
HEALTH INSURANCE IN INDIA: A LEGAL ANALYSIS

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ABSTRACT

The Health (Mediclaim) insurance segment is rapidly growing in India and provides critical financial support for increasingly expensive medical treatments in our country. While endeavouring to conduct a detailed analysis of the health insurance sector in India, the author has highlighted its importance in terms of social security for citizens and role of health insurance in protecting individuals from the financial burdens of unforeseen medical expenses due to illnesses or injuries. Health insurance in India is regulated by the Insurance Regulatory and Development Authority of India (IRDAI), which has established various regulations and guidelines to ensure consumer protection and market efficiency, including the Health Insurance Regulations 2016, guidelines on product standardization and Third Party Administrators (TPAs). This article also comprehensively examines the legal issues pertaining to *Pre-existing disease* and *Renewal of Insurance Policies* with the help of decided cases. The author has also highlighted several challenges and intricacies before stakeholders of Insurance sector in India. The article suggests for the pro-active role of government in promoting health insurance through product standardization and improving consumer protection and trust. Lastly, the article emphasizes the need for a robust regulatory mechanism to prevent unfair practices and ensure fair competition among insurers.

Keywords: Health Insurance, Mediclaim Insurance, Insurance Renewal, Pre-existing disease.

INTRODUCTION

Health insurance is a new branch of the insurance regime but is definitely one of the rapidly growing service sectors in India. It is also called as medical insurance or sickness insurance and includes perils of personal accident also covering all types of disability/loss of income, medical expenses and accidental death. As treatment of disease and health care costs have become more and more expensive, the health/mediclaim insurance has become part and parcel of life. Considering the expensive treatment, financial support from external sources is required to bring the medical facilities within the reach of a common man. The health insurance provides a protective cover of social security in terms of protection against catastrophic and unforeseen financial hardship or burden caused to any person due to happening of any unfortunate event i.e., sudden illness or injury. A health insurance plan allows policyholders to access higher-quality medical services that would otherwise be out of their grasp. Presence of Health Insurance avert the financial encumbrance upon families that may be caused due to incurring huge expenses of medical treatment. Health insurance has evolved as a suitable instrument for management of adequate healthcare system by financing treatment of illness/injury especially considering the rising costs of health facilities. In this way, the Health/Mediclaim Insurance is not only a private matter between two parties, but the product of public concerns represented in national health policy.¹

Health/Mediclaim insurance is a non-life insurance that covers Hospitalisation expenses and other medical expenses to be incurred in treatment of any disease or accidental injury. It may provide for fixed lump sum benefits or benefits upto a specific percentage of expenses incurred in medical treatment of the policyholder. According to the IRDA regulations, General Insurers and Health Insurers² may offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium remains unchanged for the tenure.³ Initially, health/mediclaim policies used to reimburse the expenses incurred by a policyholder⁴, but now cashless facility⁵ is also provided by the insurers with the help of tie-

¹ See Ermanno Pitacco, Health insurance (2014).

² Life Insurance companies cannot offer Health Insurance other than Long-term care Insurance policies. See 3(b) IRDAI (Health Insurance) Regulations, 2016.

³ See 3(c) IRDAI (Health Insurance) Regulations, 2016.

⁴ In the year of 1986, General Insurance Company (GIC), launched a policy called Mediclaim, which covers hospitalisation costs only. These policies operated through a system of reimbursement wherein the patient was expected to pay the hospital up-front and then recover the money from the insurance company by submitting a claim with supporting documents.

⁵ "Cashless facility" means "a facility extended by the insurer or TPA on behalf of the insurer to the insured, where the payments for the costs of treatment undergone by the insured in accordance with the policy terms and

ups arrangements with hospitals.⁶ Nowadays, processing of insurance claims in Health/Medicaid insurance has been taken over by Third Party Administrators (TPAs)⁷ in India. These TPAs process the claims of Health/Medicaid insurance either (i) on the cashless basis, wherein the policyholder not need to pay at the first hand rather, the payment is done by the TPAs and reimbursement is claimed from the insurance company; or (ii) or through the Insurance company where an insurer directly pays the cost of treatment to Hospital. With the presence of TPAs as intermediaries⁸, policyholders enjoy availing the cashless treatment facilities alongwith faster settlement of claims with insurance companies.

