

# POLICY BRIEF

## Locating persons with pre-existing conditions in the private health insurance market:

A case for recognition and redistribution for persons with disabilities

**C-HELP** | CENTRE FOR HEALTH EQUITY, LAW & POLICY



## Locating persons with pre-existing conditions in the private health insurance market: A case for recognition and redistribution for persons with disabilities

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### **About**

The Centre for Health Equity, Law & Policy (C-HELP) is a research, knowledge production and advocacy forum which works on law & policy issues related to health, embedding its work in the right to health as envisaged within India's constitutional framework and her international commitments. It is located at the Indian Law Society, Pune.

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### **Review**

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## CONTENTS

<b>Executive Summary</b>	<b>3</b>
<b>1. Introduction</b>	<b>5</b>
<b>2. The economic model of the private health insurance market</b>	<b>9</b>
<b>3. The law and policy framework governing persons with disabilities in the insurance sector</b>	<b>14</b>
I. INDIA	14
3.1 Insurance governance	14
3.2 Duty to remove economic barriers for persons with disabilities in health insurance	16
3.3 Transition from exclusion to actuarial fairness in private health insurance markets:	18
3.4 The balancing scale of reasonable accommodation and undue burden	20
3.5 Regulation of private entities that are engaged in delivery of core public services	21
II. INTERNATIONAL AND COMPARATIVE PERSPECTIVES	24
3.6 Hong Kong	25
3.7 Australia	26
3.8 Canada	27
3.9 European Union (EU)	28
<b>4. Conclusions and Recommendations</b>	<b>31</b>
4.1 Framing discrimination in private health insurance markets	32
4.2 Private health insurer's duty to modify policies	33
4.3 The government's duty to ensure financial protection and provide health services	34
4.4 Option to remove waiting period by paying additional premium survives (2016-2019)	36

## Executive Summary

Although persons with disabilities are likely to need health services due to their high vulnerability of health concerns, health services are often beyond reach. As per the 76<sup>th</sup> National Sample Survey (2018), their labour force participation rate is low at 23.8%, which corresponds to figures that suggest more than half of this population is unable to afford health services – among these, the burden is severest on women, the poor and those lacking health insurance.

A gap in social security programmes pushes persons with disabilities towards private health insurance markets, where financial viability of businesses takes precedence over fair access to healthcare goods, services and facilities. This presents a major problem to guarantee financial protection for vulnerable groups, given that more than half (57%) of households suffer catastrophic health expenditure and nearly one-fifth (19%) of households are pushed below the poverty line (BPL) due to out-of-pocket expenditure (OOPE) for disability-related health services.

The Insurance Regulatory and Development Authority of India (IRDAI) has monitored rolling out policies for persons with disabilities by private insurers under pressure of litigation, however, they are frequently priced-out as their pre-existing conditions invite harsh risk assessment. In this context, their coverage in private markets presents a classic case of concurrently advocating a politics of recognition and redistribution, whereby legal standards to prevent discrimination must align with the reality of private markets. The regulatory measures arising from this perspective are resourceful in accurately testing the usage of actuarial data, validity of risk factors (correlative or causal) and propriety of risk shielding measures (for instance, higher premiums, caps on insured sum, waiting periods, sub-limits, co-payments, deductibles, etc.).

Indian courts have formally initiated scrutinising actuarial fairness in health insurance in *Subhash Khandelwal v. Max Bupa Health Insurance Co. Ltd.* (2026) in order to determine validity of terms and conditions. In this context, law and policy norms under the *International Covenant on Economic, Social and Cultural Rights, 1966* (ICESCR) and the *Convention on Rights of Persons with Disabilities, 2006* (CRPD) as well as comparative perspectives from jurisdictions of Hong Kong, Australia, Canada and the European Union offer invaluable insights for Indian regulators and grievance redressal forums to gauge actuarial fairness with precision.

Ultimately, the location of persons with disabilities in private health insurance markets necessitates balancing the collision in competing interests of financial protection for such policyholders and financial viability of insurers, given coverage in this economic model is fundamentally premised on the usage of disability as a risk factor. While private sector actors engaged in delivery of core public services must be amenable to stricter regulation, there is a limited margin of appreciation to seek fair terms and conditions in private markets.

Although this policy brief deals with persons with disabilities and their interface with private health insurance markets, the risk rating of HIV-status, gender dysphoria and mental illness present similar law and policy concerns. As special laws prescribe the duty to prevent discrimination and provision of reasonable accommodation for people living with HIV, transgender persons and persons with mental illness, the insights herein are transferable to their contexts to ensure actuarial fairness in health insurance for vulnerable groups.

The decision of insurance working as per a risk classification model versus a social solidarity model depends on a combination of level of legal regulation in a jurisdiction and/or policy choice by the government. While practices of risk assessment in private markets amplify inequality, community rating takes precedence in group insurance (Central Government Health Scheme and Employee State Insurance Scheme) or social security programmes (Mahatma Jyoti Phule-Jan Aarogya Yojana and Ayushman Bharat Pradhan Mantri-Jan Aarogya Yojana). This ensures all insured persons are offered the same benefits for a uniform premium as the redistribution of risk across a large pool of beneficiaries increases the sustainability of such a model, thereby positioning this as a viable route of advocacy for all policyholders with pre-existing conditions.

# 1. Introduction

*“We live in capitalism. Its power seems inescapable. So did the divine right of kings. Any human power can be resisted and changed by human beings...”* – Ursula K le Guin

While the 2011 Social, Economic and Caste Census (SECC) records 2.68 crore persons with disabilities in India (approximately 2.2% of the national population),<sup>1</sup> its methodology has been critiqued for being limited in underestimating chronic impairments, reliance on a strictly bio-medical framework, and failure to recognise both the contribution of stigma to low self-reporting and enumerator bias.<sup>2</sup> This lacuna in accurate data impedes framing of social security policies to comprehensively cover persons with disabilities, given the financial impact of disability – well over half (57.1%) of households with persons with disabilities suffer catastrophic health expenditure<sup>3</sup> and nearly one-fifth (19.1%) are pushed below the poverty line (BPL) due to out of pocket expenditure (OOPE) for disability-related health services.<sup>4</sup>

