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| RESEARCH ARTICLE

Prospective Policy Holders on Health Insurance: An Assessment Towards Marketing Plan Proposal

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| ABSTRACT

In the health insurance industry, there is a discernible trend towards the incorporation of digital tools and platforms into marketing strategies. Competition and saturation are at an all-time high in the health insurance industry, making it difficult for businesses to differentiate themselves and acquire new policyholders therefore, more customer-centric and inventive marketing strategies are required (Usha, 2023). This study assessed the health insurance as on the point of view of the policy holders gearing towards marketing plan proposal. Issues encountered by the clients were also considered. Prospective policyholders strongly agree on the importance of evaluating premium increases, comparing costs across policies, and considering discounts. Convenience factors like telemedicine and user-friendly interfaces are valued. Across the five main criteria—premium, benefits, convenience, security, and claims—there are no appreciable variations in the assessments of health insurance by potential policyholders. Hence, the null hypothesis was accepted as individual preferences or particular policy features are generally seen by the policy holders same with the features of health insurance. According to the survey, prospective policyholders have different issues with health insurance wherein universal consensus on the found problems is evident. In this regard, main strategies formulated as strategic marketing plan for health insurance companies which are is necessary.

| KEYWORDS

Health insurance, premium, benefits, convenience, security, and claims

| ARTICLE INFORMATION

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Introduction

Perceptions of health insurance refer to the manner in which individuals regard and interact with the various determinants that impact their attitudes, including but not limited to affordability, coverage sufficiency, trustworthiness, and transparency. The primary objective of this research is to offer a thorough comprehension and contribute significant insights that may influence policy-making, enhance communication tactics, and ultimately bolster the efficacy of health insurance in catering to a wide range of requirements. The objective of this study is to conduct a comprehensive analysis of the dynamic health insurance sector, specifically targeting potential policyholders. By doing so, it seeks to offer valuable perspectives on emerging trends, challenges, prospects, and scholarly works. In this regard, recent progress in data analytics is a crucial factor in gaining a deeper understanding of prospective policyholders. Organizations are utilizing this information to customize marketing approaches and improve customer interaction, with the ultimate goal of providing more individualized insurance products (Replogle, 2024). Gaining insight into individuals' perceptions of health insurance is instrumental in shaping marketing strategies, enabling the creation of demographic-specific campaigns that effectively connect with them. Various factors, such as perceived value, accessibility, and trustworthiness, influence consumer decisions. These determinants play a significant role in molding the messaging and channels employed in marketing endeavors. Companies can increase customer engagement and contentment by effectively communicating the benefits of their health insurance offerings, customizing their strategies to suit the needs of various target audiences, and aligning their marketing strategies with these insights.

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In the health insurance industry, there is a discernible trend towards the incorporation of digital tools and platforms into marketing strategies. This encompasses the use of mobile applications, targeted online advertising, and social media to engage and connect with potential policyholders in a more efficient manner. Competition and saturation are at an all-time high in the health insurance industry, making it difficult for businesses to differentiate themselves and acquire new policyholders. More customer-centric and inventive marketing strategies are therefore required (Usha, 2023). The perpetually shifting regulatory environment pertaining to health insurance presents a substantial obstacle. In addition to ensuring compliance, businesses must navigate these changes and adjust their marketing strategies accordingly. There is a dearth of comprehensive research on the intricacies of customer segmentation among potential policyholders, particularly in light of changing consumer behaviors and the variety of demographics (Bautista, 2024). Research is required to facilitate the development of targeted marketing strategies and identify and comprehend the distinct segments comprising the prospective policyholder base. There is a dearth of comprehensive analysis in the existing body of literature regarding the efficacy of various digital marketing channels in attracting potential policyholders (Usha, 2023). Conducting research that compares the effects of different digital platforms on rates of consumer acquisition and engagement presents a substantial opportunity. The current body of research fails to sufficiently address the swift progression of regulatory frameworks that impact health insurance marketing. This deficiency creates a void in the realm of strategic marketing planning (Shannon et al., 2024). Investigating the ongoing ramifications of regulatory modifications on marketing strategies may furnish health insurance providers with indispensable insights.

Passarelli et al. (2024) say that there is a clear research gap in the practical use and outcomes of advanced analytics and AI for predicting consumer behavior and improving personalized marketing. There is a critical need for comprehensive case studies and empirical research that provide evidence of the successful integration of these technologies into health insurance marketing. Research often overlooks long-term customer value creation and retention strategies in the health insurance sector, prioritizing initial acquisition (Kamali et al., 2024).

Longitudinal studies examining strategies for sustaining and augmenting the value of policyholders over an extended period are imperative. Targeting previously unexplored demographic segments, such as younger individuals and those without conventional employment, presents significant growth prospects. Developing customized marketing strategies that target the distinct requirements and inclinations of these demographics has the potential to substantially broaden the clientele.

Novel technologies, including artificial intelligence (AI) and machine learning (ML), present prospects for augmenting predictive analytics, refining customer segmentation, and customizing communication. These advancements have the potential to boost conversion rates among potential policyholders. Successful marketing strategies have the potential to make a substantial impact on increasing health literacy among potential policyholders. Enhancing people's knowledge about health insurance benefits and optimizing policy utilization contribute to the advancement of healthcare outcomes.

Organizations not only foster business expansion, but also enhance the economic stability of individuals and families by providing financial safety nets in the face of health emergencies through the promotion of health insurance policy enrollment. Recent research findings emphasize the importance of health insurance providers' ability to consistently adapt and innovate. Organizations can significantly impact public health and business expansion by devising marketing strategies that effectively resonate with potential policyholders by comprehending and addressing pertinent trends, challenges, and opportunities. The study will primarily focus on a thorough examination and evaluation of these components, supported by current scholarly works and industry analyses.

Review of Related Studies

Premium

Insurance is a risk--management mechanism. By purchasing insurance, one safeguards themselves against unforeseen financial losses.An insurance policy is a written agreement between the policyholder (the individual or organization purchasing the policy) and the insurer. An insurance contract entails the policyholder, who is an individual or entity, paying a premium to the insurance company in exchange for protection against predetermined risks. The insurer reciprocates by compensating the policyholder for monetary damages incurred due to the covered events (Rejda, 2018).

Health insurance provides coverage for the financial burdens associated with medical expenses or injuries. It can, at its core, reimburse the insured for surgical, dental, and medical expenses, in addition to paying the healthcare provider directly. Furthermore, it can offer financial security to a person during any potential health issue, precisely when it's most critical. most needed. needed. The primary purpose of health insurance policies is to provide coverage for a proportion of the expenses incurred by policyholders for medical treatment, including hospital and professional fees (Mark, 2022). Gele et al. (2016) assert that health literacy encompasses not only the physical aspects of well-being but also the social, political, and environmental determinants. It entails the lifelong acquisition of an extensive array of competencies and skills that enable individuals to locate, comprehend, assess, and apply health information in order to make informed choices, mitigate health hazards, and improve quality of life. Maria et al. (2020) examined the effects of recent policy modifications on individuals' health insurance coverage as they seek coverage. This study investigated the impact of changes in market dynamics, regulations, subsidies, and enrollment rates on coverage decisions. The results offered policymakers and insurers valuable insights that can assist them in navigating the ever-changing healthcare landscape.

As stated by Nobles et al. (2018), consumers' inadequate understanding of health insurance is likely to result in ill-informed decisions regarding health insurance plans and usage. In understanding information or information utilization may result in a misalignment between an individual's health care requirements and their insurance coverage.

The initial step in acquiring an insurance policy is to submit an application and obtain approval. In this procedure, insurers evaluate the individual's risk level based on the likelihood of them filing a claim. This information helps insurance providers determine the cost of coverage for policyholders. This sum is referred to as the premium. Health insurance premiums play an important role in personal financial planning because they influence how people perceive healthcare accessibility and financial security. Premium cost-benefit analysis influences decisions about whether to purchase or abandon coverage.

Smith et al. (2019) underscored the significant influence of premium affordability on individuals' inclination to purchase health insurance, and its direct correlation with perceived value. The affordability of health insurance premiums, according to the authors, is a significant determinant ofof individuals' inclination to acquire health insurance. A direct correlation exists between the affordability of health insurance and its perceived value; that is, individuals are more inclined to purchase health insurance when they hold the belief that the premiums are commensurate with the level of coverage they obtaiTo put it simply, individuals who perceive health insurance as prohibitively expensive may be less inclined to recognize its value, despite their awareness of the advantages associated with its use.on.

Socioeconomic factors, such as employment status and income, influence an individual's perception of premiums, as stated by Jones and Brown (2020). When it comes to determining employee benefits, It emphasizes the importance of individual circumstances in designing employee health benefits. mployees. A person with a higher income may be able to afford a particular premium, whereas a person with a lower income may have difficulty paying the same amount. By recognizing the impact of socioeconomic affordability on the perception of affordability, organizations have the ability to develop benefit packages that are more comprehensive and efficient.

Anderson and White (2018) investigated the manner in which employers frequently regard health insurance premiums as a substantial element of comprehensive compensation packages, which has implications for their capacity to both recruit and retain proficient personnel. Employers consider health insurance a crucial element of employee compensation, presumably due to the substantial influence it has on the recruitment and retention of qualified personnel.

