

Fair play in Indian health insurance

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Abstract

In recent years there has been an increased role for health insurance in Indian health care, through government funded health insurance programs and privately purchased health insurance. Our analysis of the claims ratio and the complaints rate in the health insurance industry, suggests that there are important difficulties with the working of health insurance. The lack of fair play in this industry is derived from deficiencies in regulations, weak enforcement of regulations and faulty institutional design of consumer redress. The solutions lie in laws and regulatory processes for consumer protection. The thought process of health policy and financial policy converges in the strategy for change.

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1 Introduction

The liberalisation of the insurance sector in 1999 gave impetus to the health insurance industry in India. The first specialised health insurance company was established in 2006. Over the years, the health insurance industry has become an integral part of the Indian health landscape for two reasons. *First*, the number of Indians purchasing health insurance products has grown in the past few years. *Second*, health insurance companies have come to play an important role in the administration of Government-Funded Health Insurance Schemes (GFHISs). Consequently, large fiscal resource flows have emerged, through private health insurance companies. However, the health insurance industry is plagued with the highest number of consumer complaints in the insurance sector. This has raised concerns of efficiency and fair play in an increasingly important industry.

While there is some literature on consumer protection concerns in the overall insurance industry, the existing literature on the health insurance industry in India is sparse. In this paper, we study the functioning of this industry through an analysis of the claims ratio and the complaints rate.

Our analysis of the claims ratio shows that the functioning of the Indian health industry is neither desirable nor sustainable. While a part of the industry, the private stand-alone health insurers, appear to be selling inferior quality products to its consumers, another part of the industry, the government insurers, suffers from financial fragility. Group insurance businesses and GFHISs also raise concerns related to insolvency. We conclude that the evidence from claims ratio raises concerns about consumer protection and micro prudential regulation.

Our analysis of the complaints rate shows that India has the highest complaints rate when compared with other common law jurisdictions: Canada, Australia, UK and California. This finding must be interpreted with caution. The first adjustment pertains to the scope of health insurance in India. Health insurance in India largely covers hospitalisation only. All other compared countries provide hospitalisation, clinical visits, medication and some wellness care under health insurance, which creates an increased number of touch points and transactions, where failures can generate complaints. The second adjustment pertains to the litigation rate. India is a less litigious country when compared with advanced economies. Putting these two factors together, we view the complaints rate that prevails in the Indian health insurance industry as a source of concern. We also read a large number of court orders settling health insurance disputes. One common thread which stood out was the absence of complexity in these disputes, most relating to arbitrary and illegitimate rejection of claims by the insurers.

When we investigate the sources of these problems, they are traced to infirmities in the regulatory framework governing the health insurance industry. We identify three issues in the regulatory framework. The first issue is deficiencies in the existing regulations. For example, the regulations are not clear on disclosures that insurance companies should make to its consumers, the manner in which disclosures should be made and the procedure for settlement of claims. The second issue is poor enforcement of existing regulations. The Insurance Regulatory and Development Authority of India (IRDAI) and the insurance companies seem to easily bypass their obligations under the regulations without any repercussions. The third issue is fundamental deficiencies in the design of the insurance ombudsman, in so far as its offices and day to day administration is controlled by the insurance industry. We then engage in a comparative law analysis, where each of these issues is analysed with respect to the legal systems of Australia, South Africa, US and UK.

Finally, we turn to existing strategies for reform in the Indian insurance sector. The report of the Financial Sector Legislative Reforms Commission, provides insights into the approach to consumer protection for financial services. The report comprises of two volumes: Volume I is “Analysis and Recommendation”, and volume II is the “Indian Financial Code”, a model law for the regulation of the financial sector. We engage in counter-factual analysis of the three identified issues in a hypothetical world, where the Indian Financial Code was enacted. We find that all the three issues are suitably addressed. We conclude that the Financial Sector Legislative Reforms Commission, provides an intellectual framework through which the problems of health insurance can be understood and solved. Implementation of these measures will have important implications for health insurance in India.

The rest of the paper is organised as follows: Section 2 provides a review of the growth and prominence of health insurance in India; Section 3 presents our analysis of the claims ratio; Section 4 presents our analysis of the complaints rate; Section 5 identifies the source of problems identified in the health insurance industry; Section 6 recommends reform strategies; and Section 7 concludes.

2 Trends in Indian health insurance

Health insurance industry in India has developed in a unique way. Unlike most others in the developed world, there is no complete health insurance product available. Insurance policies in India only cover hospitalisation costs. However, even with this limited coverage, health insurance policies have now become a significant part of health expenditure. Moreover, with the government shifting from provisioning of

healthcare directly (through government hospitals) to purchasing health insurance from insurance companies for the poor, the number of people being covered by health insurance policies has grown significantly. The changes in total premium and persons covered merit a closer look at the *quality* of the health insurance policies being sold.

The development of health insurance in India can be divided into three phases: (i) employment linked phase, (ii) the Mediclaim phase, and (iii) the entry of private players.

From 1948 till 1986, all health insurance in India was linked to employment. Insurance for employees in the formal sector was introduced in 1948 through the *Employees' State Insurance Act, 1948*. Similar employment linked benefits were started for government employees, like the Central Government Health Scheme (CGHS) for central government employees, which was later expanded to other government organisations, like defence, railways and police. These schemes cover the employee and his/her family and have a parallel set of medical institutions, like hospitals, clinics and dispensaries, which are not open to the general public.¹ It was hoped that industrial and economic development of India would soon absorb the entire population of India into either the formal sector or the government sector. This would in-turn provide universal health insurance through employee linked schemes. Sadly, due to failure of central planning, the expansion of formal employment did not occur. Today, ESIS is available to formal sector workers who constitute only around 8% of the workforce in India. The rest 92% are disbarred from these schemes.

By the late 1970's and early 1980's the failure to expand formal employment had become evident. However, due to the lack of a private insurance sector, self-employed Indians or Indian employed in organisations not covered under the special schemes could not purchase health insurance even if they wanted to. In 1986, after instructions from the government, one public-sector insurer, General Insurance Company, launched a policy called *Mediclaim*, which continues till today.² *Mediclaim* is not a comprehensive medical insurance policy. It covers hospitalisation costs only. Ambulatory care, medicines and post-operative care are not covered. Even within hospitalisation costs, there are exclusions for pre-existing diseases, operations which do not require general anaesthesia, and medical conditions arising out of diseases like cancer, HIV, etc. After its inception, other government insurance companies came out with health insurance policies with identical terms. Although the number

¹For example, under Employee's State Insurance Scheme (ESIS), the Employee's State Insurance Corporation (ESIC) maintains its own hospitals; under Retired Employees Liberalised Health Scheme (RELHS), the railways maintain railway hospitals; and under Ex-servicemen Contributory Health Scheme (ECHS), defense services maintain ECHS dispensaries.

²Shahi and Gill, 2013, review the performance and progress of health insurance business in India.

of health insurance products increased, there was no product variation available to the public.³ These policies initially worked through a system of reimbursement. 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. Later, *cashless* facilities were introduced. In this, a patient could get treated in a hospital *pre-approved* by the insurer.

The third phase of health insurance in India started in 2000. The sector was re-opened to the private sector (with limited foreign participation) in 2000. This increased the number of players in the health insurance industry.⁴ From just four general insurers (all government-owned) and one life insurer, India now has 24 general insurers, 23 general insurers and six dedicated health insurance companies. Liberalisation of the insurance sector was accompanied with the setting up of an independent statutory regulator, the IRDAI, in 2000.

However, even with liberalisation, the nature of the insurance product available to individuals has largely remained unchanged. Some minor innovations like the *cashless* facility (where the hospital directly bills insurers) and some additional coverage was introduced. However, even today insurance policies cover hospitalisation costs only and there are exclusions for diseases like cancer, HIV, etc.

Even with this limited insurance coverage, the health insurance industry has seen impressive growth. Payments for insurance premiums form a significant part of the private health expenditure (See Table 1).⁵ While there are stand-alone health insurance companies (only in the private sector), life and general insurance companies also sell health insurance. Although the industry is still dominated by government insurers, which garnered 64% of the total premium in 2015-16, the biggest growth has been in private stand-alone health insurers which collected 16% of the premiums in 2015-16, up from 12% in 2013-14. The growth of the whole industry is also accelerating. For the three financial years from 2013 to 2016, the annual growth in premium collected has grown by 13.20%, 14.90% and 21.70%, respectively.