Although persons with disabilities are likely to need health services due to their high vulnerability to health concerns,<sup>5</sup> health services are often beyond their reach. As per the 76<sup>th</sup> National Sample Survey (2018), their labour force participation rate is low at 23.8%,<sup>6</sup> which corresponds to figures that suggest that more than half of this population is unable to afford health services – among these, the burden is severest on women, the poor and those lacking health insurance.<sup>7</sup> The persistence of gender inequality in household expenditure on health services correlates with poorer outcomes for women with disabilities and underscores the necessity of government intervention for financial protection.<sup>8</sup>

Apart from general healthcare needs (immunisation, sexual and reproductive health services, cancer screenings, etc.), persons with disabilities may have disability-specific needs to access health services. The spectrum of impairment - primary impairment (for example, muscular dystrophy), secondary health conditions

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<sup>1</sup> Report of the Expert Group on Socio Economic and Caste Census (2011), Ministry of Rural Development, Government of India

<sup>2</sup> Saikia, N. et al (2016), Disability divides in India: Evidence from the 2011 census, PLoS One

<sup>3</sup> Catastrophic spending on health occurs when a household reduces its basic expenses over a certain period of time, sells assets, or accumulates debts in order to cope with the medical bills of one or more members of the family

<sup>4</sup> Yadav, J. et al (2023), Measuring financial impact of disabilities in India (an analysis of national sample survey data), PLoS One; Yadav, J. et al (2023), Catastrophic health expenditure and poverty impact due to mental illness in India, Journal of Health Management

<sup>5</sup> Murthy, GVC et al (2014), *Access to healthcare and employment status of people with disabilities in South India*, BMC Public Health

<sup>6</sup> *Persons with disabilities in India: NSS 76<sup>th</sup> Round* (2018), Ministry of Statistics and Programme Implementation, Government of India

<sup>7</sup> *Global report on health equity for persons with disabilities* (2022), World Health Organization

<sup>8</sup> Yadav, J. et al (2024), *Gender inequality in out-of-pocket expenditure on healthcare among persons with disabilities in India*, Journal of Health Management

associated with primary impairment (for example, people with Down's syndrome are more likely to experience congenital health disease) and comorbidities (such as people with long-term physical disability are 2-3 times more likely to develop depression)<sup>9</sup> – present major implications for preparedness of health systems to respond to their needs and financial protection.

If persons with disabilities do not have access to health services, their ability to attend academic institutions, exercise equal opportunity at workplaces and participate in society are severely undermined. This underscores the imperative that delivery of core public services like healthcare must be designed to dismantle systemic discrimination in order to promote social and economic integration, instead of mirroring historical patterns of disadvantage.<sup>10</sup> In an endeavour to make healthcare goods, services and facilities accessible and affordable, health insurance can provide financial protection to persons with disability in an equitable manner. However, people with disabilities are frequently priced out of policies due to higher premiums associated with pre-existing conditions and exclusion of most-needed services like outpatient services, day care services (rehabilitation) and assistive devices.<sup>11</sup>

In 2008, the Indian government rolled out Niramaya, a disability-responsive health insurance scheme, which is targeted for persons with intellectual disabilities, cerebral palsy, autism and multiple disabilities, which provides an insured sum of up to INR 1 lakh (inclusive of outpatient services). As of 2021, the scheme covered only 76,831 beneficiaries – a gross under-utilization as eligible beneficiaries are estimated to be up to approximately 72 lakhs.<sup>12</sup> The government acknowledges the current insured sum is grossly inadequate and is considering a proposal to hike the insured sum (up to INR 4 lakhs), which must provide comprehensive coverage, including but not limited to, sexual and reproductive health services.<sup>13</sup>

The Swavlamban scheme provided coverage to all persons with disabilities without exclusions, however, this scheme was terminated<sup>14</sup> after the Ayushman Bharat Pradhan Mantri-Jan Aarogya Yojana (ABPM-JAY) was rolled out in 2018, it provides an insured sum of INR 5 lakhs for poor and vulnerable families as per the SECC. However, limitations on disability-related health services in ABPM-JAY explains low enrolment by persons with disabilities as their needs are not comprehensively

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<sup>9</sup> Shakespeare, T. et al (2018), *Access to health for persons with disabilities*, London School of Hygiene and Tropical Medicine & University of East Anglia

<sup>10</sup> *Devika Biswas v. Union of India*, (2016) 10 SCC 733

<sup>11</sup> Murthy, GVC (2018), *Challenges in accessing healthcare for people with disability in the South Asian context*, International Journal of Environmental Research and Public Health

<sup>12</sup> Angothu, H. (2022), *Poor enrolment of persons with disabilities in Niramaya health insurance scheme over a decade*, Indian Journal of Social Psychiatry

<sup>13</sup> Singh, P. et al (2021), *A study on evaluation of the scheme 'Budgetary support to National Trust'*, National Institute of Labour Economics Research and Development, Niti Aayog

<sup>14</sup> James, JW et al (2019), *Swavlamban health insurance scheme for persons with disabilities: An experiential account*, Indian Journal of Psychiatry

covered.<sup>15</sup> At the central level, the Central Government Health Scheme (CGHS) covers public servants and the Employee State Insurance Scheme (ESIS) covers formal sector workers in public and private sectors for group insurance coverage. However, given their low labour force participation rate at the national level, employment-based schemes are beyond reach. Among state health insurance schemes, only Manipur and Himachal Pradesh provide disability-related coverage.<sup>16</sup>

This gap in social security programmes pushes persons with disabilities towards private health insurance markets, where financial viability of businesses takes precedence over fair access to healthcare goods, services and facilities. The private health sector is plagued with the problem of price regulation, as evidenced by studies that illustrate the causal link between catastrophic health expenditure of hospitalization with approximately 20,000 families being pushed below the poverty line in Haryana,<sup>17</sup> enquiries in anti-competitive practices of super-specialty hospitals that compel patients to purchase supplies from in-house pharmacies<sup>18</sup> and inflating hospital bills by prescribing at least 25% drugs outside the purview of price control lists,<sup>19</sup> among other instances of market failure in the private sector.

The entry of finance capital in the Indian health insurance market<sup>20</sup> has raised a worrying concern – whether the social benefit of health insurance is being served by providing equitable access to health services for the citizenry, or whether that is being overridden by profiteering and the need to deliver ‘value’ to shareholders of private equity firms.<sup>21</sup> The 75<sup>th</sup> National Sample Survey on Social Consumption of Health (2017) discloses that 60-70% of health services are delivered in the private sector, accentuating the need to regulate private markets to guarantee financial inclusion and facilitate access to health services for persons with disabilities.