Furthermore, Taylor et al. (2021) examined the impact of premium costs on employers' choices regarding the provision of health insurance coverage, highlighting the need to strike a balance between cost-related factors and the commitment to offering comprehensive employee benefits. The topic of health insurance premiums is not devoid of difficulties. Furthermore, they might explore alternative insurance models that provide more economical solutions or engage in negotiations with insurance providers to secure more favorable rates. Achieving an optimal equilibrium between cost implications and the provision of high-quality advantages necessitates meticulous evaluation and strategic deliberation in order to safeguard the welfare of both personnel and the organization.

Patel and Williams (2019) argue that the complexity of comprehending and contrasting various high-priced alternatives presents individuals with difficulties in arriving at well-informed judgments. The research underscored the necessity for enhanced communication tactics in order to improve consumers'consumers' understanding of premium-relatThe authors examined the ramifications of this ignorance on individuals, emphasizing how it could lead them to make less-than-ideal decisions or even forego insurance coverage entirely. erage entirely. Moreover, it could potentially exacerbate inequities in financial protection and access to healthcare services, especially among populations that are most susceptible.

Brown and Miller (2020) assert that the escalating costs associated with health insurance premiums present a significant obstacle for employers and individuals alike, impacting the accessibility and affordability of healthcare as a whole. Elevated insurance premiums impose additional financial burdens on individuals, thereby impeding their ability to procure essential healthcare coverage. Organizations face significant obstacles due to the increase in insurance premiums. Furthermore, the escalating premiums may impede employers' ability to recruit and retain high-caliber personnel, given the increased difficulty in upholding competitive benefits packages. The difficulties associated with understanding and overseeing health insurance premiums make a valuable contribution to the wider discussion on healthcare policy and necessitate the development of inventive approaches to tackle concerns about affordability, openness, and fairness in access.

Adebayo et al. (2020) conducted a study that examined the influence of risk perception on the propensity to pay for health insurance in a developing nation. The researchers investigated the impact of people's perceptions of their health hazards on their health insurance choices, with a particular focus on developing countries. The study emphasized the importance of considering not only the financial feasibility of health insurance, but also how individuals perceive its value and its applicability to their specific health hazards. Stakeholder engagement can boost confidence in insurance systems and encourage increased participation, ultimately helping developing countries gain access to healthcare and financial security.

Benefits

Health insurance benefits individuals and families by facilitating access to care, enhancing health outcomes, and providing financial protection. Lee and Carter (2019) explained that policyholders' perceptions of health insurance benefits significantly influence their purchasing decisions. A common criterion for individuals to assess health insurance plans is the

extent to which benefits are comprehensive, encompassing specialty services, prescription medications, and preventive care. Plain and transparent communication about the advantages of an insurance policy has a significant impact on the confidence and trust individuals place in it.

In the study that was conducted by Johnson and Davidoff (2018), they examined the connection between health insurance benefits and health outcomes. They presumed the text to cover a multitude of topics, such as the impact of insurance coverage on population-specific health outcomes, the utilization of preventive services, and access to care. It is crucial to ensure that all individuals, regardless of their socioeconomic status or other demographic variables, have the opportunity to achieve optimal health outcomes through the equitable distribution of insurance benefits.s.

Meanwhile, Wang, et al. (2021) conducted a study with the objective of evaluating low-income populations' perceptions of health insurance benefits. Individuals in this demographic's viewpoints revealed varying degrees of consciousness and comprehension regarding the benefits that are available to them. Many participants expressed concerns about personal expenses and coverage restrictions. The study emphasizes the importance of mitigating disparities in healthcare utilization among vulnerable communities and confronting systemic barriers to access. Policymakers and healthcare providers can strive to establish a more equitable healthcare system by recognizing and attending to these concerns based on each individual's socioeconomic status.

The study by Adams and White (2018) has a significant impact on the dedication and general job contentment of workers towards the company. Employers acknowledge that health insurance is an essential element of the benefits bundle, which has an impact on their recruitment and retention efforts. Employers widely recognize health insurance as an essential element of their benefits bundle, aware of its significant influence on recruitment and retention endeavors. Providing comprehensive health insurance coverage in the current competitive job market not only serves as a means to recruit high-caliber candidates but also cultivates a feeling of assurance and welfare among current staff. Organizations are increasingly recognizing the provision of high-quality healthcare benefits as a significant gauge of their dedication to the well-being and health of their employees.

It should now be abundantly clear how critical insurance is for individuals and organizations' financial protection. Policyholders can recover from unanticipated disasters and catastrophes more quickly if they have adequate coverage, which provides the financial resources necessary to rebuild their lives. However, acquiring insurance offers the reassurance of financial security, irrespective of the circumstances.ituation.

Convenience

Health insurance provides financial protection and timely access to healthcare services, making it a convenient option. This element, which includes networked healthcare providers, digital platforms, and streamlined claim processes, all contributes to the convenience of health insurance.insurance.

The study by Santos et al. (2018) focused on issues related to administrative procedures, network administration, and provider remuneration, highlighting barriers that hinder convenience for both insured parties and providers. Difficulties in communication between insurers and healthcare facilities, administrative complexities in claims processing, and reimbursement delays were among the obstacles uncovered by the study.

This issue of surprise invoicing, in which patients receive emergency care from out-of-network providers without their knowledge, results in unforeseenly high costs (Hudson, Michael, et al., 2019). This occurs when you receive emergency care from a provider outside of your network, incurring unforeseen, high costs. Imagine requiring emergency surgery and then learning that your insurance did not cover the anesthesiologist. Patients may incur significant financial strain due to unexpected invoicing, which exacerbates an already difficult situation.

Colvin et al. (2020) examined the difficulties that patients seeking specific treatments may encounter as a result of insurers' prior authorization requirements, which may cause delays and access barriers. Difficulties in obtaining essential medical attention may be among these obstacles, causing dissatisfaction among patients and healthcare professionals alike. Delays may result in adverse health effects, particularly for patients who require immediate medical attention. Prior authorization necessitates an insurer's approval of a specific treatment or medication before its administration.

Smith et al. (2019) conducted the research on the digital platform that underscores the benefits of mobile applications and online portals in enabling prompt policy management, claim submissions, and real-time communication with insurers. Moreover, digital platforms play a crucial role in facilitating inquiries, providing clarifications, and promptly responding to queries, thereby fostering real-time communication between insurers and insured individuals.duals,individuals,.

Johnson and Davis (2020) emphasized the significance of streamlined claim processes in mitigating administrative burdens for policyholders. The expeditious processing and effective submission of claims are substantial factors that greatly enhance the overall convenience of health insurance. Furthermore, the research emphasizes the practicality of digital platforms in facilitating claim submission, allowing insured individuals to electronically submit claims and monitor their progress in real-time.

As demonstrated by Anderson and Harris (2018), insurance plans that have extensive provider networks enhance convenience by providing a diverse array of healthcare alternatives. This guarantees that policyholders have convenient access to

services without sacrificing quality. Accessibility allows policyholders to easily access healthcare services without having to endure lengthy travel or waiting times for appointments. Furthermore, the provision of a comprehensive network enables policyholders to access specialized care as needed, ensuring that their healthcare requirements are met without compromising on quality.

According to Patel and Chen (2017), policy design plays a crucial role in enhancing the accessibility of health insurance. By customizing policies to suit the needs of various demographic groups, including but not limited to age, income, and health status, one can promote inclusivity and extend coverage to a more extensive population. This strategy acknowledges that distinct demographic cohorts possess unique financial resources and healthcare requirements, necessitating customized insurance plans to accommodate their particular conditions. For example, implementing policies that provide premium assistance or subsidies to low-income individuals can effectively improve the affordability and accessibility of insurance for economically disadvantaged groups.

Meanwhile, Tan et al. (2023) examined the issue of provider payment delays in the health insurance industry. Payment delays have significant ramifications for healthcare providers, including cash flow limitations, operational complexities, and potential disruptions in patient care provision. Additionally, the research resulted in a more comprehensive comprehension of the underlying factors contributing to payment delays, including inefficiencies in claimclaim processing, administrative bottlenecks, and deficient reimbursement rates. The integration of efficacious remedies ascertained via research can culminate in a health insurance system that is more streamlined and environmentally viable, to the mutual advantage of providers and patients.

Security

Ensuring the security of health insurance systems protects confidential healthcare data and preserves public confidence (Jones and Smith, 2018). The implementation of data protection protocols is crucial in safeguarding health insurance data. Critical elements in safeguarding the confidentiality of sensitive medical records and preventing unauthorized access are encryption, access controls, and secure data storage, according to this consensus. Protecting the privacy of health insurance information by ensuring that data remains illegible to unauthorized parties is a critical function of encryption. A multi-layered approach to security effectively mitigates the likelihood of unauthorized access or manipulation by restricting access to particular data and specifying its access conditions.

Imam (2018) conducted a study that examined the application of QR codes for retrieving medical information, with a particular focus on personal health cards. The research revealed that QR codes, when used in conjunction with authentication and authorization credentials, can provide secure access to medical data. This method has the potential to enhance health insurance systems by facilitating access to and management of medical data in a more secure and efficient manner. This would facilitate a streamlined process for all parties involved. Imagine a hypothetical framework in which insurance companies could obtain the necessary information to facilitate informed decision-making while maintaining the utmost patient confidentiality. tients. This has the potential to enhance the overall efficiency of the healthcare system for all participants.