In addition to growth in the total premium collected, the number of people covered under health insurance policies has also increased, from 16.7% of the total population, in 2013-14, to 27.0% in 2015-16. The main driver for this growth has been the growth of persons covered under various GFHISs. As Patnaik and Shah,

³Insurance policies, similar to *Mediclaime*, were recommended by the Government of India, 1983, which recognised that government resources would not be enough to provide universal health care.

⁴This happened with the passing of the *Insurance Regulatory and Development Authority Act, 1999*, by the Parliament.

⁵Private health expenditure forms about 80% of the total health expenditure in India. Government plays a nominal role in covering healthcare costs in India. See NSSO, 2015.

Table 1 Premium and private health expenditure

Payments for insurance premium form a significant part of private health expenditure in India.

Year	Premium*	PHE	Percentage
	(Rs. trillion)	(Rs. trillion)	
2013-14	0.17	3.22	5.28
2014-15	0.20	3.42	5.86
2015-16	0.24	3.69	6.51

* Premium does not include premium collected under government health insurance schemes.

Source: IRDAI Annual Report

Table 2 Health insurance premium by type of service provider

Amongst the three types of insurers, private stand-alone health insurers had the largest growth between 2013 and 2016.

Type	2013-14	2014-15	2015-16
	(Rs. billion)	(Rs. billion)	(Rs. billion)
Govt-general	108.41 (62%)	128.82 (64%)	155.91 (64%)
Pvt-general	44.82 (26%)	43.86 (22%)	49.11 (20%)
Pvt-health	21.72 (12%)	28.28 (14%)	3946.00 (16%)
Industry total	174.95	200.96	244.48
Annual growth	13.20%	14.90%	21.70%

The figures in brackets indicate the share of each type of insurer as a percent of the total health insurance premium.

Source: IRDAI Annual Report

Table 3 Persons covered under health insurance

The number of persons covered under health insurance policies grew significantly between 2013 and 2016. The largest growth in coverage was experienced under GFHISs.

Types	2013-14	2014-15	2015-16
Government health insurance schemes	155.3 (12.0%)	214.3 (16.3%)	273.3 (20.6%)
Group health insurance	33.7 (2.6%)	48.3 (3.6%)	57.0 (4.3%)
Individual health insurance	27.2 (2.1%)	25.4 (1.9%)	28.7 (2.1%)
Total	216.2 (16.7%)	288.0 (21.8%)	359.0 (27.0%)

The number of persons is *in million*.

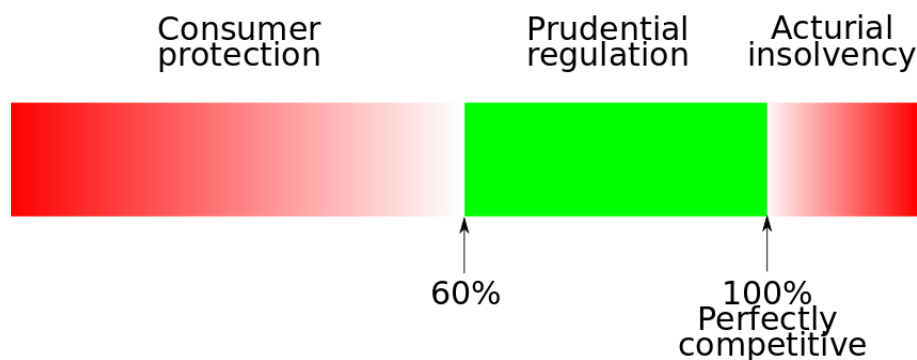
The figures in brackets indicate people insured as a percent of the total population of India.

Source: IRDAI Annual Report and World Bank

2018, argue: After many decades of trying to get government hospitals and health facilities to work, the Indian government has started shifting away from the direct provision of healthcare through government hospitals to purchasing healthcare through GFHISs. In this process, the government purchases health insurance for the poor from the existing health insurance companies. The poor then may use private hospitals to undergo covered medical procedures and the insurer reimburses the private hospital. The number of persons covered under such GFHISs has grown from 12% of the population to 20.6% between 2013-14 and 2015-16 (See Table 3).

With 20% of the population covered under health insurance and the rapid growth in the health insurance industry questions about the quality of these health insurance policies become important. How efficient is the health insurance industry in India? How do insurance companies treat their customers? In the next section, we attempt to answer these questions through two indicators: claims ratio and the complaints rate.

Figure 1 Regulatory concerns associated with the claims ratio



3 Measuring efficiency through the claims ratio

Insurance benefits from law of large numbers. The larger the insurance pool the better it is. However, to get this benefit, someone has to create an insurance pool. Insurance companies do this for a fee. This fee is the cost consumers pay for getting the benefits of insurance. The lower the fee the more efficient the insurance market is. This is commonly measured through the *claims ratio* or *Medical Loss Ratio (MLR)*.⁶ The claims ratio or MLR is defined as the percentage of the total premium collected that is paid out as claims by an insurer.⁷ The difference between total premium collected and claims paid out can be attributed to the operational costs and profits of the insurer. The closer the claims ratio is to 100%, lesser is the cost of operating an insurance company, which in turn means that the insurer is efficient. In the international experience, many regulators are agnostic about the claims ratio when it is around 100%. Figure 1 shows the range of claims ratio that insurance regulators use as an indicator for the insurer's quality.

Claims ratio above 100% indicates that the insurance company is paying more than it is collecting as premium. It points to one of the two possibilities: either (i) the insurer is consuming capital to pay out claims and will turn insolvent at a future date, or (ii) the insurer is cross-subsiding these consumers with surplus

⁶See generally, Karaca-Mandic, M. Abraham, and Simon, 2013.

⁷In multi-year contracts, the net-present value of all premiums is considered.

Table 4 MLR requirements in the US

The minimum MLR requirement for insurers in the US. MLR below the minimum requirement triggers mandatory refunds to the consumers by the insurer.

States	Individual market (in percent)	Group market (in percent)
New York	80	75
New Jersey	75	75
Maryland	60	75
Minnesota	65	75
Kentucky	65	75

Source: National Conference of State Legislatures (USA)

generated from other products. This is unsustainable and may lead to bankruptcy of the insurer.

When the claims ratio is too low, there are concerns about consumer protection. It indicates that the insurer is charging too much from the consumers. In such situations, regulators may require insurers to return some part of the premium to the consumers. For example, Table 4 shows the low water mark for claims ratios, in some states in the US, which triggers mandatory refunds to the consumers.⁸

Indian insurance companies fall on both ends of the spectrum of the claims ratio. Some private insurers have such low claims ratios that they raise consumer protection concerns, while others are either bankrupt or cross-subsidising health insurance. The claims ratio of stand-alone health insurers fell from 67% to 58% between 2013 and 2016 (See Table 5). The observed claims ratio in India would have triggered mandatory refunds if they were operating in the US. However, there are no regulations mandating minimum claims ratio in India.

On the other end of the spectrum, the claims ratio for group insurance and GFHISs (as products), and the claims ratio of government insurers (as service providers) also show grounds for concern. The claims ratio for these products and businesses

⁸This is prior to the *Affordable Care Act, 2011*. The 2011 Act sets out national mandatory MLR caps.

Table 5 Incurred claims ratio of health insurers

While the claims ratio of government insurers raises prudential concerns, the low claims ratio of private stand-alone health insurers raises consumer protection concerns.

Type	2013-14	2014-15	2015-16
	(in percent)	(in percent)	(in percent)
Govt-general	106	112	117
Pvt-general	87	84	81
Pvt-health	67	63	58

Source: IRDAI Annual Report

are above 100%, indicating that either there is cross-subsidy from other businesses or that these businesses are heading towards bankruptcy (See Tables 5 and 6). The situation for GFHISs has invited regulatory intervention. From 2016, insurers who want to participate in new GFHISs are required by IRDAI to have a claims ratio of less than 90% for their existing GFHIS products.⁹ We observe that a large portion of the premium is being used to pay commissions to agents selling health insurance, and this amount has been rising for the insurance agency (See Table 7).

Apart from the problems of the claims ratio and high agent commissions, another metric to judge the quality of health insurance industry is the complaints rate. The complaints rate of an insurance industry reflects consumer experience and satisfaction. In the next section, we estimate the complaints rate for health insurance products in India and compare it with some other jurisdictions.

4 Measuring quality through the complaints rate

Dissatisfied consumers are likely to complain. When many consumers complain against identical or similar products or services, it is indicative of the quality of those products or services. Consequently, the complaints rate is a useful metric to measure the quality of products or services in an industry. Researchers commonly

⁹See Cl. 2(11), Chapter IV of the IRDAI, 2016b.