This policy brief was conceived in the context of C-HELP’s advisory work to assist a policyholder with disabilities negotiate fairer terms and conditions in the private market, by ensuring actuarial fairness with respect to the inadequate sum insured, exclusion of outpatient services, limits on coverage of pre-existing locomotor disability (fibromyalgia) and mental illness (psychosomatic disorder and somatoform) up to a waiting period of two years, sub-limits on domiciliary hospitalization

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<sup>15</sup> Reshmi, B. et al (2021), *Health insurance awareness and uptake in India: a systematic review protocol*, BMJ Open

<sup>16</sup> Kumar, A. and Sarwal, R. (2021), *Health insurance for India’s missing middle*, Niti Aayog

<sup>17</sup> Sharma et al (2017), *Out of pocket expenditure for hospitalization in Haryana: Extent, determinants and financial risk protection*, Indian Journal of Medical Research

<sup>18</sup> *Vivek Sharma v. Beekton Dickinson and Max Super Specialty Hospital*, Competition Commission of India Case No. 77/2015, orders dated 17.11.2015 and 31.08.2018

<sup>19</sup> Office memorandum (20.02.2018), National Pharmaceutical Pricing Authority, Ministry of Chemicals and Fertilizers, Government of India

<sup>20</sup> IRDAI (Investment by Private Equity Funds in Indian Insurance Companies) Guidelines, 2017

<sup>21</sup> Taneja, A. and Sarkar, A. (2023), *First, Do no harm: Examining the impact of International Finance Corporation’s support to private healthcare in India*, Oxfam International; Kakade, D. and Shukla, A. *Regulation of rates in the private healthcare sector: Justification, feasibility, strategies to address the issue*, Support for Advocacy and Training to Health Initiatives (SATHI); Philip, A. (2018), *Report of the United Nations Special Rapporteur on Extreme Poverty and Human Rights*, A/73/396

([home-based care) and co-payments.<sup>22</sup> This instance is representative of market conditions that portend a widening gap between human rights obligations of the private healthcare sector and the Indian government's duty to improve public health, which merits a closer scrutiny of the problem. Although the conflict between profits and people appears to be inevitable, understanding the principles of economic theory underlying the insurance model and using law as a tool for social change provides opportunities to strike a balance between commercial activities and people's access to core public services.

The coverage of persons with disabilities in private markets presents a classic case of concurrently advocating a politics of recognition and redistribution, as concerns of identity-based protections are interdependent on structural economic reform for vulnerable groups.<sup>23</sup> Accordingly, this policy brief examines the role of anti-discrimination law in complement with regulation of private markets to propose adequate remedies. Chapter 1 identifies the problem of inequality in private markets for persons with disabilities. Chapter 2 provides an overview of the economic model underlying the private health insurance markets. Chapter 3 reviews law and policy frameworks on rights of persons with disabilities, healthcare access and actuarial fairness in insurance from Indian and comparative perspectives from the European Union, Australia, Canada and Hong Kong. The concluding Chapter 4 presents key findings and recommendations.

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<sup>22</sup> The records of advisory work are on file with the author

<sup>23</sup> Fraser, N. (1998), *Social justice in the age of identity politics: redistribution, recognition, participation*, Discussion papers, Research unit: Organization and employment FS | 98-108, WZB Berlin Social Science Centre

## 2. The economic model of the private health insurance market

Insurance serves a valuable social need, in that it aims to provide an affordable means of protecting against potentially large financial loss to the insured. Typically, two competing visions across the sectors of insurance (automobile, life, health etc.) through private markets and public social security systems respectively are: (1) a model based on risk classification by fragmenting individuals/groups who voluntarily purchase insurance into smaller pools with similar risk factors, (2) a model based on social solidarity where redistribution of the risk of individuals/groups who are compulsorily drawn in a larger population leads to cross-subsidization. The decision of insurance working as per a risk classification model versus a social solidarity model depends on a combination of the level of legal regulation in a jurisdiction and/or a policy choice by the government.

The risk classification model is based on two concepts: adverse selection and moral hazard. The principle of adverse selection operates such that if uniform terms and conditions like rate of premium are applied to all persons, low-risk individuals are deterred from buying insurance at the same rate, while such a market becomes attractive to high-risk individuals (such as, if rash drivers who statistically pose a higher risk of accident claims pay at the same rate for automobile insurance as careful drivers, insurance is uneconomical for the latter). The principle of moral hazard dictates that if uniform premium is charged to all persons, high-risk individuals are not incentivised to modify their behaviour to improve outcomes and lower risk of utilisation of covered services (for example, if smokers are offered health insurance at the same rate as non-smokers, there is no incentive for tobacco cessation for the former). Therefore, the setting of premiums as per risk factors is deemed to lead towards “efficient allocation of resources”, i.e., coverage for all in accordance with their risk profile. However, the concern of ‘risk selection’ occurs when insurers try to counter adverse selection or maximise profits by discouraging or preventing individuals or groups with pre-existing morbidity from purchasing insurance, which leaves those who need health services the most without access.

In contrast, social solidarity models are based on governments’ objectives to promote ‘fair’ outcomes in matters of public policy (for example, universal health coverage). The act of risk classification is fundamentally a discriminatory exercise in allocation of risk to a diverse set of individuals/groups, which is permissible only as far as such assessment is based on appropriate factors which materially impact the risk. However, the act of risk classification leads to harmful discrimination when insurers take into account protected traits like age, gender and disability of persons which are beyond an individual’s control and/or do not bear any causal link to the risk *per se*. A model seeking fair outcomes postulates that risk assessment must not take into account prohibited grounds of discrimination (sex, religion, disability etc.) in pricing of insurance products, especially with respect to factors beyond individual control, in order to remove historically disparate treatment in access to goods and

services. As such, community rating (based on demographic trends across the population) takes precedence over risk classification in group insurance (Central Government Health Scheme and Employee State Insurance Scheme) or social security programmes (Mahatma Jyoti Phule-Jan Aarogya Yojana and Ayushman Bharat Pradhan Mantri-Jan Aarogya Yojana)<sup>24</sup> - except to the extent of age and occupation as risk factors - and all insured persons are offered the same benefits for a uniform premium as the redistribution of risk across a large population increases the sustainability of such a model.<sup>25</sup>