Definition

OECD defines Health Insurance as: *“A way to distribute the financial risk associated with the variation of individual's health care expenditures by pooling costs over time (pre-payment) and over people (pooling). Any form of insurance whose payment is contingent on the insured incurring additional expenses or losing income because of incapacity or loss of good health.”*

The Insurance Act, 1938⁹ defines *Health insurance business* to mean *“the effecting of contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient travel cover and personal accident cover.”*

In the case of *Satwant Kaur Sandhu v New India Insurance Co. Ltd.*¹⁰, the Supreme Court of India also noted: *“A medicaid policy is a non-life insurance policy meant to assure the policy holder in respect of certain expenses pertaining to injury, accidents or hospitalizations.”*

conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.” See 2(f) IRDAI (Health Insurance) Regulations, 2016.

⁶ According to the IRDAI Regulations, Cashless facility shall be offered only at establishments which have entered into an Agreement with the insurer to extend such services. Such establishments will be termed as “Network Providers”. See 30(b) IRDAI (Health Insurance) Regulations, 2016.

⁷ According to the IRDAI (Third Party Administrators — Health Services) (Amendment) Regulations, 2019 a Third Party Administrator (TPA) means *“a company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under these regulations.”* See 2(1)(m).

⁸ According to IRDAI Regulations, *“Every Insurer shall disclose product-wise or location or geography-wise particulars of the TPAs that are engaged for rendering health services in their respective website, and these details shall be updated whenever there is a change.”* See 29(i) IRDAI (Health Insurance) Regulations, 2016.

⁹ Section 2 (6C).

¹⁰ (2009) 8 SCC 316.

Regulation

The Insurance Regulatory and Development Authority of India (IRDAI) has issued (a) Health Insurance Regulations 2016; (b) Guidelines on Standardization in Health Insurance the Guidelines on Product Filing in Health Insurance Business; and (c) Third Party Administrators - Health Services Regulations 2001. These regulations and guidelines regulate introduction of new Health/Medicaid Insurance products in Indian markets and also prescribe operational requirements to be fulfilled by the Insurance companies. At the same time, TPA regulations control their licensing and operations in the healthcare system as intermediaries between insurers and policyholders. The regulations/guidelines issued by IRDA are intended to promote and protect the interest of consumers in insurance markets by arranging for hassle-free dealing with insurance companies while dealing with processing of claims and other services.

KINDS OF HEALTH INSURANCE

There are different kinds of Health/Medicaid insurance products available into the market as nowadays all insurance companies while competing with each other, are endeavouring to attract higher consumer attention through their differential features and facilities to be provided under a specific insurance product. The insurance companies are providing the insurance facilities on individual basis and as well as joint/group insurance policies which cover a large number of persons under the same insurance product with standardised benefits for all of them.

Hospitalization Policies. It covers payment of expenses related to hospitalisation and incidental medical expenses incurred by the policyholder during his stay at the hospital/ nursing home. The main benefit under these insurance schemes is that a predetermined number of days stay in the hospital and hospital costs are covered in the scheme. A fixed sum is paid for each day of hospital confinement. The Hospitalisation policies are primarily considered as indemnity plans as they cover the reimbursement of expenses incurred only upto a maximum amount mentioned in the insurance policy.

Family floater health insurance. As the name indicates, a family health insurance provide coverage to family members of the policyholder also without any requirement of an additional/separate insurance policy. These insurance plans shall also cover the new born child as one of the family members of the policyholder.

Maternity Health insurance. Maternity health insurance covers all the medical expenses incurred towards maternity treatment and other additional expenses. These insurance policies also provide coverage to the policyholders in case of miscarriage.

Disease-specific Insurance. When an insurance policy covers certain specific illnesses, e.g. heart attack, cancer, stroke or disease-specific plans are issued by the insurance company, the insurance is called as Disease-specific or “dreaded disease policies”. These insurance policies generally provide indemnification in the form of payment in a lump sum amount.

Major Medical Expenses Cover. This category covers expenses related to major surgery or operations due to serious illness or disease. A high deductible is applied to major medical insurance. The insured must pay an amount of medical bills equal to the deductible, so that the insurer will pay the expenses in excess of the deductible.

Long-term Care Insurance. These insurance policies cover the expenses incurred in a nursing home, or medical expenses incurred by any policyholder in his/her own home. These insurance policies also cover the cost of receiving the assistance of another person(s) to perform the essential Activities of Daily Living (ADLs) when the policyholder is not in condition to do it by himself/herself.

