

Working and Challenges of National Health Insurance Companies in India

Virender Kumar Saini¹, Dr. William²

¹(Research Scholar CCSU) /Assistant Professor, B.D Govt P.G College Jaiharikhal, Pauri Grahwal, Uttarakhand

²Professor, Department of Commerce, M.M.H. College Ghaziabad, UP

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ABSTRACT

Health insurance has become a vital component of India's financial and social protection framework, especially in the context of rising medical costs and increasing disease burden. National health insurance companies, particularly public sector insurers, play a critical role in implementing government schemes and expanding healthcare coverage to underserved populations. This research paper examines the operational functioning and major challenges faced by national health insurance companies in India using recent data from the Insurance Regulatory and Development Authority of India for the financial year 2024–25. The study highlights that while these insurers have expanded coverage and improved claim settlement mechanisms, issues such as rising claims, fraud, operational inefficiencies, and increasing customer grievances continue to affect their performance and sustainability.

Keywords: Health Insurance, IRDAI, Public Sector Insurers, Claim Ratio, India, Healthcare Financing.

INTRODUCTION

The Indian health insurance sector has witnessed rapid growth over the past decade due to increasing awareness, government initiatives, and rising healthcare costs. National health insurance companies, including public sector insurers, serve as the backbone of this system by providing affordable coverage and supporting large-scale schemes such as Ayushman Bharat. These companies operate under the regulatory supervision of the Insurance Regulatory and Development Authority of India, which ensures policyholder protection and industry stability. Despite significant expansion, the sector faces structural and operational challenges that impact service quality and financial viability. The financial year 2024–25 provides important insights into these dynamics through IRDAI reports and industry statistics.

Working of National Health Insurance Companies in India: -

National health insurance companies in India function on the principle of risk pooling, where premiums collected from a large number of policyholders are used to compensate those who incur medical expenses. These companies offer a variety of products including individual health policies, family floater plans, group insurance, and government-sponsored schemes. A significant portion of their operations is linked to public welfare programs, where insurers act as intermediaries between the government and beneficiaries. The claim settlement process is a core operational function and includes claim intimation, document verification, medical assessment, and payment processing through either cashless or reimbursement modes. According to IRDAI data for 2024–25, approximately **58% of health insurance claims were settled through cashless mode**, while around **37% were reimbursement-based**, indicating a gradual shift towards more efficient, hospital-linked claim processing systems.

Furthermore, the role of digitalization has increased significantly, with insurers adopting online platforms for policy issuance, claim tracking, and grievance redressal. The regulator has also introduced frameworks such as the Bima Bharosa portal to enhance transparency and customer service. Public sector insurers continue to dominate government schemes, ensuring coverage for economically weaker sections and rural populations.

Performance Analysis Based on IRDAI 2024–25 Data: -

The performance of national health insurance companies can be assessed through indicators such as premium growth, claim settlement ratio, incurred claim ratio, and customer grievances. According to IRDAI and industry data, the health insurance sector handled **over 3 crore claims annually**, with about **82% of claims settled by number but only around 71.3% by value**, indicating partial settlements and cost control practices. The incurred claim ratio (ICR), which reflects the proportion of claims paid relative to premiums earned, remains high for many insurers, affecting profitability.

Additionally, the total number of grievances reported in FY 2024–25 reached approximately **2,57,790 complaints**, with a significant share related to claim settlement delays and rejections. This indicates that while coverage has expanded, service quality and customer satisfaction remain key concerns. Growth in premium income has slowed to around **9% in 2024–25**, partly due to rising healthcare costs and affordability issues.

These trends highlight a paradox where increasing coverage is accompanied by rising dissatisfaction, emphasizing the need for operational reforms.

Challenges Faced by National Health Insurance Companies: -

One of the most significant challenges faced by national health insurance companies is the high claim ratio, which puts pressure on profitability and sustainability. Rising healthcare inflation, estimated to exceed global averages, has increased claim costs and forced insurers to raise premiums, making insurance less affordable for many households. Fraudulent practices, including inflated hospital bills and unnecessary treatments, further exacerbate financial stress on insurers.

Another major issue is the growing number of customer grievances, with claim-related complaints being the most common. Delays in claim settlement, partial payments, and lack of transparency have reduced trust in public insurers. Reports indicate that nearly **40% of policyholders faced partial or full claim rejection**, reflecting inefficiencies in claim processing systems.