Table 6 Incurred claims ratio of health insurance products

The high claims ratio of GFHISs and group health insurance raises prudential concerns.

Class of business	2013-14	2014-15	2015-16
	(in percent)	(in percent)	(in percent)
GFHISs	93	108	109
Group business *	110	116	120
Individual business	83	81	77
Grand total	97	101	102

* Group business does not include government business.

Source: IRDAI Annual Report

Table 7 Percentage of commission to premium in health insurance

A large portion of the premium is being used to pay agent commissions.

Types	2013-14	2014-15	2015-16
	(in percent)	(in percent)	(in percent)
Private sector health insurers	9.97	11.99	12.16
Public sector health insurers	6.77	7.77	7.14

Source: IRDAI Annual Report

use this metric to measure the quality of products in the insurance industry.¹⁰ Insurance regulators in other jurisdictions also use this metric to assess how well insurance companies are treating their consumers.¹¹

For this paper, we define the complaints rate as the total number of complaints received in a year, per million persons covered by health insurance.

$$\text{Complaints rate} = \frac{\text{Total complaints in a year}}{\text{Million persons covered}}$$

We use complaints made to independent adjudicators, outside the insurance company. These complaints usually occur when the insurance company fails to address the grievance of the consumer. They indicate a genuine disagreement between the insurance company and the consumer as the company has decided not to address the demands of the consumer to their satisfaction.

4.1 Calculating India's complaint rate

In other common law jurisdictions, the first entity that a consumer complains to (after the insurance company) is an *ombudsman*. The ombudsman acts as an alternative to expensive formal litigation. There can be a single ombudsman office for all financial services (Canada and UK), or an ombudsman office dedicated to insurance policies (the U.S. states). So, calculating health insurance complaints rate is relatively easy.

Although India has an insurance ombudsman, the office suffers from operational issues, like persistent vacancies and backlog of complaints.¹² Consequently, Indian consumers fall back on other dispute resolution mechanisms: the consumer courts and the Integrated Grievance Management System (IGMS). These three routes of dispute resolution are described below:

Insurance ombudsman is similar to the ombudsman systems in other common law jurisdictions. An insurance ombudsman has jurisdiction over insurance claims below ₹ 2 million.

Consumer courts are specialised courts to deal with all types of consumer grievances. They operate under a special law to maintain fair practices by the sellers towards

¹⁰See, Doerpinghaus, 1991; Barrese, Doerpinghaus, and Nelson, 1995; Ak and Oztaysi, 2009; Ubl, 2010, using the complaints rate to measure quality of insurance products like auto insurance and life insurance.

¹¹Financial Conduct Authority, 2018; California Department of Insurance, 2018, publish the complaints rate data at regular intervals.

¹²All the 17 insurance ombudsman offices were found to be vacant in 2018, with over 9,000 complaints pending. See, Pradhan, 2018; DNA Correspondent, 2018.

consumers and are not bound by formal rules of procedure. There are organised into three tiers (district, state and national) depending on the amount in dispute.

IGMS is an online complaints reporting system maintained by IRDAI. Persons whose complaints have not been addressed by the insurance company for 15 days can directly register their complaints with IRDAI under this system. The regulator then follows up with the insurance company to resolve the complaint.

To calculate the complaints rate in Indian health insurance we estimate complaints in each of these three systems of redressing consumer complaints. As per our estimation process for the years 2013-14, 2014-15 and 2015-16, the complaints rate for India was 501.23, 407.17 and 360.72 respectively (See Table 8). For a detailed process of how we estimate health insurance complaints in India, please see Appendix A.

4.2 Comparing complaints rate

Is this incidence of health insurance complaints cause for concern? In order to check whether India really has a complaints problem, we compared the complaints rate in India against Canada, Australia, United Kingdom and California. These countries were chosen as they have a similar *common law* legal system, like India. Table 8 gives the complaints rate in Canada, Australia, UK, California and India, for the years 2013-14, 2014-15 and 2015-16. Our results show that the Indian health insurance complaints rate is the largest when compared with the four other jurisdictions, but not significantly different from the value seen in California. For a detailed description of how we arrived at the complaints rate in Australia, California, Canada and the United Kingdom, please see Appendix B.

A direct comparison of the complaints rate (as shown in Table 8) understates the problem of health insurance in India. In other jurisdictions, due to higher literacy, lower poverty and better legal systems, it is much easier to file complaints. India's legal systems, including the consumer forums are not easy to access.¹³ As dispute resolution is expensive, time-consuming and difficult, India is not as litigious a country as other jurisdictions. Therefore, we adjusted the numbers to compensate for this, by using the litigation rate. The litigation rate is defined as civil suits filed in a year per hundred-thousand residents of the country.

$$\textit{Litigation rate} = \frac{\textit{Civil suits filed in a year}}{\textit{Hundred thousand persons covered}}$$

¹³See, Chemin, 2009, measuring the impact of the speed of Indian judiciaries on economic activity.

Table 8 Complaints rate in different countries

India has the highest complaints rate when compared with other common law jurisdictions like Canada, Australia, UK and California (USA).

Country	2013-14	2014-15	2015-16
Canada	14.48	14.28	11.53
Australia	143.41	174.55	178.51
UK	490.15	396.09	337.54
California	464.43	436.62	351.19
India	501.23	407.17	360.72

Source: Authors' calculation

Ramseyer and Rasmusen, 2010, have calculated the litigation rate per 100,000 people for Australia, Canada, U.K. and the U.S, for the year 2010. For India, there was no such study. However, Eisenberg, Kalantry, and Robinson, 2013, estimate civil suit filings in India, by averaging the filings from 2005-2010. Adjusting for population, this translates into an estimated litigation rate for India of 346 per 100,000 people. Table 9 adjusts the complaints rate in health insurance with the litigation rate in India. The final column shows what would be the complaints rate in India, if India had the same litigation rate as these jurisdictions. Our results show that, if adjusted for the low levels of litigation in the Indian society, the complaints rate of India is orders of magnitude higher than other jurisdictions. This indicates systemic failure in the regulation of health insurance policies.

These high rates of complaints is still an understatement of the problems with the health insurance industry in India. Health insurance in India only covers hospitalisation. In contrast, insurance in all the other jurisdictions covers hospitalisation, clinical visits, medication and some wellness care. Therefore, Indian consumers invoke health insurance only a fraction of the number of times health insurance is used in the other jurisdictions. We have no method for adjusting for this lesser use of health insurance. However, it is reasonable to imagine that increased contact between the insured and the insurer in other jurisdictions, creates more chances of complaints. Consequently, if such comprehensive health insurance was available in India, the Indian health insurance complaints rate would be even higher.

Table 9 Adjusting complaints rate by litigation rate

If adjusted for general levels of litigation, India's complaints rate is orders of magnitude higher than other common law jurisdictions.

(1)	(2)	(3)	(4)	(5)
Country	Litigation rate	Percentage*	Complaints rate (2015-16)	India's complaints rate (Adjusted)
		$[\frac{346}{(2)}]\%$		$[\frac{360.72}{(3)}]\%$
India	346	–	360.72	–
Australia	1542	22.44	178.51	1607.48
Canada	1450	23.86	11.53	1511.81
UK	3681	9.40	337.54	3837.44
California**	5806	5.96	351.19	6052.34

* Percentage is of India as compared to other nations.

** We assume that the litigation rate for California is the same as USA.

Source: Authors' calculation

This high rate of complaints should be a concern for the health insurance industry. For a limited product, India’s health insurance seems to be much worse than the other jurisdictions. This raises the question: What is the reason for this poor quality? In the next section, we explore some of the regulatory and legal failures which may be the cause of this.

5 Typology of issues

What causes this high rate of consumer complaints in health insurance in India? As part of our research, we read more than 130 judicial orders on health insurance disputes. They were spread across different judicial forums like consumer courts, ombudsman and the regular civil courts (High Courts and Supreme Court). One common thread which stands out from a reading of these orders is the absence of complexity in the disputes. Most disputes were squarely covered within the contract and the insurance company did not have legitimate grounds to reject the claims. We found very few cases where the insurance company was able to defend its decisions. In some cases, the insurance company did not even contest the claim in the judicial forum and lost in default judgements.

Three cases are illustrative of the type of problems that that lead to disputes between insurers and consumers in health insurance:

Virender Dhiman’s Case Virender Dhiman’s mother was hospitalised due to a fall. The insurance company rejected Mr. Dhiman’s claim on the ground that Mr. Dhiman’s mother did not need hospitalisation. This was in spite of the fact that the insurer-approved hospital had certified that she needed hospital care. In the consumer court (where the claim was litigated), the insurer did not even appear to defend its rejection. See Appendix C for details.