Disability Income Insurance. It is primarily aimed at providing for the lost income during the disability period or during the treatment period. The benefit is usually paid as a percentage of the capital sum insured, and is paid weekly to avoid financial distress due to disability.

Government Health Insurance Schemes. (a) Employees State Insurance Scheme (ESI) for employees and family members covers employment injuries/sickness and maternity during employment. (b) Central Government Health Insurance Scheme (CGHS) for Central Government employees covers both the pre and post-hospitalisation expenses along with in-house treatment of the patient. (c) Aayushman Bharat Health Scheme provides coverage upto the amount of INR 5 lakh each year for different kinds of diseases.

PRE-EXISTING ILLNESS

The Health/Medicaid policy does not cover the indemnification of expenses for the diseases

which are pre-existing when the policy is purchased. Of what constitutes knowledge of illness is a question of fact and a matter of medical inference. Furthermore, the insurer must demonstrate that the pre-existing condition is connected to the illness discovered during the policy period for which the claim is being made.

In the case of *New India Assurance Co Ltd v. Mary Jane Govias*¹¹, the assured suffering from a dry cough was examined by an ENT specialist with laryngoscopy examination which did not infered anything serious. Due to continuous coughing, he went to another ENT surgeon who diagnosed the assured with disease of nasopharyngeal cancer (through biopsy). The insurance company rejected the claim of the nominees. NCDRD while allowing the claim noted “*when even the treating doctor was unaware that the assured was suffering from cancer or any serious disease, how could the assured know that he has a serious disease?*” The Commission held that the assured did not know of cancer at the time of taking the policy or commencement of the policy, and also had no knowledge of the same till it was revealed through biopsy. The only fact that the test was done within thirty days from the commencement of the policy, could not be construed as indicating that it was within the knowledge of the assured.

In the case of *Praveen Damani v Oriental Insurance Co. Ltd.*¹², the assured registered a claim for expenses incurred for a hysterectomy to treat fibroid in her uterus. The insurer refused to accept the claim on the ground that the assured must have had the medical condition requiring treatment even at the time of the commencement of the policy. Further, there was a clause in the mediclaim policy that “*it is not material whether the insured had knowledge of the disease or not, and that even absence of existence of symptoms of the disease prior to effective date of insurance would enable the Insurance Company to disown the liability.*” The National Commission held the clause to be impermissible to deny liability. “*If this interpretation is upheld, the Insurance Company is not liable to pay any claim, whatsoever, because every person suffers from symptoms of any disease without the knowledge of the same. This policy is not a policy at all as it is just a contract entered only for the purpose of accepting the premium without the bona fide intention of giving any benefit to the insured under the garb of pre-existing disease. Most of the people are totally unaware of the symptoms of the disease that they suffer and hence they cannot be made liable to suffer because the Insurance Company relies on their Clause 4.1 of the policy in a mala fide manner to repudiate all the claims. No*

¹¹ IV (2006) CPJ 228 (NC).

¹² IV (2006) CPJ 189 (NC).

claim is payable under the mediclaim policy as every human being is born to die and diseases are perhaps pre-existing in the system totally unknown to him which he is genuinely unaware of them. In hindsight everyone realises much later that he should have known [the onset of illness] from some symptom. If this is so every person should do medical studies and further not take any insurance policy." The National Commission noted that the burden of establishing the knowledge and the presence of medical condition was upon the insurer.

In the case of *United India Insurance Co. Ltd. v. Manubhai Dharmasinhbhai Gajera*¹³, the Hon'ble Supreme Court noted that "*when an exclusion clause is resorted to in a mediclaim policy, the terms thereof must be given effect to.*" The Insurance policy provided that "a disease would be considered *pre-existing* and hence excludible only if it were pre-existing *when the cover incepts for the first time. Only because the insured had started suffering from a disease, the same would not mean that the said disease shall be excluded.*" The court noted that as per the terms of the prospectus and the insurance policy in the present case what was necessary for non-renewal was "a pre-existing disease when the cover was incepted for the first time." The Supreme Court held that date of inception for such reckoning to be "*the date of inception of the initial mediclaim policy taken from any Indian insurance company provided the renewals have been continuous and without any break*". Therefore, just because the insured contracted or developed a disease during the term of the insurance policy, it does not automatically mean that the disease should be excluded or that renewal could be denied on that basis. Additionally, if the insured made claims in each year, the insurance company should not refuse to renew insurance policies only for that reason.

