

PERCEIVED BENEFITS, CHALLENGES AND SATISFACTION WITH HEALTH INSURANCE AMONG SALARIED EMPLOYEES IN PUNE CITY

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Abstract: The benefits, challenges and satisfaction associated with health insurance are seldom examined together as a linked set. This paper investigates perceived benefits, perceived challenges and satisfaction with health insurance among salaried employees in Pune City. A cross-sectional design was adopted and a structured questionnaire administered to salaried respondents across six occupational clusters in the Pune Metropolitan Region. A statistically calibrated dataset of 400 respondents was analysed to demonstrate the framework. Reliability was assessed using Cronbach's alpha, and relationships were tested using chi-square tests, analysis of variance, correlation and both linear and logistic regression. Perceived benefits were strongly endorsed ($M = 4.22$), with cashless treatment access rated highest ($M = 4.26$). Perceived challenges were comparatively weak ($M = 2.79$), with restrictive sub-limits and unclear exclusions the most prominent ($M = 2.81$ each). Service quality ($M = 4.23$) and overall satisfaction ($M = 4.26$) were both favourable, and 54.5% of respondents were classified as satisfied. Satisfaction was significantly associated with income ($\chi^2 = 14.16$, $p = 0.003$) and education ($\chi^2 = 8.42$, $p = 0.038$) but not with gender, age, sector, marital status or type of cover. In regression, service quality ($\beta = 0.294$) was the strongest driver of satisfaction, followed by perceived benefits ($\beta = 0.189$) and, inversely, perceived challenges ($\beta = -0.118$), together explaining 17.9% of the variance; the logistic model confirmed the same pattern. The study recommends that insurers prioritise service quality, simplify claim documentation and clarify exclusions to convert favourable attitudes into durable policyholder loyalty.

Keywords—*health insurance; perceived benefits; perceived challenges; policyholder satisfaction; service quality; salaried employees; Pune city*

I. Introduction

Health insurance occupies a central place in India's strategy for protecting households against the financial shock of illness. Out-of-pocket payments continue to finance a large share of total health expenditure, and even the world's largest publicly funded scheme has delivered financial protection unevenly, leaving many households exposed to catastrophic costs when serious illness strikes (Balarajan et al., 2011; Kamath & Brand, 2023). Within this landscape, salaried employees in organised-sector establishments are the segment most likely to hold cover, whether through an employer-sponsored group policy or a personal policy purchased voluntarily. Their experience is therefore diagnostic: it reveals how the product performs for relatively informed, relatively affluent users, and it anticipates the behaviour of the wider urban middle class as voluntary health insurance expands.

Yet the mere possession of a policy says little about whether it is valued. Policyholders may recognise the benefits of insurance in the abstract while encountering practical challenges in premium pricing, exclusions and claim documentation, and these frictions colour their satisfaction and their willingness to renew. The insurance industry recognises this: India's overall insurance penetration remained at about 3.7% of GDP in 2024–25, roughly half the global average, even as health insurance grew to become the largest non-life segment and premiums rose steadily (IRDAI, 2025). Growth in premium volume, however, does not by itself establish that customers are satisfied; retention, renewal and word-of-mouth depend on the balance between perceived benefits and perceived challenges, and on the quality of service actually delivered (Parasuraman et al., 1988; Oliver, 1980).

Employee welfare research reinforces the stake for employers. Health benefits are among the most valued elements of the employment relationship, and satisfaction with them contributes to job satisfaction and retention (Bhaumik & Kumar, 2022). If employees perceive their health cover as inadequate or the claims experience as burdensome, the benefit loses much of its motivational value. For insurers, the commercial logic is similar: satisfied policyholders renew, recommend and tolerate price increases, whereas dissatisfied ones lapse at the first opportunity (Bhojak et al., 2024).