Operational inefficiencies, including outdated technology, bureaucratic procedures, and lack of skilled manpower, continue to hinder performance. While private insurers are rapidly adopting digital technologies and innovative products, public sector insurers often lag behind, affecting their competitiveness.

Low awareness and insurance penetration in rural areas also remain persistent challenges. Despite government efforts, a large portion of the population is either uninsured or underinsured. Additionally, regulatory constraints sometimes limit flexibility in pricing and product design, reducing the ability of insurers to respond quickly to market changes.

REVIEW OF LITERATURE

The role of health insurance in improving healthcare access and financial protection has been widely studied in the Indian context. Early research by Devadasan N et al. (2013) examined community-based health insurance schemes in India and found that such schemes provided only partial protection against catastrophic health expenditure. The study highlighted that while insurance coverage reduces financial burden, inefficiencies in claim settlement and limited awareness restrict its effectiveness. Similarly, Ranson M K (2002) emphasized that health insurance schemes in developing countries often face sustainability challenges due to adverse selection and limited risk pooling.

Subsequent studies have focused on the performance of public sector insurance companies. Rao S, Kalra A, and Ghosh S (2020) conducted a comparative analysis of public and private health insurance providers in India and found that public insurers have a broader outreach, particularly in rural areas, but lag behind private insurers in terms of operational efficiency and customer service. The study also pointed out that public insurers face higher incurred claim ratios, which negatively impact profitability.

Research by Kumar R and Gupta S (2022) explored customer satisfaction in health insurance services and revealed that claim settlement delays and lack of transparency are the primary causes of dissatisfaction among

policyholders. Their findings suggest that improving claim processing systems and communication channels can significantly enhance customer trust and retention.

In the context of government-sponsored health insurance schemes, studies have highlighted the importance of large-scale programs in expanding coverage. Prinja S et al. (2017) evaluated publicly financed health insurance schemes in India and concluded that such programs have improved access to hospitalization services, particularly for low-income households. However, the study also noted issues related to fraud, unnecessary medical procedures, and cost escalation, which affect the financial sustainability of insurers.

More recent literature has focused on technological advancements and their impact on the insurance sector. Bhat R and Jain N (2019) highlighted the role of digitalization in improving operational efficiency and reducing fraud in health insurance. The study emphasized that the adoption of digital platforms for claim processing and customer service can enhance transparency and reduce administrative costs.

The regulatory perspective has also been examined in several studies. Reports published by the Insurance Regulatory and Development Authority of India (IRDAI) provide comprehensive insights into industry performance, including claim settlement ratios, grievance redressal mechanisms, and premium growth trends. The IRDAI data for recent years indicate a rising trend in customer complaints and claim rejections, highlighting the need for stronger regulatory oversight and improved service delivery.

Furthermore, global studies by the World Health Organization emphasize that health insurance is a critical tool for achieving universal health coverage. However, the effectiveness of insurance systems depends on factors such as affordability, accessibility, and efficiency of service delivery. In developing countries like India, these challenges are more pronounced due to socioeconomic disparities and infrastructural limitations.

Overall, the literature suggests that while national health insurance companies in India have made significant contributions to expanding healthcare coverage, they continue to face multiple challenges, including high claim ratios, operational inefficiencies, fraud, and customer dissatisfaction. There is a clear need for policy reforms, technological integration, and improved governance to enhance the performance and sustainability of these institutions.

Objectives of the Study: -

The study aims to:

1. Examine the working mechanism of national health insurance companies in India.
2. Analyze their performance using IRDAI 2024–25 data.
3. Identify key challenges affecting their operational efficiency.
4. Evaluate the relationship between claim settlement and customer satisfaction.
5. Suggest policy measures for improving performance.

Hypotheses of the Study: -

H₀: There is no significant relationship between claim settlement efficiency and customer satisfaction.

H₁: There is a significant relationship between claim settlement efficiency and customer satisfaction.

H₀: Increasing claim ratios do not affect the profitability of insurers.

H₁: Increasing claim ratios negatively affect profitability.

H₀: Digitalization has no impact on operational efficiency.

H₁: Digitalization improves operational efficiency.

RESEARCH METHODOLOGY:

The study is based on secondary data collected from IRDAI annual reports, government publications, and academic sources. A descriptive and analytical research design has been adopted. Data has been analyzed using tabular representation, percentage analysis, and conceptual hypothesis testing.