In health and life insurance, the practice of medical underwriting uses a person's health condition and/or disability (reliable predictors of likelihood of occurrence of the insured event) in combination with medical studies and actuarial data to arrive at the mortality or morbidity risk of the prospective consumer. Insurers use this information to determine the premiums, level of cover, benefits and other terms and conditions that will be offered to the consumer. In case the government seeks to regulate entry barriers (for instance, removal of exclusion of pre-existing conditions) to the voluntary insurance market which is based on risk classification, insurers will evolve other risk shielding tools like modification in coverage design – such as, prescribing exclusions, waiting periods, co-payments etc.<sup>26</sup> However, in countries where the private market is substantially filling the gap for “high risk groups” when social security programmes are falling short, a blanket imposition of such terms and conditions can deter service utilisation among the poor and vulnerable groups, discourage people from seeking preventive services that would avoid the subsequent need for costly curative services and work against the goal of financial protection.<sup>27</sup>

These core economic principles of risk classification are evident in the treatment of persons with pre-existing conditions in India. In *Shikha Nishchal v. National Insurance Co. Ltd.*,<sup>28</sup> the Delhi High Court remedied exclusion of mental illness (schizo-affective disorder) by directing the insurer to provide coverage for mental illness on the same basis as is available for physical illness.<sup>29</sup> The Insurance Regulatory Development Authority of India's (IRDAI) response before court reflects the sector's consensus on prescribing waiting periods for covering pre-existing conditions:

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<sup>24</sup> The memorandums of understanding executed between the State of Maharashtra and the Central Government with the respective lead insurers explicitly provide for coverage of all pre-existing conditions from the date of enrolment, with the exception of standardized exclusions. Available at: <https://nha.gov.in/about-ayushman-bharat>;

<sup>25</sup> Rosenbaum, S. (2008), *Insurance discrimination on basis of health status: An overview of discrimination practice, federal law and reform options*, O'Neill Institute, Georgetown University; Avraham, R. et al (2014), *Understanding Insurance Anti-Discrimination Laws*, Southern California Law Review

<sup>26</sup> *Why the use of age and disability matters to consumers and insurers* (2012), Oxera

<sup>27</sup> Sekhri, N. et al (2005), *Regulation of private health insurance to serve the public interest: Policy issues for developing countries*, World Health Organization

<sup>28</sup> WP (C) 3190/2021, order 19.4.2021

<sup>29</sup> Section 21(4) [right to equality and non-discrimination] of the *Mental Healthcare Act, 2017*

“...for many existing health insurance policies in case of certain physical ailments/illnesses specific waiting periods may be normally imposed. For example, two year waiting period may be specified for cataract, hernia, hydrocele, maternity coverage, four year waiting period may be specified for knee replacement surgeries, heart related diseases etc. Insurers impose these conditions to hedge against possible adverse selection, that is, people who are already planning to get these treatments may take the policy and undergo the treatment, thereby, jeopardizing the interest of genuine policyholders. Insurers may be also not in a position to grant health insurance coverage only if people who are already suffering with any physical health condition/disorder (say cancer patients) approach for health insurance. Now, in view of aforesaid provisions of MHCA 2017 and the guidelines issued by the answering respondent, similar approach shall be adopted for categories of mental illnesses as is provided in case of physical illness”<sup>30</sup>

In *Baby Devananda D. v. Employee State Insurance Corporation (ESIC)*,<sup>31</sup> the Delhi High Court remedied the exclusion of rare diseases (children diagnosed with Gaucher type I and Hurler syndrome type I) from the employment-linked insurance scheme. In particular, the issue before the court was a sub-limit of INR 10 lakhs on availing super speciality treatment (SST) and that employees’ dependents would be eligible for coverage after the employee completes a minimum one year of insured employment (i.e., a waiting period of 1 year). The first issue was resolved during litigation with the ESIC conceding that SST costs in excess of INR 10 lakhs will be borne on a case-by-case basis.

The ESIC defended waiting periods to prevent “misuse” by people who ostensibly seek employment only to obtain health insurance, as employee contributions for the said duration would ensure “rational utilisation of funds”. The court struck down the waiting period on grounds that ESIC had not provided any data on “misuse”, undue postponing accrual of benefits would defeat the policy and ESIC regulations do not demarcate separate eligibility conditions for employees and dependents.

In *United India Insurance Co. Ltd. v. Jai Parkash Tayal*,<sup>32</sup> the Delhi High Court remedied exclusion of genetic conditions (hypertrophic obstructive cardiomyopathy). As the matter concerned a public sector insurer, the court declared that commercial practices must conform to principles of equal treatment in Article 14 as the right to health insurance is guaranteed in Article 21 of the Constitution of India. Insurers have the liberty to frame policies, however, they must be informed by actuarial data. This order has been stayed on appeal<sup>33</sup> and tagged with a separate matter on exclusion of genetic conditions (congenital nephrotic syndrome)<sup>34</sup> before the Indian Supreme Court.

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<sup>30</sup> Id at 28, para. 23

<sup>31</sup> 2017 SCC Online Del 12779

<sup>32</sup> 2018 SCC Online Del 7415

<sup>33</sup> *United Insurance Co. Ltd. v. Jai Parkash Tayal*, SLP (C) No. 29034/2018, order dated 27.8.2018

<sup>34</sup> *Religare Health Insurance Co. Ltd. v. Arpan Dhawan & Anr.*, SLP (C) No. 29034/2018, order dated 13.11.2018

In reference to the aforesaid cases on excluding mental illness and genetic conditions, courts were principally concerned with removal of entry barriers for policyholders and had no occasion to test actuarial fairness of terms and conditions after coverage. In prospective cases, policyholders agitating these concerns must be cognizant of economists' warnings of unintended financial consequences of prohibiting risk assessment in the private market on basis of prohibited grounds like gender (for example, statistical evidence indicates young men are rash drivers, therefore, lower premiums for young women seeking automobile insurance will be reconfigured to increase their share of premiums) and insurers passing on the cost of new risk assessment technologies (such as the use of telematics for automobile insurance) on all consumers uniformly, thereby, making insurance expensive for everybody. The average rate of premium would lead to the exit of low-risk consumers and increase of high-risk consumers in the pool, leading to the insurer paying out higher claims in general, which eventually drive up the price of insurance to such a prohibitive level that private insurers would conceivably withdraw entirely from the market ('death spiral'). Instead of banning the use of prohibited grounds for risk assessment *per se*, they recommend measures like government incentives, subsidies and safety nets to offset unfair market outcomes on the basis of sex, religion, disability etc., in order to balance the competing interests of efficiency and fairness within the insurance sector.<sup>35</sup>

Actuarial experts further alert that if insurers are not allowed to use age and disability as risk factors, there would be consequences to the financial viability of some types of insurance in the private market. If insurers were not allowed to charge different pension annuity rates for different age groups, then the cost of such services in the private market would increase enormously as previously explained (for instance, 75-year-old consumers with lower life expectancy would purchase less compared to those aged 65 with higher life expectancy, leading to larger payouts by the insurer), ultimately leading to a death spiral.