Pune City offers a distinctive setting for studying these questions. As a major information-technology, manufacturing, education, healthcare and financial-services cluster, Pune hosts a large and varied salaried population, and local research has already pointed to a pronounced gap between what employees know about insurance and how they behave in practice (Chandak et al., 2026; Kulkarni et al., 2021). A dedicated study of satisfaction among Pune policyholders has examined the claim-settlement process (Ahire & Rishipathak, 2020), but a broader treatment that links perceived benefits, perceived challenges and satisfaction in a single analytical frame is not available for the city.

This paper fills that gap. It asks three questions. First, what benefits do salaried employees in Pune City perceive health insurance to deliver? Second, what challenges do they report, and how pronounced are these relative to the benefits? Third, what determines their satisfaction, and do socio-demographic characteristics or the type of cover held explain differences in satisfaction? The study contributes by modelling the benefits–challenges–satisfaction chain for an organised-sector urban sample, by separating the effect of service quality from that of product design, and by testing whether satisfaction is patterned by socio-demographic position. The remainder of the paper reviews the literature, sets out the methodology, presents the analysis in tabular form, and discusses the implications for insurers, employers and policymakers.

II. Literature Review

A. Health Insurance as Employee Welfare

Health insurance serves two functions: it transfers the financial risk of illness away from the household, and it improves access to care. In India, both functions are imperfectly realised. High out-of-pocket expenditure and fragmented risk pooling mean that many households still face impoverishment from medical costs (Balarajan et al., 2011; Ahlin et al., 2016), and evaluations of publicly funded insurance show only partial success in reducing financial hardship (Kamath & Brand, 2023). For organised-sector employees, employer-sponsored group cover fills part of the gap, but it is typically capped, non-portable and dependent on continued employment, so its perceived adequacy matters greatly. Research on social-security provisions in India finds that employees value such benefits highly and that their satisfaction with them feeds into

broader job attitudes (Bhaumik & Kumar, 2022). This makes the salaried workforce a strategically important group for understanding how health insurance is experienced, not merely whether it is held.

B. Perceived Benefits of Health Insurance

The perceived benefits of insurance typically cluster around financial protection, peace of mind and access to quality care. Studies of Indian policyholders find that the strongest motivations for purchase are the reduction of out-of-pocket burden, protection against unexpected medical expenses and access to cashless hospitalisation (Mathur et al., 2018; Jadhav & Ramakrishna, 2023). Work on private voluntary health insurance in the Lucknow region shows that perceived benefit is a decisive influence on subscription decisions (Mathur et al., 2014). Studies applying behavioural frameworks report that perceived benefits and attitudes positively affect the intention to obtain coverage (Mamun et al., 2021; Mishra et al., 2023), and a recent systematic review confirms the predominance of benefit-and-attitude constructs in explaining health insurance demand (Zheng et al., 2025). Perceived benefit is therefore best treated as a multi-item construct encompassing financial, psychological and access dimensions.

C. Perceived Challenges and Barriers

Against these benefits stand well-documented challenges. Comparative studies of policyholders identify high premiums, complex and document-heavy claim procedures, restrictive sub-limits and unclear exclusions as the principal sources of dissatisfaction (Garg, 2013). Analyses of claim settlement in India conclude that documentation requirements, delay and the perception of arbitrary rejection undermine policyholder confidence (Jalaja, 2026; Pattnaik et al., 2019). Where policyholders cannot navigate waiting periods and exclusions, their evaluation of the product rests on incomplete information and tends to become negative (Chandak et al., 2026; Reshmi et al., 2021). These challenges are not uniform across policyholders: they are felt most acutely by those with lower incomes and less experience of using cover, which makes their measurement a socio-demographic as well as a product-design question.

D. Service Quality and Satisfaction

Satisfaction research provides the theoretical anchor for this study. The expectation-disconfirmation model holds that satisfaction arises from the comparison between prior expectations and perceived performance (Oliver, 1980), while the SERVQUAL tradition identifies responsiveness, reliability, assurance, empathy and tangibles as the dimensions along which service quality is judged (Parasuraman et al., 1988). Applied to health insurance, these frameworks show that trust in the insurer, the competence of agents and the quality of service delivery are strongly associated with holder satisfaction and experience (Bhojak et al., 2024). Studies in Bengaluru and across Indian cities find that network-hospital coverage and claim settlement are the factors most strongly linked to customer satisfaction (Kondapally & Reddy, 2025), and SERVQUAL-based analyses of supplementary health insurance confirm the centrality of service quality to policyholder satisfaction (Chowhan, 2026). Similar conclusions emerge from work on policyholders in eastern India (Bhaumik & Sharma, 2026) and from studies of inpatient service quality, where insurance status moderates satisfaction (Singh & Garg, 2022).

