GOVERNMENT OF INDIA
MINISTRY OF FINANCE
DEPARTMENT OF FINANCIAL SERVICES
RAJYA SABHA
UNSTARRED QUESTION No. 235
TO BE ANSWERED ON TUESDAY, 4th FEBRUARY, 2025/MAGHA 15, 1946 (SAKA)

Health Insurance Payout

235. Smt. Priyanka Chaturvedi:

Will the Minister of Finance be pleased to state:

(a) whether the Ministry is aware that only 71 per cent of health insurance claims were paid out in 2024-25;
(b) whether the Ministry has assessed the legitimacy of rejecting and disallowing health insurance claims and related complaints received against public, private and standalone health insurers;
(c) if so, the details thereof; and
(d) the measures taken by the Ministry to ensure health insurers provide full coverage to eligible beneficiaries and whether the Ministry has issued any guidelines to health insurers regarding the same?

ANSWER

THE MINISTER OF STATE IN THE MINISTRY OF FINANCE (SHRI PANKAJ CHAUDHARY)

((a) to (d):
Insurance Regulatory and Development Authority of India (IRDAI) has submitted that during the FY 2023-24, insurers had received 325.72 lakh health insurance claims including 17.85 lakh claims outstanding from FY 2022-23. Out of these 268.59 lakh (82.5%) claims were paid during the same year and 20.73 lakh (6.36%) claims carried forward to next year.

Insurance Companies process the claims as per the terms and conditions of the policy. Some of the reasons for repudiating the claims could be claim being inadmissible on account of being an exclusion, hospitalization within waiting period, sum insured limit being exhausted, claim within deductible limit, fraudulent claims etc,. A few reasons for disallowance could be non-medical expenses, co-payment, deductibles, various sub-limits opted under the policy, capping of benefits, etc.

IRDAI has put in place various mechanisms to address grievances relating to denial of claims or unfair terms imposed on policyholders, such as Bima Bharosa portal and Grievance Redressal Mechanism at individual company level. The policyholders can submit their grievances through these channels and monitor the status. The policyholders have the right to approach the Insurance Ombudsman without any charges. Insurers must comply with the ombudsman awards within 30 days, or they must pay penal charges of Rs. 5000/- per day for each day of delay.

Further, IRDAI has advised the insurance companies to take various measures to improve the customer claim settlement experience. Some of the measures are:

i. No claim shall be repudiated without the approval of the Insurer's Product Management Committee (PMC) or a three-member sub-group of PMC called the Claims Review Committee (CRC).
ii. In case, the claim is repudiated or rejected or disallowed partially, details shall be communicated to the claimant along with full details giving reference to the specific terms and conditions of the policy document.
iii. If a customer is not satisfied with decision of the insurer on the claim, he/she may lodge a complaint with grievance redressal officer of insurer. The policyholders have the right to approach the Insurance Ombudsman without any charges. Insurers must comply with the Ombudsman's decision within 30 days, or they need to pay penal charges of Rs. 5000 per day for each day of delay.
iv. Shorter timelines for processing and settlement of claims have been introduced for reimbursement/cashless/pre-authorisation.
v. Suo-moto payment of interest at bank rate plus 2 percent in event of delay beyond specified timelines.

Insurers are also required to provide wider choice by offering diverse insurance products catering to all ages, regions, occupational categories, medical conditions/ treatments, all types of hospitals and health care providers to suit the affordability of the policyholders/prospects. Further, the insurers may reward the policyholder for claim free year by giving an option at the time of renewal of policy to choose the 'No Claim Bonus' either by increasing the sum insured or decreasing the premium amount.

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