Suman Kapoor’s Case The insurer rejected the hospitalisation costs of an organ donor, in a liver transplant operation, on the ground that the insurance covers costs of the recipient and not the donor. The consumer court found that the policy had a clause which *explicitly* stated that donors in organ transplant cases were covered under the policy. See Appendix D for details.

Shashi Khanna’s Case This cases involves *porting*: a process by which the insured could change their insurer. Shashi Khanna had *ported* his insurance and then made a claim. The insurer rejected the claim on the ground that he had not disclosed a pre-existing medical condition. However, the previous claim had been made under Mr. Khanna’s previous insurer (before porting). The court held that the insurer had the opportunity to get all previous claim data from the previous insurer, when

porting, but did not do so. The insured had made all disclosures to the previous insurer and did not know he had to do it all over again, when porting. See Appendix E for details.

We find that these failures can be broadly classified into three failures in the legal/regulatory system for insurance in India: (i) gaps in the regulations made by the insurance regulator, especially regulations governing consumer protection, (ii) poor enforcement of existing regulations which does not act as effective deterrence to insurers; and (iii) the design of the insurance ombudsman, which suffers from conflicts of interest and institutional support.

5.1 Gaps in regulations

A reading of disputes in the health insurance sector in India indicates lack of regulatory oversight. Health insurance consumers often complain about rejection of legitimate claims by insurance companies, lack of information about network hospitals, use of technical terms, and difference between the advertised product and the actual product. Many of these complaints can be traced back to deficiencies in the existing regulations. These regulations are not clear on the information that insurance companies must disclose to its consumers, the manner in which it must be disclosed, and a clear procedure for settlement of claims.

We find that insurance companies often reject legitimate claims only to lose in dispute resolution mechanisms, like the ombudsman and the consumer fora. For example, in the case of Virender Dhiman, the insurance company rejected his claim on the ground that his mother did not need hospitalisation, in spite of documentary evidence to the contrary (See Appendix C). In the case of Suman Kapoor, the insurance company completely ignored the fact that his policy did insure organ donations (See Appendix D). In the case of Shashi Khanna, the insurance company invoked the *pre-existing diseases* clause, violating the porting provision under the existing regulations (See Appendix E).

The insurance ombudsman (in its annual reports) has repeatedly stated that insurance companies often reject claims without any reasoning and do not re-examine complaints against such rejection. This behaviour flows from the text of existing regulations which do not lay down the procedure for settlement of claims or the redress of consumer grievances against rejection of claims. Regulation 27 of the *IDRAI, Health Insurance Regulations, 2016*, only lays down the time period within which a claim should be settled and the manner in which claim documents should be submitted. The detailed procedure for settlement is left to the discretion of the insurance company. Similarly, Regulation 17 of the *IRDAI (Protection of Policyholders' Inter-*

ests) Regulations, requires every insurance company to develop its own procedure to redress consumer grievances.

Consequently, health insurance disputes are not settled in accordance with the law but in an ad-hoc manner. As an example of how this can be done, the UK Financial Conduct Authority (FCA) mandates a wide range of financial service providers (including insurance companies) to establish, implement and maintain effective and transparent procedures for the reasonable and prompt handling of complaints. It mandates financial service providers to *investigate* complaints competently, diligently and impartially; *assess* the complaints fairly, consistently and promptly; *offer* redress where appropriate; *explain* to the consumer its assessment, decision and proposed redress; and *comply* with the proposed redress accepted by the complainant.¹⁴

Another common grievance of health insurance consumers is that insurance companies leave out crucial information from the policy document. For example, insurance companies enter into agreements with different hospitals to provide cash less facilities to its policy holders. These hospitals are called network hospitals. Policy holders are often unaware of the identities of network hospitals, the rates applicable in network hospitals and rates applicable in hospitals outside the network. Since policy holders are not aware of this information, they incur out of pocket expenditure by going to hospitals outside the network. The insurance ombudsman (in its annual reports) also found cases where the network hospitals charged policy holders more than the rates agreed with insurance companies. Many times, insurance companies simply deny cash less medical facility without any reasoning, as in the cases of Virender Dhiman (See Appendix C) and Shashi Khanna (See Appendix E). However, the existing regulations do not require insurance companies to disclose this information in the policy document. Regulation 29(ii) of the *IDRAI, Health Insurance Regulations, 2016*, only mandates insurance companies to display product-wise cashless services on its website.

This provision is insufficient for three reasons: (i) it does not obligate insurance companies to ensure that this information reaches its policy holders, (ii) it does not specify the particulars of the information that insurance companies must disclose, and (iii) it does not obligate insurance companies to inform policy holders of any change in the information. To help think about how this can be done, Section 1013D of Australia's *Corporations Act*, mandates financial service providers to disclose, in its *Product Disclosure Statement*, any significant benefits of a financial product or service, the circumstances under and the ways in which those benefits maybe provided. In UK, Regulation 4.5.2 of the Conduct of Business Source book of the

¹⁴Regulation 1.4, Dispute Resolution Source book, FCA, 2017, lays out the procedure for dispute resolution by financial service providers.

Financial Conduct Authority Handbook, requires financial service providers to ensure that information given to consumers does not disguise, diminish or obscure important items, statement or warnings.

Technical terms used in health insurance policies are also a source of disputes. They are often vague or undefined. In disputes, the insurer tries to take advantage of the vagueness to deny claims. For example, ‘pre-existing diseases’, ‘active line of treatment’, ‘enhancement of sum insured’, ‘reasonable and customary charges’ and ‘proportionate clause’ are terms that are used, but have not been defined adequately in this field. Regulation 20 of the *IDRAI, Health Insurance Regulations, 2016*, states that phrases and terms used in health insurance policies shall carry the same meaning as IRDAI may specify through guidelines. The latest guidelines, *Guidelines on Standardisation in Health Insurance*, are incomplete, in so far as they only define few technical terms, like ‘pre-existing diseases’ and ‘reasonable and customary charges’.

This regulation is insufficient because it does not obligate insurance companies to ensure that policy holders understand the language used in the policy. In contrast, in South Africa, consumers have a right to information in plain and understandable language.¹⁵ It is unconscionable conduct for a financial service provider to knowingly take advantage of the inability of the consumers to understand the language of an agreement. Similarly, the UK prohibits unfair commercial practices.¹⁶ This includes misleading actions and omissions, as well as aggressive commercial practices. Misleading omissions is defined to include practices that fail to identify its commercial intent, unless this is already apparent from the context.

5.2 Poor enforcement of regulations

The failure of insurers to settle claims which are later proved to be legitimate indicates a lack of consequences for rejecting valid claims. There are no penalties embedded in the existing regulations for rejecting valid claims even when the rejections are in violation of the regulations. In the field of health insurance, insurance companies seem to violate regulatory requirements repeatedly without any repercussions.

For example, Regulation 33(d)(iv) of the *IDRAI, Health Insurance Regulations, 2016*, mandates insurance companies to communicate rejection or repudiations of claims to the policy holders. Regulation 33(c)(i) prohibits insurance companies from engaging agents for the purpose of rejection of claims of policy holders. In practice, it is the agents of insurance companies who decide whether to accept or reject a claim.

¹⁵Section 22, South Africa, 2009, codifies the right to information in plain and understandable language for consumers.

¹⁶Regulations 3 and 6 United Kingdom, 2008, prohibit unfair trade practices.

The agents communicate the decision to the policy holder as well. For instance, in the cases of Virender Dhiman (See Appendix C) and Suman Kapoor (See Appendix D), it was the agent of the insurance company which rejected their claims. The insurance ombudsman (in its annual reports) has observed that insurance companies often deny any knowledge of the decision taken by the agent. However, neither insurance companies nor its agents have been penalised by IRDAI for violating the law.

In multiple cases, after more than a year of dispute resolution processes, the insurer is required to pay for the insured amount and small values for litigation costs and harassment damages. Usually the costs imposed are even below the time value of the claimed amount. For example, in the cases of Virender Dhiman (See Appendix C), while the claim amount rejected was ₹ 80,461, the insurer was fined ₹ 5,000 only. In such situations, it is *rational* for the insurer to dispute the claim and then delay payments. Even after losing the dispute, the insurer comes off better than before. Rejection of legitimate claims furthers the surplus of insurance companies.