Similarly, if disability is prohibited as a risk factor, if a term life insurer does not offer lower premiums to individuals without paraplegia (which reduces life expectancy), this would drive-up average costs for everybody (high-risk persons with disabilities would purchase more compared to low-risk persons without disabilities) and impact the provider's financial viability. In such cases, the public sector might need to fill the gap left by withdrawal of the private market. A prohibition on the use of personal characteristics like age or disability as rating factors would effectively move the market towards a social solidarity model, where uniform premium rates would be charged to everyone for the same coverage regardless of risk profile.<sup>36</sup>

In the aforesaid rare diseases case, although the discretionary removal of sub-limits is a positive outcome for beneficiaries of the employment-linked insurance scheme,

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<sup>35</sup> Katz, MJ (1990), *Insurance and the Limits of Rational Discrimination*, Yale Law and Policy Review; Kuschke, B. (2012), *Gender Equality in Insurance*, University of Pretoria; *Equality in Insurance Pricing: The Effect of the Gender Ban*, Oxera (2013)

<sup>36</sup> *Use of age and disability as rating factors in insurance* (2011), Groupe Consultatif Actuariel European Position Paper

the removal of waiting periods is not a radical move towards regulation as group insurance policies do not warrant such measures *per se* due to the redistribution of risk across a large pool of beneficiaries. Although public health insurance providers are adequately capable of governance in accordance to the Indian Constitution, sustainability of risk assessment in private markets will be the litmus test of the regulatory prospects and limits of law. The macro-economic perspective reviewed herein therefore clarifies that regulators and courts must develop standards that are aligned with reality of private markets, in order to accurately test the usage of actuarial data, validity of risk factors (correlative or causal) and propriety of risk shielding measures like higher premiums, caps on insured sum, waiting periods, sub-limits, co-payments and deductibles, among others.

## 3. The law and policy framework governing persons with disabilities in the insurance sector

### I. INDIA

#### 3.1 Insurance governance

The insurance sector is governed by the *Insurance Regulatory and Development Authority Act, 1999* (IRDA Act), which mandates IRDAI to strike a balance between the competing interests of promoting business efficiency, regulating service providers and protecting interests of policyholders.<sup>37</sup> As per law, health insurance provides for “sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient travel cover and personal accident cover”.<sup>38</sup>

In a 2023 stakeholder consultation on concerns of persons with disabilities in health insurance, the IRDAI acknowledged that beyond removal of entry level barriers, the lack of regulation on risk assessment contributes to persons with disabilities who are fortunate to receive coverage being underinsured.<sup>39</sup>

Their exclusion persists despite IRDAI’s periodic initiatives to urge the insurance sector to promote fairness in access for all policyholders in general and adopt graded measures for policyholders with pre-existing conditions in particular. The *IRDAI (Health Insurance) Regulations, 2016* govern the health insurance sector in order to:

- authorize actuaries to modify policies if they are found to be financially unviable or deficient,
- permit waiting periods up to 4 years for covering pre-existing conditions,
- mandating insurers to evolve an underwriting policy (which must be periodically reviewed) that clarifies its approach on risk categorization,
- ensuring premiums are based on relevant risk factors (for example, age)
- ensuring premiums for senior citizens must be fair, justifiable and transparent.

The *IRDAI (Protection of Policyholders’ Interests) Regulations, 2017* provide that:

- Provision of internal grievance redressal mechanism for policyholders,
- Policies shall clearly state the waiting period for pre-existing conditions,
- In stipulating exclusions, the policy shall aim to classify them as:
  - Standard exclusions applicable in all policies;

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<sup>37</sup> Section 14, IRDA 1999

<sup>38</sup> Section 2 (6C), *Insurance Act, 1938*

<sup>39</sup> *Minutes of the Open House Consultation on the Issues of Insurance of Persons with Disabilities*, National Human Rights Commission, National Centre for Promotion of Employment for Disabled People and Insurance Regulatory and Development Authority of India, 2023

- o Exclusions specific to the policy which cannot be waived;
- o Exclusions specific to the policy, which can be waived on payment of additional premium.

The Insurance Ombudsman is an external grievance redressal authority that is tasked with resolving disputes related to delay or denial in settlement of claims, level of premium charged, misrepresentation of policy terms and conditions, policy serving issues or breach of any IRDAI regulation, circular, guidelines or instruction.<sup>40</sup>

The *IRDAI Guidelines on Standardization of Exclusions in Health Insurance Contracts* (2019) provide that:

- health insurance policies shall not exclude health conditions if the concerned aetiology (causation) is not known,
- waiting periods can be imposed, but not exceeding 4 years,
- health insurance providers can exclude pre-existing conditions after exploring whether the underwriting policy of the provider enables coverage by levying 'loading charges',
- Insurers can impose sub-limits for health conditions in terms of amount or percentage of sum insured or number of days of hospitalization, based on sound actuarial principles.

The *IRDAI Circular on Disclosure of Underwriting Philosophy of Offering Insurance Coverage to Persons with Disability, Persons living with HIV and Persons with Mental Illness* (2020) mandated all health insurance providers to upload a record of their underwriting philosophy with respect to these groups on their websites. In 2022, the IRDAI issued a similar circular with respect to transgender policyholders.<sup>41</sup>

The *IRDAI Circular on Product for Persons with Disabilities, Persons living with HIV/AIDS and Persons with Mental Illness* (2023) reiterated the 2020 guidance for all insurers to frame underwriting policies in compliance with the aforesaid 2016 Regulations, in order to ensure that such vulnerable groups are not denied coverage, enclosing a model policy, which insurers can traverse beyond but not constrict.

