GOVERNMENT OF INDIA
MINISTRY OF FINANCE
DEPARTMENT OF FINANCIAL SERVICES
**RAJYA SABHA**
**UNSTARRED QUESTION No. 295**

## ANSWERED ON TUESDAY, 22 JULY, 2025/ 31 ASHADHA, 1947 (SAKA)

## Status of health insurance claim settlement

295 Smt. Renuka Chowdhury:

Will the Minister of Finance be pleased to state?
(a) the current average time taken by insurance companies and third-party administrators (TPAs) for the claim settlement;
(b) the current share of health insurance claims being processed through the cashless route, versus reimbursement claims;
(c) the number of hospitals currently onboarded to National Health Claims Exchange (NHCX), and the steps being taken to expand participation;
(d) the total number of pending health insurance claims in the last five years, year-wise; and
(e) whether any policy reforms have been proposed to improve efficiency, transparency, and accountability in the health insurance claim settlement process, if so, the details thereof?

**ANSWER**

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

**(**a) As per IRDAI Master Circular on Health Insurance Business dated 29.05.2024, insurers are required to decide on the request for cashless authorization within 1 hour of receipt of such request and grant final authorization within 3 hours of the receipt of discharge authorization request from the hospital. However, the data related to the average time taken by insurance companies and third-party administrators (TPAs) for the claim settlement is not maintained by IRDAI.

(b) IRDAI has informed that during FY 2023-24, 58.39% of total claims were settled through cashless mode in terms of count and 66.16% in terms of amount.

(c) As per the data provided by National Health Authority, the number of hospitals onboarded to National Health Claims Exchange (NHCX) is 450 as on 28.03.2025.

(d): The data pertaining to paid and outstanding health claims for the last 5 Financial Years is furnished below: -

| As on 31st March | Paid Claims | | Outstanding Claims | |
|---|---|---|---|---|
| | Number | Amount | Number | Amount |
| 2024 | 2,68,59,974 | 83,493.17 | 20,72,978 | 7,584.57 |
| 2023 | 2,35,75,048 | 70,929.82 | 17,83,509 | 6,246.88 |
| 2022 | 2,18,52,201 | 69,498.48 | 20,05,686 | 5,978.44 |
| 2021 | 1,40,30,761 | 43,354.60 | 14,73,180 | 5,657.56 |
| 2020 | 1,67,71,266 | 40,025.59 | 16,05,724 | 4,221.79 |
| Total | 10,30,89,250 | 3,07,301.66 | 89,41,077 | 29,689.24 |

*Source: IRDAI's Hand Book on Indian Insurance Statistics 2023-24*

**(**e) In order to bring in more transparency, efficiency and accountability and to improve the customer claim settlement experience, IRDAI has revamped health insurance framework and notified IRDAI (Insurance Products) –Regulations,2024 on 20.03.2024 and issued a Master Circular on Health Insurance Business on 29.05.2024 wherein it has taken various measures as enclosed at Annexure-1.

**Annexure referred to in reply of Rajya Sabha Unstarred Question no. 295 for 22.07.2025.**

i. Insurance companies shall provide Customer Information Sheet (CIS) to each policyholder. CIS shall provide details of coverage offered, exclusions, sub-limits/deductibles, capping, waiting periods, etc.

ii. Shorter timelines for processing and settlement of claims have been specified.

iii. 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).

iv. 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. 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 insurer shall acknowledge the complaint and provide resolution within 14 days of receipt. The insurer shall also provide reasons for rejecting a complaint drawing reference to the specific terms and conditions of the policy.

v. 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, monitoring of claims settlement processes.

vi. Constitution of Policy Holder Protection Committee to review the Grievance Redressal mechanism;

vii. Appointment of an officer designated as Grievance Redressal Officer not only at the Head Office/Corporate office level but also at every other office;

viii. Policyholders enabled to submit their grievances directly through Bima Bharosa portal and monitor the status thereof on a real time basis.

ix. The Insurance Ombudsman is a Grievance Redressal forum setup with an aim to resolve grievances of aggrieved policyholders in a speedy and cost-effective manner. The 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.