5.3 Design of insurance ombudsman

The rule of law requires that a system for adjudication must be fair, independent and impartial. The law which establishes the insurance ombudsman violates the basic principle of rule of law, i.e. it is not an independent and impartial body, but is led by the insurance industry.

This is apparent from three infirmities in the law. *First*, the Executive Council of Insurers (ECI) administers and supervises the office of the insurance ombudsman. The ECI consists of nine members, out of which seven members are representatives of insurance companies. The remaining two are representatives from IRDAI and the central government.¹⁷ *Second*, the ECI plays a crucial role in the appointment of the insurance ombudsman. Till recently, the Governing Body of Insurance Council (GBIC), precursor to the ECI, was responsible for the appointment of the insurance ombudsman.¹⁸ In 2017, the law was modified to provide for the appointment of the insurance ombudsman through a Selection Committee. However, the ECI enjoys widespread powers in the process. It determines the selection criteria (with approval from the central government), administers the application process, short lists eligible candidates for the Selection Committee and includes representatives on the Selection Committee.¹⁹ *Third*, offices of the insurance ombudsman are funded by the insurance

¹⁷See Rule 5, Government of India, 2017b, which lays out the composition of the ECI.

¹⁸See Rule 6, Government of India, 1998, which constituted the GBIC.

¹⁹Three out of four members on the Selection Committee are members of the ECI. See Rule 7,

industry. The budgeted expenses of the insurance ombudsman, including the salary and allowances of its staff, is borne by the Life Insurance Council and the General Insurance Council.²⁰

Insurance companies should have no role in the selection and administration of the insurance ombudsman. This is because insurance companies are interested parties in disputes with the insured. An industry-led insurance ombudsman implies that insurance companies act as judges in their own cause; it violates the principle of *nemo iudex in re sua*. For example, the financial ombudsman in the UK does not include any financial service provider, including insurance companies, on its board.²¹ Further, members of the board must be independent from the regulator, and the board must ensure that the panel of ombudsmen includes independent persons.²²

Apart from the problem of independence, the insurance ombudsman also suffers from poor capacity. There are only 17 ombudsman offices for the entire country. In March, 2018, all offices of the insurance ombudsman were vacant.²³ Some of these offices were vacant for 2-3 years in 2017 resulting in a large backlog of cases.²⁴ For example, the position of the insurance ombudsman in Mumbai was vacant for 2 years, between 2016 and 2018.²⁵ It is not possible to complain online to the ombudsman; all complaints have to be written, no complaints by phone are allowed. This imposes substantial costs on the insured, especially in a country like India.

These three reasons, including gaps in the existing regulations, poor enforcement of regulations, and failures in the design of the insurance ombudsman, are not exhaustive. There may be other reasons for the problems of the health insurance industry. However, multiple disputes studied by us, including the ones shown here, show them to be the most common. These issues are also easily solvable. India already has a dedicated insurance regulator: the IRDAI, which has been empowered to make regulations governing insurance companies. However, in our opinion, these regulations require sound understanding of consumer protection and a systematic approach to regulation. In the next section, we propose a systematic way of making

Government of India, 2017b.

²⁰See Rule 12, Government of India, 2017b, which creates provisions for the offices of the ECI and the insurance ombudsman.

²¹See, Financial Ombudsman Service, 2017, for the composition of the financial ombudsman in the UK..

²²See Cls. 3(3) and 4(2), Part II, Sch. 17, United Kingdom, 2000.

²³See, Executive Council of Insurers, 2018, for a list of the ombudsman offices and officers currently appointed.

²⁴Saraswathy, 2017, notes that only 7 of the 17 ombudsman office were filled up in August 2017.

²⁵Moneylife Digital Team, 2017, notes that Mumbai gets three to four times the average complaints, and vacancies lead to piling up of cases.

consumer protection regulations which may resolve these issues.

6 Strategy for reform

Since 2002, there have been concerns about consumer protection in the insurance market (Mahal, 2002). While there is some literature describing various redress mechanisms available to insurance consumers, it does not evaluate the processes for redress (Jothi and Gupta, 2012; and Yadav and Mohania, 2014).

In the recent past, concerns related to consumer protection have been highlighted in relation to unit linked insurance policies. Halan, Sane, and Thomas, 2014, estimated the loss to consumers due to mis-selling of unit linked insurance policies to be between ₹ 1.55 and ₹ 1.62 trillion between 2004-05 and 2011-12. A mystery shopping exercise by Halan and Sane, 2016, showed that bank managers, even when asked to advise on a tax-saving investment scheme, try to steer away the customers from savings products to insurance products with the lowest returns.

Other literature on consumer protection has largely focussed on comparing the efficiency of internal grievance redress mechanisms of private and public insurance companies in India (Ibrahim and Rehman, 2012; Bawa and Kaur, 2014; Raman and Uma, 2015; and Rajpurohit and Nawal, 2016). However, to our knowledge, the overall industry has not been studied.

The Financial Sector Legislative Reforms Commission, provides insights into the approach to consumer protection for financial services. The Commission was setup on 24th March 2011, to review the legal and institutional structures of the financial sector in India. One of the areas the Commission focussed on was consumer protection. The work of the Commission culminated into a two volume report: a report on “Analysis and Recommendations”²⁶ and the “Draft Financial Code”,²⁷ a model law for the regulation of the financial sector. Part VII of the *Code*, contains provision on consumer protection, encompassing both preventive and curative measures. This provides an intellectual framework through which the problems of regulation of health insurance can be understood and solved. In coming years, the implementation of this reform strategy will have important implications for health insurance.

The IRDAI recognised the need for specialised health insurance regulation in 2013.²⁸ Even the legislature has given separate recognition to health insurance as

²⁶Financial Sector Legislative Reforms Commission, 2013, contains the recommendations of the Commission to reform the governance of the financial sector in India.

²⁷Financial Sector Legislative Reforms Commission, 2015, is the draft law proposed by the Commission based on its recommendations.

²⁸The IRDAI brought out the first *Health Insurance Regulations* in 2013.

a business.²⁹ Consequently, the regulatory framework for health insurance was overhauled in 2016.³⁰ These regulations were in addition to the rights and protections of consumers under the *IRDAI (Protection of Policyholders' Interests) Regulations*.

However, in spite of these legal changes, our analysis shows that the quality of health insurance services in India is poor. We argue that this is because the changes in regulations have not been driven by a strong understanding of consumer protection principles.

6.1 The consumer protection cycle

Health insurance is a financial service and suffers from the common problems of all financial services like information asymmetry, and difference in the bargaining powers of consumers and financial service providers.³¹ This justifies the need for a higher standard of protection of financial consumers.³²

In the field of finance, solving the problem of consumer protection involves a two-pronged approach: *prevention* and *cure*. Prevention entails certain rights to the consumers to promote their interests. This includes protection against unfair terms, protection against unfair conduct, protection of personal information and requirement of fair disclosures. It also imposes a fiduciary duty on the financial service provider to act with professional diligence. Cure entails the creation of an independent redress agency where consumers can seek redress, through mediation and adjudication. In extreme cases, there may be need for punishments like fines, bans, etc.³³

Any regulatory framework which seeks to protect consumers should contain both these approaches. The regulatory cycle for consumer protection begins with the regulator identifying the broad principles of consumer protection required for a financial service, like the *right to information*, the right to appropriate advice and the right to a strong redress system. This general principle may need some tailoring for specific financial services. For example, in securities regulation information about the entity issuing the security is important. In health insurance, information about the

²⁹Section 3(iii), Government of India, 2015, defined “health insurance business” as 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.

³⁰The IRDAI came out with new regulations. See, IRDAI, 2016d.

³¹For the reasons for financial regulation, see generally Goodhart et al., 2013.

³²See Chapter V, Financial Sector Legislative Reforms Commission, 2013, for the rationale behind higher degree of consumer protection for financial services.

³³See, Cohen, 1975, examining the federal remedies imposed for fraudulent and deceptive practices in USA.

hospitals where the insurance is accepted is critical. On the basis of the identified principles, the regulator will frame regulations.

Information/prevention is usually not enough and redress mechanisms are needed in all financial regulation. In case of any consumer dispute, the redress agency of the regulator (ombudsman) should be the preferred option of resolution for consumers. It should be convenient and cost-effective for consumers to approach it. At regular intervals (yearly) the redress agency should make statistical reports about the nature of complaints filed before it. The regulator should analyse these reports to determine whether disputes are arising because of minor technical issues or persistent and large scale failures to protect consumers. If the disputes are arising because of technical issues, then the regulator should make minor changes in the regulations. But if the disputes are persistent, then the regulator is required to go back to the drawing board and attempt to find missing principles of consumer protection which may require rewriting of regulations on consumer protections for the industry/product.³⁴ Figure 2 is a representation of this cycle.

