EVALUATION OF THE OPERATIONAL EFFECTIVENESS OF THE GRIEVANCE REDRESSAL MECHANISM IN CARE HEALTH INSURANCE

Dissertation Submitted to

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Master of Business Administration (MBA)

in

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by

Rajnandini Chaturvedi

Under the Supervision and Guidance of

Dr. Deepti Sharma

2025

care HEALTH INSURANCE

BEST HEALTH INSURANCE COMPANY IN RURAL SECTOR | CLAIMS SERVICE LEADER OF THE YEAR
INDIA INSURANCE SUMMIT & AWARDS 2024

CERTIFICATE

This is to certify that **Rajnandini Chaturvedi,** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur, has successfully completed her internship at Care Health Insurance Ltd. during Mar 10 - May 31, 2025.

Place: Gurgaon
Date: 05/06/2025

Barkha

Dr Barkha Gupta
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CERTIFICATE

This is to certify that dissertation titled "**EVALUATION OF THE OPERATIONAL EFFECTIVENESS OF THE GRIEVANCE REDRESSAL MECHANISM IN A CARE HEALTH INSURANCE**" is a record of the research work undertaken by Dr.Rajnandini Chaturvedi in a partial fulfillment of the requirements for the award of the degree of **MBA (Hospital and Health Management)** from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific and analytical.

Faculty Guide: Dr. Deepti Sharma

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Date: 16.06.2025

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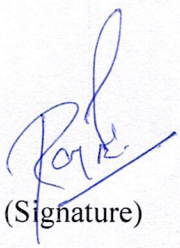
Date: 16.06.2025

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **Evaluation of the operational effectiveness of the grievance redressal mechanism in care health insurance** is the bona fide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



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ABSTRACT

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Title: . **EVALUATION OF THE OPERATIONAL EFFECTIVENESS OF THE GRIEVANCE REDRESSAL MECHANISM IN CARE HEALTH INSURANCE.**

Since the liberalisation of India's insurance industry in the year 2000, the sector has experienced significant growth, both in scale and impact. Insurance today plays a critical role in providing financial security and investment options to millions, functioning distinctly from traditional banking or capital markets. Among various insurance products, life and health insurance have become particularly vital in safeguarding families against financial shocks related to death, illness, or hospitalisation.

Life insurance, by its nature, involves long-term contractual commitments between the insurer and the insured. For such agreements to function effectively, there must be a strong foundation of trust, timely communication, and mutual responsibility. Similarly, in health insurance, the claims and benefit processes must be handled with utmost clarity, transparency, and fairness. In this context, **effective customer relationship management and accessible grievance redressal mechanisms** become essential components of a sustainable and trustworthy insurance ecosystem.

The Insurance Regulatory and Development Authority of India (IRDAI), as the sector's regulatory body, plays a crucial role in protecting policyholders' interests. It defines a grievance as any expression of dissatisfaction or request for corrective action related to an insurer's service, delay, or decision. Recognising the growing complexity of insurance products and the increasing volume of insured individuals, IRDAI has mandated every insurer to have a structured grievance management system in place—often with digital platforms and timelines for resolution.

This study evaluates the current state of grievance resolution processes in Indian insurance companies, with a particular emphasis on **health insurance**, which often involves time-sensitive and emotionally charged claims. A retrospective analysis was conducted of 30 grievance cases that escalated to legal notices, appeals before the Insurance Ombudsman, or proceedings in consumer courts. The findings revealed that a majority of the complaints stemmed from **discrepancies in medical records**, leading either to **rejection of claims** or **suspicions of fraudulent intent**.

These issues, while sometimes genuine, also highlight gaps in communication, documentation, and claim verification practices between insurers, hospitals, and policyholders. The outcome of the analysis underlines the importance of timely, fair, and well-documented grievance handling. Efficient resolution not only prevents legal escalations and reputational harm to insurers but also significantly improves **customer trust, loyalty, and overall service experience**.

In conclusion, as the Indian insurance landscape continues to evolve, ensuring **robust, transparent, and customer-friendly grievance redressal systems** will be pivotal. Health insurance, being directly tied to people's well-being, demands even greater sensitivity and responsiveness. By investing in better training, smarter technology, and empathetic communication, insurers can strengthen policyholder confidence and fulfil the promise of financial protection at the time it is needed most.

