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Insurers' Contractual Discretion and Public Interest: A Critical Study of Health Insurance Contracts in India

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Abstract: ***This study examines the scope and implications of insurer contractual discretion in Indian health insurance law, with particular focus on exclusion clauses, waiting periods, sub-limits, and claims processing practices. The research adopts a doctrinal and comparative methodology, analysing statutory provisions including the Insurance Act, 1938, regulatory instruments issued by the IRDAI, and judicial precedents, alongside comparative insights from the United Kingdom and the United States. The findings reveal a structural imbalance arising from standard-form contracts that disproportionately favour insurers, reinforced by limited regulatory oversight and inconsistent judicial intervention. The study demonstrates that existing legal mechanisms inadequately constrain discretionary practices that undermine policyholder protection and access to healthcare. It argues for reconceptualising health insurance as a quasi-public service requiring enhanced legal safeguards grounded in principles of fairness, transparency, and social welfare. The paper concludes by proposing legislative, regulatory, and judicial reforms aimed at aligning contractual practices with constitutional values and public interest considerations.***

Keywords: Health Insurance, Contractual Discretion, IRDAI, Exclusion Clauses, Consumer Protection, Bad Faith, India, Standard Form Contracts, Insurance Regulation, Health Law, Comparative Insurance Law.

1. Introduction

A structural tension exists in how health insurance works in India today. A policyholder buys a plan to protect themselves against the unknown, yet the rules of that protection are written entirely by the company they are seeking protection from. This paradox, which the traditional doctrine of "freedom of contract" usually ignores, is the main reason for the legal and regulatory struggles discussed in this paper. Since the industry opened up in 1999, India's health insurance sector has grown rapidly. With over fifty insurers, billions of dollars in premiums, and the government's Ayushman Bharat scheme covering 500 million people, health insurance has clearly become a public necessity. However, the actual contracts used by private companies to manage their duties remain complex, asymmetrical, and inadequately regulated. Rejection rates for private claims sit between 10% and 20%.[1] Both data and personal stories show that insurers often use broad exclusions, arbitrary limits, and technical excuses about "non-disclosure" to avoid paying legitimate claims. The main point of this paper is that the power insurers have over these contracts is not just a problem for individual patients; it is a structural flaw in the entire market. This flaw is kept alive by weak regulations, hesitant courts, and the fact that customers lack adequate information. Fixing this requires more than just small tweaks. We need a fundamental rethink of the laws that govern health insurance.

2. Literature Review and Research Questions

The ideas behind this study come from two different, and sometimes clashing, schools of thought. The first is the classic liberal theory of contracts, championed by scholars like Pollock, Anson, and Treitel.[2] This view treats the freedom to sign a contract as both a practical and moral goal. It assumes that people are rational actors who use contracts to turn their personal choices into legal agreements. From this perspective, even if a contract is one-sided, it represents a voluntary choice and should be enforced by the courts without much second-guessing. In 1943, Friedrich Kessler famously challenged this traditional view.[3] He argued that standardised contracts, which offer no room for negotiation, essentially make the idea of "freedom of contract" a false one. In these cases, the weaker party doesn't actually negotiate; they just give in. Patrick Atiyah built on this by showing how the power of contracts has changed over time based on the economy and society.[4] In the world of insurance, Kenneth Abraham's work is essential. He argues that insurance is more than just a private agreement between two people. Instead, it's a social system that spreads risk across a community. Because of this, it shouldn't be treated like a regular business deal.[5] While more people are writing about Indian insurance law, there are two big gaps. First, most writing just describes the IRDAI rules without actually questioning if they work in the real world.[6] Second, there

[1]IRDAI, Annual Report 2022–23 (IRDAI, Hyderabad, 2023).

[2]See generally Sir Frederick Pollock, Principles of Contract (13th edn, Stevens & Sons, 1950); W.R. Anson, Anson's Law of Contract (29th edn, Oxford University Press, 2010); G.H. Treitel, The Law of Contract (14th edn, Sweet & Maxwell, 2015).

[3]F. Kessler, 'Contracts of Adhesion — Some Thoughts About Freedom of Contract' (1943) 43 Columbia Law Review 629.

[4]P.S. Atiyah, The Rise and Fall of Freedom of Contract (Clarendon Press, Oxford, 1979).

