ANALYSIS OF THE TRENDS OF PREMIUM RECEIPT FOR THE PERIOD 2005 TO 2021

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

by

Dr. Piyush Gupta

Under the Supervision and Guidance of

Dr. Monika Chaudhary

2022

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled ANALYSIS OF THE TRENDS OF PREMIUM FOR THE PERIOD 2005 TO 202 1 is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Name of Student

Date

CERTIFICATE

This is to certify that (Name of Student) in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management from the IIHMR University, Jaipur has completed her/his internship at TATA AIG GIC Ltd. during Marc 22, 2022 to June 19, 2,022.

Place: Date:	Preceptor/Head of the Organization Name of the organization

CERTIFICATE

This is to certify that dissertation titled ANALYSIS OF THE TRENDS OF PREMIUM RECEIPT FOR THE PERIOD 2005 TO 2021 is a record of the research work undertaken by Dr. Piyush Gupta in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide IIHMR University, Jaipur	School Dean IIHMR University, Jaipur
Date	Date

Abstract

"Insurance refers to a legal contract between two parties wherein the first party i.e., the insured transfers the risks of possible losses in the future to the second party i.e., the insurance company in exchange for a small amount of compensation termed as a premium.

Insurance can further be divided into two broad categories-

1. Life Insurance- The risk insured for is the life of the individual and the loss is the life of the insured or an accident like a Road traffic accident or a terminal illness rendering the insured incapable to continue with the normal lifestyle like the one he/she had before the occurrence of the incident.

There are many types of life insurance products. A brief description of the most common are:

Credit Life: A decreasing-term insurance product related to a borrower's outstanding debt, credit life insurance is a credit life insurance policy. If the insured person dies before paying back the loan, the credit life insurance policy will cover the outstanding balance. The maximum amount of time covered by a credit life insurance policy was ten years. An extremely limited quantity of credit-debt life insurance was available. Borrowers beyond the age of 70 are not eligible for credit life insurance, and current policies expire at the age of 71. The borrower does not have to obtain credit life insurance as a condition of borrowing. Life insurance plans that are owned by the lender can be used to pay the debt.

Endowments: In the event that the insured lives during a set period of time, the policy's face value will be paid out, but if the insured is still alive, the complete face value will be paid out. The endowment of a whole life insurance policy, despite the fact that it is rarely considered in this context, is 100 years old. The insurance will reach its full face value if the insured lives to be 100 years old. Endowment policies, like whole life insurance, give coverage in the event of a premature death. The majority of endowment periods are for 5, 10, or 20 years, or until a specified age, such as 65. The insurance company will pay the face value of the policy if the insured is still alive at the end of the endowment term.

Whole Life All of the insured's financial needs are covered up to age 100. For the duration of the insurance, the premiums will remain the same as long as they are paid

on time. When an insurance policy is originally purchased, premiums are higher than the amount needed to pay for the policy's expenses. When a policyholder reaches a certain age, the excess becomes more valuable, which can be used to offset growing insurance premiums or meet the non-forfeiture provisions of the contract.

Variable Whole Life: Investment features are incorporated into a life insurance policy in order to increase its cash value. The method was developed in able to profit from investment returns that were superior to those of traditional whole life insurance.

Modified Life: a whole life insurance policy with built-in investing characteristics, intended to boost the cash value of a traditional policy. This new technology developed to take advantage of investment returns that outperformed those of traditional whole life insurance.

Universal Life: Life insurance coverage includes a separate savings account that earns interest on a routine basis. The side fund is used to counteract the rising costs of the term insurance. Out-of-pocket premiums can stay stable as long as the system is adequately supported.

Interest rates affect the growth of the side fund. While the side funds do well when interest rates are high, they do not do well when interest rates are low.

An rise in term insurance premiums might lead to a withdrawal from a side fund to assist pay for this increase in insurance costs. If interest rates continue to be so low, it is probable that the side fund will be depleted and the insured would have to raise premiums or lower its face value.

Variable Universal Life: three components that fit together, with the exclusions of:

- **Accumulation Account:** There are a wide range of investing options accessible through variable life insurance providers. It is possible for the policyholder to perform part of his or her own personal investment management using the policy's money transfer provisions. However, despite the fact that mutual funds are less responsive to market changes than individual stocks or bonds, the fund's growth is closely tied to the success of the underlying portfolio of assets.
- **Life Insurance Amount:** In the event of an insured's death, the insurance payment will be paid.
- **Policy Fees:** In most instances, the price of life insurance is calculated by multiplying the monthly premium by the annual premium. When a client's insurance account balance is inadequate to cover the monthly premium, the insurance company collects the premiums from the account. A prospectus for

a product must provide information about any costs associated with a policy's expenses.

- **Term Life:** provide a short-term financial safety net that may or may not be renewable. These policies are often created for individuals who want wall to wall coverage for a set length of time. The cash value of a term life insurance policy is zero. Premiums for short-term insurance are often lower than those for long-term plans, although they might rise annually or remain constant for a predetermined period, depending on the policy type.

2. General insurance-

Everything is insured. Fire, engineering, marine, and other make up India's General Insurance categories.

From a practical and a general perspective, let's take a closer look at them. In India, there are a number of different types of general insurance, as described below:

- Health Insurance
- Travel Insurance
- Motor Insurance
- Marine Insurance
- Home Insurance
- Commercial Insurance

1. Health Insurance

In the event of hospitalisation as a result of an accident or sickness, Digit's Health Insurance covers the associated medical expenditures.