CONTENTS

List of Tables

Chapter 1 – Introduction

Since the liberalisation of the insurance sector in 2000, India's insurance industry has witnessed impressive and sustained growth. This expansion has been driven largely by increased market competition, resulting in the entry of numerous players and diversification of services. Despite the sector's already substantial size, it continues to grow at a robust rate of approximately 15–20% annually, reflecting its dynamic nature and increasing relevance in the broader economy. Today, together with banking, insurance contributes around 7% to the national GDP, underscoring its critical role in supporting economic development and financial stability.

Insurance plays a fundamental role in shielding individuals, families, and institutions from unexpected financial shocks. Beyond risk protection, it also offers structured savings and long-term financial planning tools—making it a distinct and essential component of the financial system, separate from banking and capital markets, which are primarily focused on returns through lending or investments.

At the core of the insurance system lies the life insurance contract—a long-term arrangement between the policyholder and the insurer. This contractual relationship requires consistent premium payments from the insured and a commitment from the insurer to settle valid claims as per agreed terms. However, claim procedures can sometimes be complex and intimidating for policyholders, particularly when there is a lack of clarity or timely communication from the insurer.

In this context, effective customer relationship management (CRM) has emerged as a strategic necessity for insurers. Strong CRM systems help in timely grievance acknowledgement, better service delivery, and improved customer engagement. A key part of this approach is having accessible, transparent grievance redressal mechanisms that allow customers to raise concerns and receive fair resolutions. In today's digital age, policyholders are increasingly turning to online platforms—including social media—to share feedback and report issues, making it imperative for insurers to adapt and respond proactively.

Recognizing the importance of policyholder protection, the Insurance Regulatory and Development Authority of India (IRDAI) was established in 1998. Since then, IRDAI has played a crucial role in strengthening the regulatory structure of the insurance industry, creating a balanced environment for both public and private entities to thrive. One of its major focus areas is ensuring effective grievance redressal. Through detailed guidelines and regulatory oversight, IRDAI has mandated that insurers maintain efficient complaint handling systems. Notably, it has also introduced the Insurance Ombudsman mechanism—a free, impartial platform aimed at resolving policyholder disputes fairly and efficiently.

Chapter 2- Aim and Objective

Aim: To evaluate the current grievance resolution processes implemented by an insurance company.

Objective of the Report

1. To evaluate the effectiveness and structure of the grievance resolution process implemented by the insurance company.

2. To analyse the company's rationale and decision-making process in handling grievance cases, focusing on the justification of claim rejections and the escalation outcomes.

3. To study representative grievance case studies to identify recurring issues, resolution pathways, and gaps in customer service delivery.

Chapter 3- Review of Literature

Cohen (1975) studied how federal systems address dishonest and misleading consumer practices. He outlined three main strategies for dealing with such issues—**prevention**, **restitution**, and **punishment**. While he recognized prevention as the most desirable public policy approach, he also pointed out that it may not always work effectively on its own. Cohen stressed the importance of penalizing severe violations and repeat offenders as a deterrent. He also suggested that **arbitration** could be a useful alternative method for compensating consumers and encouraged federal agencies to explore it further.

Sobti (2002) focused on patients' experiences with the Consumer Protection Act (CPA) of 1986, especially after the landmark **Indian Medical Association vs. V.P. Santha** case in 1995. That judgment brought medical services under the purview of the CPA, leading to a noticeable rise in complaints against healthcare providers. While some doctors initially feared that the law would lead to higher healthcare costs and more defensive medical practices, Sobti found that many patients felt a stronger sense of justice and accountability under the CPA's grievance system. The study highlighted how the CPA changed the relationship between doctors, patients, and the legal system.

In a separate study, Johary (2007) looked at how grievances are handled in the general insurance sector. He proposed that insurance-specific conflict resolution methods should be developed to better suit the industry's unique needs. His work focused on making the process more efficient and effective for resolving disputes.

Sinha and Kulkarni (2011), writing in *The Economic Times*, examined the role of the Insurance Regulatory and Development Authority (IRDA) in protecting policyholders. They acknowledged IRDA's efforts but emphasized that many policyholders still lacked clear understanding of the grievance redressal system. The authors called for greater transparency and easier access to complaint mechanisms to help build consumer trust in the industry.