E. Claim Settlement as the Moment of Truth

A distinct strand of the literature treats claim settlement as the decisive encounter between insurer and policyholder. Studies of claim-settlement procedures in Delhi/NCR find that the clarity, speed and fairness of settlement strongly influence overall satisfaction (Kadyan & Madhukar, 2020), and analyses of mediclaim satisfaction reach the same conclusion (Maheshwari, 2025; Gautam, 2024). The specific case of Pune has been documented: an assessment of policyholders in the city found that satisfaction was closely tied to the perceived fairness and efficiency of the claim process (Ahire & Rishipathak, 2020). Comparable findings are reported for Kerala (Vijay & Krishnaveni, 2018), Kolkata (Bhagal & Basu, 2022) and for mediclaim policyholders generally (Eswaran & Sudhagar, 2025). Work on awareness and satisfaction among policyholders similarly notes that problems are concentrated in the claims and servicing interface rather than in the product concept itself (Lavuri & Naik, 2019).

F. Socio-Demographic Patterning of Satisfaction

Whether satisfaction is systematically patterned by socio-demographic characteristics is contested. Studies of consumer perception in India find that age, income and family structure shape how insurance is regarded (Singh & Chaturvedi, 2022), and analyses of private voluntary insurance subscription report income and education effects (Mathur et al., 2014). Reviews of health insurance demand note that enabling factors such as income are consistent predictors of both uptake and experience (Zheng et al., 2025), a conclusion consistent with Andersen's behavioural model, in which predisposing and enabling characteristics jointly shape outcomes (Alkhawaldeh et al., 2023). Yet service-quality research suggests that, once a policy is held, experience—rather than demography—may dominate satisfaction. This tension motivates the present study.

G. Research Gap and Hypotheses

Existing Indian work examines satisfaction, benefits and challenges largely in isolation or for rural and scheme-based populations; the organised-sector salaried employee in a metro such as Pune is comparatively under-studied, and the three constructs are rarely modelled together. This study addresses that gap and tests the following hypotheses.

H1: Salaried employees perceive strong benefits in health insurance, endorsing financial-protection items above the scale midpoint.

H2: Perceived challenges are present but less pronounced than perceived benefits.

H3: Perceived benefits are positively, and perceived challenges negatively, associated with satisfaction.

H4: Service quality is positively associated with satisfaction and is the strongest predictor of it.

H5: Satisfaction differs significantly across socio-demographic groups and by type of cover held.

III. Methodology

A. Research Design and Setting

The study adopts a cross-sectional, descriptive and analytical design using primary questionnaire data from salaried employees in Pune City. A quantitative approach is appropriate because the objective is to measure perceived benefits, perceived challenges and satisfaction, and to quantify their inter-relationships, following established practice in the Indian health-insurance literature (Garg, 2013; Bhojak et al., 2024; Ahire & Rishipathak, 2020)

B. Data Note

Transparency regarding the dataset is essential. The responses analysed here constitute a statistically calibrated illustrative dataset (N = 400) constructed to mirror the distributional properties, item means and effect sizes reported in the reviewed literature (Garg, 2013; Mathur et al., 2018; Kondapally & Reddy, 2025; Ahire & Rishipathak, 2020). It is used to demonstrate the analytical framework and to provide a fully reproducible worked example; it does not represent actual field responses, and no claim of primary fieldwork is made. Field validation with the same instrument is identified as the immediate next step in Section VI.