Regardless of who the coverage is purchased for, it covers the most important aspects of health care.:

- Accidental Hospitalization (pre & post)
- Injuries and hospitalizations due to carelessness
- Procedures in daycare
- Treatment for Psychiatric Illness
- An annual physical exam
- Hospital Cash on a daily basis

With a few established conditions, the protection may be expanded to include the following:

- Maternity benefit with Infertility benefit
- Critical Illness
- Organ Donation
- AYUSH (Alternate Treatment)

The health insurance premium is calculated based on:

- Age
- Pre-existing medical conditions
- Personal Habits
- The kind of insurance coverage
- Medical history in your family

2. Travel Insurance

When you go outside of India, you'll need a travel insurance policy to protect any potential financial loss. Medical or non-medical emergencies may necessitate a financial burden on families.

The maximum number of days you can be gone at a time is 180 days. Each year, the policyholder has the option of taking more than one trip. This is something that will be covered by your travel insurance.:

- Loss of Baggage
- Loss of Passport
- Hijacking
- Medical Emergencies
- Delayed Flights
- Accidental Deaths
- Adventure Sports

Travel insurance includes international assistance as well as unique characteristics like as:

- Zero Deductibles.

- Smartphone-enabled claim process.
- Customized Travel Plan Cover.
- Missed call claim facilitation.

3. Motor Insurance

To drive lawfully in India, you must have a motor insurance policy.
In general, there are two sorts.
a) Third-Party Liability
b) Comprehensive Package Policy.

Damage to third parties, such as public property or people or a third-party vehicle, can be covered by a Third-Party Policy. The Motor Vehicles Act stipulates that this is the very minimum need for lawfully operating a vehicle in India.

Comprehensive Package plans include coverage for both you and your vehicle in the event of damage or loss to third parties and your own assets. An accident, theft, fire, natural calamities and other events may be responsible for the damages.

4. Home Insurance

When you create your house, you put in many hours of labour and spend money that you've earned. The things you buy are priceless to you, and so need to be preserved.

The valuables in your home are protected by a policy from a third party. Insurance for all of your belongings is included as part of this comprehensive package.

Robbery, theft of valuables, fire, and other natural disasters can all be covered by insurance.

5. Commercial Lines

All insurance products that have a direct impact on a company's day-to-day operations are included in Commercial Lines of Insurance. The following types of insurance policies are available for purchase:

- Property Insurance
- Engineering Insurance
- Liability Insurance

- Marine Insurance
- Employees Benefit Insurance
- Business Interruption

Each sector or business may require a different level of insurance, based on factors such as the type of work performed, the level of risk involved, and the amount of money being invested.

A cement plant's unique insurance policy will be different from an IT company's. For a cement plant, the price is going to be more than it would be for a showroom or a conditioner.

As a result, the amount of risk exposure is the sole determining factor in insurance. Those who work in the cement mill are more likely to be injured than those who work in the showroom.

6. Mobile Insurance

It's as simple as it sounds. Accidental damage to your phone is covered by mobile insurance. Insurance will cover the cost of repairing your phone's screen if it is damaged in an accident.

Mobile insurance is available for both the buyer's old and new phone. Protection for the most costly phones you can obtain at a very low cost.

7. Bicycle Insurance

In contrast to cars and two-wheelers, many are increasingly fascinated with high-priced bicycles. It really doesn't matter if it's a fad or a shift in lifestyle, Bicycle Insurance is a hot commodity these days."

What is Health Insurance?

Insurers agree to reimburse customers for medical expenses throughout the policy term if they are covered by medical insurance or health insurance. If the insured falls ill or has an unlucky event that necessitates hospitalisation, they may be responsible for medical costs. Each time, a certain sum known as a premium must be paid by the policyholder in order to get the policy's coverage benefits. The insurance company sets the monthly, quarterly, half-yearly, or even annual premiums that policyholders must spend without fail.

In India, health insurance is a necessity.
The growing costs of healthcare make it difficult for many people to get the necessary and high-quality medical care they need. This means that you must have everyone protected by a solid health insurance plan in order to protect yourself and your loved ones from these charges.

Classification of health insurance plans in India

The following are general classifications of Indian health insurance plans:

- Hospitalization. Insurance policies that cover hospitalisation and medical expenses are known as hospitalisation plans. A "top-up" policy is another sort of hospitalisation coverage. Typically, top-up insurance have a higher deductible than established policies and procedures.
- Family floater health insurance. A family health insurance plan is a single health insurance policy that covers everyone in the family. That illness is assumed to affect every member of a family at some time.
- Pre-existing disease cover plans. If a policyholder already has a pre-existing condition, it will be covered under this insurance. To protect against conditions such as diabetes and renal failure, many insurance policies include pre-existing condition coverage. Insureds are given coverage after two to four years of waiting.
- Senior citizen health insurance. Elderly members of the family might benefit from this sort of insurance coverage. Protects against health difficulties as you become old.
- Maternity health insurance coverage. Prenatal and postnatal care are covered by maternity health insurance, as well as maternity care itself.

- Hospital daily cash benefit plans. Daily cash benefits are insurance plans with specified benefits that pay a set amount for each day of hospitalisation.
- Critical illness plans. A lump sum payment is made for some serious diseases, including as heart problems, cancers, and strokes. These are benefit-based policies
- Disease-specific special plans. Dengue Care and Corona Kavach policies are two examples of disease-specific plans offered by some insurance companies.