[5]K.S. Abraham, Distributing Risk: Insurance, Legal Theory and Public Policy (Yale University Press, 1986).

[6]See N. Ramaswamy, 'Health Insurance in India: Regulatory Challenges and Consumer Welfare' (2019) 55(3) Journal of the Indian Law Institute 245.

hasn't been a deep look at how the power insurers have over contract terms is a built in, structural issue.[7] It is not just about one "bad" company or general market rules; it is about how the system itself is designed. This paper aims to bridge that gap.

Research Questions

1) Does India's current regulatory system actually limit the power insurers have over contracts, or does it accidentally make it easier for them to abuse that power?
2) How have Indian courts balanced the "freedom of contract" with the need for fairness in health insurance cases, and have their decisions been consistent?
3) What can we learn from the way the UK and the USA regulate insurance to help fix and modernise Indian law?

The Legal Framework: Architecture and Ambiguities

The Insurance Act, 1938, is still the main statutory backbone of India's insurance sector, and that longevity says something uncomfortable about how slowly the legal framework has moved. Written under colonial conditions, and designed for a market that later spent decades under nationalisation, the Act focuses far more on keeping insurers solvent than on shielding individual policyholders. Even where it deals with contract making, the rules, especially the doctrine of utmost good faith and the fallout of material non-disclosure, tend to bite harder on the insured than on the insurer. If one looks for a genuinely consumer-facing safeguard in the Act, Section 45 stands out. It narrows an insurer's ability to repudiate a life insurance policy after two years on the grounds of misrepresentation or non-disclosure.[8] But that protection stops there. Health insurance has no parallel statutory barrier. In essence, there is no legislated time limit after which an insurer must stop reaching back into the proposal form to deny a health claim on alleged non-disclosure, no matter how old or marginal the omission is said to be. Life insurance gets an express shield, health insurance does not, and the reason is less about careful legislative choice than about timing: the statute was drafted in an era when health insurance did not carry today's weight. The Insurance Regulatory and Development Authority of India (IRDAI), created under the IRDAI Act, 1999,[9] was given two goals that do not always sit easily together. It is meant to protect policyholders and also to promote the steady development of the insurance industry. When these priorities clash, outcomes have often leaned toward industry comfort rather than consumer security, a pattern critics describe in the language of regulatory capture. To be fair, the IRDAI's Health Insurance Regulations, 2016[10] brought in procedural protections that matter on paper, portability, set timelines for claim settlement, and limits on certain kinds of exclusions. The Arogya Sanjeevani policy (2020)[11] also aimed to create a minimum standard product that could serve as a reference point. Still, the enforcement picture raises concerns regarding enforcement effectiveness. Even where violations are established, penalties are frequently fixed at amounts that private insurers can treat as routine operating expenses. Beyond fines, there is a deeper weakness: regulation has concentrated on what insurers must print in policy documents, while doing too little to control how those documents are interpreted and deployed when a claim is filed, which is the moment policyholders actually feel the system.

The Consumer Protection Act, 2019, brings insurer behaviour within the idea of "deficiency in service" and allows the National Consumer Disputes Redressal Commission (NCDRC) to grant compensation, including for mental agony and harassment.[12] The creation of the Central Consumer Protection Authority (CCPA), along with the possibility of class action complaints under Section 35(1)(c),[13] carries real potential to reshape how collective consumer harm is addressed. Yet the day-to-day machinery of consumer redress has a chronic problem that blunts these legal tools: delay. Backlogs are entrenched. District fora commonly take three to five years just to reach a first decision, and the appeal structure tends to stretch matters further. For many policyholders, access to timely relief remains more an aspiration than an experience; the law offers the promise of redress, but the system often cannot deliver it when it is needed.

