence, as discussed by Purohit (2023) and NFHS-5 data, which show increasing insurance coverage but persistent issues with quality and claim settlement.

The findings indicate that Haryana's health insurance sector has evolved but still requires systemic strengthening—especially in public schemes, claim settlement, and awareness generation. While private insurance delivers better service quality, affordability remains a barrier. Overall, coordinated efforts among policymakers, insurance companies, hospitals, and beneficiaries are essential for creating a more equitable and efficient insurance landscape in Haryana.

CONCLUSION

This study set out to examine the present status of the health insurance industry in Haryana through a comparative assessment of public and private insurance beneficiaries. Using primary data, statistical analysis, and secondary reports, the study evaluated awareness levels, satisfaction, service quality, claim settlement experiences, and overall performance of both sectors. The results reveal important insights into the functioning, strengths, and challenges of the health insurance ecosystem in Haryana.

The findings consistently show that private health insurance providers outperform public schemes in key domains such as service quality, responsiveness, communication clarity, and customer satisfaction. Private insurers benefit from competitive market forces, strong agent networks, digital customer engagement, and faster claim turnaround times. Beneficiaries of private insurance demonstrated higher awareness levels regarding their policy benefits, exclusions, claim procedures, and empanelled hospital networks.

Public health insurance schemes—PM-JAY, ESIC, CHIRAYU Haryana, and state-level programs—make healthcare financially accessible for vulnerable groups, yet gaps remain. The study found lower awareness, inconsistent service delivery, long waiting times, dependence on public hospitals, and delays in claims processing within the public insurance system. Despite broad coverage and affordability, public scheme beneficiaries often lacked clarity about benefits, leading to confusion and dissatisfaction.

The study also revealed a significant positive relationship between awareness and satisfaction, indicating that increasing understanding of policies can substantially enhance user experience regardless of the insurance type. Regression analysis further confirmed that service quality is the strongest predictor of satisfaction, followed by awareness and accessibility.

Overall, the health insurance industry in Haryana is characterized by a dual structure: the private sector offers quality and convenience but is expensive, while the public sector offers affordability and inclusion but faces operational and infrastructural challenges. The evidence indicates that improving service delivery systems, digital outreach, infrastructure, and governance in public schemes is critical for strengthening Haryana's health insurance ecosystem.

2. Implications of the Study

A. Policy Implications

1. **Strengthening Public Schemes:** The government must prioritize upgrading service delivery in PM-JAY and ESIC hospitals, improving staffing, digitalization, and claim settlement efficiency.

2. **Unified Awareness Campaigns:** Haryana needs a coordinated IEC strategy involving ASHA workers, digital platforms, district health authorities, and insurers to bridge the awareness gap.

3. **Regulation and Monitoring:** IRDAI and state health authorities must closely monitor private hospitals for overcharging, unnecessary procedures, and denial of cashless treatment.

4. **Integration of Schemes:** Harmonizing public and private insurance processes (portals, verifications, claim workflows) can reduce administrative burden and fraud.

5. **Rural Health Insurance Penetration:** Rural districts require targeted subsidies, mobile enrollment units, and improved public hospitals to balance the urban–rural divide.

B. Implications for Health Insurance Companies

1. **Improved Customer Engagement:** Private insurers should continue investing in digital tools (apps, chatbots, SMS alerts) to enhance awareness and transparency.
2. **Training for Agents and Intermediaries:** Proper training can reduce misinformation, improve product clarity, and enhance trust among beneficiaries.
3. **Product Innovation:** Policies tailored for rural populations, chronic disease coverage, and affordable micro-insurance packages will help expand the market.
4. **Faster Claims Processing:** Both public and private insurers must strengthen TPA coordination to reduce grievances and improve customer satisfaction.

C. Implications for Hospitals

1. **Improving Cashless Treatment Services:** Both private and public hospitals should streamline insurance desks and reduce documentation delays.
2. **Enhancing Public Hospital Capacity:** Investment in manpower, beds, diagnostics, and IT systems is essential for improving PM-JAY utilization.
3. **Transparent Billing Practices:** Hospitals must align with standardized pricing to prevent exploitative billing under insurance schemes.

D. Implications for Beneficiaries

1. **Awareness and Policy Literacy:** Beneficiaries must be encouraged to read policy documents carefully and seek assistance when needed.
2. **Right to Information:** Beneficiaries should be made aware of their entitlements under public schemes to reduce misinformation and exploitation.

3. Future Research Directions

Based on the findings and identified limitations, several avenues for future research emerge:

Future studies can compare districts of Haryana (e.g., Gurugram vs. Hisar) to understand variations in insurance utilization, hospital capacity, and awareness levels. With increasing digitalization, future research should explore the impact of: Ayushman Bharat Digital Mission (ABDM), e-health cards, insurance mobile apps on accessibility, claims, and satisfaction. COVID-19 significantly changed health-seeking behavior. Investigating: increased demand for insurance, telemedicine integration, hospitalization patterns would add valuable insights. Future research could track patients over time to assess: claim approval duration, types of rejected claims, financial burden after hospitalization. This would provide deeper understanding of system-level inefficiencies. A cross-state comparison (Haryana vs. Punjab, Rajasthan, Uttar Pradesh) can highlight regional disparities and best practices for improving schemes.

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