History of Health Insurance in India

First health insurance products were available only in 1986, when the Central Government Health Insurance Scheme and Personnel' State insurance schemes for private sector employees were launched to provide coverage for government employees. As of present, there are 20 private sector insurance businesses in India, in addition to the government-sponsored general insurance companies, selling their own products.
Indian government created 'Mediclaim' in 1986 with INR 15,000 and INR 5 Lakh minimum and maximum health coverage. Public sector insurance firms guarantee a minimum of INR 50,000, whereas private sector businesses promise a minimum of INR 1 lakh, with a minimum of INR 3 lakh being guaranteed by 95% of online health insurance policies.
The cost of healthcare in India has risen at an exponential rate in the last several decades, and a medical treatment that would have cost roughly INR 10,000 in the 1980s and 1990s now costs more than INR 50,000. The advent of cutting-edge medical technology has driven up the price of medical operations, and the rise of for-profit corporate hospitals has exacerbated the problem. Many therapeutic options, including angioplasty, MRI, or CT scan, were just not available at the time.

A report from Marsh India states that medical inflation in India is presently 18 percent, and consumers who previously purchased policies with an amount assured of INR 1 Lakh are now willing to pay premiums of INR 1 Lakh for plans that give Rs 1 Crore as a reward.

When health insurance was first introduced in India, it was solely for individuals and their families, and it only reimbursed for hospitalisation costs. Every item covered by the policies had sub-limits and limitations as well. Health care began to alter and more people began purchasing health insurance policies in the 1990s as the number of private hospitals grew and life expectancy improved, thus removing sub-limits.

In 2001, the Insurance Regulatory and Development Authority (IRDA) created third-party administrators as a link between hospitals and insurance companies, allowing insurance firms to offer cashless amenities on their policies. More than twice as many health insurance plans are sold in India now as in 2003-04 because of the rise of the service industry and particularly the IT sector.

Acknowledgment

“No one who achieves success does so without acknowledging the help of others”

I would like to express my special thanks to **Dr. PR Sodani** (President, IIHMR University, Jaipur) for giving me this opportunity to pursue my Summer Internship **at Tata Aig General Insurance Company Limited.**

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Dr. Piyush Gupta
IIHMR University
Jaipur

Abbreviations

TPA- Third Party Aggregator
PPN- Preferred Partner Network
NBFC- Non-Banking Finance Companies
AUM- Asset Under Management
AIG- American International Group
IRDAI- Insurance Regulatory and Development Authority of India
AI- Artificial Intelligence
RPA- Robotic Process Automation

Introduction

Company Profile- Tata AIG General Insurance Company Limited

"Tata AIG General Insurance Company Limited" is a joint venture between the Tata Group and the American International Group that offers "general insurance" (AIG). In 2020, Tata AIG General Insurance Company Limited will celebrate its twentieth year in operation. Over the years, it has made a reputation for itself in the industry by launching a variety of groundbreaking products and services.

In order to meet the requirements of both individuals and businesses, "Tata AIG General Insurance Company Limited offers a variety of General Insurance plans." Commercial Lines provides a wide range of products, including property and business interruption insurance (D&O), professional liability (professional liability), and general liability, as well as highly specialized coverage such as representatives & warrants and environmental insurance, for both consumers and businesses. Each product is backed by a team of specialists throughout the connection. In India, Tata AIG General Insurance Company Limited's branches have an in-house claims staff of 400 or more. Its public face is made up of 450 personnel scattered across offices in India who handle all of the company's customer service needs.

Tata AIG General Insurance Firm Limited focuses on three product categories: travel insurance, marine insurance, and liability insurance, with the goal of being India's most desired general insurance provider. Tata AIG General Insurance Company Limited is achieving its aim of becoming India's most sought-after general insurance business by strategic alliances with major Indian enterprises in a variety of sectors."

As of September 30, 2020, Tata AIG General Insurance Company Limited has AUM of roughly Rs. 14,295 crore and a staff of approximately 6220 personnel spread over 200 offices in India. They have an Agency with 40,000+ licenced agents and 437 licenced brokers, as well as an online platform for customers to buy and sell the company's products. Affinity partnerships with banks, NBFCs, and HHFCs are the responsibility of the Bancassurance & Affinity team. "Go Digital" is a business strategy developed by Tata AIG General Insurance Company Limited to make it easier for customers to acquire insurance goods online. As a result, "it makes the sale to policy issuing process simple."

"The new Tata AIG Academy, which launched in May 2014 and seeks to act as a resource for Tata AIG's distributor network, focuses on general insurance education. This entails matching training programs to Tata AIG General Insurance Company Limited's strategic business and growth goals, as well as equipping its workers and

business partners to succeed in a fast changing competitive environment."