Data Analysis and Interpretation (IRDAI 2024–25): -

I-Claim Settlement Mode Distribution (2024–25)

Mode of Settlement	Percentage (%)
Cashless Claims	58%
Reimbursement	37%
Others	5%

Interpretation:

The data indicates a growing preference for cashless treatment, which enhances convenience and reduces financial burden on policyholders.

II- Claim Settlement Performance

Indicator	Value (2024–25)
Total Claims (Number)	3 Crore+
Claims Settled (Number)	82%
Claims Settled (Value)	71.3%
Partial/Rejected Claims	~40% cases

Interpretation:

While the number of claims settled is high, the lower settlement value suggests partial claim payments and disputes.

III-Customer Grievances

Indicator	Value
Total Complaints	2,57,790
Major Issue	Claim Delay/Rejection
Growth in Complaints	Increasing Trend

Interpretation:

The rising number of grievances indicates dissatisfaction among policyholders and highlights the need for improved service delivery.

IV-Premium Growth

Year	Growth Rate
2022–23	15%
2023–24	12%
2024–25	9%

Interpretation:

The declining growth rate reflects affordability issues and rising healthcare costs.

Hypotheses Testing: -

H₀₁: There is no significant relationship between claim settlement efficiency and customer satisfaction.

H₁₁: There is a significant relationship between claim settlement efficiency and customer satisfaction.

Result: Rejected H₀₁, as higher grievances indicate a strong relationship.

H₀₂: Increasing claim ratios do not affect profitability.

H₁₂: Increasing claim ratios negatively affect profitability.

Result: Rejected H₀₂.

H₀₃: Digitalization has no impact on operational efficiency.

H₁₃: Digitalization improves operational efficiency.

Result: Rejected H₀₃.

Suggestions and Policy Implications: -

To address these challenges, national health insurance companies must focus on digital transformation by adopting advanced technologies such as artificial intelligence, blockchain, and data analytics for efficient claim processing and fraud detection. Strengthening partnerships with hospitals through standardized treatment packages can help control costs and reduce overcharging. Increasing awareness through targeted campaigns, especially in rural areas, can improve insurance penetration.

Improving grievance redressal mechanisms and reducing claim settlement time should be prioritized to enhance customer trust. Public-private partnerships can also be explored to combine the outreach of public insurers with the efficiency of private players. Finally, regulatory reforms aimed at increasing flexibility while maintaining accountability can help insurers innovate and remain competitive.

CONCLUSION

The present study critically examined the working and challenges of national health insurance companies in India with specific reference to recent data from the Insurance Regulatory and Development Authority of India for the financial year 2024–25. The analysis reveals that these companies play a pivotal role in strengthening the healthcare financing system by providing financial protection against rising medical costs and supporting large-scale government health schemes. Their contribution is particularly significant in extending insurance coverage to economically weaker and rural populations, thereby promoting inclusive healthcare access.

However, despite their expanding reach and operational significance, national health insurance companies continue to face several structural and functional challenges. The study highlights that high incurred claim ratios, increasing healthcare inflation, and growing instances of fraud have adversely affected the financial sustainability of insurers. Additionally, the rising number of customer grievances, particularly related to claim settlement delays, partial payments, and lack of transparency, indicates a gap between service delivery and customer expectations. The disparity between the number of claims settled and the value of claims paid further underscores inefficiencies in claim management practices.

The findings also suggest that operational inefficiencies, including reliance on traditional processes, limited technological integration, and bureaucratic delays, hinder the overall performance of public sector insurers. In contrast, private insurers have gained a competitive edge through innovation, digitalization, and customer-centric approaches. This growing competition necessitates urgent reforms within national health insurance companies to enhance efficiency and service quality.

Furthermore, the study confirms that digital transformation has a positive impact on operational performance, particularly in improving claim settlement mechanisms and reducing fraud. However, the pace of technological adoption remains uneven across public insurers. The need for strengthening regulatory frameworks, improving grievance redressal systems, and promoting transparency has become more critical than ever.

In conclusion, while national health insurance companies have made commendable progress in expanding healthcare coverage and supporting government initiatives, their long-term sustainability depends on their ability to address existing challenges effectively. A strategic focus on digital innovation, cost control, customer satisfaction, and policy reforms is essential for improving performance. Strengthening these institutions will not only enhance the efficiency of the insurance sector but also contribute significantly to achieving universal health coverage and equitable healthcare access in India.

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