Martinez and Garcia (2019) highlighted the importance of transparent policy provisions, robust data protection protocols, and reliable insurance providers in fostering a positive perception of security among potential policyholders. Security considerations include the importance of transparent communication regarding data protection and highlighting the dependability of the insurance provider. Clear policy terms ensure that policyholders fully comprehend the extent of their coverage, along with the responsibilities and benefits associated with their insurance plans. The insurer's transparency promotes confidence and trust, while also reducing any uncertainty about the protection of personally identifiable health information. Potential policyholders are more inclined to experience a sense of assurance when they are cognizant of the insurance provider's demonstrated dependability and dedication to safeguarding their welfare.

Rodriguez and Garcia (2018) discuss the critical role that employee training plays in ensuring the security of the health insurance system. They investigate how personnel who have received adequate training can function as a primary barrier against a range of security risks, such as cyber-attacks and data intrusions. This training prepares personnel to effectively manage security incidents and keeps them abreast of the most recent data protection techniques.Recognizing the importance of employee training can help health insurance providers improve their overall security measures and reduce the likelihood of data intrusions involving sensitive patient information..

As per Smith and Anderson (2017), the insurer's stability plays a crucial role in guaranteeing the reliability of health insurance coverage. Ensuring sustained coverage over time necessitatesa careful a careful evaluation of insurance providers' financial stability and long-term viabThe financial stability and long-term viability of insurance providers directly influence individuals' access to consistent and sustainable coverage. iders. Furthermore, the stability of insurance providers inspires confidence among regulatory bodies, consumers, and healthcare providers, thereby cultivating trust in the insurance industry and encouraging engagement in coverage initiatives.

Meanwhile, Dela Cruz et al. (2024) evaluated the regulatory frameworks pertaining to the solvency of insurers in various jurisdictions, focusing on the consequences for market competitiveness, consumer protection, and financial stability. The results

of their research carry substantial ramifications for policymakers and regulatory bodies charged with ensuring the financial stability of insurers, fostering market competition, and protecting consumers in the health insurance sector.

Claims

The processing and certification of health insurance claims, as perceived by the individual, constitute the healthcare encounter in its entirety. As a result, insurance companies can gain substantial returns by investing in claims experience enhancement, such as increased customer retention and a favorable brandable brand reputation.

According to Smith and Patel (2019), transparent claims management and a seamless claims experience contribute to increased levels of policyholder trust, loyalty, and overall satisfaction. An effortless claims process, distinguished by streamlined documentation and effective correspondence, augments convenience and reduces anxiety for policyholders amidst a period that is frequently arduous.

The processing of health insurance claims can affect both employers and employees. Moreover, White and Johnson (2021) have established that timely and precise claims settlements play a significant role in maintaining cost control and ensuring the stability of healthcare expenditures. Insurers must acknowledge the criticality of efficient claims processing in order to sustain robust alliances with corporate client groups and adapt to the ever-changing demands of the business landscape.

Santiago et al. (2024) emphasized the significance of language barrier awareness and cultural sensitivity in claims processing as a means to increase customer confidence and satisfaction. Insurers can foster more favorable experiences for their clients by emphasizing the importance of insurance providers comprehending and valuing their clients' cultural heritages, thereby strengthening their relationship with customers.

In their study, Lim et al. (2022) investigated the impact of repeated denials of claims on policyholders' loyalty to their insurance provider and their perceptions of the provider. The results of their research shed light on the significant adverse consequences that denials of claims can have on policyholders' trust and loyalty. When policyholders experience recurring denials or delays in the processing of their claims, it undermines their trust in the insurer's dependability and dedication to delivering coverage. By doing so, an organization not only upholds policyholders' confidence and allegiance, but also aids in the preservation of a favorable standing and competitiveness within the insurance sector.

Friedman et al. (2022) address a notable obstacle in employer-sponsored health insurance plans: the constraint of limited provider networks. Although these networks may offer lower premiums, they frequently limit patient options by including a smaller number of contracted healthcare providers. This may present challenges for individuals seeking to consult specialists, locate strategically situated providers, or circumvent exorbitant out-of-network expenses.

In order to prevent any potential ambiguity throughout the claims procedure, policyholders ought to diligently peruse their policies and acquaint themselves with the exclusions. Although insurance is essential for protecting against a wide range of risks, these exclusions are critical for upholding the insurance's integrity and preventing improper coverage utilization.

The classification of health insurance may be challenging due to several defining characteristics (Ali, 2019). These include the type of participation, whether it is mandatory or voluntary, the entitlement to benefits, the membership level (individual or family), the methods of fundraising (taxes, flat-rate premiums, earnings-based premiums), the mechanism and extent of risk combinations, and others. Misclassification may lead to the denial of health insurance coverage.

Stavenstein et al. (2020) study examines how consumers use online transparency tools to compare the plans and providers of various insurance providers, with the aim of determining the extent to which these tools influence the health insurance selection process. It offers online resources that assist people in understanding and comparing health insurance plans. These tools may include customer evaluations, provider networks, plan summaries, and cost calculators as potential attributes. This may entail comprehending the intricacies of benefits, evaluating costs in accordance with individual requirements, and conducting research on in-network providers affiliated with various plans.

According to Hanoch and Barnes (2017), healthcare systems rely on consumers' health insurance literacy, which encompasses their overall understanding of social health insurance and governs their capacity to make informed decisions regarding health care coverage selection and utilization. Prior research has established a correlation between inadequate knowledge regarding health insurance and unfavorable health decisions, including excessive medical expenses.

In the study conducted by Dela Cruz (2019), public health care represented an efficient mode of health service provision. Ensuring the successful provision of health care services in the country ultimately depends on the national government's ability to identify efficient and effective solutions to these challenges and issues. Given this, it is critical to understand the extent to which public health institutions are capable of satisfying the growing public need for effective healthcare services.

Health inequities, inadequate access to health care, and ignorance regarding social health insurance are considered significant health concerns in the Philippines (Bredenkamp et al., 2017). The country has made insufficient efforts to tackle the issue of social health insurance awareness, in contrast to other nations that have prioritized the engagement of covered communities through diverse strategies to enhance public awareness and ensure that individuals are well-informed about their health insurance rights.

As per Guarino et al. (2019), the Philippines' health situation has improved, although not to the same extent as that of

other South Asian nations. Population-based indicators show that the country is undergoing a significant epidemiological and demographic transition, as evidenced by an increase in life expectancy, a reduction in fertility, and a substantial reorientation of risk factors. Climate change, rapid urbanization, and high population density have started to influence the phenomenon of novel infectious diseases emerging and reappearing.

Ogundeji et al. (2019) asserted that individuals take into account a variety of factors, including their level of education, when making premium purchases. According to the collected data, the majority of social health insurance policyholders hold a bachelor's degree or higher (55.3%), while the majority of those without social health insurance coverage are college undergraduates (48.4%). Individuals with more education and health insurance literacy are better informed about health insurance benefits and coverage. As a result, they are more inclined to enroll in social health insurance.

Sigua et al. (2020) assert that health expenditures continue to significantly burden Filipinos financially, prompting the implementation of the Universal Health Care Law to improve financial security and healthcare accessibility. The legislation aims to rectify the disparities encountered by the national health system as a result of inconsistent care provision and insufficient funding structures. Without posing a financial burden, the government and its shareholders continue to strive for an efficient healthcare system that provides residents with high-quality care.

As Garcia and Martinez's (2019) research highlighted fees and charges as crucial factors that influence individuals' decisions when selecting health insurance policies. The study highlights the importance of transparent fee structures, clear communication about charges, and the perception of fairness in shaping the favorable perceptions of prospective policyholders.

According to Smith and Johnson (2018), awareness influences the way in which individuals view health insurance. Insufficient knowledge regarding the intricacies, advantages, and scope of a policy may contribute to unfavorable perceptions. Effective communication and educational initiatives as crucial for increasing policyholders' awareness and comprehension were identified. Insufficient knowledge may arise from a multitude of factors, encompassing insufficient correspondence from insurance providers, intricate policy language, and restricted availability of educational materials.

On establishing and maintaining trust in insurers is critical in shaping individuals' perceptions of the value of health insurance, as Brown et al. (2019), transparent communication, equitable claim processing, and ethical business practices are all components of trust that positively influence this perception. In health insurance policies, there are limitations and exclusions. Effective communication regarding exclusions and limitations is crucial for managing the expectations of policyholders and ensuring that all parties are cognizant of the scope of protection offered by their insurance plans.

The provision of health care coverage in the United States is distinct from that of the majority of industrialized nations, which have universal health care systems. As an illustration, coverage is universal in the United Kingdom, where general taxation and a payroll tax contribute a lesser sum to the funding for national insurance. This represents approximately 10.5% of the total population.

Additionally, there is private voluntary insurance, which is considered a means to acquire healthcare services more quickly (Thorlby & Arora, 2019). In a similar fashion, private health insurance and competing non-governmental, not-for-profit health insurance funds provide alternatives to mandatory health coverage in Germany. In addition to the universally applicable Statutory Health Insurance System, a significant proportion of the populace in Japan procures supplementary private health insurance. The National Health Insurance System of Israel automatically enrolls permanent residents and citizens, offering coverage through four nonprofit, competitive plans.

Effective access to healthcare services is contingent upon the extent to which health insurance policies provide coverage. Smith and Johnson (2018) emphasize the significance of the scope of covered services in determining the efficacy of health insurance coverage. Policies that encompass a wide array of services, such as preventive care, prescription medications, and specialized treatments, achieve comprehensive coverage and cater to the diverse requirements of healthcare consumers.