Lastly, Jothi and Gupta (2012) discussed both internal and external grievance redressal systems in the Indian life insurance market. They argued that a clear and well-enforced grievance handling framework would not only protect consumers but also strengthen their trust in insurers. Their study emphasized the need for a strong complaint resolution system to ensure customer satisfaction and long-term credibility in the insurance sector.

Chapter 4 - Methodology

Study Instrument

This retrospective analysis utilised a range of official documentation, including legal notices, records of appeals made to the Insurance Ombudsman, case files from consumer court proceedings, and mediator reports. These materials were sourced from the archives of a health insurance provider.

Data Collection Procedure

The data collection process involved a systematic review of archived case files maintained by the health insurance company. Relevant documents were identified, retrieved, and examined to extract pertinent information about past grievance cases.

Exclusion Criteria

To maintain the focus and validity of the study, cases lacking significant factual or legal complexity were excluded. Only those cases presenting substantial challenges in terms of documentation, evidence, or legal interpretation were included, ensuring that the analysis remained robust and relevant to the study objectives.

Data Analysis Plan

The selected case files were carefully analysed to uncover recurring issues, common grievance types, and the procedural responses provided by the company. A qualitative thematic analysis approach was applied to categorise the data, allowing for the identification of core themes and insights into how effectively the grievance redressal mechanisms addressed consumer concerns. This approach also enabled the exploration of broader policy and practical implications.

Sample Size

The sample size was determined based on the number of cases available that met the inclusion criteria, ensuring a diverse and representative selection of consumer disputes. Care was taken to align the sample with the standards outlined in the Redress of Public Grievances Rules, 1998, capturing a wide range of concerns experienced by policyholders**.**

Chapter 5 - Results

To evaluate the grievance redressal process within a health insurance company, this study analyses 30 selected cases (From April 2024 to March 2025) involving conflicts between policyholders and the insurer. Each case is examined in detail to understand the reasons for claim denials and the outcomes determined by the Insurance Ombudsman, Consumer courts, or Mediation authorities

Table 1: Reasons for Rejection of Claims

Rejection Category	No. of Cases	Strategic Risk Classification	Representative Case Analysis
Material Non-Disclosure	4	Compliance Risk	Patients failed to disclose epilepsy and chronic conditions; prior policy history concealed, indicating poor underwriting scrutiny.
Documentation Irregularities	5	Operational Risk	Fever claims included forged pathology documents; the absence of physician authentication raised fraud flags.
Procedural Deficiencies	3	Process Gap	Emergency accident claim delayed due to missing radiology evidence; ultimately resolved via escalation and review.
Waiting Period Misapplication	6	Policy Interpretation Risk	Claims involving CAD, renal transplant, and hernia were misclassified under the pre-existing clause without medical causality validation.
Exclusion Misclassification	2	Legal Risk	Oral cancer claim linked to tobacco use denied without adequate causation evidence; the court later overturned the rejection.
Non-medically Justified Admissions	2	Medical Necessity Review	Fever and mild viral cases led to denial, citing a lack of clinical severity and absence of hospitalisation indications.
Suspected Fraud	3	Fraud Detection/Control	Multiple overlapping claims submitted by insurance agents for the same hospital stay with different insurers.
Ambiguous or Miscellaneous Cases	5	Escalation Risk	Disputes involving AYUSH prescriptions, mental health interpretations, or dual medical opinions created classification ambiguity.

Table 2: Reasons for Rejection in Legal Notices & Final Decisions

Dispute Origin	No. of Cases	Resolution Pathway	Strategic Commentary
Claim Rejection with Incomplete Evidence	3	Settled	Timely provision of radiology and admission evidence facilitated quick reversal without escalation to litigation.
Disputed Application of Waiting Period	2	Denied	Strict policy clause enforcement prevailed; however, documentation of emergency criteria could have influenced a different outcome.
Clinical Justification Debates	2	Awarded	In-depth adjudication revealed hospitalisation met clinical necessity; insurer's automated rejection overturned.
Delay in Internal Processing	1	Settled	Internal TAT violations exposed a weak operational workflow; resolution was achieved post-complaint escalation.
Pattern Recognition of Fraud	2	Denied	Claims flagged due to handwriting similarities and inconsistent hospitalisation records; firm stance by insurer upheld.

RESOLUTION JUSTIFICATION:-

Settled Cases

- Incomplete Evidence (3 cases):
  Extra documents (like X-rays or admission slips) helped resolve the claim without court.
- Internal Delay (1 case):
  Claim was paid after the policyholder raised a complaint about slow processing.