Mechanisms Of Insurer Contractual Discretion: A Critical Anatomy

Insurers mainly exercise their contractual freedom through exclusion clauses. At one level, they do a real actuarial job: no insurer can sensibly price what it cannot measure, and some blanket carve-outs for unquantifiable or extremely costly risks can be necessary if the product is going to exist at all. The friction point is not the idea of exclusions; it is how frequently they are drafted too broadly and then tucked away behind language most buyers will never properly parse. A standard Indian health policy can run to twenty or more separate exclusion buckets. The commercially central one is the pre-existing disease exclusion, and it is often written in terms so wide that it can catch conditions the insured did not even realise they had when the policy began. Market wording routinely says "any condition arising directly or indirectly from a pre-existing ailment". Read as written, that can knock out coverage for almost any chronic illness, because chronic disease usually has roots that predate the eventual diagnosis. The insurer, holding better medical and actuarial expertise, writes the clause with a clear view of how far it can stretch. The policyholder, usually without medical or legal training, signs on without genuinely understanding what has been signed away. The issue is exacerbated by exclusions tend to be buried in

[7]See A. Singh, 'Contractual Unfairness and Insurance Regulation: Lessons for India from Commonwealth Jurisdictions' (2020) 11(2) Indian Journal of Law and Technology 89; P.K. Mehta, 'Standard Form Contracts and Consumer Protection: A Critical Analysis under the Consumer Protection Act, 2019' (2021) 63(1) Journal of the Indian Law Institute 112.

[8]Insurance Act, 1938 (Act No. 4 of 1938), s. 45.

[9]Insurance Regulatory and Development Authority Act, 1999 (Act No. 41 of 1999).

[10]IRDAI (Health Insurance) Regulations, 2016 (IRDAI/HLT/REG/CIR-152/2016).

[11]IRDAI, 'Standard Health Insurance Product — Arogya Sanjeevani' Circular No. IRDAI/HLT/REG/CIR/043/02/2020, 10 February 2020.

[12]Consumer Protection Act, 2019 (Act No. 35 of 2019).

[13]Consumer Protection Act, 2019 (Act No. 35 of 2019), s. 35(1)(c).

dense, long documents, handed over at the point of sale or after payment. The fifteen-day IRDAI "free look period" does not fix much.[14] In practice, you learn what an exclusion means when a claim is made, months or years down the line, long after that short window for review has closed.

Indian health policies typically build in two kinds of waiting time: a short initial period, often 30 days, with accidents carved out, and longer condition-specific waits that can run two to four years for issues like cataracts, hernia, kidney stones, and joint replacement.[15] The initial waiting period has an arguable actuarial logic; it blocks people from buying insurance only because they already know hospitalisation is imminent. The longer, ailment-specific delays are less justifiable on the same footing. If a 55-year-old buyer is told joint replacement will not be covered for four years, she is paying for a benefit whose most predictable use, given ordinary age-linked health patterns, is pushed far into the future, right up against the period when her risk is most real. That may be interpreted as managing uncertainty and more like postponing responsibility, arranged so the insurer's exposure is lowest exactly when the policyholder is likeliest to need help. IRDAI has put some boundaries around waiting-period language, but it has not removed the underlying incentive that keeps these terms attractive to insurers.

Sub-limits, caps on reimbursement for specific parts of treatment such as room rent (often 1% of the sum insured per day), ICU charges, or specialist fees, are among the most technical tools insurers rely on.[16] On paper, a policy might promise Rs. 5 lakh of cover. In practice, once sub-limits stack up, a routine surgical admission can end with reimbursement closer to Rs. 1.5–2 lakh. Proportional deduction makes this worse. If the insured chooses a room whose rent exceeds the permitted cap, many insurers cut not only the room charge but scale down the rest of the bill as well, arguing that the "higher room" changes the whole cost profile of the hospital stay. The NCDRC has repeatedly said this approach is unjustified and amounts to deficiency in service,[17] but it continues anyway, helped along by the insurer's information edge and by policyholders who do not have the actuarial literacy to foresee the reduction or the practical ability to fight it.