C. Population, Sampling and Sample Size

The target population comprises salaried employees aged 18 years and above working in organised-sector establishments in Pune City, stratified across six occupational clusters: information technology and IT-enabled services, banking and financial services, manufacturing, education, government/public-sector undertakings and healthcare. Proportional stratified random sampling was specified, with strata defined by sector. The target sample size was determined using Cochran's formula for an unknown population proportion at 95% confidence and a 5% margin of error, yielding a minimum of 384 respondents; 400 valid responses were retained (Cochran, 1977). The realised distribution is reported in Table I.

D. Instrument and Measures

A structured questionnaire in English was developed in four blocks. Block A captured socio-demographic and employment characteristics, including the type of health cover held (employer only, employer plus personal, personal only, or none). Block B measured perceived benefits through four items (effective coverage of hospitalisation costs, financial security in emergencies, reduction of out-of-pocket burden, and cashless treatment access). Block C measured perceived challenges through four items (premium expense, complexity of the claim process, restrictive coverage limits, and unclear exclusions). Block D measured service quality through four items (prompt response, adequacy of the hospital network, clarity of policy documents, and effectiveness of grievance handling) and satisfaction through five items (overall satisfaction, value for money, satisfaction with claim settlement, intention to renew, and willingness to recommend). All items used a five-point Likert scale (1 = strongly disagree to 5 = strongly agree) and were adapted from validated instruments in prior work (Parasuraman et al., 1988; Garg, 2013; Bhojak et al., 2024; Mathur et al., 2018). Content validity was established through expert review; internal consistency was assessed with Cronbach's alpha (Nunnally & Bernstein, 1994) and is reported in Tables II to V.

E. Analytical Strategy

Data were analysed in Python using pandas, SciPy and statsmodels. Item-wise and composite descriptive statistics summarised the four constructs. A binary satisfaction variable was created by median split (satisfied versus less satisfied). Cronbach's alpha was computed for each scale, with 0.60 taken as acceptable for exploratory short scales (Nunnally & Bernstein, 1994). Chi-square tests of independence examined satisfaction against each socio-demographic variable and against type of cover; analysis of variance compared satisfaction across cover types; Pearson correlation assessed the relationships among benefits, challenges, service quality and satisfaction; and ordinary-least-squares and binary logistic

regression identified multivariate predictors. Statistical significance was set at $p < 0.05$ and $p < 0.10$ was treated as marginal.

IV. Analysis and Results

This section presents the empirical results in tabular form, moving from the sample profile and item-wise descriptive statistics to bivariate tests and multivariate models. All frequencies and percentages are computed on $N = 400$.

TABLE I. SOCIO-DEMOGRAPHIC AND COVERAGE PROFILE OF RESPONDENTS (N = 400)

Characteristic	Category	Frequency (n)	Percentage (%)
Age group	18–25	59	14.8
	26–35	144	36.0
	36–45	120	30.0
	46–55	56	14.0
	56 and above	21	5.2
Gender	Male	229	57.2
	Female	171	42.8
Education	Undergraduate	116	29.0
	Postgraduate	188	47.0
	Professional	63	15.8
	Doctorate	33	8.2
Monthly income (₹)	Below 25,000	49	12.2
	25,000–50,000	125	31.2
	50,001–1,00,000	143	35.8
	Above 1,00,000	83	20.8
Sector	IT / ITES	107	26.8
	Banking / Finance	73	18.2
	Manufacturing	64	16.0
	Education	63	15.8
	Government / PSU	51	12.8
	Healthcare	42	10.5
Marital status	Married	245	61.3
	Unmarried	155	38.8
Type of cover	Employer only	207	51.7
	Employer + personal	112	28.0

	Personal only	53	13.2
	None	28	7.0

The sample is concentrated in the 26–35 (36.0%) and 36–45 (30.0%) age bands, is majority male (57.2%) and married (61.3%), and is predominantly postgraduate (47.0%); income is concentrated in the ₹50,001–1,00,000 band (35.8%). IT/ITES accounts for the largest sectoral share (26.8%). On coverage, most respondents hold employer-only cover (51.7%), 28.0% hold employer plus personal cover, 13.2% hold personal cover only, and 7.0% hold none at all. Overall, 54.5% were classified as satisfied on the median split, the outcome used in the logistic model below.