According to Smith and Johnson (2018), insurance agents play a crucial role in enhancing the clarity and accessibility of health insurance coverage. A consistent and dependable insurance agent network plays a crucial role in ensuring the efficacy and broad accessibility of health insurance coverage. Insurance agents play an intermediary role by providing assistance to individuals as they navigate the intricate aspects of policy options, terms, and conditions.

Sarah et al. (2021), study investigated the relationship between young adults' health insurance literacy and how it impacts their plan selection. The researchers then investigate how this level of comprehension influences the health insurance plan selection decisions of young adults. Simply put, the research explores young adults' health insurance knowledge and its influence on the plans they choose.

The COVID-19 pandemic has had a profound effect on the health insurance industry, presenting obstacles and necessitating adjustments to suit the distinctive conditions precipitated by the worldwide health emergency.

Johnson et al. (2020) examined the pandemic's effects on health insurance coverage, noting the increased need for comprehensive policies that provide adequate protection against COVID-19-related medical expenses. During the pandemic, it became necessary for insurers to modify their offerings in order to meet the changing demands of healthcare.

In their study, Smith and Brown (2021) investigated the impact of health insurance on the accessibility of COVID-19 testing and treatment. The authors underscored the importance of transparent communication regarding coverage and benefits, which enables individuals to effectively navigate the intricate landscape of healthcare during the pandemic. Constant research

and discourse surrounds the optimization of health insurance coverage in response to the ever-changing challenges presented by public health emergencies, as a consequence of the COVID-19 pandemic's demand for adaptable and robust systems.

Health insurance has encountered unparalleled difficulties in response to the COVID-19 pandemic and the changing demands of the healthcare industry. In their article, Johnson et al. (2020) examine the difficulties encountered by health insurance systems amidst the pandemic, with a particular focus on the resource constraints caused by the increased need for testing, treatment, and associated services. Insurers must maintain financial stability while navigating the complexities of managing increased claims.

Communication and information dissemination during the pandemic, by Smith and Brown (2021), emphasizes the significance of transparent and plain communication regarding policy benefits and coverage. Given the ongoing changes in the healthcare industry, it is critical that health insurers address the challenges presented by the COVID-19 pandemic in order to ensure the continued efficacy and availability of coverage for communities and individuals. In the ever-changing healthcare environment, the insights gained from the pandemic continue to be of utmost importance. Insurers of health must adjust to and confront the obstacles brought to light by COVID-19 in order to maintain the efficacy and availability of health coverage for all. This may entail maintaining consistent and transparent communication regarding policy modifications, increased transparency regarding benefit utilization, and adaptation to novel healthcare delivery models that emerged during the pandemic.

Understanding the difficulties and repercussions of uninsured status is essential in order to formulate effective approaches to rectifying healthcare coverage deficiencies. Socioeconomic factors influence the decision of individuals to remain uninsured, according to Martinez et al. (2019). In determining the uninsured population, variables including employment status, income level, and access to employer-sponsored coverage are significant determinants.

According to Long and Coughlin (2017), policy decisions like Medicaid expansion have an impact on the percentage of uninsured individuals. Variations in eligibility requirements and the provision of cost-effective coverage alternatives through government initiatives may have an impact on the population lacking health insurance. Hall and McCue's (2019) research explores the consequences of not having health insurance, including delayed or skipped medical treatment, increased financial burden, and limited access to preventive services.

The study by Hudson et al. (2021) examines the relationship between health insurance customer retention and satisfaction with customer service. It investigates the impact of various service providers' customer service strategies on customer loyalty. We expect the study to investigate the customer service strategies used by various health insurance providers. This may entail an examination of the organization's communication modalities (telephone, online messaging, etc.), the proficiency and assistance provided by their staff, and the overall satisfaction of customers during their interactions with the organization.

Appleby et al. (2020) conducted a study to investigate the correlation between health insurance providers' marketing strategies and their impact on the insurance agent profession. Insurance companies can substantially influence the training and sales strategies employed by insurance agents, as well as their methods. This can have an impact on the training that agents undergo to ensure their understanding of these strategies and their ability to proficiently convey their value propositions to customers. A marketing campaign that emphasizes cost-effectiveness, for instance, could prompt sales representatives to emphasize affordability in their discussions. The aforementioned factors may ultimately influence consumer comprehension and the variety of insurance plans presented to them.

According to Omari and Karasneh (2021), a well-informed consumer is crucial for promoting positive outcomes in health care. Even with health insurance coverage, impoverished individuals often neglect to seek necessary medical attention due to their lack of health literacy. It is common for individuals living in poverty (indigents) to encounter challenges in maintaining health literacy. This may result in them forgoing essential medical treatment despite having health insurance. Comprised of unfamiliar medical procedures and terms, the healthcare system can be perplexing. For individuals with limited health literacy, this may appear to be an overwhelming amount. Health literacy, defined as the capacity to comprehend and navigate the healthcare system, entails understanding treatment alternatives, recognizing when it is appropriate to seek medical attention, and communicating effectively with healthcare providers.

To synthesize the gathered literature, premiums serve as the fundamental financial support system, mandating recurring payments in return for insurance coverage. The benefits component provides policyholders with access to a wide variety of medical services, including emergency procedures and routine checkups, so that they may obtain essential care without experiencing undue financial strain. Modern insurers prioritize convenience by offering mobile applications and online portals that facilitate provider searches, access to policy information, and claim submission. Prioritizing security measures guarantees the protection of individuals' financial and physical well-being in the event of injury or illness. In conclusion, streamlined claims processing guarantees prompt reimbursement, thereby bolstering policyholder confidence and contentment. Fundamentally, a comprehensive health insurance policy harmoniously amalgamates these components, providing reassurance and indispensable assistance in maneuvering through healthcare industry obstacles. By acknowledging these apprehensions and offering policies that fulfill the demands of potential policyholders, health insurance providers have the ability to cultivate confidence and active participation, thereby enhancing the overall perception of health insurance in a favorable light.

I. SIGNIFICANCE OF THE STUDY

The research study was important since its findings were used as a preference to understand consumer behavior and to spread awareness on health insurance. Information obtained from this study could be helpful to the management of insurance as a basis for a marketing plan.

Insurance Company. The study could also have contributed to the development of the healthcare system in the Philippines by providing policymakers and stakeholders with insights into the factors affecting the enrollment of Filipinos in health insurance programs.

Agents. The study also provided a comprehensive understanding of the perception of selected prospective policyholders on health insurance by addressing the misrepresentation and lack of understanding about health insurance.

Employees. This study helped employees to deliver the information needed to handle customers' inquiries and improved work efficiency and service quality.

Researcher. This paper assisted the researcher in gaining knowledge and awareness in the field of the study, as well as emphasized the significance of work and its impact in the research field and how it contributed to new information significantly.

Future Researchers. The study's recommendations informed policy decisions and strategies aimed at improving the accessibility, affordability and quality of healthcare services in the country.

Theoretical Framework

People's decisions about their health are mostly influenced by how they balance the potential benefits and barriers their choices can possibly have. The Theory of Planned Behavior is widely used to understand and predict human behavior, including decisions related to health insurance.

The Theory of Planned Behavior (TPB) can be applied to explore individuals' intentions and choices regarding enrollment and utilization. Ajzen's model comprises three main components: attitudes toward the behavior, subjective norms, and perceived behavioral control. In the case of health insurance, attitudes reflect individuals' evaluations of the benefits and drawbacks of having coverage, subjective norms capture social influences affecting their decisions, and perceived behavioral control assesses the perceived ease or difficulty of obtaining and using health insurance. Research by Patel and Johnson (2019) effectively employs the TPB to analyze factors influencing individuals' intentions to enroll in health insurance plans, shedding light on the interplay between attitudes, subjective norms, and perceived behavioral control in the decision-making process.

It is an important factor to help health insurance industry to sustain the demand and access to healthcare. Different influences on health decisions can be made through the very basic concept of education. Planned behavior might explain what factors determine the intension of people purchasing health insurance.

Conceptual Framework

Understanding and addressing these concepts are essential for insurance providers and policymakers to meet the expectations and needs of individuals seeking health insurance coverage. Convenience refers to the ease and user-friendliness of accessing and managing health insurance services. Prospective policyholders value streamlined processes, simplified paperwork, digital tools that make enrollment, claim submissions, and policy management hassle-free. Accessibility is a critical consideration for prospective policyholders when choosing health insurance. It encompasses the availability and proximity of healthcare providers, hospitals, and specialists within the insurance network. Security is a fundamental aspect of health insurance, encompassing the protection of sensitive personal and medical information. Prospective policyholders expect robust privacy measures to safeguard their data, including secure digital platforms and compliance with regulatory requirements, such as IC (Insurance Commission). Reliability refers to the consistent delivery of promised benefits and services by health insurance providers. Prospective policyholders seek insurance companies with a track record of honoring claims and providing timely reimbursements. The transparency and clarity of fees and charges associated with health insurance policies greatly impact prospective policyholders' decisions. Individuals expect clear explanations of premium costs, deductibles, copayments, and any additional charges.

Guided by the theoretical framework, the researcher will develop a conceptual framework as shown below.