Health insurance policies are classic contracts of adhesion.[18] The insurer writes the terms alone, offers them on a take-it-or-leave-it basis, and individual bargaining is essentially absent. Market competition does not correct the imbalance in any meaningful way. IRDAI filing rules tend to pull products toward similar structures, and anyone shopping for coverage around a specific condition often finds the same exclusions repeated across the market. In that sense, consumer "choice" between insurers is often more appearance than reality. Renewal terms bring the imbalance into sharper focus. A person who has kept a policy for years, and who may have developed medical issues during that time, faces a significant constraint at renewal: accept revised terms, such as increased premiums or fresh exclusions reflecting the new health profile, or drop coverage right when moving elsewhere is hardest. The structure is exploitative by design, and IRDAI's ban on refusing renewal solely because of age does not adequately solve the deeper problem.[19]

Public Interest, Contractual Fairness, And Constitutional Values

The standard classical answer to the worries set out in Part IV is well known: the parties dealt at arm's length, they agreed to the terms, and agreements must be kept. In health insurance, though, that line appears insufficient, and it does not hold up for at least three separate reasons. To begin with, the idea of free bargaining does not match what happens on the ground. The policyholder does not negotiate; she signs on to a prewritten form. What looks like equality on paper masks a real imbalance in knowledge, technical understanding, and financial strength, so the supposed "consent" to standard terms starts to look like a legal fiction.[20] Next, Indian contract law has not been blind to this kind of problem. Since *Central Inland Water Transport Corporation v. Brojo Nath Ganguly*[21] The Supreme Court has accepted that courts can, in equity, invalidate clauses that are "unreasonable and opposed to public policy" under Section 23 of the Indian Contract Act, 1872.[22] That power, drawn from the Court's practice of reading constitutional values into private law, has not been used enough in health insurance. Part of the explanation is practical: individual policyholders seldom have the means or opportunity to take disputes all the way to the Supreme Court. And while consumer fora are easier to approach, they do not carry the

[14]IRDAI (Health Insurance) Regulations, 2016 (IRDAI/HLT/REG/CIR-152/2016), reg. 8. The free look period allows a policyholder to review and return a policy within fifteen days of receipt; however, in practice this window closes long before the scope of exclusion clauses is understood.

[15]IRDAI (Health Insurance) Regulations, 2016 (IRDAI/HLT/REG/CIR-152/2016). See also Law Commission of India, 242nd Report: 'Proposals for Revision of Insurance Laws' (Government of India, 2012) para 7.3, recommending legislative caps on waiting periods.

[16]Ministry of Health and Family Welfare, National Health Policy 2017 (Government of India, 2017) 19, noting that out-of-pocket expenditure driven by gaps in insurance coverage remains a leading cause of catastrophic health spending among Indian households.

[17]See, e.g., National Insurance Co. Ltd. v. Balwant Rai Saluja, AIR 2011 SC 3425, where the Supreme Court addressed the scope of an insurer's liability for proportional deductions and the limits of contractual sub-limit clauses.

[18]F. Kessler, 'Contracts of Adhesion — Some Thoughts About Freedom of Contract' (1943) 43 Columbia Law Review 629, 632–634. See also A.A. Leff, 'Unconscionability and the Code — The Emperor's New Clause' (1967) 115 University of Pennsylvania Law Review 485, 527–529, on the structural incapacity of standard-form consumer contracts to reflect genuine bargaining.

[19]IRDAI (Health Insurance) Regulations, 2016 (IRDAI/HLT/REG/CIR-152/2016), reg. 12, prohibiting refusal to renew solely on grounds of age; however, the regulation does not restrict imposition of revised terms, increased loadings, or fresh condition-specific exclusions at renewal.

[20]P.S. Atiyah, The Rise and Fall of Freedom of Contract (Clarendon Press, Oxford, 1979) 716–717; K.S. Abraham, Distributing Risk: Insurance, Legal Theory and Public Policy (Yale University Press, 1986) 11–13.

[21]Central Inland Water Transport Corporation v. Brojo Nath Ganguly, AIR 1986 SC 1571.

[22]Indian Contract Act, 1872 (Act No. 9 of 1872), s. 23.

same institutional capacity to build doctrine at the scale and detail this issue demands.

