GOVERNMENT OF INDIA
MINISTRY OF FINANCE
DEPARTMENT OF FINANCIAL SERVICES
LOK SABHA
UNSTARRED QUESTION No. 870

TO BE ANSWERED ON TUESDAY, 11th FEBRUARY, 2025/ 22 MAGHA, 1946 (SAKA)

REJECTION OF HEALTH INSURANCE CLAIMS

870. Shri Pramod Tiwari:

Will the Minister of Finance be pleased to state:
(a) whether, as per report of Insurance Regulatory and Development Authority of India (IRDAI), insurance companies denied significant percentage of health insurance claims during the financial year which ended on 31st March 2024;
(b) if so, the details thereof and the reasons therefor; and
(c) the steps proposed to be taken by Government to mitigate the risk of claim rejection, create consumer awareness and build consumer confidence, developing a modified standardized health insurance product and offering government platforms to improve operational efficiency?

ANSWER

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

(a) to (c): Insurance companies process health insurance claims as per the terms and conditions of the policy. As per data published by Insurance Regulatory and Development Authority of India (IRDAI), during 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 (82.46%) claims were paid during the same year, 36.4 lakh (11.18%) claims were repudiated and 20.73 lakh (6.36%) claims carried forward to next year.

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.

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

i. Insurers to have in place, a Policyholders' Protection, Grievance Redressal and Claims Monitoring Committee (PPGR&CM) which shall establish suitable systems and processes towards protection of the interests of policyholders through efficient and effective grievance redressal mechanism and monitoring of claims settlement processes.

ii. 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).
iii. 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.
iv. 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.

In order to ensure that customers are fully aware about the terms and conditions of the policy and to build policyholder confidence, IRDAI has mandated that:-

i. Insurance companies will provide Customer Information Sheet (CIS) to each policyholder. CIS shall provide details of coverage offered, exclusions, sub-limits/deductibles, capping, waiting periods, etc.
ii. Insurers to have in place well-defined service parameters, turnaround times, procedure for expeditious resolution of complaints, steps to prevent mis-selling and unfair business practice;
iii. Free look period of 30 days (from the date of receipt of the policy document) is given to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms, he/she has the option to cancel his/her policy.

.

****