In the case of *Manju Bala v. LIC of India*¹⁴, it was decided that the application of the rule of *Uberrima fidei* will render the policy invalid, if there is deliberate suppression of pre-existing illness. The fact that a kidney transplant was undergone in 28 days after the policy is a strong ground to infer that there was a material suppression of facts of pre-existing ailment. Such an onset of serious problem could not have been so sudden.

In the case of *Satwant Kaur Sandhu v. New India Assurance Co. Ltd.*¹⁵, the Hon'ble Supreme Court noted that the "*Section 45 of the Insurance Act, 1938, which places restrictions on the right of the insurer to call in question a life insurance policy on the ground of misstatement*

¹³ (2008) 10 SCC 404 Also see *Kanwaljit Singh v. National Insurance Co. Ltd.*, (2019) 8 SCC 22.

¹⁴ IV (2008) CPJ 253.

¹⁵ (2009) 8 SCC 316.

after a particular period, has no application in a case of mediclaim policies and applies only in a case of life insurance policy. Nonetheless, it is a contract of insurance falling in the category of contract uberrimae fidei, meaning a contract of utmost good faith on the part of the assured. Thus, it needs little emphasis that when an information on a specific aspect is asked for in the proposal form, an assured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge. It is not for the proposer to determine whether the information sought for is material for the purpose of the policy or not. Of course, obligation to disclose extends only to facts which are known to the applicant and not to what he ought to have known. The obligation to disclose necessarily depends upon the knowledge one possesses. His opinion of the materiality of that knowledge is of no moment."

Similarly, in the case of *United India Assurance Co Ltd v. Satish Chandra*¹⁶, it was noted that a literate person shall be presumed to know all the terms of the policy. Where death resulted within 7 days of taking policy by heart attack and the deceased was a known case of diabetic with hyper tension, the exclusion of ailment within 1 month from the date of policy will operate.

In the case of *Tarlok Chand Khanna v. United India Insurance Co Ltd.*¹⁷, it was reiterated that the burden of proving existence of pre-existing illness was only on the insurer. The fact of death with a few days by heart attack after knee replacement surgery cannot mean the non-disclosure of knee problem could be attributed to death by heart attack.

In the case of *LIC v. Manish Gupta*¹⁸, the proposal form contained a specific query i.e., *whether the proposer had suffered or was suffering from cardiovascular disease?* This was answered in negative by the assured whereas the documentary investigation revealed that insured had suffered from rheumatic heart disease since childhood. There was a clear failure on the part of the respondent to disclose the past history of cardiovascular disease which was held to be a valid ground for repudiation of claim by the insurer.

Notice of Disease

The requirement of notice within a period of contracting illness or when it gets to be known to

¹⁶ III (2010) CPJ 5.

¹⁷ I (2012) CPJ 84.

¹⁸ (2019) 11 SCC 371.

the insured is essential for the insurer to verify the correctness of the claim. Failure to comply with such a requirement could be a ground for repudiation. In the case *Tata AIG General Insurance Co. Ltd. v K Lalitha*¹⁹ it was held that failure to report in writing loss of vision within the period of 30 days to the insurer shall be taken as justification for the insurer to repudiate the policy. The National Commission noted: “*We would like to note that the requirement of giving written notice to the insurer is not a mere formality, the purpose of the said requirement being to give an opportunity to the insurer to independently investigate the claim made by the insured. If the intimation of the loss is not given to the insurer, the evidence, which would be available immediately or soon after occurrence of the loss may be lost, or destroyed or manipulated thereby, adversely affecting the interest of the insurer. It is towards achieving this objective that the insurer insists upon a prompt intimation of the loss to it by the insured. The insurer being a company, it is only logical for it to insist upon a written intimation so as to avoid any controversy as to whether the loss was intimated to them by the insured or not.*”

RENEWAL OF HEALTH/MEDICLAIM POLICY

Renewal of an insurance policy refers to a recurrence of the original insurance policy with the same terms and conditions unless varied with the consent of both parties. Renewal has certain advantages, viz, the normal exclusions of certain types of illnesses within 1 or two years from the commencement of the policy will not operate against the insured. Health/Medical Insurance policies being contractual arrangements between the parties, renewal of the same cannot be claimed as a matter of right by the insured. The insurer may refuse to renew an insurance policy issued to policyholder if Insurer is of opinion that it is not prudent to continue or if any kind of fraud comes into knowledge of insurer. However, a renewal of Health insurance policy cannot be denied by an insurer only (a) because of high incidence of claims by the Customer (b) on the grounds of age, if the Customer has renewed the Policy without any break²⁰.