6.2 Gaps in regulations

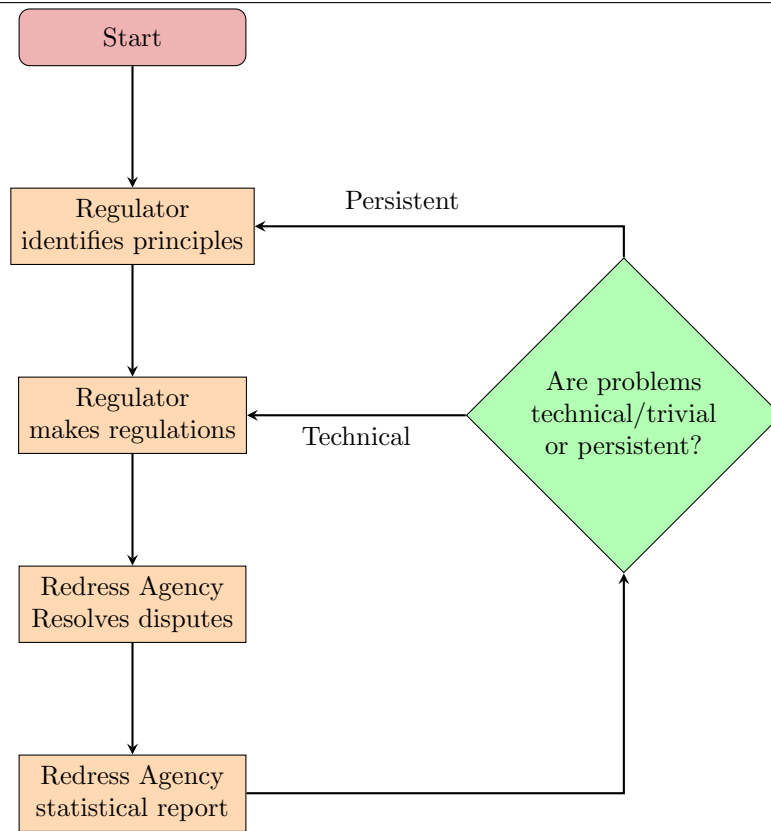
The three deficiencies in the existing regulations we identified (arbitrary rejection of claims, lack of information about network hospitals, and use of technical terms) could have been mitigated in the presence of adequate protections in the regulations.

To mitigate the problem of arbitrary rejections, the regulator should specify the procedure for the settlement of claims and resolution of complaints made to the insurer. Section 119 of the *Code*, mandates the regulator to specify the process to be followed by a financial service provider to receive and redress complaints. These processes should be embedded in the *rule of law*. As an example, Section 119 of the *Code*, requires the regulator to specify the manner in which a complaint should be made, the process to be followed to receive and redress complaints, as well as the time limits for each step of the process. These provisions impose an obligation on the regulator to devise processes that ensure redressal in a prompt and fair manner.

Awareness about network hospitals is essential to exercise the benefit of cash less services under a health insurance contract. It is not sufficient to mandate insurers to explain “product-wise cash less services” on its website. An insurer should be obligated to disclose this information in the policy document. Section 112 of the *Code*, obligates financial service providers to disclose information which is reason-

³⁴See Chapter V, Financial Sector Legislative Reforms Commission, 2013, for broad principles of designing a consumer redress system with a feedback loop to the financial regulation making process.

Figure 2 Consumer Protection Cycle



ably required by a consumer to make an informed transactional decision. For health insurance, the regulator should specify the information that must be disclosed, including the list of network hospitals, the rates applicable in the network hospitals and the rates applicable in hospitals outside the network. Section 113 of the *Code*, requires financial service providers to disclose any material change to such information. It follows that the insurer should be obligated to also disclose any change in the list of network hospitals to the insured immediately. In case of failure to make disclosures, the *Code*, penalises the insurer.³⁵

Use of technical terms, which the insured are unable to understand, is patently unfair. Insurers should have the right to protection against *unfair terms*. Under Section 109 of the *Code*, unfair terms in a non-negotiated financial contract, like insurance contracts, are treated as void *ab initio*. This includes terms that are not expressed in reasonably plain language that is likely to be understood by the consumer; is not legible and presented clearly; and is not readily available to the consumer affected by the provision.³⁶

6.3 Enforcement of regulations

It is not sufficient to grant rights to consumers, without adequate capacity to enforce those rights against insurers. We pinpointed two examples of poor enforcement: rejection of claims by the agents of insurers and inadequate penalties for violation of contract terms by the insurer.

The existing regulations explicitly provide that the decision to reject claims should not be with the insurance agents and it should be communicated directly by the insurer. Yet, insurance agents continue to reject and communicate the decision to the insured. Under Section 125 of the *Code*, all financial service providers are held liable for any act or omission of its representatives. Such a provision will preclude the insurer from arguing that the decision to reject claims was taken by the agent, and not the insurer.

In case of any violation, insurers are asked to pay nominal litigation costs and harassment damages as compensation to the insured. The fact that these violations are persistent, shows that the penalties do not act as a deterrence to the insurer. To act as a deterrence, there is a need to ensure that the violator pays a fine higher than the gain made through the violation. Therefore, the penalty should be a multiple of the illegitimate gain from the violation. Section 96 of the *Code*, envisages that the regulator should impose penalties based on the nature and seriousness of the

³⁵See Section 151(2)(b), Financial Sector Legislative Reforms Commission, 2015.

³⁶See Section 109(3)(b), Financial Sector Legislative Reforms Commission, 2015.

violation, the consequences and impact of the violation, the conduct of the person upon the discovery of violation and repetitive nature of the violation.

6.4 Design of the redress agency

In addition to prevention, the consumer protection framework should facilitate resolution of complaints. This entails the creation of an independent redress agency where consumers are able to submit complaints, through mediation and adjudication. We identified two problems in the design of the insurance ombudsman, lack of independence and persistent vacancies.

To ensure prompt and fair handling of complaints, the insurance ombudsman must be independent. Presently, the appointment and administration of the ombudsman is controlled by the ECI, which is dominated by members of the insurance industry. To the contrary, Section 17 and Schedule I of the *Code*, provide a clear process for the appointment of financial sector regulators, independent of the finance industry. Under these provisions, all appointments are made by the Central Government, from amongst a pool of candidates short-listed by a Selection Committee. The Selection Committee is appointed by the Central Government, and does not include any representation from the finance industry. The process for short-listing candidates by the Selection Committee is provided under the law. In addition to the process, Section 17 of the *Code*, lays down factors that the Selection Committee must consider for short-listing candidates. These include merit of the person and ability to exercise independent judgement in the discharge of duties. The Selection Committee must ensure there is no conflict of interest and maintain proportionate representation of different skills.

The problem of vacancies can be addressed through the use of technology. This will also improve access to redress for insurance consumers all over India. The ombudsman should have the ability to carry out video hearings, digital handling of complaints, telephonic/online registration of complaints and maintain online tracking of compensation payments. Under Section 137 of the *Code*, the Financial Redress Agency (equivalent of the insurance ombudsman) must make use of technology to improve access to the Redress Agency and enable discharge of its functions in an efficient manner. In addition to this, Section 3 of the *Code*, empowers all financial regulators, including the Financial Redress Agency, to open offices in any part of the country.

7 Conclusion

India has very limited health insurance plans, which most consumers can buy. It only covers hospitalisation. However, since liberalisation of the insurance sector, health insurance premiums have become a substantial part of the Indian health expenditure. Private persons are buying health insurance, and governments are building state-funded health insurance programs which use the services of private health insurance companies, on a large scale. This merits a study of the *quality* of health insurance provided in India.

The literature has concentrated on tracking the growth and the benefits of financial services on households. However, such literature assumes that financial products and firms behave the same way they do in other jurisdictions. In our paper, we question this assumption by testing the quality of one type of insurance product, health insurance policies. We find that the quality of health insurance products, when measured in terms of complaints generated, are substantially inferior to other jurisdictions with similar legal systems. It may be the case that with such poor levels of *consumer protection*, households which purchase basic financial products, like health insurance, are worse off than households which do not.