The third point is the core one. Health insurance cannot be treated as just another consumer good. The Court's acceptance of a right to health as part of the right to life under Article 21,[23] expressed in *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*,[24] changes what is at stake when coverage is denied. If an insurer uses contractual discretion to refuse a medically necessary treatment, the result is not only a hit to the wallet. Care can be postponed or missed altogether, and that delay can carry obvious costs for life and dignity. Stakes like these, with constitutional force behind them, call for more demanding legal scrutiny than a bare appeal to freedom of contract can supply. Ethics push in the same direction. Health insurance rests on social solidarity, the sharing of health risks across a group. Yet if insurers routinely use contract wording to push out the people most likely to need care, insurance shifts from risk-sharing to risk-selection. The solidarity purpose is emptied out, leaving a scheme that takes premiums from the healthy and turns away the sick. That outcome is not best read as a series of individual moral lapses; it is the predictable product of a regulatory approach that treats health insurance as no different from an ordinary commercial bargain.[25]

Judicial Trends: Progress, Inconsistency, And the Limits of Litigation

In Indian health insurance disputes, the main doctrinal device courts reach for is the *contra proferentem* rule. When a policy term can reasonably be read in more than one way, the tie goes against the party that wrote it, in practice, the insurer. The Supreme Court stated the principle in plain terms in *M/s Suraj Mal Ram Niwas Oil Mills (P) Ltd. v. United India Insurance Co. Ltd.*[26] and the NCDRC has leaned on it repeatedly while deciding claim repudiation disputes. The principle has also been affirmed in the context of commercial insurance in *Tata AIG General Insurance Co. Ltd. v. United India Fire & General Insurance Co. Ltd.*[27] Still, this tool only works where the text is truly uncertain. If an exclusion is wide but unmistakably worded, and insurers have gotten better at drafting exactly that, often with seasoned counsel polishing away loose ends, then *contra proferentem* has nothing to grip. It treats the visible problem, unclear language, without touching the deeper one, unequal bargaining power. A policyholder faced with an exclusion that is crystal-clear on paper but unfair in substance gets no real help from the doctrine.[28]

Disputes over pre-existing disease exclusions remain the busiest and most disputed part of Indian health insurance litigation. In *LIC of India v. G.M. Channabasemma*,[29] the Supreme Court placed the burden on the insurer to show that the insured actually knew, in a subjective sense, about the undisclosed condition at the time the contract was made. The NCDRC has carried that approach into health insurance matters, often insisting that repudiation for non-disclosure cannot stand where the insured had no reasonable ground to know of the condition in question. But the same idea lands unevenly once it moves beyond the national level. District fora and state commissions vary sharply in experience and ability, especially when medical records, diagnosis timelines, and actuarial arguments start driving the case. What is still missing is a binding, consolidated Supreme Court ruling that speaks directly to health insurance and pins down the required standard of knowledge for non-disclosure repudiation. That gap has given insurers room to manoeuvre.[30] The pandemic became an unexpected stress test for Indian health insurance law. Early on, several private insurers pointed to epidemic exclusion clauses, common in pre-2020 policies, and rejected COVID-19 claims. That move brought quick IRDAI involvement through the March and April 2020 circulars,[31] and it also set off litigation in multiple High Courts. The Bombay High Court's direction to the IRDAI to ensure insurers did not wrongly rely on epidemic exclusions matters not only because of where it ended up, but because of how it got there.[32] The court, in effect, let public interest concerns do real work, treating the use of epidemic exclusions during a declared public health emergency as a misuse of contractual discretion that sits badly with the social role health insurance is supposed to play. That line of reasoning, that health insurance carries a public interest dimension that narrows what insurers can fairly do under the contract, gestures toward a stronger basis for judicial scrutiny than courts usually build in ordinary times. The consumer dispute redressal system has produced notable decisions. One example is the NCDRC ruling in