In the case of *Purnima Prasad v. Oriental Insurance Co Ltd.*²¹, the Patna High Court while dealing with a dispute relating to renewal of Insurance policy decided that if, during the term of the policy, the insured person becomes ill for the first time and the insurer has to cover the

¹⁹ LNINDORD 2015 NCDRC 2865.

²⁰ “Break in policy” means “the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.” See 2(e) IRDAI (Health Insurance) Regulations, 2016.

²¹ AIR (2006) Pat 158.

expenses, the insurer cannot refuse to renew the policy claiming it has become too burdensome or expensive. The court had aptly remarked: *“Any tendency to undertake risk selection so as to insure low-risk individuals and exclude the high risk ones from insurance via exclusion conditions would impose a heavy financial burden on the people who are prone to get sick and most in need of risk protection, obviously works against the constitutional perspective.”*

Later, in the case of *United India Insurance Co Ltd. V. Manubhai D Gajera*²², the Hon’ble Supreme Court held, where a renewal is based on mutual consent, there is no automatic renewal. However, a mediclaim policy issued by a PSU insurer where a senior citizen is involved would stand on a somewhat different footing. Though there is no legal right of automatic renewal, but the courts are required to strike a balance. It will depend on the terms of the contract, the constitutional scheme and applicable statutory scheme. It cannot be that wherever renewal is subject to mutual consent, a functionary that is part of the State under Art. 12 of the Constitution may at its whims and caprice refuse to renew. When an insurance policy is cancelled, the conditions precedent therefor must be fulfilled as per terms of the prospectus and the policy. The Supreme Court noted that *“renewal of mediclaim policy subject to just exceptions should ordinarily be made. But the same does not mean that the renewal is automatic. The mediclaim policy holders are not entitled to automatic renewal, but indisputably, they are entitled to be treated fairly. When a policy is cancelled, the condition precedent therefore must be fulfilled. Some reasons must therefore be assigned. When an exclusion clause is resorted to, the terms thereof must be given effect to. What is necessary is a pre-existing disease when the cover was inspected for the first time. Only because the insured had started suffering from a disease, the same would not mean that the said disease shall be excluded; if the insured had made some claim in each year, the Insurance Company should not refuse to renew insurance policies only for that reason.”* The court further noted *“It is essential that while the public sector insurance companies are not put to undue burden keeping in view the statutory changes and policy decisions of the Central Government, they also cannot be permitted to act arbitrarily and unreasonably. They cannot be permitted to create a social condition which would negate all human rights.”*²³ There is no escape from the fact that the appellant insurers are a part of the “State” within the meaning of Article 12 of the Constitution. Only because the public sector insurance companies cease to enjoy the said monopoly would not by itself be sufficient to hold that they are not required to follow the constitutional or

²² AIR 2009 SC 446.

²³ Para 55.

statutory norms.²⁴ If they are a part of the State their action must be fair and reasonable.²⁵ One important facet of the matter which must be taken note of is the duty on the part of the State to act fairly. Such a fair dealing is expected at the hands of the State within the meaning of Article 12 of the Constitution of India.²⁶ Further, there cannot be any doubt whatsoever that Article 14 of the Constitution of India which encompasses within its fold obligations on the part of the State to act fairly which operates also in the contractual field, but the said principle would be applicable more in a case where bargaining power is unequal or where the contract is not a negotiated one and/or is based on the standard form contracts between unequals.²⁷ The duties and functions of IRDA, however, are to see that the service providers must render their services keeping in view the nature thereof. It will be appropriate if the Central Government or the general insurance companies also issue requisite circulars. IRDA is requested to consider the matter in depth and undertake a scrutiny of such claims so that in the event it is found that the insurance companies are taking recourse to arbitrary methodologies in the matter of entering into contracts of insurance or renewal thereof, appropriate steps in that behalf may be taken.²⁸ When the terms and conditions of contract of insurance are fixed, the protective umbrella over the interest of the policy holders becomes fully open. The insurance companies cannot either in their prospectus or in the terms of policy lay down any condition which would be derogatory to the terms and conditions approved by IRDA. If the contract of insurance itself provides for renewal of an insurance policy the same may not mean that the assured has a legal right of automatic renewal, but the courts are required to strike a balance.²⁹”