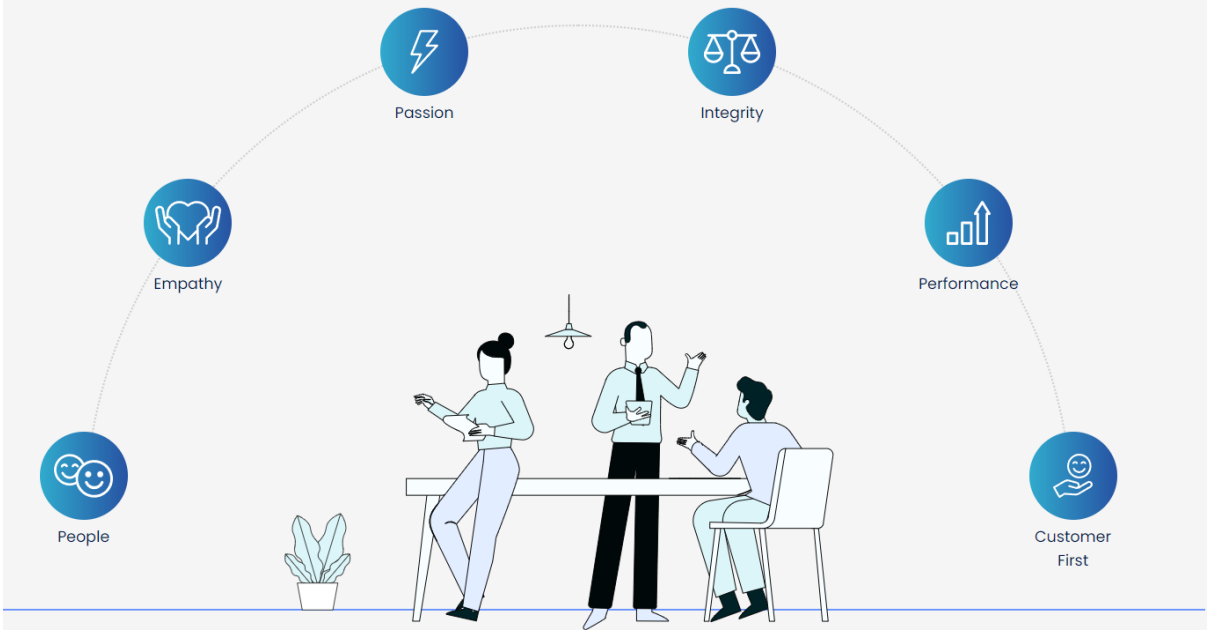
Vision

Canada's leading general insurance provider by 2025, putting customers first and providing them with risk management options to reduce expenses.

Mission

"Create a better world for our users by offering innovative risk solutions and preserving their security," the company's purpose says.

Our 6 Core Values



People- Establish meaningful relationships with internal and external colleagues, as well as customers and associates all across the world. We're here to form long-term, mutually beneficial partnerships founded on tolerance, mutual regard, and mutual respect. Developing and rewarding our diverse workforce is a primary concern for us.

Empathy. When it comes to serving our communities, we must always put their needs first by treating everyone and everything with respect, love, and compassion.

Passion. Be committed to what we do. It is imperative that we have a strong desire to succeed and an unwavering commitment to solving our clients' concerns. Remind yourself and others that you're proud of yourself and your company.

Integrity. Fairness, honesty, and openness are essential in how we do our company. It's imperative that everything we do be able to endure public scrutiny.

Performance. Daily work and service quality must always meet or exceed our company's strictest standards.

Customer First. We must foresee the needs of our customers and go above and beyond to meet needs.

Review of Literature

"Ellis et al. (2000) examined a wide range of Indian health insurance schemes." The necessity for a competitive environment was discovered, and it can only be achieved through the opening up of the insurance industry.

Public and private enterprises were studied in terms of health insurance marketing by Aubu (2014, 2014) in comparison. There were more positive responses from private sector services due of new tactics and XJM 17,1/2 100 technologies employed by them, according to a recent research

Health insurance claimants in the public and private sectors were polled by Nair (2019) to see how pleased they were with their experiences with their insurance companies. Almost all of the people who took part in the survey said they had filed a claim for compensation with a third-party administrator. When it comes to disputes, the public sector is more satisfied than the private sector.

With out community health insurance, it is impossible to create an equitable healthcare system in Europe and Japan, according to Devadasan et al (2004). Community health insurance programmes in India may educate the Indian government a lot.

Health insurance in India was the subject of a study by Kumar (2009). According to the findings, insurance can be an effective tool for mobilising resources, reducing risk, and providing access to health care. However, this will only happen if the Government of India implements structural changes in this area.

According to Dror et al. (2006), rural and low-income Indians are eager to pay for their health insurance. People who have insurance are more eager to pay for it than those who do not.

A study by Jayaprakash (2007) sought to uncover the roadblocks that hinder citizens from purchasing health insurance plans in India and the strategies that might be employed to lower the sector's claims ratio.

Personal variables impacting health insurance policy purchases in India were examined by Yadav and Sudhakar (2017). It is important for health insurance customers to be aware of the tax advantages and financial stability that come with their policy.

Health insurance in India was examined from the standpoint of customers, according to Thomas (2017).Before selecting a health insurance provider, customers look at a variety of factors, including the availability of a strong hospital network, the breadth of coverage, and the responsiveness of customer service representatives.

Micro health insurance enrollment in Karnataka is declining, according to a study by Savita (2014). Lack of funds, a lack of knowledge, and internal factors all contributed to this decrease in expenditure. The key problem for the microinsurance industry, on the other hand, is tailoring the plan to the specific needs of the consumer. In India, Shah (2017) studied the health insurance market following the country's liberalisation. It was

discovered that premiums collected and claims paid have a substantial link, and that demographic characteristics influenced whether or not respondents held insurance policies.

Studying the potential and problems of health insurance in India were Binny and Gupta (2017). Market companies are taking advantage of these chances to grow their businesses and become more competitive in the market. New products are required to address structural issues, such as a high claim ratio and changing customer expectations.

India's health insurance market was examined by Chatterjee et al (2018). The purpose of this study was to examine the present state of the Indian healthcare insurance market. In India, a change from short-term to long-term care is needed because of the country's tendency to prioritise the needs of its people.