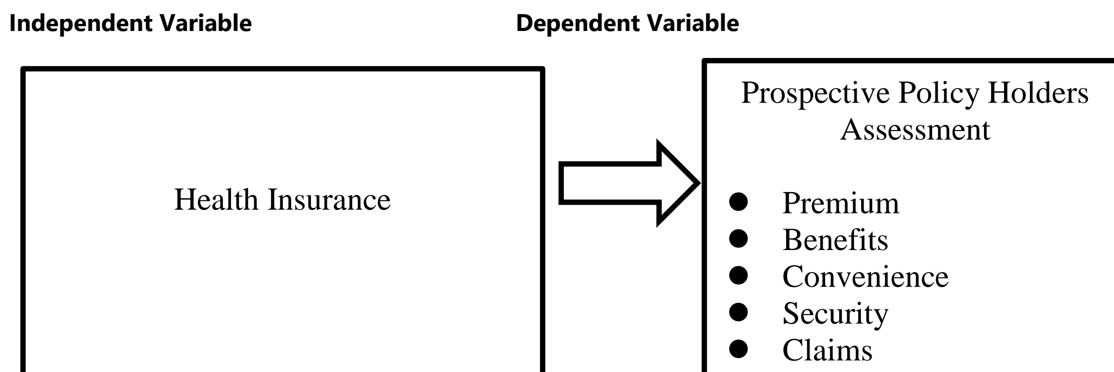

Figure 1. Conceptual Framework of the Study

The conceptual framework presents the variables of the study and the process leading to the output. It starts with the variables of the study as the basis for analysis and assessments. Findings will be taken from a survey questionnaire that will assess prospective policy holder perception on health insurance and the results of the study will serve as the basis for a proposed health care service improvement. The researcher, therefore, has developed the following conceptual framework to guide the research.

Statement of the Problem

This study aims to assess the health insurance as on the point of view of the prospective policy holders gearing towards marketing plan proposal

Specifically, it will seek answers to the following questions:

1. How do the prospective policy holders assess health insurance in terms of:
   1.1. Premium;
   1.2. Benefits ;
   1.3. Convenience;
   1.4. Security; and
   1.5. Claims?
2. Is there a significant difference on the assessment of the respondents on the perception of selected prospective policy when two group of respondents is considered?
3. What are the issues encountered by the respondents on health insurance?
4. What strategic marketing plan may be proposed based on the findings of the study?

Hypothesis

H01. There is no significant difference on the level of implementation in the automated delivery process of the logistic company as perceived by the respondents.

Definition of Terms

These key terms will be given the following conceptual and operational definitions for better understanding of the study.

Accessibility. Involves the availability of information, the simplicity of enrollment processes, and the ease of reaching and interacting with insurance providers.

Benefits. It shields you from unexpected medical bills and getting the care you need without worrying about breaking the bank.
Client. It refers to an individual or entity known as policyholder or insured that purchases health insurance coverage, pays premium to the insurance company or provider.

Convenience. It refers to the ease and accessibility of obtaining and managing insurance coverage, services, and related information.

Health Insurance. This serves to cover an insured individual's medical, surgical, and dental expenses, which can also include the cost for their prescription meds. It can either be in the form of reimbursements or directly paid for by the healthcare provider.

HMO (Health Maintenance Organization). It is a healthcare delivery system comprising private health care insurance providers. This type of health insurance is one that employees usually receive from their employees as part of their employee benefits.

Insurance. It is a means of protection from financial loss in which, in exchange for a fee, a party agrees to compensate another party in the event of a certain loss, damage, or injury.

Insured. This refers to the person or group of persons protected by the health insurance plan.

Out-of-pocket. These are probable expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Premium. This refers to the cost you will be paying for your health insurance plan. This cost highly depends on the coverage you choose, the more add-ons, the higher the cost.
Private Insurance. This type of health insurance is usually bought by an individual voluntarily.

Prospect Client. It refers to an individual or entity who is considering purchasing health insurance coverage but has not yet finalized the transaction. This person or entity may be researching different insurance options, comparing plans, or evaluating various insurance providers to determine the most suitable coverage for their needs.

Reliability. It is considered reliable when it consistently delivers on its promises, offering dependable coverage, transparent terms, and consistent service quality.

Security. This refers to the assurance and protection of sensitive information, financial assets, and the overall well-being of policyholders within the context of health coverage.

Scope and Delimitation of the Study

The study will focus on the assessment of health insurance companies in Guangdong, China. The scope and delimitation will serve as guidelines that directed the readers and future researchers of the paper. The research will comprise two (2) types of respondents – client and prospect client customers. There will be one hundred fifty (150) respondents included in this research. The respondents will be profile according to age, civil status, income status, educational attainment, and respondent classification.

The study will assess the perception on health insurance in terms of premium, benefits, convenience, security, and claims. The researcher will confine the collection of data from selected areas in Guangdong, China and will use a survey questionnaire as a primary instrument for gathering data.

Methods and Techniques Used

This study will use a descriptive research design. It seeks to systematically gather information to provide a detailed description of a phenomenon, situation, or population. Its focus is on answering questions related to what, when, where, and how, rather than delving into the reasons or causes behind the research problem. This design has a high external validity as it is carried out within the natural environment of the respondents, without any manipulation of variables (Chaudhari, 2021). The researcher decided to use this method because it is appropriate when describing the relationship between variables, in this case—the use of automated delivery process in selected logistic companies. It also often uses surveys as data collection method from a large sample size easily and in a cost-effective manner. (Sirisilla, 2022).

This study uses a quantitative approach wherein the process of collecting and analyzing numerical data takes place which is ideal for identifying or testing relationships. It emphasizes objective evaluation and statistical or numerical analysis of data collected through questionnaires and surveys (Fleetwood, 2023). This approach would be helpful because it takes little time in the data collection process and covers a broad population in a short period.

The respondents of this study will be obtained from selected policyholders residing or working in Guangdong, China comprising one hundred fifty (150) individuals who will answer the questionnaire prepared by the researcher. Purposive sampling, a non-probability sampling technique, will effectively be used in the research. The survey will also be examined by the researcher's adviser and be presented to the researcher's panelists for comments and suggestions. The data collected in this

research study contained assessments of the participants' experiences with health insurance policies. The questionnaire was finalized and distributed to the respondents.

Respondents of the Study

A total of one hundred fifty (150) respondents is expected to participate in this study. There will be five insurance companies for this study that provided their number of prospective clients. The researcher will ensure the participants to enrich the data of the research.

Table 1. Distribution of Respondents

Insurance Companies	Population	Sample Size	Percentage
A	150	30	20%
B	260	30	11.54%
C	195	30	15.38%
D	180	30	17%
E	160	30	19%
Total	**945**	**150**	**16%**

Instrument of the study

In order to obtain significant data for this study, a survey questionnaire and google forms will be used as tools to gather accurate and complete information from the respondents. The primary research instrument will be used in this research is a survey questionnaire. A questionnaire will serve as a research instrument consisting of a series of questions and other prompts to gather information regarding the profile, awareness, accessibility, and understanding of the respondents.

The instrument composed of two parts which are:

Part I. The prospective policy holders assessment on health insurance in terms of premium, benefits, convenience, security, and claims.

Part II. The issues encountered by the prospective policy holder on health insurance.

An expert panel consisting of health insurance experts renowned for their wide experience, along with experts from the Graduate School, will assess the instrument's validity. Prior to data collection, the instrument must be subsequently submitted to the Graduate School Office. Before beginning the main data collection, a preliminary survey will evaluate the dependability of each measuring item after receiving approval from the Graduate School. Gray (2009) states that conducting a pilot study can reduce non-response rates and improve the accuracy, clarity, and reliability of the questionnaire. The sample surveys will be distributed to a total of ten (10) prospective clients from the selected health insurance companies in Guangdong, China. This preliminary study will highlight notable concerns and apply essential modifications before conducting the official survey. The wording and presentation of the questionnaire will be altered to improve its reliability.

Data Gathering Procedure

The survey method will be applied by the researcher for data gathering whereas, the respondents will answer the survey questionnaire through online forms. The survey questionnaire will be disseminated to the respondents of the study in China for two (2) weeks.

The information gathered from related literature and other relevant materials will be used to support the research claim and characterized variables of the study. The respondents that accepted the invitation in answering the survey questionnaires will not undergo interviews if the data results showed consistency for analysis.

The primary data will be collected through the following procedures:

1. The survey questionnaire will be forwarded to the panel of experts for research instrument validation.
2. The research instrument will be submitted to the Graduate School Office and the University Research Ethics Committee (REC) for the approval of survey questionnaire dissemination.
3. A letter of request will be sent to the managers of the study sites for the permission in data gathering and explain that there is no conflict of interest to either party involved in conducting the research.
4. After the approval of the managers, the researcher will disseminate the questionnaires that will be answered by the respondents through online forms. The researcher will explain the confidentiality of the information that will be gathered from the respondents in compliance with the Data Privacy Act of 2012.
5. The researcher will check if all the items will be answered for the conduct of the study after the instruction of ten to fifteen minutes' response from the respondents to avoid any stress on their part.
6. The researcher will make an assurance that the copy of the output shall also be provided to the study site.