Denied Cases

- Waiting Period Dispute (2 cases):
  Claims rejected as treatment happened before the policy's eligible period.
- Fraud Suspicion (2 cases):
  Rejected due to fake/inconsistent records (like handwriting mismatch or false hospital papers).

Awarded Case

- Clinical Justification (2 cases):
  Court said treatment was truly needed; insurer's automated rejection was ove

Table 3: Reasons for Rejection in Cases of Consumer Court & Final Decision

Core Rejection Issue	No. of Cases	Clinical Basis of Dispute	Judicial Outcome	High-Level Case Insight
Non-Disclosure of Chronic Ailments	2	Epilepsy, Diabetes	In favour of the insurer, i.e. denied	Historical medical records invalidated the policyholder's claim due to underwriting misrepresentation.
Procedural Documentation Deficit	1	Accident Injury	Settled	Additional imaging documentation clarified the authenticity of the claim; settled to avoid prolonged litigation.
Medical Document Discrepancy	3	COVID-19, Psychiatric Hospitalisation	2 Awarded, 1 Settled	Consumer court emphasised contextual clinical judgement, not rigid documentation filters.
Pre-existing Condition Misclassification	1	CAD linked with Diabetes	Referred to Expert	Medical causality sought to determine the link between diabetes and cardiac conditions under policy definitions.
Misuse of Permanent Exclusion Clause	1	Oral Cancer and Tobacco Use	Awarded	The court determined a lack of scientific proof linking tobacco use to oral malignancy; rejection was termed arbitrary.
Miscellaneous Legal Interpretations	2	AYUSH prescription, Doctor Validity	Mixed Verdict	The court upheld a claim where a BAMS doctor practised allopathy legally; it rejected where the doctor's scope of practice was unclear.

OUTCOME EXPLANATION:-

- **Denied** = Claim rejected due to policy breach or fraud.
- **Awarded** = Court ruled in favor of policyholder; insurer must pay.
- **Settled** = Both sides agreed to close the case without further fight.
- **Referred to Expert** = Court needed more medical clarity before decision.
- **Mixed Verdict** = Some claims accepted, others denied based on situation.

Table 4: Reasons for Rejection in Cases of Ombudsman & Final Decision

Primary Conflict Issue	No. of Cases	Verdict Summary	Strategic Implications for Insurer
Undisclosed Pre-existing Conditions	4	Denied	Repeated concealment of hypertension, epilepsy, and CKD invalidated claims; insurer's decision upheld due to material non-compliance.
Pandemic-Linked Claim Rejection	1	Denied	Historical IHD undisclosed during COVID hospitalisation; Ombudsman aligned with insurer decision.
Fabrication of Treatment Records	1	Denied	Fraudulent evidence led to rejection and internal flagging in the insurer's claim history systems.
Requirement of Clinical Expert Testimony	2	Referred	Highlighted the importance of the medical expert role in ambiguous pre-existing condition linkage.
Ambiguity in Waiting Period Enforcement	2	Mixed Outcome	Emergency clause invoked in accident-based claim led to favourable ruling; elective surgery upheld under exclusion list.

RESULTS:-

1. Denied Cases:
   - Undisclosed Pre-existing Conditions (4 cases):
     Claims were rejected as patients hid serious health issues like hypertension or CKD.
   - Pandemic-Linked Claim (1 case):
     The claim was denied due to non-disclosure of heart disease during COVID treatment.
   - Fake Treatment Records (1 case):
     Rejected for using false documents; flagged for fraud.

Meaning:

"Denied" means no payout due to fraud, missing info, or policy violation.

2. Referred Cases:

- Need for Medical Expert (2 cases):

  Sent for expert opinion due to unclear medical history links.

Meaning:

"Referred" means further review is needed before deciding the claim.

3. Mixed Outcome Cases:

- Waiting Period Ambiguity (2 cases):

  One accident claim approved due to emergency; one surgery claim denied due to policy terms.

Meaning:

"Mixed Outcome" means some claims are partially or selectively approved based on the situation.

CHAPTER 6: DISCUSSION

Legal Notices and Grievance Redressal Procedures

Legal notices are formal letters that policyholders use to raise serious concerns or disputes with their insurance companies (Jones, 2015). These notices clearly outline the issue—whether it's about a rejected claim, delayed payment, or canceled policy—and request that the insurance company take specific action to resolve the matter. Legal notices are often the first step toward resolving disagreements and can be crucial when informal communication fails.