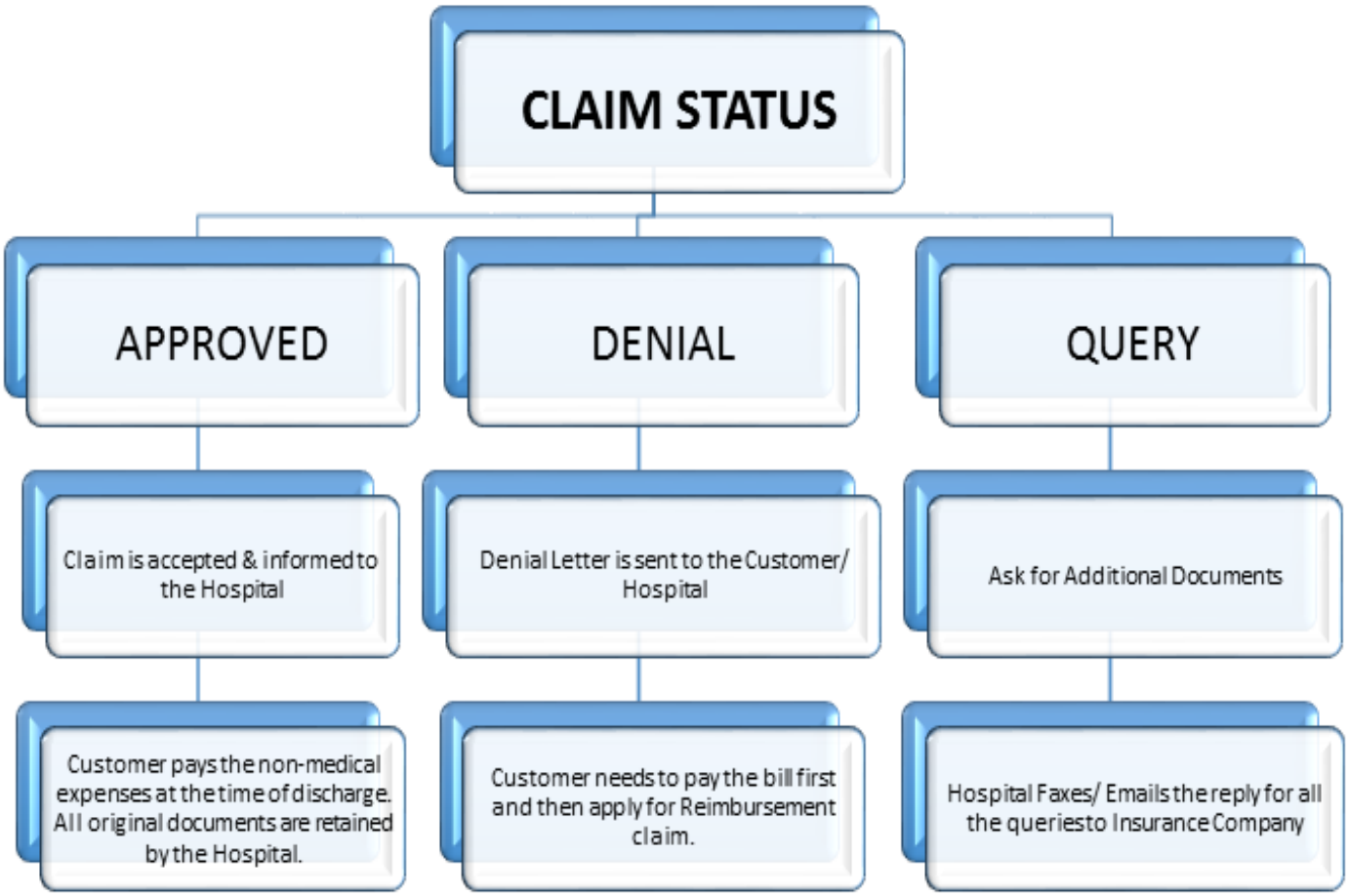
Gambhir et al. (2019) studied private sector Indian insurance coverage for outpatient care. Despite the fact that health insurance is not a good deal, private health insurance companies have increased their market share substantially.

In the health insurance industry, Chauhan (2019) looked at medical underwriting and rating methods. Underwriting a health insurance policy requires consideration of the insured's lifestyle, profession, health, and other behaviours. Health insurance has been the subject of much research in India and throughout the world. Underwriting profit or loss hasn't been studied as a factor in the health insurance company's performance.

Observational Analysis of Workflow

"In the past, health insurance required the individual to pay the hospital bill in full before filing a claim with the insurance company for reimbursement." "The Cashless Hospitalization Process for Health Insurance Claims Using Third Party Administration Services" was launched in 2002 by India's insurance regulatory and development authority (IRDA).

Reimbursement



In case of a Non-Paneled TPA/ Insurance Company

In such a case the Hospital TPA intimates the TPA/Insurance Company of the admission of the insured at the hospital so that the necessary investigation and other procedural requirements of the reimbursement claims can be initiated since a Cashless Authorization does not happen in a Non-Network Service provider

A request for authorization for cashless access may be declined if-

- The TPA is unable to obtain more information due to insufficient, ambiguous, or incorrect information.
- Insurance does not cover the illness/disease that necessitates hospitalisation.

• There is not enough money left in the person's insurance policy to pay the charges of hospitalisation.

Cashless

- A TPA ID card is issued to a person once they are insured by a Health Insurance Policy. A physical ID card may not be issued if the insurance is provided through their company, but they may have an E-card. They will be able to use the CASHLESS service at the Networked Hospitals due to this card.

- Only the insurance company's network hospitals provide cashless hospitalisation. Paying for medical care in full after admission is not required under the concept of cashless hospitalisation.

- As long as the hospitals in the network have agreed to specific terms and circumstances, Third-Party Administrators can offer their insured patients the Cashless option.

- The denial of a pre-authorization request does not mean that treatment will be denied, coverage denied, or your right to prefer reimbursement claims rejected. As long as the insured has paid the hospital bills, he or she can file a claim for reimbursement.

The procedure for obtaining cashless hospitalisation.

Unplanned hospitalization

- "Produce the ID card issued by the insurance company or TPA at the Hospital Help Desk – along with any other ID Proof such as a driver's licence, identification card, passport, voter card, etc. in respect to the patient."
- Complete and re-submit the Hospital Help Desk Pre-Authorization Form with the patient's details, as instructed.
- Please do not forget to include our ID Card Number. If your workplace has adopted the policy, you may also provide your Employee Number.
- Treatment information is completed by the treating physician, and the hospital fills in the projected treatment costs.