Data Processing and Statistical Treatment

Prior to all statistical analyses, there will be several data preparation steps to be taken. The data-set will be consisted of a sample of one-hundred fifty (150). The researcher will arrange and classify the data in this study to easily interpret and evaluate the responses. The data that gathered data will be tallied, tabulated, and analyzed to summarize and interpret the results using descriptive statistical measures as follows:

Frequency Distribution. It provides a tabular representation illustrating the number of observations in a defined interval. It will identify the respondents based on the information listed in their profiles such as age, gender, department, and length of services. The data assorted present the frequency of varying values or sets of values of variables.

Percentage Distribution. Also known as relative frequency distribution. The researcher will use it to measure the responses, in terms of input, process, output and feedback, and percentage of each class frequency to the total number of participating respondents.

Average Weighted Mean (AWM). This will be used to identify the mean of the 4- point numeric rating scale for the significant benefits of the system that improve the employees' productivity in terms of the elements which are input, process, output and feedback.

Analysis of Variance. To test for significant differences in the average weighted mean (AWM) scores for the significant benefits of the system (input, process, output and feedback,) that improve employees' productivity, the statistician used ANOVA (Analysis of Variance).

The instrument will use a 4-point rating scale in which the respondents expressed their degree of agreement or disagreement on given indicators using the following responses which were stated on the table below.

Table 2

Rating Scale with Verbal Interpretation

Rating Scale	Verbal Interpretation
3.25- 4.00	Strongly Agree
2.50- 3.24	Agree
1.75- 2.49	Disagree
1.00- 1.74	Strongly Disagree

Presentation, Analysis, and Interpretation of Data

1. How do the prospective policy holders assess health insurance in terms of premium, benefits, convenience, security, and claims?

The table below shows the assessment of the prospective policy holders as the respondents on the health insurance in terms of premium.

Table 3

Assessment of the Prospective Policy Holders to Health Insurance in Terms of Premium

Premium	Weighted Mean	Verbal Interpretation	Rank
1. We evaluate premiums in relation to our total financial condition.	3.14	Agree	3
2. We evaluate premium costs among different policies to choose which insurance plan would be most suitable.	3.45	Strongly Agree	2
3. We consider expected premium increase into our plan of choice.	3.65	Strongly Agree	1
4. We assess whether the premium pays for additional services including wellness programs or preventative care.	2.96	Agree	5
5. We consider insurance coverage discounts or incentives to lower the rate.	3.03	Agree	4
Overall Mean	**3.25**	Strongly Agree	

As illustrated, the overall mean score for the assessment to health insurance in terms of premium resulted to weighted mean of 3.25 with verbal interpretation as “strongly agree”. In detail, at rank one, “We consider expected premium increase into our plan of choice” with weighted mean of 3.65 and verbal interpretation of “strongly agree” followed by the rank two to which

is "We evaluate premium costs among different policies to choose which insurance plan would be most suitable" with weighted mean of 3.45 and verbal interpretation of "strongly agree". At third, "We evaluate premiums in relation to our total financial condition" with weighted mean of 3.14 and verbal interpretation of "agree". Fourth ranked indicator is "We consider insurance coverage discounts or incentives to lower the rate" with weighted mean of 3.03 and verbal interpretation of "agree". The lowest ranked indicator which is "We assess whether the premium pays for additional services including wellness programs or preventative care" indicated a weighted mean of 2.96 and verbally interpreted as "agree".

Relevant to the findings, consumers that want informed decisions that meet their long-term financial planning must first understand possible premium adjustments, claims Hsu and Price (2022). Bhatia and Sharma (2021) claim that consumers usually perform thorough research to ensure they choose solutions with the highest value for their financial expenditure. Alhassan and Agyemang (2020) underline that one knowing their financial situation will help one to make decisions avoiding needless financial difficulty. Ghosh and Dutta (2020) assert that reductions and incentives are rather crucial in attracting policyholders since they can greatly lower total premium expenses. On the other hand, in line with the lowest scored indicator, Choi and Lee (2023) note that although additional services are valuable, many consumers may prefer immediate expenses over long-term benefits, hence lowering their contact with these offerings.

The table below shows the assessment of the prospective policy holders as the respondents on the health insurance in terms of benefits.

Table 4

Assessment of the Prospective Policy Holders to Health Insurance in Terms of Benefits

Benefits	**Weighted Mean**	**Verbal Interpretation**	**Rank**
1. We look for insurance policies that provide complete coverage including inpatient and outpatient therapy and required medical procedures.	3.14	Agree	2
2. We examine closely the spectrum of coverage for prescription medications.	3.45	Strongly Agree	1
3. We value the extra advantages that provides vision, dental, and mental health care.	2.65	Agree	5
4. We assess the system of healthcare providers in terms of access to particular doctors and specialists.	2.66	Agree	4
5. We look for the availability of free preventative treatment that gives tremendous benefit.	3.03	Agree	3
Overall Mean	**2.99**	Agree	

It can be gleaned from the table that the overall mean score for the assessment to health insurance in terms of benefits resulted to weighted mean of 2.99 with verbal interpretation as "agree". In detail, at rank one, "We examine closely the spectrum of coverage for prescription medications" with weighted mean of 3.45 and verbal interpretation of "strongly agree" followed by the rank two to which is "We look for insurance policies that provide complete coverage including inpatient and outpatient therapy and required medical procedures" with weighted mean of 3.14 and verbal interpretation of "agree". At third, "We look for the availability of free preventative treatment that gives tremendous benefit" with weighted mean of 3.03 and verbal interpretation of "agree". Fourth ranked indicator is "We assess the system of healthcare providers in terms of access to particular doctors and specialists" with weighted mean of 2.66 and verbal interpretation of "agree". The lowest ranked indicator which is "We value the extra advantages that provides vision, dental, and mental health care" indicated a weighted mean of 2.65 and verbally interpreted as "agree".

The result of the overall mean may be in line with with KFF survey findings showing many insured adults have unresolved insurance-related problems, hence generating suffering (KFF, 2023). Meanwhile, studies on health insurance literacy show that consumers' pleasure and faith in insurance benefits are always subjected to demanding and complex implications dependent on constant system finding (HLRP, 2020. In addition, studies reveal that among employee benefits which increase satisfaction and output, dental and vision insurance are rather important (Procare Consulting, 2023). Further, participants to a YouGov (2024) survey feel that coverage of mental health issues is absolutely necessary for health insurance policies. Moreover, rising premium prices obviously influence customers since studies directing their decisions obviously suggest (JAMA Network Open, 2024). Hence, although consumers see premium in respect to their financial condition, sometimes discounts or subsidies enable consumers to develop techniques to save money, therefore influencing their choice of plans (ijf MR, 2024). Research showing that consumers could find it difficult to negotiate and fully use the advantages given by their insurance support this conclusion, which causes annoyance in several domains including wellness programs (BMC Geriatrics, 2024).

The table below shows the assessment of the prospective policy holders as the respondents on the health insurance in terms of benefits.

Table 5
Assessment of the Prospective Policy Holders to Health Insurance in Terms of Convenience

Convenience	**Weighted Mean**	**Verbal Interpretation**	**Rank**
1. We consider the availability of healthcare facilities.	2.55	Agree	5
2. We look for the policies on health insurance with telehealth features for simple remote consultations.	2.92	Agree	2
3. We look for plans including easily navigable web interfaces for managing claims and healthcare.	2.57	Agree	4
4. We evaluate the availability of nearby healthcare facilities as the insurance company's network to reduce travel time for visits.	2.61	Agree	3
5. We assess the insurance company's mobile app for fast access to information and services.	3.10	Agree	1
Overall Mean	**2.75**	**Agree**	

The table 5 shows the overall mean score of 2.75 which is verbally interpreted as "agree" for the assessment to health insurance in terms of convenience. In detail, at rank one, "We assess the insurance company's mobile app for fast access to information and services" with weighted mean of 3.10 and verbal interpretation of "agree" followed by the rank two to which is "We look for the policies on health insurance with telehealth features for simple remote consultations" with weighted mean of 2.92 and verbal interpretation of "agree". At third, "We evaluate the availability of nearby healthcare facilities as the insurance company's network to reduce travel time for visits" with weighted mean of 2.61 and verbal interpretation of "agree". Fourth ranked indicator is "We look for plans including easily navigable web interfaces for managing claims and healthcare" with weighted mean of 2.57 and verbal interpretation of "agree". The lowest ranked indicator which is "We consider the availability of healthcare facilities" indicated a weighted mean of 2.55 and verbally interpreted as "agree".

Therefore, by allowing users tools to monitor health indicators and enable contact with healthcare professionals so enabling healthcare management, mobile apps help to relieve healthcare management (Iribarren et al., 2021; Nguyen et al., 2019; Wei et al., 2020). Telehealth offers convenience (Roundstone Insurance, 2023)—very appreciated for their accessibility and economy—by means of remote consultations. Convenience drives most of the respondents to a McKinsey and Company (2021) survey choosing telemedicine. Convenience characterizes it; so, selecting an insurance plan often considers this (IJFMR, 2024). The need of easily navigable web interfaces for handling claims and healthcare keeps constant in line with improvements in digital healthcare services that offer user-friendly platforms considerable attention to improve consumer experience and streamline healthcare management operations (April International, 2024). Emphasizing convenience factors like telemedicine and mobile apps usually reflects more broad consumer inclinations toward more easily available and effective healthcare choices. These preferences are influencing the sluggish shift in marketing and design of health insurance products to match evolving client needs (KFF Survey, 2023).

The table below shows the assessment of the prospective policy holders as the respondents on the health insurance in terms of security.