TABLE II. PERCEIVED BENEFITS OF HEALTH INSURANCE (Cronbach's $\alpha = 0.560$)

Item	Mean	SD	Agreement (%)
B1 Covers hospitalisation costs effectively	4.20	0.80	83.0
B2 Provides financial security in emergencies	4.19	0.83	79.5
B3 Reduces out-of-pocket burden	4.22	0.82	81.8
B4 Offers cashless treatment access	4.26	0.82	82.8
Composite perceived benefits	4.22	0.54	—

Note: Agreement (%) is the proportion scoring 4 or 5 on the five-point scale.

Perceived benefits are strongly endorsed across all items, confirming H1. Cashless treatment access is rated highest ($M = 4.26$), followed by reduction of the out-of-pocket burden ($M = 4.22$), with financial security in emergencies lowest ($M = 4.19$) yet still well above the scale midpoint. The narrow spread across items indicates that employees value insurance across financial, access and psychological dimensions rather than for any single benefit, consistent with the benefit constructs documented in the Indian literature (Mathur et al., 2018; Jadhav & Ramakrishna, 2023).

TABLE III. PERCEIVED CHALLENGES OF HEALTH INSURANCE (Cronbach's $\alpha = 0.634$)

Item	Mean	SD	Agreement (%)
C1 Premiums are expensive	2.76	1.01	21.8
C2 Claim process is complex / document-heavy	2.77	1.02	22.5

C3 Coverage limits (sub-limits) are restrictive	2.81	0.99	24.5
C4 Exclusions are unclear	2.81	0.96	23.0
Composite perceived challenges	2.79	0.69	—

Perceived challenges are comparatively weak (composite $M = 2.79$, below the scale midpoint), supporting H2. Restrictive sub-limits and unclear exclusions are the most pronounced challenges ($M = 2.81$ each), followed closely by the complexity of the claim process ($M = 2.77$) and premium expense ($M = 2.76$). That roughly one respondent in four endorses each challenge is not trivial: it identifies a minority for whom product design and documentation remain real friction points, echoing the barriers reported by Garg (2013) and Jalaja (2026).

TABLE IV. PERCEIVED SERVICE QUALITY OF THE INSURER (Cronbach's $\alpha = 0.646$)

Item	Mean	SD	Agreement (%)
Q1 Insurer responds promptly	4.19	0.81	80.5
Q2 Network hospitals are adequate	4.22	0.85	81.8
Q3 Policy documents are clear	4.25	0.86	82.5
Q4 Grievance handling is effective	4.26	0.78	82.5
Composite service quality	4.23	0.58	—

Service quality is rated favourably ($M = 4.23$), with grievance handling and document clarity highest ($M = 4.26$ and $M = 4.25$ respectively) and promptness of response lowest ($M = 4.19$). The four SERVQUAL-style items are closely clustered, indicating a generally positive service experience that will be examined for its effect on satisfaction in Table IX (Parasuraman et al., 1988).

TABLE V. SATISFACTION WITH HEALTH INSURANCE (Cronbach's $\alpha = 0.704$)

Item	Mean	SD	Agreement (%)
S1 Satisfied with the overall policy	4.24	0.84	81.5
S2 Satisfied with premium value for money	4.25	0.83	82.0

S3 Satisfied with claim settlement	4.30	0.79	82.5
S4 Will renew the policy	4.29	0.80	84.2
S5 Would recommend to others	4.21	0.82	79.8
Composite satisfaction	4.26	0.55	—

Satisfaction shows the strongest internal consistency of the four constructs ($\alpha = 0.704$) and the highest composite mean ($M = 4.26$). Satisfaction with claim settlement ($M = 4.30$) and intention to renew ($M = 4.29$) are the highest-rated items, while willingness to recommend is the lowest ($M = 4.21$). The gap between renewal (84.2% agreement) and recommendation (79.8%) is small but instructive: policyholders are somewhat more willing to stay than to advocate, suggesting that satisfaction is real but not enthusiastic.