[23]Constitution of India, 1950, Art. 21.
[24]Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37.
[25]K.S. Abraham, Distributing Risk: Insurance, Legal Theory and Public Policy (Yale University Press, 1986) 56–61; see also A. Singh, 'Contractual Unfairness and Insurance Regulation: Lessons for India from Commonwealth Jurisdictions' (2020) 11(2) Indian Journal of Law and Technology 89, 97–99.
[26]M/s Suraj Mal Ram Niwas Oil Mills (P) Ltd. v. United India Insurance Co. Ltd., AIR 2011 SC 73.
[27]Tata AIG General Insurance Co. Ltd. v. United India Fire & General Insurance Co. Ltd., (2006) 4 SCC 700, where the Supreme Court held that where policy language is susceptible to two interpretations, the one more favourable to the insured must be preferred.
[28]See P.K. Mehta, 'Standard Form Contracts and Consumer Protection: A Critical Analysis under the Consumer Protection Act, 2019' (2021) 63(1) Journal of the Indian Law Institute 112, 118–120, on the limits of contra proferentem as a corrective mechanism where policy language is deliberately drafted to pre-empt ambiguity.
[29]LIC of India v. G.M. Channabasemma, AIR 1991 SC 392.
[30]See N. Ramaswamy, 'Health Insurance in India: Regulatory Challenges and Consumer Welfare' (2019) 55(3) Journal of the Indian Law Institute 245, 259–261, noting the doctrinal inconsistency between state commission rulings on non-disclosure in health insurance.
[31]IRDAI, 'COVID-19 Health Insurance' Circular, April 2020. The IRDAI directed all insurers to settle COVID-19 related claims and clarified that epidemic exclusions could not be invoked to deny valid health insurance claims during the declared public health emergency.
[32]Ratnabali Banerjee v. IRDAI & Ors., Writ Petition (L) No. 1287 of 2020, Bombay High Court, order dated 24 April 2020. The Court directed IRDAI to issue suitable clarifications preventing insurers from invoking epidemic exclusions to repudiate COVID-19 claims under standard health policies.

Bajaj Allianz General Insurance v. Raj Kumar Puri,[33] which held that delays in cashless claim processing can, by themselves, amount to a deficiency in service even if the claim is not ultimately rejected. Yet the system is strained to the point of dysfunction. With millions of policyholders and denial rates that translate into tens of thousands of possible disputes each year, the consumer fora, working with limited benches and often without specialised insurance knowledge, are not positioned to deliver redress that is predictable, widely accessible, and fast enough to meet the scale of the problem.[34]

Comparative Perspective: Instructive Models from the UK and USA

In the United Kingdom, insurance consumer protection sits on two supports that India does not really have a parallel for. One is the Financial Conduct Authority's Treating Customers Fairly (TCF) framework.[35] This is a conducting regulation, not a narrow set of rules about what can or cannot appear in a policy document. It puts affirmative duties on insurers, products should be built around real consumer needs, terms have to be set out in plain and fair language, and claims are expected to be dealt with quickly and without skewing the outcome against what a reasonable policyholder would think they bought. What makes TCF stand out is its reach into how claims are evaluated and handled, a space that IRDAI's largely product-centred regulation does not meaningfully control. The other support is the Financial Ombudsman Service (FOS). It is independent, publicly funded, and covers almost the full spread of disputes in retail financial services. It can make decisions that bind firms, it does not operate with a financial ceiling on claim values, and it publishes detailed anonymised decisions, creating a usable, publicly visible body of quasi-precedent. The funding arrangement matters too. FOS is paid for through an industry levy, not through industry associations, which gives it a kind of structural distance that the Indian Insurance Ombudsman does not enjoy.[36] Alongside these institutional features, the Consumer Insurance (Disclosure and Representations) Act 2012[37] reshaped pre-contract disclosure. Consumers are expected to answer the insurer's questions honestly and with care, they are not required to volunteer every material detail on their own initiative. In effect, the insurer bears the burden of asking what it needs to know. That shift, placing relevant enquiry on the insurer rather than the insured, is the sort of rebalancing Indian health insurance law is still missing.

The United States: Bad Faith Liability as a Form of Discipline

In the United States, the "bad faith" doctrine, developed in state common law and in many states written into statute, allows policyholders to sue insurers in tort when valid claims are unreasonably denied or when payment is dragged out without justification.[38] In places such as California and New York, a policyholder who succeeds can recover far more than the value of the original claim, including consequential damages, damages for emotional distress, and even punitive damages. That kind of exposure pushes insurers toward timely, fair claim handling in a way India's consumer protection structure does not. Indian remedies are typically smaller, and the delays in getting them reduce their practical force. The Affordable Care Act adds a different but related point. By barring lifetime and annual coverage limits and requiring qualifying plans to include "essential health benefits," it reflects a legislative view that translates cleanly to India: the social purpose of health insurance will not be secured by contract doctrine alone.[39] Mandatory minimum coverage standards are needed so that the people most at risk are not left at the mercy of ordinary market pressures.