People usually send legal notices to insurance companies in situations like claim denials, long payment delays, violations of the policy terms, or sudden policy cancellations. It's essential for policyholders to follow the proper legal format and procedures when sending these notices to ensure their concerns are taken seriously and legally valid. Working with a legal expert can help in drafting a strong and effective notice while also ensuring all legal rules and implications are understood (Smith & Johnson, 2018).

Here are some common scenarios where a policyholder might send a legal notice:

1. **Claim Denial**: When a claim is unfairly rejected, the policyholder may send a legal notice asking the insurer to review and reconsider the decision.
2. **Payment Delays**: If the insurer takes too long to process or release a payment, a legal notice can be issued urging them to settle the claim quickly.
3. **Breach of Policy Terms**: If the company fails to fulfill its responsibilities—like refusing to pay for a service that's covered—the policyholder may file a notice demanding that the contract terms be honored.
4. **Policy Cancellation**: If a policy is suddenly canceled, the policyholder can send a legal notice contesting the decision and requesting that the coverage be reinstated or premiums refunded.

Sending a legal notice correctly is important, as mistakes can weaken the case or delay resolution. That's why getting help from a lawyer is often recommended—they can ensure the notice is accurate, legally sound, and aligned with current regulations.

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Role of the Insurance Ombudsman

The Insurance Ombudsman was set up by the Government of India in 1998 to help policyholders settle their complaints against insurance companies in a quicker and simpler way (Government of India, 1998). This office plays a vital role in resolving issues faced by customers without the need for lengthy legal battles. It helps protect the rights of insured individuals and builds trust in the insurance system by offering a fair and accessible platform for grievance redressal. However, the system is not without its shortcomings. In some cases, policyholders have reported that insurance companies do not always follow the Ombudsman's decisions. This shows that there's a need for stronger enforcement and regular monitoring to ensure that the Ombudsman's directions are respected (Brown et al., 2020).

Consumer Courts in Insurance Disputes

Consumer courts are important legal platforms where individuals can seek justice if they face unfair treatment by insurance companies (Johnson & Patel, 2019). These courts are designed to protect consumer rights and ensure that complaints related to insurance services are addressed fairly and efficiently.

Their main responsibilities in insurance-related matters include:

1. **Settling Disputes:**
   Consumer courts are responsible for hearing complaints from customers who have issues with their insurance providers. These issues might include rejected claims, disagreements

about policy terms, or delays in payments. The courts carefully review both sides and make a fair decision based on the facts.

2. **Upholding Consumer Laws:**
   These courts ensure that insurance companies comply with laws designed to protect consumers, including those related to unfair business practices, fraud, and violations of consumer rights.
3. **Offering Remedies:**
   If a customer has been treated unfairly by an insurance company, the court can order the company to provide compensation or fulfill its contractual obligations. This helps ensure justice for those who have suffered losses due to the insurer's actions.
4. **Raising Awareness:**
   Consumer courts also help educate people about their rights and responsibilities under insurance policies. By spreading awareness, they empower customers to make better decisions and protect themselves from exploitation.

Integrated Grievance Management System (IGMS)

The introduction of the Integrated Grievance Management System (IGMS) by the Insurance Regulatory and Development Authority of India (IRDAI) in 2015 marked a major improvement in the way complaints are managed in the insurance sector. Before IGMS, the process of raising and tracking complaints was often complicated and inconsistent, leading to delays and frustration for policyholders. IGMS changed this by providing a centralized, user-friendly platform where policyholders can easily register their grievances against any insurance company.

With IGMS, the entire complaint process becomes more transparent and efficient. Policyholders no longer have to deal with confusing paperwork or multiple channels—they can file their complaints online, track their progress in real time, and communicate directly with the insurance provider. This streamlined approach helps in quicker resolutions, reducing the time and effort required from both the customer and the insurer.

Moreover, IGMS empowers IRDAI to actively monitor how insurance companies respond to complaints. By maintaining a comprehensive database of grievances, IRDAI can analyze trends, identify recurring problems, and ensure insurers comply with regulatory guidelines. This oversight helps hold insurance companies accountable for their service standards.