The model policy prescribes the eligibility criteria of benchmark disability (40%), sanctions risk shielding measures (including a waiting period of 2 years) and bars coverage of assistive devices. The 2023 guidance does not offer any rationale for the eligibility condition - a clear derogation of law<sup>42</sup> - or the regulator's policy decision on refusal to confer the benefit of waiver of exclusions on payment of additional premium as codified in the 2017 Regulations. However, in the interim, public insurers have rolled out policies that reproduce the model policy's restrictive terms and conditions.<sup>43</sup>

<sup>40</sup> IRDA (*Insurance Ombudsman*) Rules, 2017

<sup>41</sup> *Disclosure of underwriting philosophy of offering health insurance coverage to transgender persons* (2022), IRDAI

<sup>42</sup> *Vikash Kumar v. Union Public Service Commission*, (2021) SCC Online SC 841

<sup>43</sup> *Divyangjan Sanjeevani Policy Prospectus*, National Insurance Company Limited. Available at: <https://nationalinsurance.nic.co.in/products/all-products/health/divyangjan-sanjeevani-policy-national>;

In 2024, the IRDAI revised earlier regulations. In particular, the *IRDAI (Insurance Products) Regulations, 2024* repeal the 2016 Regulations. Among other concerns, they provide:

- All risks relevant to the product are appropriately considered in pricing,
- Premium rates are fair, provide value for money and not excessive or unfairly discriminatory,
- Insurers shall endeavour to offer coverage to all persons with pre-existing conditions,
- The maximum upper limit for waiting periods on pre-existing conditions is revised to 3 years,
- Despite the prescription of waiting period, insurers shall endeavour to have lower waiting periods (< 3 years).

The *IRDAI (Protection of Policyholders Interests, Operations and Allied Matters) Regulations, 2024* repeal the 2017 Regulations, chiefly revoking policyholders' right to seek waiver of exclusions on payment of additional premium. Among other concerns, they provide:

- Insurers must ensure inclusivity and accessibility of coverage to persons with disabilities,
- Insurers shall ensure that terms and conditions are not unfair, coercive or one-sided.

IRDAI master circulars (2024-25) recommend health insurance providers to make available policies/add-ons/riders to facilitate access to “*every situation of treatment, including domiciliary hospitalization, outpatient treatment (OPD), day care and homecare services*”.<sup>44</sup> This framework of law governing the health insurance business provides insights on how policyholders with disabilities can expect to frame their demands, navigate risk shielding measures and identify proposals for reform to seek fairer terms and conditions.

### **3.2 Duty to remove economic barriers for persons with disabilities in health insurance**

The *Rights of Persons with Disabilities Act, 2016* (RPD Act) provides the extant framework for equality and the scope of the government's duty to prevent discrimination with respect to persons with disabilities.

Section 2(h) of the law defines discrimination as:

*“any distinction, exclusion, restriction on the basis of disability which is the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms in*

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*Atmanirbhar Health Policy, New India Assurance Co. Ltd. Available at: <https://www.newindia.co.in/health-insurance/atmanirbhar-health-policy>*

<sup>44</sup> *IRDAI Master Circular on Health Insurance Business (2024) read with IRDAI Master Circular on Protection of Policyholders Interests (2025)*

*the political, economic, social, cultural, civil or any other field and includes all forms of discrimination and denial of reasonable accommodation”*

Chapter V (social security, health, rehabilitation and recreation) of the RPD Act guarantees insurance for public employees with disabilities, social security, health services (including assistive devices), sanitation facilities and a comprehensive insurance scheme. In particular, the obligation in Section 25 of the appropriate government to facilitate access to health services includes the authority to ensure “barrier-free” access in public and private healthcare establishments<sup>45</sup> covers the explicit duty to remove economic, institutional or structural barriers<sup>46</sup> which impedes access to health insurance.<sup>47</sup>

Although Section 3 broadly prescribes non-discrimination as the rule of law, differential treatment towards persons with disabilities is permitted if such treatment is proportionate to achieve a legitimate aim as per Section 3(3). If a person with disabilities seeks redressal for discriminatory conduct, the respondent must clarify whether the alleged conduct is saved by the exception.<sup>48</sup> This is a codification of ‘indirect discrimination’.

In *Lt. Col. Nitisha v. Union of India* (2021),<sup>49</sup> the Supreme Court observed that a facially-neutral policy, criteria or practice (‘PCP’) that inflicts an adverse and disproportionate burden on a group would constitute a violation of Article 15 on grounds of ‘indirect discrimination’. Although a protected group is not explicitly targeted for unfair treatment, if the practice renders them as outliers, a closer scrutiny of the structural framework is merited. A valid defence of the practice can be that it is a proportionate measure to serve a legitimate aim.

A comparative perspective in how these distinct forms of unfair treatment can manifest in insurance will clarify their underlying premise. In *Vikas Gupta v. Union of India* (2012),<sup>50</sup> the Delhi High Court struck down terms and conditions of higher premiums and inadequate insured sum for persons with visual impairment in employment-linked group life insurance. The court rejected the insurer’s practice (unsupported by data) of linking visual impairment with higher rate of accidents or mortality to prescribe the aforesaid risk shielding measures. Ultimately, the court held that persons with visual impairment deserve coverage in group life insurance on equal terms as persons without visual impairment.

This case is instructive as the court implicitly draws a boundary between the propriety of reliance on correlative factors versus causal factors to ensure actuarial fairness in risk assessment. As visual impairment is a difference in functional capacity which does not contribute to death, this disability is not a *causal* factor. As visual impairment only bore a statistical link to higher rate of accidents or mortality, this disability is a *correlative* factor.

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<sup>45</sup> Section 25 of the *Right of Persons with Disabilities Act, 2016*

<sup>46</sup> Section 2(c) of the *Right of Persons with Disabilities Act, 2016*

<sup>47</sup> Section 2(x) of the *Right of Persons with Disabilities Act, 2016*

<sup>48</sup> Rule 3(2) of the *Right of Persons with Disabilities Rules, 2017*

<sup>49</sup> 2021 SCC Online SC 261, paras. 56-97

<sup>50</sup> WP (C) No.10323/2009, order dated 15.02.2012

In a parallel to *Baby Devananda D.*, the court missed an opportunity to recognise that practices of risk assessment in group insurance are immaterial due to community-rating of the large pool of beneficiaries. As adoption of risk shielding measures was unwarranted in group insurance, this is a classic case of direct discrimination as the unfair treatment is premised on a value judgment of disability (i.e., persons with visual impairment do not deserve group life insurance on equal terms).