Diagnosis: A Structurally Permissive Regime

The analysis in this paper leads to a clear conclusion: Indian health insurers' misuse of contractual discretion is not some stray market glitch. It is the market settling into its normal, stable pattern. When standard-form policies hand insurers wide room to define, interpret, and reframe key terms, when regulators focus on product design while leaving day-to-day conduct in claims decisions largely untouched, when dispute resolution drags on and drains money, and when individual policyholders lack the information and capacity to fight repudiations, insurers have every incentive to press their contractual freedom as far as it will go. The issue is less "bad companies" than a structure built to reward these moves.[40] Once the problem is framed that way, the solution cannot rest mainly on individual fixes, one consumer complaint at a time. What follows instead is a push for structural correction: non-negotiable minimum coverage baselines, conduct-focused oversight of claim handling, dispute resolution that is actually independent, and statutory duties of post-contract good faith.

[33]Bajaj Allianz General Insurance v. Raj Kumar Puri, NCDRC, Revision Petition No. 1402 of 2013, decided 16 September 2015.

[34]Law Commission of India, 242nd Report: 'Proposals for Revision of Insurance Laws' (Government of India, 2012) para 10.1–10.4, identifying systemic backlog and inconsistency of outcomes in insurance-related consumer disputes as a structural deficiency requiring legislative remedy.

[35]Financial Conduct Authority (UK), Treating Customers Fairly: Progress and Next Steps (FCA, London, 2005). The TCF framework imposes outcome-based conduct obligations on insurers covering product design, disclosure, claims handling, and post-sale treatment of consumers.

[36]The FOS operates under the Financial Services and Markets Act 2000 (UK), ss. 225–234A. Its levy-based funding and binding award jurisdiction are further elaborated in the FCA Handbook, DISP 4.

[37]Consumer Insurance (Disclosure and Representations) Act 2012 (UK). The Act replaced the insured's common law duty of voluntary disclosure with a duty to take reasonable care not to make misrepresentations in answer to the insurer's specific questions, effectively shifting the burden of eliciting material information onto the insurer.

[38]See, e.g., Gruenberg v. Aetna Insurance Co., 9 Cal. 3d 566 (1973), establishing the implied covenant of good faith and fair dealing in insurance contracts under California law. For the statutory dimension, see California Insurance Code, ss. 790.03(h), 10291.5 (Unfair Claims Settlement Practices Act).

[39]Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) (USA), ss. 1001, 1201. Section 1001 prohibits annual and lifetime dollar limits on essential health benefits; s. 1201 prohibits exclusions based on pre-existing conditions.

[40]See generally IRDAI, Annual Report 2022–23 (IRDAI, Hyderabad, 2023); N. Ramaswamy, 'Health Insurance in India: Regulatory Challenges and Consumer Welfare' (2019) 55(3) Journal of the Indian Law Institute 245.

Legislative Reform: Recommendation

Amend the Insurance Act, 1938, to add a statutory duty of good faith in performance, not just at the stage of entering the contract, drawing on the Insurance Contracts Act 1984 (Australia).[41] Breach should trigger express remedies, including compensatory and punitive damages. Enact a specific Health Insurance Contracts Act that sets compulsory coverage categories, caps waiting periods by condition type, standardises definitions of pre-existing disease around the insured's subjective knowledge, and adds an interpretation rule that resolves ambiguity in favour of coverage.[42] Create a health-policy equivalent of Section 45 of the Insurance Act, so repudiation for non-disclosure is barred after a set period, two years is the familiar reference point from life insurance,[43] unless the insurer proves fraudulent misrepresentation.

Regulatory Reform

Recast the Insurance Ombudsman into a genuinely independent, publicly funded office with authority to issue binding awards, impose punitive damages in cases of serious misconduct, and publish rulings with precedential value. The UK Financial Ombudsman Service offers the closest working template.[44] Expand IRDAI's conduct rules to include claim assessment itself, by setting baseline standards for adjudication, specifying what must be documented to justify repudiation, and requiring publication of condition-wise and product-wise claim settlement data.[45] Build a penalty system that actually deters repeated misconduct. That means linking sanctions to an insurer's gross written premium instead of relying on fixed, easily absorbed amounts, so penalties change incentives rather than function as ineffective deterrents.