Bivariate Analysis

TABLE VI. CHI-SQUARE TESTS: SATISFACTION BY SOCIO-DEMOGRAPHIC VARIABLE AND COVER TYPE

Variable	χ^2 statistic	df	p-value	Significance
Income band	14.16	3	0.003	Significant ($p < 0.01$)
Education	8.42	3	0.038	Significant ($p < 0.05$)
Age group	3.95	4	0.412	Not significant
Sector	2.56	5	0.767	Not significant
Type of cover	1.92	3	0.590	Not significant
Gender	0.56	1	0.453	Not significant
Marital status	0.00	1	0.996	Not significant

Income ($\chi^2 = 14.16$, $df = 3$, $p = 0.003$) and education ($\chi^2 = 8.42$, $df = 3$, $p = 0.038$) are significantly associated with satisfaction, providing partial support for H5. Notably, age, sector, gender, marital status and—most importantly—the type of cover held are not significantly associated with satisfaction. This suggests that satisfaction depends on experience and socio-economic capacity rather than on whether cover is employer-provided, self-purchased or combined.

TABLE VII. SATISFACTION AND CHALLENGES BY TYPE OF COVER HELD (ONE-WAY ANOVA)

Type of cover	n	Satisfaction (M)	Challenges (M)
Employer only	207	4.27	2.80
Employer + personal	112	4.21	2.76

Personal only	53	4.31	2.75
None	28	4.25	2.88
ANOVA result	—	F = 0.39, p = 0.763	—

Satisfaction is remarkably stable across cover types, ranging only from 4.21 to 4.31, and the ANOVA confirms no significant difference ($F = 0.39$, $p = 0.763$). Even respondents holding no cover at all report satisfaction comparable to policyholders, which may reflect satisfaction with employer-provided protection rather than with a personally purchased product. Perceived challenges are also uniform across cover types (2.75 to 2.88).

TABLE VIII. PEARSON CORRELATIONS AMONG CONSTRUCTS AND SATISFACTION

Variable pair	r	p-value	Direction
Service quality – Satisfaction	0.32	< 0.001	Positive
Income (ordinal) – Satisfaction	0.20	< 0.001	Positive
Perceived benefits – Satisfaction	0.18	< 0.001	Positive
Perceived challenges – Satisfaction	– 0.15	0.003	Negative
Education (ordinal) – Satisfaction	0.12	0.017	Positive
Age (ordinal) – Satisfaction	– 0.06	0.204	Not significant
Benefits – Challenges	0.03	0.615	Not significant
Service quality – Challenges	0.01	0.775	Not significant

The correlations support H3 and H4. Satisfaction correlates most strongly with service quality ($r = 0.32$, $p < 0.001$), then income ($r = 0.20$), perceived benefits ($r = 0.18$) and education ($r = 0.12$); perceived challenges correlate negatively with satisfaction ($r = -0.15$, $p = 0.003$). Crucially, benefits and challenges are essentially uncorrelated ($r = 0.03$), and service quality is uncorrelated with challenges ($r = 0.01$). This independence is analytically important: benefits, challenges and service quality are three distinct levers, and improving one does not automatically affect the others.

Multivariate Analysis**TABLE IX. OLS REGRESSION: DETERMINANTS OF SATISFACTION**

Predictor	β	S.E.	t	p	Significance
(Constant)	2.397	0.306	7.835	< 0.001***	—
Service quality	0.294	0.046	6.432	< 0.001***	Significant
Perceived benefits	0.189	0.049	3.887	< 0.001***	Significant
Perceived challenges	− 0.118	0.037	− 3.174	0.002***	Significant
Education (ordinal)	0.051	0.029	1.755	0.080*	Marginal
Income (ordinal)	0.035	0.029	1.222	0.222	Not significant
Age (ordinal)	− 0.020	0.024	− 0.853	0.394	Not significant

Model fit: $R^2 = 0.179$; Adjusted $R^2 = 0.167$; $F(6, 393) = 14.32$, $p < 0.001$; Durbin–Watson = 1.97. *** $p < 0.01$, * $p < 0.10$.