We also explore some of the reasons for the such poor quality of insurance products: regulatory failure. The failures can be traced to gaps in regulation drafted by the regulator, poor enforcement of regulations and failures in the design of the redress mechanism. This creates incentives for insurers to reject valid claims. We propose changes which may reduce such behaviour of insurance companies. This includes a feedback loop system between the regulator and grievance redress agencies to continually improve existing regulations and identify areas which require new regulations.

There is a need for collaborative work between health policy thinkers and financial sector policy thinkers in addressing these problems, as the concerns of health policy and the concerns of financial sector policy point in the same direction. The Financial Sector Legislative Reforms Commission, has substantial insights into these problems and the solutions proposed there would help considerably. These solutions can be implemented in part under the under present laws, through the rewriting of regulations. However, a clearer approach to regulation of financial services, including health insurance, require changes in the foundational legislation governing finance in India.

Appendices

A Health insurance complaints in India

We calculated the total number of health insurance consumer complaints from the three sources of redress, i.e. consumer courts, IGMS and the insurance ombudsman, in the following manner:

A.1 Consumer courts

Consumer courts do not publish statistics of health insurance cases. However, the consumer courts websites aggregate statistics and individual orders in consumer disputes. The aggregate statistics released include the total number of consumer complaints in different sectors, like insurance, banking, real-estate and consumer goods. However, insurance is not divided into types of insurance like life, general, health. In order to estimate the number of health insurance complaints, we resorted to a sampling strategy as follows.

We downloaded *all* the decisions of two district consumer forums (Central and South Mumbai) for a period of ten months.³⁷ This gave us 279 decisions of these two forums for the said time period.³⁸ We then read each decision to determine if it was an insurance case or not. Insurance cases were further analysed to identify if they were about health insurance.

We found 117 orders to be insurance decisions. Of the 117 insurance decisions of the consumer forums, 37 (31.62%) were about health insurance products. We were able to determine that 30 decisions did not deal with health insurance. However, for the rest 50 decisions we were unable to positively identify whether the dispute was about a health insurance product or not. To be conservative, we assumed these cases to be not related to health insurance.³⁹

We used the percentage derived from the two consumer forums (31.62%) to estimate the total health insurance cases in district consumer forums of India. We

³⁷The decisions are from the period 30 May, 2013 to 29 March, 2014. Available at NCDRC, 2017.

³⁸393 orders were passed during this period by these two forums, however, 279 orders were available for download.

³⁹In many decisions, the parties would have reached a compromise and the courts just recorded that the parties had settled the matter. This did not provide us with adequate information to determine the nature of the insurance dispute. However, since the name of the litigants is identified in the order, and all insurance companies are registered with the insurance regulator, we were able to confidently separate insurance decisions from other decisions.

used the broad classification statistics of the National Consumer Disputes Redressal Commission (NCDRC) website, which identifies whether cases are insurance related or not. There are 620 districts and district forums in the country. Since districts are not homogeneous, we divided them into three categories, tier I (metros) with 30 districts, tier II (semi-urban districts) with 88 districts and tier III (rural districts/remainder) with 502 districts.⁴⁰ Next, we randomly selected four district forums out of tier II and four district forums out of tier III. For tier I, we looked at a sample of 21 forums out of 30 forums, for tier II we looked at a sample of 4 forums out of 88 forums and for tier III we looked at a sample of 4 forums out of 502 forums. We chose Mumbai, Delhi, Kolkata and Bangalore from tier I district list; Cuttak, Tiruchirappalli, Guntur and Aligarh from tier II district list and; Shimla, Azamgarh, Patiala and Wayanad from tier III district list. We used the data from *Computerization and Computer Networking of Consumer Forums in Country*, to find out the total number of insurance sector cases filed in the chosen district forums for the period 1 January, 2015 to 12 September, 2017.⁴¹ We summed the total number of insurance sector cases for each of the three categories of cities and divided the values by the respective number of district forums chosen for the analysis. This gave us the average number of consumer complaint cases related to the insurance sector in each category of cities. We used the average number of consumer complaints cases to calculate the total number of consumer complaints cases: 110,631.21. Assuming that 31.62% of the total number of insurance sector pertain to health insurance, the number of health insurance complaints works out to 34,981.58 over the two year and nine month period. Or, 12,721 health insurance cases per year (for all of India). Table 10 shows our calculation.

A.2 IGMS

For IGMS, we used three years of complaints statistics published by IRDAI to estimate the total number of insurance complaints filed using IGMS.⁴² IGMS aggregates complaints from two sources: (i) those made to the internal redress systems of the insurer and (ii) those made to the insurance regulator, IRDAI. For our analysis, we were interested in complaints made to IRDAI. Since there was no way to separate out the complaints in IGMS as internal and external, we assumed that 30% of the health

⁴⁰For tier classification, we used the same system by which house rent allowance is calculated for central government employees. This classification is based on population and urbanisation studies from the census. See Ministry of Finance, Government of India, 2015.

⁴¹Sector wise consumer complaint cases can be accessed from Government of India, 2017a.

⁴²See IRDAI, 2014; IRDAI, 2015; IRDAI, 2016a.

Table 10 Estimating health insurance cases in consumer forums

A substantial proportion of health insurance complainants depend on the general consumer protection law.

Tier	No. of district forums	Average insurance cases for tier*	Total insurance cases*	Total health insurance cases*
I	30	184.52	5535.71	1750.39
II	88	74.75	6578.00	2079.96
III	502	196.25	98517.50	31151.23
Total	620	–	110,631.21	34,981.58
Average annual health insurance cases filed in all district forums				12,721

* The period of calculation is from 1st January, 2015 to 12th September, 2017.
Source: NCDRC website

Table 11 Health insurance complaints filed before IGMS

Consumers file complaints to the insurance regulator, IRDAI, through IGMS.

Complaints	2013-14	2014-15	2015-16
	(in million)	(in million)	(in million)
Total	63,335.00	60,688.00	59,083.00
Health insurance (External and Internal)*	23,433.95	25488.96	26587.35
External* (30% of health insurance)	7030.18	7646.68	7976.20

* Complaints that are directly made to the regulator are termed *external*, while complaints that reach the regulator through insurance agency are *internal*.

Source: IRDAI Annual Report

insurance complaints were filed by the consumers to the regulator and not to the internal system of the insurers.⁴³ Table 11 is our estimation of external complaints on health insurance.

A.3 Insurance Ombudsman

We used the annual reports of GBIC as our source of information about health insurance complaints to the insurance ombudsman.⁴⁴ The insurance ombudsman's report do not segregate complaints based on topic. For the years 2013-14, 2014-15, and 2015-16, insurance complaints numbered 34,916, 31,101, and 32,959 respectively. We assumed that 31% of the total number of consumer complaints filed with the insurance ombudsman were related to disputes regarding health insurance products.⁴⁵ Table 12 gives the number of health insurance complaints filed before the insurance ombudsman using this calculation.

⁴³We use the same percentage as derived from the two district consumer forums, Central and South Mumbai.

⁴⁴See Governing Body of Insurance Council, 2014; Governing Body of Insurance Council, 2016a; Governing Body of Insurance Council, 2016b.

⁴⁵We used the same percentage as derived from two district consumer forums (Central and South Mumbai).

Table 12 Health insurance complaints filed before Ombudsman

Consumers file complaints to the insurance ombudsman, a specialised body to resolve consumer grievances in the insurance sector.

Complaints	2013-14 (in million)	2014-15 (in million)	2015-16 (in million)
Total	34,916	31,101	32,959
Health insurance (31% of total)	10823.96	9641.31	10217.29

Source: GBIC Annual Report

We estimate the total number of complaints adding up our estimates from each of the three routes. Table 13 gives the total number of consumer complaints and the corresponding coverage statistics are provided in Table 14.⁴⁶

B Health insurance complaints in other jurisdictions

We calculated the health insurance complaints rate in Australia, California, Canada and UK, in the following manner:

B.1 Australia

For Australia, we used the health insurance coverage statistics published by the Australian Prudential Regulatory Authority. In the year 2013-14, 2014-15 and 2015-16, 23.90 million, 24.43 million and 24.74 million persons were covered under health insurance, respectively. In the same years 3427, 4265 and 4416 health insurance complaints were filed before the insurance ombudsman, respectively.⁴⁷ We calculated the complaints rate in Australia for the year 2013-14, 2014-15 and 2015-16, which was 143.4, 174.5 and 178.5, respectively (See Table 8).

⁴⁶See IRDAI, 2016a, Pg. 47.

⁴⁷See Commonwealth Ombudsman, 2016.