- The insurance company will get this form if it is filed online.
- If the provided information is insufficient, the insurance company/TPA will evaluate the request and seek more documents/clarifications
- According to our terms and conditions and any exclusions therein, we will either approve or deny your request based on its merits after we have all the information needed.

Planned Hospitalization

- Prior to admission, the patient must call the TPA assistance desk at the hospital to complete all of the necessary paperwork so that the approval may be issued prior to admission.
- Pre-Authorization forms must be filled out and sent to the hospital's support desk together with the admissions recommendations and ID cards and evidence of identity.
- This permission is verified by the hospital's TPA desk staff at the time of admission. The request must be received by the TPA office at least 2-4 days prior to the hospitalisation.
- A change in the date, facility, illness type, or surgeon performing the surgery will invalidate the authorisation. There must be a fresh authorisation in this situation.
- The authorisation is sent through postal mail to the hospital, which is the recipient. At the time of discharge, the patient is expected to pay any remaining consumables, as well as any difference in the amount of the bed fee or any other payment that is needed by the policy terms and conditions.

"Once the request is received by the TPA/Insurance Company, it is processed. To determine whether or not you need to be hospitalised for treatment, the medical team at the insurance company/TPA will conduct an evaluation of your health insurance policy. It is possible that other terms of your insurance policy may be examined.

Depending on the condition, treatment, sum insured, etc., the TPA/Insurance Company will grant us authorization to spend a particular amount. Pre-authorization is the term for this type of authorisation. This pre-authorization allows you to receive hospital care up to the permitted maximum without having to pay for it out-of-pocket.
TPA/Insurance Company will submit a second or final request on behalf of an insured after he or she has been discharged from the hospital if they have not granted them enough money to meet their medical expenses. The terms and circumstances of your health insurance policy will govern the authorization of an extra amount by TPA/Insurance Company."

In the absence of a TPA cashless facility, TPA needs certain documents."

- A completed claim form by the applicant.
- This is the original discharge summary from the hospital.
- Doctors' consultation report and specialised fees.
- The patient has undertaken laboratory testing with the doctor's consent.
- Medications invoices are included with each prescription.
- Any other record of the hospitalisation.
- Copies of regulations, if available."

What is Insurance Premium?

'Insurance premium' refers to the amount of money that an individual or a company/business pays to get health insurance. Insurance premiums are affected by a variety of factors and can vary directly from one person to next."

In order to keep their insurance policy and coverage active, an individual or corporation must pay a recurring premium to the insurance company. When calculating rates, insurance firms take a wide range of factors into consideration, especially when it comes to health insurance. Medical issues, smoking, and other lifestyle behaviours, as well as the location of the policyholder's house and the type of work they do, all influence the chances of a claim being filed."

There are actuaries employed by insurance companies to estimate the probability of claims being filed by covered individuals for serious illnesses or life-threatening conditions like cancer or heart attacks across various age groups. ".. The cost of life insurance will rise in direct proportion to the level of risk an individual poses. Instalments might be paid monthly, biannually, or even annually. In some situations, customers may be able to pay the whole policy term's premium in a single payment before researchers study."

When it comes to covering all of a policy's associated responsibilities, insurance firms rely on the insurance premium. The insurance firm may also invest the premium in assets in order to generate returns and cover part of the costs associated with the coverage.

How is the Insurance Premium calculated?

In addition to using a reliable insurance premium calculator, there are various other aspects that must be taken into consideration when determining rates:

• Age

• Area of residence

• The nature of the job

• Medical conditions and history

Smoking and other bad habits in one's life

• The likelihood that the insured person will file a claim.

• Income

• Body Mass Index (BMI)

• Marital status and relatives

• Gender

• Hobbies that carry a significant degree of danger.

• The history of global travel

• Debts

According to the insurance sector, mortality costs are taken into account as well, which is how much insurance companies will pay if the policyholder dies. To get to this result, the elements listed above are analysed. Insurance rates are also influenced by insurance firms' operating expenditures, such as the cost of office space, pay for workers, commissions for agents, etc. A last consideration is the interest received on premiums that are put into an investment portfolio.

Premium computation is a multi-step procedure that varies from person to person and policy to policy, as can be seen from the examples given.

The assumption and diversification of risk are the foundations of the insurance industry's business models. Pooling and redistributive taxation of risk is an essential part of the basic insurance model. Reinvesting premiums into other interest-generating assets is the most common way that most insurance firms make money. Insurance firms, like any other private company, strive to maximise profits while reducing cost.

Risk Assumption and Pricing

Health insurance, property insurance, and financial guarantors all have different revenue models. But risk pricing and charging a premium for taking it is just the beginning of an insurer's job role.

There is a Rs. 100,000 conditional pay-out on an insurance policy offered by the corporation. Conditional payment policies need an assessment of the likelihood that a buyer will trigger the conditional payment and an extension of that risk depending on the policy's duration.

Here, insurance underwriting is essential. Insurance companies would overcharge certain customers and short change others if they didn't have a strong underwriting process in place. Customers who aren't high-risk might be priced out, resulting in higher premiums for everyone else. An effective risk pricing strategy should result in more premium income than the firm spends on conditional payments.

Insurance claims are, in a way, an insurer's real product. When a customer submits a claim, the firm is responsible for processing it, verifying its accuracy, and making a payment to the consumer. These adjustments are required to weed out false claims and lower the company's liability.

Interest Earnings and Revenue

How much money is received by the insurance firm from its policies? The money might be kept on hand or deposited into a savings account, but neither of these options is very expense: Even if inflation doesn't rise, those savings will still have to contend with it. Instead, it can locate short-term, secure assets in which to place its capital. While the corporation waits for prospective payouts, it earns additional interest income. Treasury bonds, high-quality corporate bonds, and interest-bearing cash equivalents are all popular choices for this kind of investment.