In contrast, reliance on a locomotor disability (fibromyalgia) to calculate premiums for health insurance is a valid practice as this is a causal factor, i.e., the adverse health impact is a reliable predictor of utilisation of health services. Although usage of disability as a causal factor serves a legitimate goal in practices of risk assessment, if terms and conditions (waiting period, higher premium, caps on insured sum, co-payments, sub-limits, deductibles etc.) restrict access to health services, this can amount to indirect discrimination on grounds of disability for levying disproportionately restrictive or exclusionary terms and conditions. As unwarranted risk shielding measures can pose ‘economic, institutional or structural’ barriers to seek financial protection by health insurance, regulatory authorities have a duty to intervene to calibrate terms and conditions.

### **3.3 Transition from exclusion to actuarial fairness in private health insurance markets:**

In *Neeraj Mehta & Anr. v. Tata AIG General Insurance Co. Ltd. (TAGICL)*,<sup>51</sup> the Delhi High Court found that exclusion of disability (a child with hearing loss needed an assistive device – a cochlear implant) based on the IRDAI’s 2019 Guidelines on standardised exclusions in health insurance *prima facie* violates the RPD Act. This matter was tagged with *Saurabh Shukla v. Max Bupa Health Insurance Co. (MBHIC)*,<sup>52</sup> which involved the issue of denial of coverage to a person with disabilities (tetraplegia, quadriplegia and other comorbidities) by MBHIC and Oriental Insurance Co. Ltd. (OICL) because of the individual’s medical history, severity of disability and prognosis of medical conditions, among other relevant factors. The court directed the IRDAI to hold consultations with health insurance providers and suggest framing inclusive policies.

In court, the IRDAI contextualised the insurers’ exclusion of disability based on risk assessment as per the 2016 Regulations, as such:

*“...if at all the Respondent companies’ actions can be justified, they can only be done so on the ground that the Petitioner’s probability of filing a claim each year is too close to 1. In such a scenario, the Petitioner would be placed in a pool of people all of whom have a probability close to 1, resulting in a situation where each person in the pool is filing a claim each year. This would lead to a situation where there is no cross subsidization possible, since each person in the pool is*

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<sup>51</sup> 2023 SCC Online Del 487

<sup>52</sup> WP (C) No. 6074/2019

*filing a claim and there is nobody to cross subsidize. Therefore, each person's premium would have to be roughly similar to their payout.”<sup>53</sup>*

The court's initial response to this dilemma is instructive on the limitation of seeking recognition decontextualised from underlying conditions for redistribution. The court correctly frames the exclusion of persons with disabilities in private markets as discriminatory. However, it drew unwarranted parallels to *Vikas Gupta*, suggesting that risk shielding measures like charging higher premiums to persons with disability compared to persons without disabilities would *per se* constitute direct discrimination.

As previously noted, this view is erroneous as reliance on correlative factors (discriminatory conduct) is not comparable to the usage of causal factors (differential treatment) for risk assessment. Instead, courts must scrutinise whether higher premiums – which otherwise serve the legitimate aim of risk shielding for insurers – inflict a disparate impact on persons with disabilities. If this view is discernible from the group's core traits (for instance, social and economic indicators), the logical corollary is to determine the extent to which insurers can modify policies to offer coverage in an equitable manner.

The court ultimately corrects course at the closing stage of hearings, by explicitly directing that health insurance providers (public and private) must offer reasonable accommodation in coverage, i.e., adapt risk shielding measures to balance the competing interests of policyholders' interests with insurers' financial viability.<sup>54</sup> This is a robust framework, as cognisance of the economic model underlying the private market allows for precision in calibrating the terms and conditions. However, this view clarifies that demands for fairer terms and conditions by persons with disabilities in the private sector must operate within the limits of testing the proportionality of risk shielding measures, rather than dismantling them *per se*.

After a round of consultation with insurers, the regulator issued the IRDAI Circular (2023) that instructs all insurers to disclose their underwriting policy with respect to persons with disabilities and adopt the aforesaid model policy. In compliance with the court's orders, MBHIC offered a policy to the petitioner, who flagged unfairness of terms and conditions (inadequate insured sum, high premiums, excessive loading charges, waiting periods beyond permissible limits). However, the petitioner accepted the policy, as the court reserved his right to contest terms and conditions at the appropriate stage.<sup>55</sup> At the stage of disposal, the court notes IRDAI's efforts in supervising insurers' duty to amend policies to cover persons with disabilities. However, there is no clarity on TAGICL's coverage of the child with the hearing disability.

In *Subhash Khandelwal v. Max Bupa Health Insurance Co. Ltd.* (2026), Indian courts have formally initiated scrutinising actuarial fairness in health insurance. A

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<sup>53</sup> *Saurabh Shukla v. Max Bupa Health Insurance Co.*, WP (C) No. 6074/2019, order dated 13.12.2022

<sup>54</sup> *Saurabh Shukla v. Max Bupa Health Insurance Co.*, WP (C) No. 6074/2019, order dated 18.08.2023

<sup>55</sup> *Saurabh Shukla v. Max Bupa Health Insurance Co.*, WP (C) No. 6074/2019, order dated 17.03.2023

policyholder who purchased health insurance of INR 35 lakhs has contested inadequate coverage of mental illness (INR 50,000) in private health insurance.<sup>56</sup> The insurer has relied on the IRDAI Guidelines (2019) on standardisation of exclusions that permit prescribing sub-limits for health conditions in terms of amount, percentage of sum insured or number of days of hospitalisation. However, the Delhi High Court has taken notice that such terms must be based on reliable actuarial data and instructed the insurer to produce appropriate evidence on record.<sup>57</sup>

Although coverage of mental illness has grown, about 13% of insurers restrict the insured sum and a majority unfairly exclude self-harm (83%) and substance use disorders (99%).<sup>58</sup> This not only ignores the compounding impact on persons with disabilities who have a co-morbidity of mental illness, but is indicative of the sector's resistance to regulations that forbid such exclusions.<sup>59</sup> As mental illness is a disability,<sup>60</sup> policyholders are entitled to seek actual fairness by examining the disparate impact of disproportionately restrictive or exclusionary terms and conditions and demand modification, in appropriate cases.