Table 6
Assessment of the Prospective Policy Holders to Health Insurance in Terms of Security

Security	**Weighted Mean**	**Verbal Interpretation**	**Rank**
1. We assess the financial soundness and standing of the insurance provider to have peace of mind.	2.92	Agree	1
2. We examine the insurance company's dependability in managing claims and providing assistance for clients.	2.72	Agree	3
3. We look for exact information on coverage limitations and exclusions to minimize unplanned costs.	2.56	Agree	5
4. We seek clarity in policy terms and conditions for the awareness of the insurance company's rights and obligations.	2.81	Agree	2
5. We look for performance in first-rate customer service to guarantee assistance under difficult circumstances.	2.59	Agree	4
Overall Mean	**2.72**	**Agree**	

The table 6 shows the overall mean score of 2.72 which is verbally interpreted as "agree" for the assessment to health insurance in terms of security. In detail, at rank one, "We assess the financial soundness and standing of the insurance provider to have peace of mind" with weighted mean of 2.92 and verbal interpretation of "agree" followed by the rank two to which is "We seek clarity in policy terms and conditions for the awareness of the insurance company's rights and obligations" with weighted mean of 2.81 and verbal interpretation of "agree". At third, "We examine the insurance company's dependability in managing claims and providing assistance for clients" with weighted mean of 2.72 and verbal interpretation of "agree". Fourth ranked indicator is "We look for performance in first-rate customer service to guarantee assistance under difficult circumstances" with weighted mean of 2.59 and verbal interpretation of "agree". The lowest ranked indicator which is "We look for exact information on coverage limitations and exclusions to minimize unplanned costs" indicated a weighted mean of 2.56 and verbally interpreted as "agree".

Studies on financial transparency in insurance showed that consumers are more likely to trust and stick to insurers who display financial transparency and stability, therefore relieving them of concerns on the capability of the insurer to meet their demands (Logue et al., 2022). Research stressing the requirement of transparent communication of policy specifics considerably effects consumer confidence supports the significance of finding clarity in policy terms and conditions. Clear insurance term information consumers are more likely to maintain long-term relationships with their insurers and feel confident in their purchasing choices (Aldboush & Ferdoush, 2023). According to ACCC (2024), simplified and transparent policy paperwork is highly required since the complexity of insurance contracts results in customer uncertainty.

Finally, the complexity of benefit structures highlights the need of correct knowledge on coverage constraints and exclusions as data reveal many customers find it difficult to understand these elements. As per PMC (2019), clear explanations and system simplification help to raise consumer knowledge and reduce unexpected costs.

The table below shows the assessment of the prospective policy holders as the respondents on the health insurance in terms of claims.

Table 7

Assessment of the Prospective Policy Holders to Health Insurance in Terms of Claims

Claims	**Weighted Mean**	**Verbal Interpretation**	**Rank**
1. We look for insurance providers recognized for their simple and quick handling of policies.	3.13	Agree	3
2. We assess whether the insurance provider guides or assists during the claims process.	3.19	Agree	2
3. We look for insurance provider with electronic claims filing to expedite processing timeframes.	3.43	Strongly Agree	1
4. We assess the insurance provider's record of denied claims to find out how often do clients encounter problems with claims paid for.	2.51	Agree	5
5. We look for insurance provider that offer open channels of contact on the status of client claims.	2.76	Agree	4
Overall Mean	**3.00**	**Agree**	

The table 7 shows the overall mean score of 2.72 which is verbally interpreted as "agree" for the assessment to health insurance in terms of claims. Specifically at rank one, "We look for insurance provider with electronic claims filing to expedite processing timeframes" with weighted mean of 3.43 and verbal interpretation of "strongly agree" followed by the rank two to which is "We assess whether the insurance provider guides or assists during the claims process" with weighted mean of 3.19 and verbal interpretation of "agree". At third, "We look for insurance providers recognized for their simple and quick handling of policies" with weighted mean of 3.13 and verbal interpretation of "agree". Fourth ranked indicator is "We look for insurance provider that offer open channels of contact on the status of client claims" with weighted mean of 2.76 and verbal interpretation of "agree". The lowest ranked indicator which is "We assess the insurance provider's record of denied claims to find out how often do clients encounter problems with claims paid for" indicated a weighted mean of 2.51 and verbally interpreted as "agree".

Comparatively to conventional paper-based systems, electronic claims processing drastically lowers mistakes, speeds payment processing, and increases general efficiency (Invensis, 2023). Additionally, a study in Ghana demonstrated that electronic claims systems reduce costs and improve processing times, making them more efficient than manual systems (Nsiah-Boateng et al., 2022).

The importance of assessing whether the insurance provider guides or assists during the claims process is underscored by research showing that clear communication and assistance from insurers can enhance consumer satisfaction and trust. Good direction helps policyholders negotiate difficult claims processes, hence lowering uncertainty and enhancing their whole experience (KFF, 2023). The preference for insurance providers recognized for their simple and quick handling of policies aligns

with findings that streamlined processes facilitated by technology lead to faster claim resolutions and higher customer satisfaction. Reducing manual labor and accelerating claim adjudication have been much aided by automation and artificial intelligence (Access Healthcare, 2024).

Meanwhile, the value placed on open channels of contact regarding the status of client claims reflects the need for transparency in the claims process. Online portals made possible by modern health technology solutions let patients monitor their claim progress in real-time, therefore improving openness and lowering frustration (BLK Assistance, 2024). Further, the assessment of an insurance provider's record of denied claims is crucial as high denial rates can lead to financial strain for both providers and patients. Studies have shown that claim denials are a significant issue, with high rates leading to increased administrative costs and negative patient experiences (KFF, 2023; Access Healthcare, 2023).

2. Is there a significant difference on the assessment of prospective policy holders when grouped according to the identified constructs?

The table below shows the significant differences on the assessment of prospective policy holders based on premium, benefits, convenience, security, and claims.

Table 8

Significant Differences on the Assessment of Prospective Policy Holders based on the Identified Constructs

Constructs	**T-Value**	**Critical Value**	**P-Value**	**Decision**	**Remark**
Premium	0.065	1.655	0.800	Accept	Not significant
Benefits	1.087	1.655	0.081	Accept	Not significant
Convenience	0.232	1.655	0.631	Accept	Not significant
Security	0.003	1.655	0.956	Accept	Not significant
Claims	1.426	1.655	0.066	Accept	Not significant

The table 8 shows the significant difference on the prospective policy holders based on premium, benefits, convenience, security, and claims. P-value on premium 0.800, benefits 0.081, convenience 0.631, security 0.956 and claims 0.066 since p-value is greater than 0.05 the null hypothesis is accepted, therefore there is no significant difference on the assessment of premium, benefits, convenience, security, and claims.

While policyholders' priorities include rates and benefits, a 2021 study by Abdullah Al Mamun et al. indicated that the perceived value and general attitude toward health insurance have a more major influence on their choice. This fits the results showing no appreciable variation in ratings depending just on these criteria. According to 2021 BMC Public Health research, the fulfillment of expectations and perceived value more affects patient satisfaction with health insurance than only convenience alone5. This helps to underline how policyholder judgments are not much different depending on convenience.

Trust in the insurance provider and emotional advantages have a more significant influence on consumer satisfaction towards health insurance according to a study on the Indian Journal of Forensic (2024), than security aspects by itself. The NCBI (2021) study emphasizes that while effective claims processing is important, it is not the only factor influencing policyholder distinction or satisfaction. More important are supposed value and confidence in the insurance program.

3. What are the issues encountered by the respondents on health insurance?

The table below enumerates the possible issues that may be encountered by the prospective policy holders on heath insurance provider.

Table 9
Assessment on the Possible Issues that may be Encountered by the Prospective Policy Holders on Health Insurance

Possible Issues on Health Insurance	**Weighted Mean**	**Verbal Interpretation**	**Rank**
1. Great financial difficulty and annoyance from significant processing and claim settling delays.	2.70	Agree	8
2. Denied claims are denied because pre-existing conditions are not reported or any policy term concerns.	2.80	Agree	6
3. Partial claim approvals resulting to unnecessary out-of-pocket expenses.	2.90	Agree	3
4. Misunderstandings and misinterpretation of policy terms because of precise language and complicated vocabulary used in insurance contracts.	2.97	Agree	2
5. Confusing eligibility requirements and exclusions leading to unsure claim processing.	2.88	Agree	4
6. Improper knowledge of the degree of coverage causing the claims to be underfunded.	2.83	Agree	5
7. Too strict policies leading to unsatisfying insurance provider performance.	2.99	Agree	1
8. Ignoring the necessary knowledge especially on medical issues leading to coverage gaps and compromising the process of claims.	2.76	Agree	7
9. Overlooked terms and conditions resulting to problems during claim processing.	2.66	Agree	9
10. Mis-sold products for extra commissions leaving clients with unsuitable coverage.	2.58	Agree	10
Overall Mean	2.81	Agree	

It can be gleaned on table 9 that possible issues can be encountered in the health insurance company as analyzed by the prospective policy holders with overall mean of 2.81 and verbal interpretation of "agree". At rank 1, "Ignoring the necessary knowledge especially on medical issues leading to coverage gaps and compromising the process of claims" with mean score of 2.99 and verbal interpretation of "agree" followed by the indicator "Misunderstandings and misinterpretation of policy terms because of precise language and complicated vocabulary used in insurance contracts" with mean score of 2.97 and interpreted as "agree". On the third issue, 'Partial claim approvals resulting to unnecessary out-of-pocket expenses" at mean score of 2.90 and interpreted as "agree" and next is "Confusing eligibility requirements and exclusions leading to unsure claim processing" with mean score 2.88 and interpreted as "agree". The fifth rank is "Improper knowledge of the coverage degree causing the claims to be underfunded" at mean score of 2.83 and interpreted as "agree", and next is "Denied claims are denied because pre-existing conditions are not reported or any policy term concerns" at mean score 2.80 and verbally interpreted as "agree". Rank 7 is "Ignoring the necessary knowledge especially on medical issues leading to coverage gaps and compromising the process of claims" with mean score of 2.76 and interpreted as "agree", at eight rank is "Great financial difficulty and annoyance from significant processing and claim settling delays" with mean score of 2.70 and interpreted as "agree". The last set of indicators are "Overlooked terms and conditions resulting to problems during claim processing" and "Mis-sold products for extra commissions leaving clients with unsuitable coverage" at mean score of 2.66 and 2.58 with interpretation as "agree" respectively.