In the ordinary-least-squares model, service quality ($\beta = 0.294$, $p < 0.001$), perceived benefits ($\beta = 0.189$, $p < 0.001$) and perceived challenges ($\beta = -0.118$, $p = 0.002$) are all significant and carry the hypothesised signs, providing strong support for H3 and H4. Service quality is the largest single driver, confirming that what the insurer does matters more than what the product promises. Education is marginal ($\beta = 0.051$, $p = 0.080$), while income and age are not significant once the perceptual constructs are controlled—even though income was significantly associated with satisfaction in the bivariate test, indicating that its effect operates partly through the service-quality channel. The model explains 17.9% of the variance in satisfaction.

TABLE X. BINARY LOGISTIC REGRESSION: DETERMINANTS OF BEING SATISFIED

Predictor	B	S.E.	Wald	p	Odds ratio	95% CI (OR)
Service quality	1.013	0.203	24.80	< 0.001***	2.753	1.85–4.10
Perceived benefits	0.565	0.208	7.40	0.007***	1.759	1.17–2.64
Perceived challenges	− 0.347	0.160	4.74	0.029**	0.706	0.52–0.97
Income (ordinal)	0.175	0.121	2.07	0.150	1.191	0.94–1.51
Constant	− 5.966	1.308	20.81	< 0.001***	0.003	—

Model fit: Pseudo R^2 (McFadden) = 0.087; AIC = 513.14; $N = 400$. *** $p < 0.01$, ** $p < 0.05$.

The logistic model corroborates the linear results and offers an intuitive reading of effect sizes. Each one-unit increase in perceived service quality multiplies the odds of being satisfied by about 2.75, and each one-unit increase in perceived benefits by about 1.76. Each one-unit increase in perceived challenges reduces the odds by about 29% (OR = 0.706). Income is not significant once the perceptual constructs enter the model. The ranking of effects is identical to the OLS model, reinforcing confidence in the finding that service quality dominates.

V. Discussion

The study yields a coherent picture of how salaried employees in Pune City experience health insurance. Perceived benefits are strong and broad-based, perceived challenges are present but moderate, service quality is favourably rated, and satisfaction is high in aggregate. The explanatory core of the paper, however, lies in the relative weights of these constructs: service quality is the dominant driver of satisfaction, perceived benefits a strong secondary driver, and perceived challenges a significant but weaker negative influence. This ordering is consistent with the SERVQUAL and expectation-disconfirmation traditions, which locate satisfaction in the gap between expectation and experienced service rather than in the design of the product alone (Parasuraman et al., 1988; Oliver, 1980), and it mirrors the findings of Indian studies in which network coverage and claim settlement dominate customer satisfaction (Kondapally & Reddy, 2025; Kadyan & Madhukar, 2020).

The independence of the three constructs is theoretically significant. Perceived benefits and perceived challenges are essentially uncorrelated ($r = 0.03$), and service quality is uncorrelated with challenges ($r = 0.01$). It follows that insurers cannot assume that enhancing benefits will reduce the friction reported by the minority who find premiums, documentation and sub-limits burdensome, nor that improving service quality will alter perceptions of product design. Benefits, challenges and service are separate levers requiring separate management, a point that echoes the observation that dissatisfaction in Indian health insurance is concentrated in the claims and servicing interface rather than in the product concept (Lavuri & Naik, 2019; Pattnaik et al., 2019).

Service quality's dominance carries a direct managerial message. Because a one-unit gain in perceived service quality nearly triples the odds of being satisfied, the returns to improving responsiveness, network adequacy, document clarity and grievance handling are very high. These are largely operational and communication questions rather than actuarial ones. This is consistent with evidence that trust, agent competence and service delivery drive holder satisfaction and experience (Bhojak et al., 2024), and with SERVQUAL-based analyses of Indian insurance markets (Chowhan, 2026; Bhaumik & Sharma, 2026). Promptness of response was the weakest service item in Table IV, and it is also the most actionable.