Table 13 Health insurance complaints in India

Consumers are mostly approaching dispute redress mechanisms (consumer courts) outside the insurance regulatory framework.

Source	2013-14	2014-15	2015-16
IGMS	7030.18 (22.99%)	7646.68 (25.48%)	7976.20 (25.80%)
Insurance ombudsman	10823.96 (35.40%)	9641.31 (32.13%)	10217.29 (33.05%)
Consumer forums	12721.00 (41.61%)	12721.00 (42.39%)	12721.00 (41.15%)
Total	30575.14	30008.99	30914.49

The figures in brackets indicate the share of each source of complaint as a percent of the total consumer complaints.

Source: Authors' calculation

Table 14 People insured under private health insurance in India

The number of persons purchasing insurance is steadily rising.

Type	2013-14	2014-15	2015-16
	(in million)	(in million)	(in million)
Group health insurance	33.7	48.3	57.0
Individual health insurance	27.3	25.4	28.7
Total	61.0	73.7	85.7

Source: IRDAI Annual Report

B.2 California

For California, we used the health insurance coverage statistics published by the Henry J. Kaiser Family Foundation. In the year 2013-14, 2014-15 and 2015-16, 19.73 million, 20.48 million and 21.16 million persons were covered under health insurance, respectively. In the same years, 9165, 8943 and 7432 complaints were filed before California's insurance ombudsman, respectively.⁴⁸ We estimated the complaints rate in California for the year 2013-14, 2014-15 and 2015-16, which was 464, 437 and 351, respectively (See Table 8).

B.3 Canada

For Canada, we used the coverage statistics published by the Canadian Life and Health Insurance Association. In the year 2013-14, 2014-15 and 2015-16, 44 million, 44 million and 45 million persons were covered under health insurance, respectively. In the same years, 637, 628 and 519 health insurance complaints were filed, respectively.⁴⁹ We estimated the complaints rate in Canada for the year 2013-14, 2014-15 and 2015-16, which was 14.48, 14.28 and 11.53, respectively (See Table 8).

B.4 U.K.

For United Kingdom, we got coverage statistics from data published by the Organisation for Economic Co-operation and Development. For the year 2013-14, 2014-15 and 2015-16, 6.8 million, 6.9 million and 6.9 million persons were covered under health insurance, respectively. In the same years, 3333, 2733 and 2329 health insurance complaints were filed before the statutory financial ombudsman.⁵⁰ We estimated the complaints rate in United Kingdom for the year 2013-14, 2014-15 and 2015-16, which was 490.14, 396.08 and 337.54, respectively (See Table 8).

C Not appearing in court

Insurance companies seem to reject claims hoping that the insured will not approach dispute redress mechanisms. This is done in two steps. The first step involves rejecting the *cashless facility*. Even if the insurance covers cashless claims (the insurer

⁴⁸See California Department of Insurance, 2014; California Department of Insurance, 2015; California Department of Insurance, 2016.

⁴⁹See Ombudsman for Life and Health Insurance, 2016.

⁵⁰See Financial Ombudsman Service, 2016, Pg. 57.

directly paying the hospital), the insurer rejects the cashless facility. This forces the insured, in the midst of a medical emergency, to pay medical expenses out-of-pocket. After paying for the expenses, when the insured makes a claim, the claim is rejected.

The following is an example of such a dispute, where once challenged in the consumer forums, the insurer did not even appear before the court to dispute the claim.

Virender Dhiman purchased a health insurance policy for himself and his family. In June 2016, Virender's mother fell down and had to be hospitalised. The hospital charged Virender ₹ 80,461 for his mother's treatment. The cashless facility was not provided to Virender by the insurer. Consequently, Virender had to pay out-of-pocket. After his mother was discharged, Virender applied for reimbursement through his insurance agent. The insurer rejected the claim on the ground that hospitalisation was not necessary.

The proceedings, initiated by Virender, against the insurer in the Amritsar district consumer forum is an example of common behaviour of insurers in India. The consumer forum found that Virender had filed all requisite documents. This included a certificate, from the insurer approved hospital, that his mother needed hospitalisation. The consumer forum judge also noted that *the insurance company did not appear before the consumer forum*. It directed the insurer to repay the hospital bills and awarded ₹ 5000 only, as compensation and litigation fees.⁵¹

D Ignoring contract terms

India does not have protection against unfair terms written into its financial sector laws, including insurance. Insurers are free to exclude anything from health insurance. However, in many cases we see the insurer rejecting claims which are *explicitly covered* by the insurance contracts. The following is one example of such rejection:

In 2001, Suman Kapoor purchased a health insurance policy, which covered him, his wife and two sons. Since then, he renewed the policy without a break. In 2008, Suman was detected with end-stage liver disease due to Hepatitis-C. To save his life, Suman's son donated 50% of his liver, for which he was hospitalised. After discharge, Suman's son contacted

⁵¹Tribune News Service, 2017.

the agent of the insurance company for reimbursement of his hospitalisation expenses. The agent rejected the claim stating that the policy did not cover hospitalisation expenses of organ donors. Suman Kapoor, complained to the Delhi district consumer forum.

The judge found that the contract had a clause that *explicitly* entitled the organ donor, reimbursement of expenses incurred by him. The district forum ordered the insurance company to settle the claim, as well as pay compensation and litigation costs to Suman's son. The insurance company challenged the order of the district consumer forum before the state consumer commission, which upheld the order.⁵²

In the absence of a clause specifically covering the situation, there may have been an interesting legal conflict about organ donation. However, the insurance company had clearly thought of the situation and had drafted a clause explicitly covering it. Yet, it rejected the claim on the same ground.

E Commissions and porting

IRDAI has introduced a concept called *porting*. An insured person can change the insurer and continue with the benefits accrued related to pre-existing diseases and time bound exclusions, from the previous insurer. However, this has created incentives for agents to encourage customers to port frequently, as this creates commission income for them at each transaction. While porting is supposed to be seamless, it seems that insurers have not developed systems to communicate with each other. This imposes difficulties upon customers. The following example highlights the consequence of lack of communication between insurers and the incentive to port policies:

In 2001, Shashi Khanna purchased a health insurance policy from insurance company A. Since then, he renewed the policy without a break. In 2010, Shashi was treated for an autoimmune disease, *sacroïdosis*, for which he was reimbursed by insurance company A. In 2012, Shashi ported from insurance company A to insurance company B, on the assurance that he will not lose any renewal benefits related to *pre-existing* diseases and time bound exclusions.

In 2013, Shashi was hospitalised due to a fungal disease, *cryptococcal meningitis*. The hospital charged him ₹ 2,51,251. Shashi informed insur-

⁵²Gail, 2017.

ance company B about his hospitalisation, which denied cash less medical treatment facility and Shashi had to pay out-of-pocket. Thereafter, Shashi contacted insurance company B for reimbursement of his hospitalisation expenses. Insurance company B rejected the claim and cancelled his policy on the ground that Shashi did not disclose his previous medical condition, *sarcoidosis*. However, *cryptococcal meningitis* and *sarcoidosis* are not related to each other. Exposure to one, does not increase the probability of exposure to the other.

Shashi filed a complaint against insurance company B, before the Jalandhar district consumer forum. The district consumer forum held that insurance company A cannot deny Shashi the sum insured under the preceding insurance policy with insurance company A, before he switched over to insurance company B. The order of the district consumer forum was upheld by the Punjab State Consumer Commission and NCDRC. The NCDRC found that insurance company B did not just reject the claim, but rendered Shashi's policy void *ab initio*. This defeated the purpose of porting a health insurance policy, i.e. to transfer the credit gained by a policy holder from one insurance company to the other. Moreover, insurance company B had the right to investigate for a period of 15 days, before accepting the offer for porting and issuing the policy to Shashi. Once the policy was issued, the insurance company B cannot deny Shashi's claim at least up to the sum insured under the preceding policy.⁵³

In 2016 the regulator banned commissions on porting.⁵⁴ However, with varying rates of commissions provided by insurance companies, and each yearly renewal constituting a new contract, there are still incentives for agents to port consumers from low commission products to high commission products. In light of no *fiduciary duty* rules, such transactions are perfectly legal and legitimate in India.

When porting is to take place, consumers are specifically told that their previous protections and privileges would continue. Since Shashi had made a claim on his 2010 *sarcoidosis* incidence, he presumed that the insurer had all the information about his previous claims and porting would not require him to disclose facts already on record with the insurer.

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⁵³National Consumer Disputes Redressal Commission, 2016.

⁵⁴See Cl. 15, Sch. I, IRDAI, 2016d.

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