In the case of *Dr. T Suresh v The Oriental Insurance Co Ltd.*³⁰, the insurer refused to renew the policy on the ground that the insured was undergoing medical treatment. It was held that once a policy was taken and it was being renewed from time to time then it became a continuous phenomenon and the insured was entitled for renewal of the policy.

In the case of *N. M. Bijlani, IAS (Retd.) v. New India Assurance Co. Ltd.*³¹ it was held that where a policy was renewed by the insured in spite of being aware of fact of exclusion clause being there in policy as regards disease acquired by the insured, the insurer was not liable to

²⁴ Para 30.

²⁵ Paras 25 and 26.

²⁶ Para 41.

²⁷ *Id.*

²⁸ Para 68.

²⁹ Para 34.

³⁰ AIR 2010 AP 86.

³¹ AIR 2017 Guj 57.

pay the medical claim. However, where the insurer assured the insured of non-incorporation of exclusion clause in renewed policy with loaded premium, and despite said assurance, exclusion clause was incorporated in the renewed policy, it was held that the insurer cannot take the plea of exclusion clause and was liable to pay medical reimbursement.

In the case of *United India Insurance Company Ltd. v. Mohanlal Aggarwal*³², the Gujarat High Court noted that “Frequency of claim when it arises under the cover issued under a medicaid scheme, which the insurer is bound to honour under the contract, cannot constitute a ground for evading the liability, nor can it be said that such frequency amounts to a high moral hazard entitling the insurer to cancel or refuse to renew the cover.” The Court evolved the following six principles:

“(1) The insured has an option under the existing medicaid insurance policy to continue the cover by payment of renewal premium in time in respect of the sum insured.

(2) In case of renewal without break in the period, the medicaid insurance policy will be renewed without excluding any disease already covered under the existing policy which may have been contracted during the period of the expiring policy. Renewal of medicaid insurance policy cannot be refused on the ground that the insured had contracted disease during the period of the expiring policy so far as the basic sum insured under the existing policy is concerned.

(3) In cases where the insured seeks an enhancement of the amount of sum insured at the time of renewal, the option to renew will not extend to the amount of such enhancement and renewal in respect thereof will depend upon the mutual consent of the contracting parties.

(4) Renewal of a medicaid insurance policy cannot be refused, despite timely payment of the renewal premium, on the ground that continuance of the cover would become more onerous or burden some for the insurer due to the insured contracting a covered disease during the period of the existing policy.

(5) The insurer may refuse renewal, even in cases where the insured has an option to renew the policy on payment of the renewal premium in time, on the grounds, such as, misrepresentation, fraud or non-disclosure of material facts that existed at the inception of the contract and would

³² AIR (2004) Guj. 191.

have vitiated the contract of insurance at its inception or non-fulfilment of obligations on the part of the insured or any other ground on which the performance of the promise under the contract is dispensed with or excused under the provisions of the Contract Act or any other law or when the insurer has stopped doing business.

(6) The Government insurance companies continue to be 'State' within the meaning of art 12 of the Constitution notwithstanding the entry of private companies in the field of general insurance, ending their monopoly by virtue of insertion of S 24A in the Act of 1972 and they cannot arbitrarily cancel or refuse to renew an existing mediclaim policy."

PROBLEMS OF HEALTH INSURANCE IN INDIA

Lack of Knowledge

A large number of people in India still do not have knowledge about health insurance. There is still lack of basic knowledge and exposure about health or Mediclaim insurance policies which is one of the major challenges. People are under the impression that health insurance is a tax saving or an investment tool. This unawareness about health insurance is also seen in large numbers in the rural areas, where the majority of the potential market is still untouched. At the same time, high insurance costs limit accessibility for middle-income and low-income families is also reducing the affordability of health insurance.