Reinsurance

Reinsurance is used by certain firms to mitigate that risk. Insurers acquire reinsurance to protect themselves from excessive losses owing to their significant exposure to risk. Reinsurance The ability of insurance businesses to stay afloat and avoid going bankrupt owing to paid claims depends on reinsurance, which is required by regulators for companies of a specific size and kind.

Insurance companies may write too many policies based on models that suggest minimal storm risk in a certain geographic area. If a storm were to strike that area, the insurance firm may face significant damages. Insurance firms may go out of business in the event of a natural disaster if reinsurance does not take some of the risks off the table.

Insurance companies are only allowed to offer policies with a maximum of 10% of the policy's value unless they are reinsured. As a result of the ability to shift risks, insurance firms may be more aggressive in their pursuit of market share. The inherent swings of insurance firms, which can see considerable variations in earnings and losses, are also eased out through reinsurance.

It is similar to arbitrage for many insurance firms. Individual customers pay a greater premium for insurance, but when these policies are reinsured in bulk, the premiums are cheaper.

Methodology

TATA AIG's annual reports as well as other publications, journals, and websites are used in the research. Efforts have been undertaken to analyse the health insurance

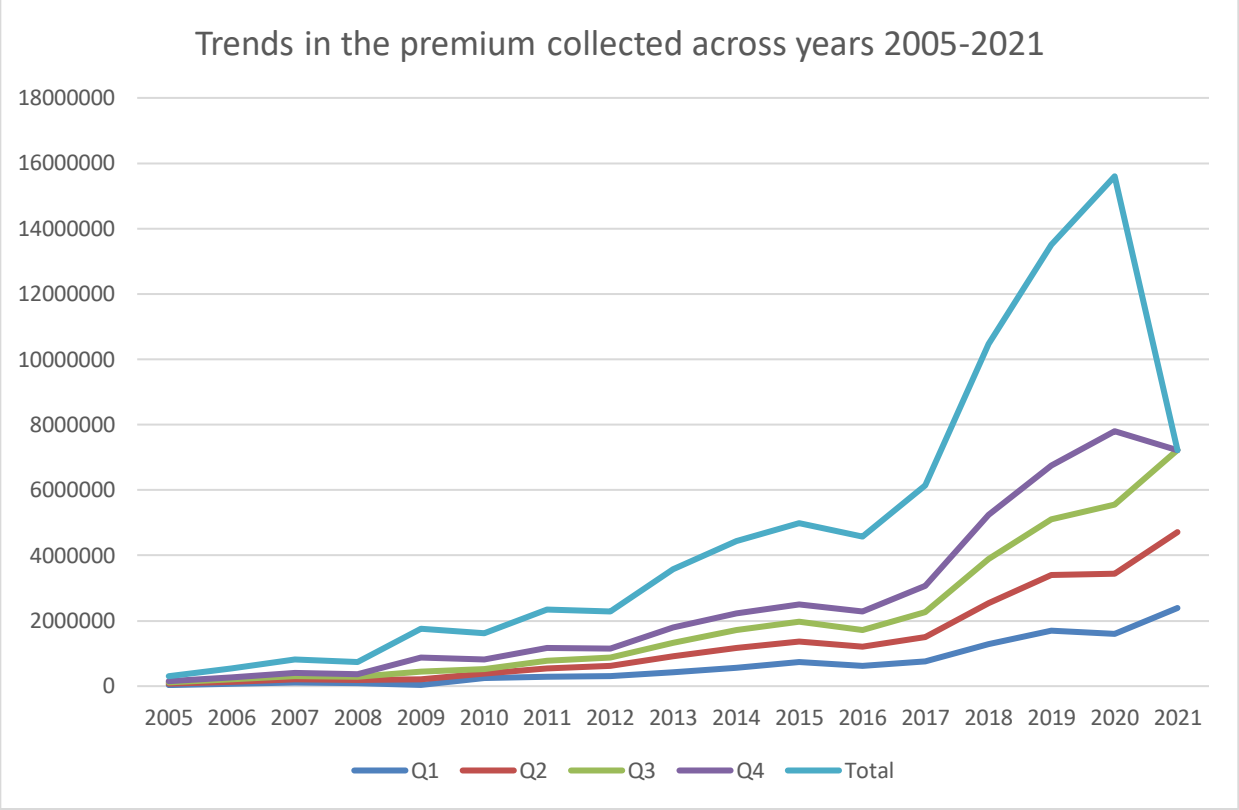
sector. The study's needs and kind required the use of appropriate research techniques. According to the study's stated aims, the data gathered has been categorised, tabulated, and examined. From 2005–2006 through 2021–2022, a 17-year span, the data will be analyzed.

Results.

The quarter-wise results of the financial statements are as below. The value of the statement taken is the Net premium received in the particular quarter.

Year	Q1	Q2	Q3	Q4	Total
2005	38061	38061	38061	38062	152245
2006	68308	68309	68308	68309	273234
2007	101714	101714	101714	101715	406857
2008	92703	92703	92703	92703	370812
2009	36388	176669	227132	439045	879234
2010	238294	153391	134251	285675	811611
2011	283897	257508	228940	401043	1171388
2012	298578	317497	259995	271079	1147149
2013	428599	481994	408138	471820	1790551
2014	556340	611564	555151	496306	2219361
2015	730034	629297	603996	529997	2493324
2016	610413	592970	509640	573578	2286601
2017	760687	735979	774557	800925	3072148
2018	1295155	1240511	1360233	1337095	5232994
2019	1692420	1711471	1704545	1642710	6751146
2020	1600373	1833743	2124953	2241458	7800527
2021	2390573	2322600	2512600		

Plotting the above-collected data makes the graphical representation the same as below.