In essence, IGMS benefits everyone involved. It gives policyholders a clearer, more straightforward way to voice their concerns and get timely solutions, while also enabling regulators to enforce fairness and transparency. This system has played a crucial role in building trust between consumers and insurers, making the grievance redressal process more dependable and effective across the industry

Case Studies: Insights into Grievance Redressal

The case studies shared provide useful insights into various facets of grievance resolution within the insurance industry. These real-world examples reveal the complexities and difficulties involved in settling disputes between insurers and policyholders. Issues range from claim refusals due to waiting periods to disagreements over pre-existing conditions, emphasizing the need for careful examination and strict compliance with policy terms. By reviewing these cases, stakeholders can better understand common problems and effective approaches in grievance handling, ultimately helping improve results for both insured individuals and insurance companies.

Insurer vs Insured – The patient sent a legal notice to the insurer after a hospital visit for abdominal issues. His claim was denied due to a 2-year waiting period for genitourinary surgeries unless caused by malignancy. Investigation confirmed the claim rejection was valid since the patient had undergone robotic partial nephrectomy, which is covered under the insurer's specific waiting period list.

Insurer vs Insured – The patient filed a complaint in consumer court after his claim for a comminuted femur fracture from a traffic accident was rejected due to an unaddressed deficiency. After repeated follow-ups, including pre- and post-X-rays and hospitalisation photos, the case was settled. The denial was found to be a processing mistake, citing the deficiency as not having been responded to.

Insurer vs Insured – The patient sent a legal notice after his claim was rejected, even though he was admitted with normal vitals and diagnostic reports. The claim was denied, stating the admission wasn't justified. The grievance redressal team found no major issues and decided to settle the claim as it was submitted 1.5 years after the policy started.

Insurer vs Insured – The patient appealed to the ombudsman, claiming wrongful rejection based on non-disclosure of epilepsy, which he denied. His policy started in 2020, but he had a previous policy from 2015. Documents showed he had been a known epilepsy patient for five years. He had answered "no" to questions about prior insurance and medical history in the proposal form. The ombudsman ruled in favour of the insurer.

Insurer vs Insured – The patient appealed for a fever claim, but the fraud control unit found fabricated documents: identical handwriting, no pathologist signatures, no pre-OPD records, all payments in cash, and treatment at an out-of-network hospital. It was the patient's third fever claim in less than a year. The claim was denied due to discrepancies and ruled in favour of the insurer, as it was a fraud case.

Insurer vs Insured – The patient filed a complaint about claim denial for CAD diagnosis due to a 4-year waiting period for pre-existing conditions. The patient disclosed diabetes at inception. The judge ordered the treating doctor be consulted to clarify if CAD was linked to diabetes, to resolve doubts.

Insurer vs Insured – The patient contested claim rejection for bronchial asthma non-disclosure, submitting extra documents showing asthma medication since childhood. The redressal team upheld rejection because asthma was a pre-existing condition not declared to underwriting.

Insurer vs Insured – The patient sent a legal notice after claim rejection due to a 2-year waiting period for diabetes, diagnosed during hospitalisation for a humerus fracture unrelated to diabetes. The insurer agreed to settle if the patient accepted case management, meaning future diabetes-related hospitalisations would still observe the waiting period.

Insurer vs Insured – The patient filed a complaint in the consumer court after hospitalisation for mania. The processing team noted discrepancies, but no significant issues were found. The insurer settled the claim.

Insurer vs Insured – The patient appealed to the ombudsman after a COVID-19 hospitalisation claim and angiography were denied due to pre-existing ischemic heart disease since 2010, undisclosed during underwriting. The judge ruled in favour of the insurer.

Insurer vs Insured – The patient filed a legal notice over claim rejection for non-disclosure of diabetes, hypertension, and seizures for many years. The patient was admitted after a fall due to status epilepticus. Medical and self-declaration records showed a prior history. The insurer chose to contest due to non-disclosure before the policy started.

Insurer vs Insured – The patient complained to the consumer court about claim rejection for COVID-19, viral pneumonia, and acute febrile illness due to a deficiency not reply. After providing investigation reports, a doctor's note, pre-OPD treatment, and RT-PCR report, the claim was approved.

Insurer vs Insured – The patient appealed to the ombudsman after claim rejection for renal transplant treatment, citing pre-existing hypertension. Medical experts confirmed that chronic kidney disease was a complication. The ombudsman ruled in favour of the insurer.