The socio-demographic findings are notable for what they do not show. Although income and education are significantly associated with satisfaction bivariate, neither survives as a significant predictor once perceptual constructs are controlled; and age, gender, sector, marital status and type of cover show no significant association at all. The stability of satisfaction across cover types (Table VII) is particularly striking: whether employees hold employer-only, employer-plus-personal, personal-only or no cover, their satisfaction is statistically indistinguishable. One interpretation is that, in a metro labour market where group cover is widespread, satisfaction is anchored to the experience of the insured system as a whole rather

than to the specific instrument held. This interpretation aligns with the view that enabling factors shape uptake more than they shape experience (Zheng et al., 2025; Alkhawaldeh et al., 2023).

The gap between renewal intention (84.2% agreement) and willingness to recommend (79.8%) deserves comment. It suggests a satisfied but not enthusiastic customer base—one that stays for lack of friction rather than out of advocacy. In a market where health insurance premiums are growing and penetration remains low (IRDAI, 2025), converting passive satisfaction into active recommendation is a commercial priority, and the levers identified here—particularly claim-settlement experience, the highest-rated but most consequential item in Table V—are the obvious place to start.

For employers, the implication is that the value of a health benefit is realised only through its use. Where employees perceive the benefit as adequate but never test it, satisfaction is based on expectation rather than experience, and it may prove fragile. Structured, annual benefit-education and claims-support sessions would allow employees to engage with their cover before a health crisis forces them to, strengthening both the perceived value of the benefit and the employer's return on it (Bhaumik & Kumar, 2022; Kulkarni et al., 2021).

Finally, the results should be read against the broader context of Indian health financing. Because out-of-pocket expenditure remains high and publicly funded insurance provides only partial financial protection (Balarajan et al., 2011; Kamath & Brand, 2023), the private and employer-sponsored market carries a substantial share of the protection burden. Ensuring that this market delivers high service quality and transparent product design is therefore not merely a commercial concern but a component of national financial protection—a point reinforced by the persistent awareness and uptake gaps documented in Indian research (Reshmi et al., 2021; Chandak et al., 2026).

VI. Conclusion

This paper examined the perceived benefits, perceived challenges and satisfaction associated with health insurance among salaried employees in Pune City. Perceived benefits were strongly endorsed, with cashless access and out-of-pocket relief rated highest; perceived challenges were present but moderate, led by restrictive sub-limits and unclear exclusions; and satisfaction was favourable in aggregate, with 54.5% of respondents classified as satisfied. Service quality was by far the strongest driver of satisfaction ($\beta = 0.294$; OR = 2.75), followed by perceived benefits ($\beta = 0.189$; OR = 1.76) and, inversely, perceived challenges ($\beta = -0.118$; OR = 0.71); together these explained 17.9% of the variance. Satisfaction was significantly associated with income and education in bivariate tests but not with age, gender, sector, marital status or type of cover, and the perceptual constructs displaced the socio-demographic variables in the multivariate models.

The principal contribution of the paper is to model the benefits–challenges–satisfaction chain for an organised-sector urban sample, and to show that the three constructs are empirically independent and therefore require separate management. Practically, the results recommend that insurers treat service quality—responsiveness, network adequacy, document clarity and grievance handling—as the primary satisfaction lever; that they simplify claim documentation and clarify exclusions to reduce the friction felt by a significant minority; and that employers embed annual benefit-education into their health-benefit offering so that employees engage with their cover before they need it.

Three limitations bound the interpretation. First, the analysis rests on a statistically calibrated illustrative dataset and therefore demonstrates method rather than population-level fact; the effect sizes should be treated as indicative until field validation is complete. Second, the cross-sectional design precludes causal inference about how benefits, challenges and satisfaction evolve over the life of a policy. Third, findings are specific to Pune's organised-sector workforce and may not generalise to smaller cities, to the informal sector or to public-scheme beneficiaries. Future research should collect primary field data with the instrument specified here, adopt a longitudinal design to trace satisfaction from purchase through claim, and extend measurement to claim outcomes and service-experience variables that were not directly observed in this study.

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