In line with the findings, underlining the inexperience of policyholders knowledge of health insurance terminology, Drs. Abhishek Mittal and Neeraj Gupta, 2023 routinely cause coverage gaps and issues submitting claims. According to a LocalCircles (2024) poll most misreading of policy requirements and misunderstandings in contracts resulting from ambiguity results from technical jargon and complex terminology.

The Mittal and Gupta analysis for 2023 emphasizes even more how erroneous information of the degree of coverage could result in underpaid claims, therefore exposing policyholders. The KFF poll (2023) shows that pre-existing conditions not reported are a common issue among policyholders, typically resulting in denials of claims. Although local circles (2024) found that major delays in claim processing could lead to financial problems and displeasure, insurers will pay extra for extended hospital visits.

Many policyholders overlook some terms, which results in disputes all during the claim process. The complicated terminology employed in contracts aggravates this problem considering the survey findings. Mittal and Gupta (2023) discuss how sometimes insurance salespeople mis-sell products for extra costs, therefore depriving consumers with improper coverage.

4. What strategic marketing plan may be proposed based on the findings of the study?

The results of the study proposes a strategic marketing plan for a health insurance provider to satisfy policyholders' demands and preferences. Important techniques include promoting simplicity, boosting communication and education, providing discounts and incentives, addressing financial concerns, fostering trust and security, and tailoring product offers. Simplifying policy language and starting educational efforts to assist policyholders on coverage, qualifying criteria, and exclusions starting will help policies to be clearer. Electronic systems have to be set up and claims aid needed must be provided. Development of user-friendly digital platforms and increase of telehealth services should take first priority. Stressing financial regularity and boosting customer service standards would help to create security and confidence.

Summary of Findings, Conclusions and Recommendations of the Study

Summary of Findings

The results of the data highlighted the following observations.

1. The Assessment of the Prospective Policy Holders on Health Insurance

With reference to premium, benefits, convenience, security and claims of health insurance as perceived by the prospective policy holders,strong agreement among participants about reviewing predicted premium increases, premium costs among different policies, and insurance coverage reductions or incentives to lower rates.

Respondents said they also seek for more from vision, dental, and mental health care as well as for complete coverage, free preventative treatment, access to particular specialists and experts. They also agreed they wanted insurance covering local hospitals, telemedicine possibilities, and obviously navigable web interfaces handling claims and treatment.

They also look for first-rate customer service performance and adequate knowledge of coverage limits and exclusions to help to lower down expected expenses. About claims, respondents said they search for insurance companies with electronic claims filing, guide or assist during the claims process, offers open lines of contact on policy status, and review the insurance provider's record of denied claims to find how often consumers run across issues paid for. Regarding cost, features, ease, security, claims, everyone usually agrees on the assessment of health insurance.

2. The Significant Difference According to the Identified Constructs

The statistical tests examining potential differences in prospective policyholders' assessments across five key constructs: premium, benefits, convenience, security, and claims. The study shows that the p-values for all five constructions are higher than 0.05, the conventional significance level. More especially, the p-values for security and claims. As a result, the null hypothesis is accepted for each construct, indicating that there are no statistically significant differences in the assessments of prospective policyholders across these five aspects of health insurance. This implies that views and assessments of these elements among policyholders are rather homogeneous.

3. Issues Encountered on Health Insurance

The many issues prospective policyholders in health insurance could run across. The mean overall shows general consensus on the found problems. The three most important issues are too rigorous rules resulting in unsatisfactory performance of insurance companies. Conflicts resulting from sophisticated phrasing in insurance agreements. Approvals of partial claims leading to unneeded out-of-pocket costs.

Other major issues include unclear eligibility criteria, incorrect understanding of coverage, and refused claims resulting from unreported pre-existing diseases. Though remaining within the "Agree" range, the lowest-ranked issues are terms and conditions and mis-sold products.

These results imply that policyholders have mostly difficulties with policy strictness, contract understanding, and claim approvals. The constant "Agree" answers for all the questions show that prospective policyholders understand different possible problems in health insurance, so pointing areas where insurers should improve their services and communication to raise consumer satisfaction.

4. Strategic Marketing Plan Proposal

The recommended strategic marketing plan for health insurance firms stresses on four primary approaches satisfying policyholders' needs and preferences. These make up starting campaigns of education and simplifying policy language helps to enhance communication and education. Improving claims processing with concentrated help and digital technologies. Expanding telehealth services and user-friendly digital platforms help to offer ever more convenience. handling financial concerns with open pricing, discounts, and incentives. Focusing financial stability and improving customer service will help to create confidence and security. Making products match certain needs helps to prevent mis-selling.

These strategies aim to raise clarity, efficiency, accessibility, and confidence in health insurance products thereby enhancing policyholder satisfaction and hence market positioning for insurance providers.

Conclusions

The following conclusions are hereby drawn on the findings of the study.

1. Prospective policyholders strongly agree on the importance of evaluating premium increases, comparing costs across policies, and considering discounts. They want thorough coverage with access to specialists and preventative care. Convenience factors like telemedicine and user-friendly interfaces are valued. Respondents prioritize clear communication about coverage limits and efficient claims processing, including electronic filing and assistance. Overall, there is general agreement on the assessment of health insurance across premium, benefits, convenience, security, and claims aspects.
2. The study finds from the statistical analysis that, across the five main criteria—premium, benefits, convenience, security, and claims—there are no appreciable variations in the assessments of health insurance by potential policyholders. The null hypothesis is approved when p-values for all constructions above 0.05, therefore implying a rather homogeneous view among policyholders. This implies that, independent of individual preferences or particular policy features, policyholders generally see and assess these features of health insurance in same manner.
3. According to the survey, prospective policyholders have different issues with health insurance wherein universal consensus on the found problems is evident. Important issues are tight rules, complicated contracts, and partial claim approvals resulting in out-of-pocket costs. Other important problems include unclear qualifying standards and coverage misinterpretation. The constant "Agree" answers for all the items show that these issues are well-known and point to areas where insurance companies could concentrate on strengthening services and communication to raise customer satisfaction in the health insurance market.
4. There are four main strategies formulated as strategic marketing plan for health insurance companies which are: improving communication by means of simplified language and education; enhancing claims processing using digital technologies; using user-friendly platforms and telehealth to increase convenience; and handling financial issues and fostering confidence

These strategies seek to raise policyholder happiness and market positioning by improving clarity, efficiency, accessibility, and confidence in health insurance.

Recommendations

The findings of the research may propose a strategic marketing plan for a health insurance company to address the issues that may be encountered by the prospective policy holders.

1. *Enhancement of Communication and Education*

Streamline Policy Documentation. Make clear, brief policy statements to help to reduce misunderstandings and misinterpretation, and for transparent communication.

Programs on Education. Start projects to notify policyholders about their coverage, eligibility requirements, and exclusions, therefore addressing the issue of inadequate awareness of coverage degree.

2. *Manage Arguments Improved*

Use Systems for Electronic Claims. File electronic claims can reduce processing times and errors.

Help with Offers of Claims. Lead policyholders through the claims procedure so boosting their confidence and pleasure by means of committed assistance.

3. *Emphasize Simplicity*

Provide Easily Navigable Online Tools. Reflect consumer preferences for simplicity, thereby enhancing mobile apps and web interfaces for straightforward management of claims and healthcare service.

Expand Telehealth Services. Encourage telehealth tools for remote consultations, which are becoming significant given their economy and accessibility.

4. *Sort Financial Problems*

Offer Discounts and Incentive Policies. Discounts or incentives serve to appeal to premiums.

Transparent Pricing. Tell policyholders exactly any premium adjustments so they may make sensible financial decisions.

5. *Create Trust and Security*

Stress Constancy in Finances. Encouragement of the financial stability of the insurance provider will comfort policyholders of their choice.

Enhance Customer Service. Stress the need of first-rate customer service in order to support under difficult circumstances, therefore significantly affecting satisfaction.

6. *Customize Product Lines*

Tailor Products According to Needs. Customize insurance products that match specific demands, such mental health coverage which consumers are progressively requesting by means of adaptation.

Avoid Mis-Selling. Make sure products are sold depending on fit instead of commissions so that consumers avoid incorrect coverage.

These strategies may enable a health insurance company to meet normal obstacles they face, satisfy public satisfaction with their services, and fulfill the needs of possible policyholders.

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