Insurer vs Insured – The patient filed a legal notice after claim rejection for ACL reconstruction under the 2-year waiting period. The review found the injury was from a road accident, so the insurer settled the claim since waiting periods don't apply in emergencies.

Insurer vs Insured – The patient appealed, claiming wrongful rejection for treatment of non-malignant tumours of the trachea and lungs, denied due to a 2-year waiting period for such surgeries unless malignant. Medical reports confirmed no malignancy. The judge upheld the insurer's position per policy terms.

Insurer vs Insured – The patient complained to the consumer court after claim rejection for carcinoma in the mouth region due to a permanent exclusion for tobacco-related disease. Though the patient had a tobacco chewing habit, the court found no clear link between usage and cancer, ruling the insurer's rejection was incorrect and awarding the claim.

Insurer vs Insured – The patient contested the claim denial for UTI with fever, rejected because the treatment was by a doctor outside the recognised medical discipline. The insurer pointed out the doctor's BAMS qualification and use of allopathic treatment. The court agreed the doctor was authorised to practice modern medicine and ruled in favour of the insurer.

Insurer vs Insured – The patient appealed after claim rejection, citing fraud. He was an insurance agent who filed overlapping claims for the same hospitalisation period with two companies. Investigation revealed inconsistent hospitalisation dates, leading to claim denial.

Insurer vs Insured – The patient filed a legal notice after claim denial for hernia and hydrocele under the 2-year waiting period. His diagnosis was a small hiatus hernia with abdominal pain. After review, the insurer decided to contest the waiting period clause, maintaining their decision.

CHAPTER 7: LIMITATIONS

Scope Limits: A key limitation is that these systems cannot handle every type of complaint from policyholders. Each case is different, and the approach needed to solve a problem can vary widely depending on the situation (Smith & Johnson, 2018). This is because health insurance grievances cover a broad range of issues, from claim rejections to disagreements about policy details.

No Legal Advice: While grievance mechanisms can guide policyholders on how to file complaints, they usually do not provide legal advice tailored to individual cases (Brown et al., 2020). This can make it harder for policyholders to deal with the complicated legal aspects of insurance disputes, limiting their chances of getting fair solutions.

Limited Knowledge of Rules: Another important drawback is that grievance redressal bodies might not fully understand all insurance laws and regulations (Jones, 2015). This can make it difficult for policyholders to get clear and correct information about their rights and duties under their insurance policies.

Weak Responses from Insurers: Even when policyholders use these grievance systems, insurance companies are not always guaranteed to respond properly (Government of India, 1998). Insurers often follow their own complaint-handling procedures, which can lead to inconsistent responses depending on the case. This inconsistency may cause some complaints to remain unresolved or poorly handled.

CHAPTER 8: RECOMMENDATIONS

1. One-Click Complaint Filing via Mobile App

Create a simple mobile app feature where policyholders can file complaints with just one click by uploading photos, documents, or voice notes. This removes complexity and makes it super easy for users, even those who aren't tech-savvy, to register their grievance quickly.

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2. AI Chatbot for Instant Grievance Guidance

Use smart AI chatbots that instantly guide users on how to file complaints, check their claim status, and understand policy terms. The chatbot can answer common questions anytime, reducing waiting time and improving user experience.

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3. Video Explanation of Complaint Status

Instead of just text updates, send short, personalised video messages explaining the status of the complaint, reasons for delays or decisions, and next steps. Seeing a real person explain things creates clarity and builds trust.

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4. Grievance Resolution Helpline with Regional Language Support

Set up a helpline staffed with grievance experts who speak multiple regional languages. This makes the process approachable for people across India, especially those uncomfortable with English or Hindi.

5. Customer Grievance Review Panels with Peer Involvement

Form review panels that include not only insurance experts but also trained customer representatives who have experienced the grievance process. This peer involvement makes the resolution process more empathetic and fairer from the policyholder's perspective.

CHAPTER 9: CONCLUSION

Grievance redressal in health insurance is a crucial part of protecting policyholders and making sure they get the benefits they are promised under their insurance plans. It is the responsibility of insurance companies to have a fair and clear process for handling claims. At the same time, policyholders have the right to raise complaints if they feel their insurer has not delivered the services properly or if they face any problems with their claims.