Claims and Settlement Complications

According to the existing IRDAI regulations, an insurer shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last 'necessary' document.³³ Also, where a claim is denied or repudiated, the communication about the denial or the repudiation shall be made only by the Insurer by specifically stating the reasons for the denial or repudiation, while necessarily referring to the corresponding policy conditions. The insurer shall also furnish the grievance redressal procedures available with the Insurance Company and with the Insurance Ombudsman along with the detailed addresses of the respective offices.³⁴ However, difficulties arise at the time of settlement of insurance claims due to unclear terms and conditions and even genuine claims are rejected by insurance companies due to small technical reasons. Existing

³³ See 27(i) IRDAI (Health Insurance) Regulations, 2016.

³⁴ See 33(d)(iv) IRDAI (Health Insurance) Regulations, 2016.

regulations do not provide for any penalties for rejecting genuine claims made by eligible policyholders in compliance of the terms and conditions of insurance policy.

Information Asymmetry

A state of asymmetric information refers to a situation where “*one party knows something relevant to the transaction that the other does not*”. Most of the times, insured does not disclose information about underlying health conditions and the insurer may not fully know the exact risk status of a proposer and so may not price the risk correctly. In the case of *Satwant Kaur Sandhu v. New India Assurance Co. Ltd.*³⁵, the Supreme Court of India had advised insurance companies to offer a fair deal and ensure clarity of all the terms and conditions of their offer with transparency without any hidden agenda. Even they should not take recourse to “*ticketing contract*”.

Adverse selection

Consumers tend to seek or accept more health care services when they have health insurance compared to when they do not have it. Similarly, health care providers tend to offer more services, and sometimes more expensive ones, to individuals with health insurance. Insurers naturally prefer to cover lower-risk individuals and are often hesitant to insure those with higher risk. This is also termed as “*cherry-picking*” or “*cream-skimming*”. The inverse is also true, which is called “*adverse selection*”, whereby the higher risk persons would want to purchase health insurance more than a healthy person with low risk.

Lack of Penal deterrence for Insurance Companies

In the health insurance industry, insurance companies appear to repeatedly violate regulatory requirements without facing any consequences. When violations occur, insurers are only asked to pay minimal litigation costs and compensation for damages. The fact that these violations persist shows that the penalties are not deterring the insurers. To serve as a deterrent, it's essential to ensure that violators pay fines that exceed the gains made through the violations.

Practical and Operational Issues

³⁵ (2009) 8 SCC 316.

Many network hospitals are charging policyholders more than the rates agreed upon with insurance companies. Additionally, insurance companies often deny coverage for cashless medical facilities without providing any explanation. Disputes also arise from the technical terms used in health insurance policies, as they are often vague or undefined. Insurers sometimes take advantage of this ambiguity to deny claims.

CONCLUSION AND SUGGESTIONS

With the advent of new technologies and changing demands/consumer preferences, insurance companies are introducing improvised and innovative Health/Medicaid insurance products to satisfy customers' need. Still, the segment of Health/Medicaid insurance business is prone to high claim ratio alongwith fraudulent claims. However, immediate investigation of the claims can allow the insurers to curb unfair practice and protect their interest against wrongful claims. Insurers also need to make the insurance policy clauses very clear with explicit terms highlighting various inclusions and exclusions in detail.

The Central and State governments in India can add value to the healthcare system by putting their strengthened efforts for increasing consumer awareness. The Government need to promote health insurance as an essential facet of the healthcare system to establish confidence and faith in Health/Medicaid insurance products. At the same time, the government through its executive expertise can ensure standardization and simplicity of Health/Medicaid insurance products. This will lead to enhanced consumer protection with guaranteed basic and minimum facilities to be provided to consumers at minimal costs without technical hassles. The Government can also boost the policyholders' trust through an efficient grievance redressal mechanism which operates as the first point of contact for general public.

Lastly, the IRDA also has to ensure that this sector develops rapidly and benefit of insurance efficiency goes to the consumers. It has to protect the Health/Medicaid insurance segment against unfair practices from both the insurer and policyholders. IRDA needs to develop a regulatory mechanism wherein insurance companies are unable to distort and exploit the market by prioritising the high-profit upstream segment while neglecting the lowstream segment of rural or semi-urban areas where the major section of India's population resides. The IRDA also need to frame new policies to promote fair competition among Health/Medicaid insurance companies to extract the benefit of cost-efficiency and innovation.

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