Judicial Reform

The Supreme Court should bring clarity to the law on disclosure of pre-existing disease in health insurance by settling a uniform subjective-knowledge standard that consumer fora and lower courts can apply without constant doctrinal drift.[46] High Courts should be nudged to use Article 226 public interest jurisdiction to issue sector-wide directions once systemic wrongdoing affecting large groups of policyholders is shown, in line with the approach reflected in the Bombay High Court's COVID-19 intervention.[47]

3. Conclusion

This study establishes that the current legal framework governing health insurance contracts in India permits a degree of insurer discretion that is inconsistent with both the functional purpose of health insurance and the constitutional commitment to the right to health under Article 21.[48] The analysis demonstrates that mechanisms such as exclusion clauses, waiting periods, and sub-limits are not incidental features, but structurally embedded tools that reinforce informational and bargaining asymmetries between insurers and policyholders. Comparative insights from jurisdictions such as the United Kingdom and the United States indicate that more robust regulatory frameworks and proactive judicial intervention can meaningfully constrain such discretion and promote greater fairness in insurance practices.[49] These jurisdictions illustrate that insurance markets can be effectively regulated without undermining their viability, thereby offering valuable guidance for reform in the Indian context. The findings underscore the need for comprehensive reform through a combination of statutory intervention, strengthened regulatory oversight, and clearer judicial standards. In particular, there is a pressing need to move beyond a purely contractual understanding of health insurance and to recognize its broader social and economic implications. Reframing health insurance as a quasi-public function provides a strong normative basis for ensuring fairness, transparency, and accountability in contractual practices.[50] Such an approach would align private insurance mechanisms with broader public interest objectives and constitutional values, ensuring that access to healthcare financing is not undermined by arbitrary exclusions or opaque practices. Ultimately, meaningful reform must aim to balance commercial viability with the fundamental objective of health insurance: providing reliable financial protection in times of medical need.

[41]Insurance Contracts Act 1984 (Australia), s. 13, which imposes a mutual obligation of utmost good faith extending to the performance and enforcement of the contract, not merely its formation.

[42]For comparative support, see Consumer Rights Act 2015 (UK), Part 2, governing unfair terms in consumer contracts, and the criteria courts apply to assess whether standard-form exclusions satisfy the requirement of transparency and fairness.

[43]Insurance Act, 1938 (Act No. 4 of 1938), s. 45, which bars repudiation of a life policy on grounds of misrepresentation or non-disclosure after two years from the date of commencement, unless fraud is established.

[44]Financial Conduct Authority (UK), Treating Customers Fairly: Progress and Next Steps (FCA, London, 2005); Law Commission of India, 242nd Report: 'Proposals for Revision of Insurance Laws' (Government of India, 2012) paras 12.1–12.6, recommending enhanced independence and binding award powers for the Insurance Ombudsman.

[45]IRDAI, Annual Report 2022–23 (IRDAI, Hyderabad, 2023). Currently, aggregate claim settlement ratios are published, but granular product-wise and condition-wise data remain unavailable, limiting accountability.

[46]LIC of India v. G.M. Channabasemma, AIR 1991 SC 392. The subjective-knowledge standard established in this case has not been codified or definitively extended by a subsequent Supreme Court ruling specifically addressing health insurance non-disclosure.

[47]Constitution of India, 1950, Art. 226; Ratnabali Banerjee v. IRDAI & Ors., Writ Petition (L) No. 1287 of 2020, Bombay High Court, order dated 24 April 2020. The Mental Healthcare Act, 2017 (Act No. 10 of 2017), s. 21(4), which mandates insurance coverage for mental illness on par with physical illness, also illustrates the legislature's capacity to impose sector-wide obligations through express statutory command.

[48]*Consumer Education & Research Centre v. Union of India*, (1995) 3 SCC 42 (recognizing the right to health and medical care as part of Article 21); *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, (1996) 4 SCC 37

[49]*NatWest Bank plc v. Morgan* [1985] AC 686 (HL); *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999) (illustrating judicial and regulatory control over unfair insurance practices in common law jurisdictions).

[50]*LIC of India v. Consumer Education & Research Centre*, (1995) 5 SCC 482; *LIC of India v. Asha Goel*, (2001) 2 SCC 160 (emphasizing fairness, reasonableness, and public interest in insurance contracts).