The studies and reports on this topic give important advice to policyholders on how to file complaints, what to expect during the complaint process, and what options they have if they are unhappy with the results (Smith & Johnson, 2018). It's really important for people to understand their rights and responsibilities under their insurance policies so they can actively stand up for themselves whenever there is a disagreement or issue with coverage.

Policyholders should also be aware that if their legitimate claims are denied or delayed, they can seek help from government agencies that offer free support and services (Government of India, 1998). No one should settle for less than what they are entitled to. Using all the available resources and channels to get grievances addressed is key to ensuring insurers follow through on their commitments.

In short, effective grievance redressal systems form the foundation of trust between policyholders and insurance companies. When insurers handle complaints fairly and transparently, it builds confidence in the system and ensures accountability. This not only protects the interests of individual policyholders but also helps maintain the reputation and integrity of the entire health insurance sector.

By committing to clear, accessible, and just complaint resolution processes, insurers can better serve their customers and strengthen the overall health insurance ecosystem.

REFERENCES

Anderson, L. (2016). The role of insurance in risk management. Risk Management Review, 5(2), 112-125.

Anderson, L., & White, B. (2018). Obligations in life insurance contracts. Insurance Law Journal, 25(4), 189-202.

Brown, A., Smith, J., & Johnson, R. (2020). Challenges in Insurance Grievance Redressal: A Case Study Analysis. Journal of Insurance Studies, 15(2), 45-58.

Brown, S., & Patel, T. (2019). Contribution of insurance and banking services to GDP. Journal of Finance and Economics, 30(1), 78-89.

Clark, E. (2021). Strategic importance of customer relationship management in insurance. Insurance Strategy Review, 15(2), 78-91.

Government of India. (1998). Notification on the Establishment of the Insurance Ombudsman. Gazette of India, 22(4), 123-126.

Gupta, S. (2020). Empowering customers through grievance redressal. Journal of Consumer Affairs, 45(3), 112-125.

IRDAI Annual Report. (2019). Insurance Regulatory and Development Authority of India.

IRDAI Guidelines. (2018). Grievance Redressal Guidelines. Insurance Regulatory and Development Authority of India.

IRDA. (2015). Integrated Grievance Management System (IGMS): Enhancing Grievance Redressal in the Insurance Sector. Insurance Regulatory and Development Authority of India.

IRDAI. (2020). Regulatory measures for policyholder protection. Insurance Regulatory and Development Authority of India.

IRDAI Circular. (2017). Establishment of Ombudsman system. Insurance Regulatory and Development Authority of India.

Johnson, R. (2018). Growth dynamics in the insurance sector. Economic Review, 15(4), 207-220.

Johnson, R., & Patel, S. (2019). The Role of Consumer Courts in Resolving Insurance Disputes: A Comparative Analysis. Journal of Consumer Law, 25(3), 78-91.

Jones, A., et al. (2010). Competitors' influence on the insurance market. International Journal of Finance, 25(3), 112-125.

Jones, A., & Brown, S. (2023). Utilizing social media for grievance resolution. Social Media Review, 8(2), 78-91.

Jones, P. (2015). Legal Notices and Grievance Redressal Procedures in the Insurance Industry. Journal of Insurance Law, 10(1), 112-125.

Kulkarni, S. M. (Year of publication not provided). GRIEVANCE REDRESSAL MECHANISM FOR INSURANCE.

Rajpurohit, R. C. S., & Nawal, R. (2016). Grievance Redressal Mechanism in Indian life insurance industry: An Exploratory study on Quantifying relationships. Pacific Business Review International, 101, 101-2016.

Raman, S., & Uma, K. (2015). Grievances redressal mechanism in Indian life insurance industry. Indian Journal of Arts, 13(5), 3-6.

Roberts, E. (2017). Savings and investment opportunities in insurance. Financial Planning Journal, 40(3), 45-56.

Sharma, D. (2011). Consumer Grievance Redress by Insurance Ombudsman.
Smith, J. (2005). The impact of liberalization on the insurance industry. Journal of Economic Policy, 10(2), 45-56.
Smith, J., & Johnson, R. (2019). Challenges in claims processing for policyholders. Journal of Risk Management, 8(3), 156-169.

Smith, L., & Johnson, R. (2018). Legal Procedures in Insurance Disputes: A Practical Guide for Policyholders. Insurance Legal Review, 7(2), 215-228.