Conclusion and Discussion

The above-undertaken analysis depicts the following interpretations-

1. Slight dip in the premium collection in the years 2008,2010,2012,2016.
2. Steep rise in the premium collection in the year 2017,2018,2019,2020.

Reasons for decline

The year 2008 saw a global economic downfall and thus can be associated with the bump in the premium collection. There were multiple bank collapses as the crisis escalated quickly to a worldwide economic shock. Since credit became more hard to get and international commerce decreased, the global economy slowed during this time. evictions and foreclosures occurred as a result of a collapse in the housing market and an increase in unemployment. Several businesses failed. People had difficulty maintaining their normal lifestyle and thus the premium collection saw a slight dip. The entry of Max Bupa, Bharti AXA, as a competitor in the same sector caused a distribution of the premium between the companies.

The Great Recession, the world's most severe economic crisis, lasted from December 2007 to June 2009. Subprime mortgages and cheap interest rates contributed to the

collapse of the housing market during the economic crisis.Premium collection dropped as a result of the economic crisis because of public fear. Future Generali General Insurance CEO KG Krishnamoorthy Rao ascribed this to the slowing in economic development. "Non-life business has a direct impact on the country's economic progress." Since India's GDP growth has slowed in the last two years, the sector has seen a decline in its new business premium collection.

Reasons for the increase

The Unique selling proposition of ours that is **no deduction on the paid amount in case the claim is found admissible** is the major cause of the increase in Y-O-Y increase of the premium amount collected. The aggressive marketing involving the active work of agents for the grass root level marketing, digital marketing, and social media marketing has led to an increase in the premium collection.

During the Covid pandemic, the necessity of health insurance came to light, and thus people started to realize its importance and aggressive purchase of health insurance began causing the premiums collection to steep up.

- A CAGR of 20% has been seen in India's health insurance industry during FY16, according to a PWC report.
- Only 3% of India's entire population is covered by retail health policies (not funded by the government), therefore there is still room for expansion.
- A significant increase in demand is expected, given the learning lessons from other nations' experience with SARS and MERS.

The following are the findings of their studies:

Go digital across the journey

- 'Wellness' and 'health' are becoming increasingly important to a new generation of Indians.
- Consumers who aren't digital natives are increasingly turning to digital channels due to market conditions.
- According to the results of our poll, consumers expect healthcare providers and intermediaries to provide simple digital techniques at each stage of the journey.
- As a result of the ongoing COVID-19 situation, more and more people are expected to use digital channels.

• Imperative: Digital inputs are expected at every stage of the health insurance process, including reviewing and renewing coverage, according to a consumer pulse survey. As a result, insurers are under pressure to create digital assets that make the customer's journey as simple and straightforward as possible at each and every point:

- Among the places where customers conduct research online
- Customers can be steered to the right product via digital assets.
- service transitions between the unassisted and the assisted
- claims adjudication.

Launch innovative products that serve unmet needs

- As a result, customers are looking for alternative to cash transactions, as well as a wider variety of illnesses covered and reduced premium prices.
- IRDAI.:Several of these customers' concerns have been addressed by the IRDAI (Guidelines on Standardization of Exclusions in Health Insurance Contracts) circular and the (TPA – Health Services) (Amendment) Regulations, 2019.

• Imperatives:

- The use of primary research and analytics by insurers can help them better understand their clients.
- Implicit needs from clients should be addressed by health insurers. According to just 3% of respondents, insurers should consider implementing customizable solutions that allow customers to pick the qualities they want covered.
- Make the most of new technologies like wearables and IoT with analytics to reshape the market place.

Scale distribution excellence

- Until lately, traditional channels controlled the delivery of health insurance.
- Agents are expected to remain the leading distribution channel since clients have a high degree of trust in them.
- In order to enable new distribution channels swiftly, IRDAI released 'Guidelines on Filing of Minor Modifications in the Authorized Individual Insurance Products offered by General and Stand-Alone Health Insurers on Certification Basis' It will help insurers reach a broader audience.
- Digital distribution will presumably be accelerated by COVID-19.
- Imperatives:
- With the help of training programmes and technology-enabled nudges, insurers have established distribution capabilities that can expand.

- Innovative business methods and new-age alliances can be pursued by insurers. - A digital distributor journey may be made simple and intuitive by these companies.

Minimize pain points for claims Scale distribution excellence

- Claim settlement performance has enhanced.

- A high level of satisfaction was found in their survey sample, indicating that insurers are already aware of and taking steps to minimize negative claims experiences.
- The lack of network hospitals, lower than full bill coverage, the absence of a dedicated questions desk, and a lack of transparency in the procedure are all cited as reasons for discontent with cashless settlements in their consumer pulse survey.
- According to their primary and secondary research, the reasons for discontent with reimbursement settlement include partial claim settlement, delay in payment, piecemeal demands for documentation, and a lack of clarity in the course of the project.
- Covid-19 is expected to force insurers to automate claim settlement processes. Insurers who cover the condition are already making the transition to digital, and it will help them keep up with a rapid increase in supply.

• Imperatives:

-Minimize dependence on manual communication for the processing of cashless claims.

-In light of the ongoing pandemic, insurers must guarantee that personal interaction is kept to a minimum and make submitting reimbursement claims as simple as possible by providing an online self-service facility.

- Invest in RPA for claims processing and AI for fraud analytics to increase your claim processing capability.

-In order to avoid customer dissatisfaction during the claims process, insurers should communicate openly and honestly with their clients.

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