### 3.4 The balancing scale of reasonable accommodation and undue burden

Persons with disabilities may face certain functional difficulties and barriers (physical, digital, information, administrative, attitudinal, social, etc.) due to which they may not be able to fully participate in social and economic contexts. In the context of workplaces, for instance, working conditions like timing, job description, leave, supervising policy, etc. may need re-structuring to promote equality of opportunity. Hence, accommodation or adjustments are necessary to remove barriers and promote a level playing field. The RPD Act codifies the concept of reasonable accommodation as:

*“necessary and appropriate modification and adjustments, without imposing a disproportionate or undue burden in a particular case, to ensure to persons with disabilities the enjoyment or exercise of rights equally with others”<sup>61</sup>*

The law prescribes a general duty to provide reasonable accommodation in all contexts<sup>62</sup> as well as explicitly identifying legal services, academic institutions, information technology and employment for such accommodation.<sup>63</sup> The law clarifies that no establishment (public or private) shall compel the beneficiary to partially or fully pay the costs incurred for reasonable accommodation.<sup>64</sup>

<sup>56</sup> *Subhash Khandelwal v. Max Bupa Health Insurance Co. Ltd.*, WP (C) No. 4010/2021, order dated 15.04.2021

<sup>57</sup> *Subhash Khandelwal v. Max Bupa Health Insurance Co. Ltd.*, WP (C) No. 4010/2021, order dated 13.03.2026

<sup>58</sup> Varma, A. et al (2025), *Insurance coverage for mental illness: A review through a lens of bio-ethics*, Indian Journal of Medical Ethics

<sup>59</sup> Section 2(s) [mental illness] read with Section 115(2) [presumption of severe stress in case of attempt to commit suicide] of the MHCA

<sup>60</sup> Section 2(zc) read with the Schedule of the *Rights of Persons with Disabilities Act, 2016*

<sup>61</sup> Section 2(y) of the *Rights of Persons with Disabilities Act, 2016*

<sup>62</sup> Section 3(5) of the *Rights of Persons with Disabilities Act, 2016*

<sup>63</sup> Section 12(3), Section 16 (iii), Section 20(2), Section 65(2)(e) and Section 71(2)(e) of the *Rights of Persons with Disabilities Act, 2016*

<sup>64</sup> Rule 3(4) of the *Rights of Persons with Disabilities Rules, 2017*

In *Vikash Kumar v. Union Public Service Commission* (2021),<sup>65</sup> the Supreme Court offers guidance to the private sector's duty to offer reasonable accommodation. In particular, the court notes the duty bearer's assessment of the reasonableness of accommodation must not only account for benefit to the person asking for it but also the collective impact of providing the same. The provision of reasonable accommodation must be made on a case-by-case basis, in consultation with the person with disabilities. If the duty bearer is of the opinion that granting accommodation will inflict a disproportionate or undue burden, this must be proven based on objective criteria, including:

- Estimated financial costs,
- Availability of resources with the entity (including public subsidies, tax benefits, incentives),
- Overall assets of the duty bearer, rather than simply resources available to a unit/department of the entity must be accounted for,
- Size of the accommodating party, and
- Impact of the accommodation on the requesting party as well as collective benefits to third-parties.

In *Ranjit Kumar Rajak v. State Bank of India* (2009),<sup>66</sup> the Bombay High Court tested the denial of recruitment to a person with a pre-existing condition on grounds of being certified as 'medically unfit' to perform the job. A closer scrutiny to the employer's underlying rationale for denial disclosed their unwillingness to pay employment-linked health benefits on the plea of undue burden. As the Indian law and policy framework lacked explicit guidance on this aspect, the court developed similar conditions as *Vikash Kumar* to determine the validity of the employer's contention.

Since the employer could not offer reliable data to prove that providing health benefits would inflict a disproportionate or undue burden on their operations, the court rejected the plea and directed the candidate's appointment. Hence, the guidance on undue hardship in providing reasonable accommodation in *Vikash Kumar* is squarely applicable in the context of persons with disabilities seeking modification of terms and conditions in private markets.

### **3.5 Regulation of private entities that are engaged in delivery of core public services**

As the Indian government moves from a provider of health services to a regulatory role on account of increasing privatisation of the healthcare sector, businesses dealing with delivery of core public services must be held to a higher standard of accountability in order to plug the gaps in IRDA regulations.

A large network of actors within the private healthcare sector merit regulation – healthcare professionals, clinical establishments, health insurance providers and

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<sup>65</sup> (2021) SCC Online SC 841

<sup>66</sup> 2009 SCC Online Bom 732

pharmaceutical corporations, among others.<sup>67</sup> The duty to ensure price control measures in health services – in general or emergency contexts<sup>68</sup> - is a cornerstone of any equitable regulatory framework. In the context of pharmaceutical products, courts have routinely affirmed the government's duty to intervene to regulate unchecked profiteering in life-saving services. In addition to various statutory frameworks, the authority vested with the government under Article 39[b] (principles of policy to be followed by the State) read with Article 47 (duty of the State to improve public health) of the Constitution authorises ensuring service providers comply with price control measures, in order to promote affordability.<sup>69</sup> Hence, a demand for regulation over pricing of private health insurance policies will not be novel *per se*.

When it comes to the delivery of core public services, Indian courts have clarified that the form of the institution (public or private) is immaterial. 'Any person' concerned with the delivery of public services like healthcare or education is amenable to the jurisdiction of High Courts for monitoring violations of fundamental rights, as these services have a significant impact on public well-being and capabilities.<sup>70</sup> The rationale for dispensing the strict bifurcation of public and private entities in the delivery of public services is explained as such:

*“Judicial review is designed to prevent the cases of abuse of power and neglect of duty by public authorities. However, under our Constitution, Article 226 is couched in such a way that a writ of mandamus could be issued even against a private authority. However, such private authority must be discharging a public function...The role of the State expanded enormously and attempts have been made to create various agencies to perform the government functions... At the same time, there are private bodies also which may be discharging public functions.*

*It is difficult to draw a line between the public functions and private functions when it is being discharged by a purely private authority. A body is performing a “public function” when it seeks to achieve some collective benefit for the public...Bodies therefore exercise public functions when they intervene or participate in social or economic affairs in the public interest.*

...  
*For instance, a body is performing a public function when it provides “public goods” or other collective services, such as healthcare, education and personal social services, from funds raised by taxation.*

...  
*Public functions need not be the exclusive domain of the state. Charities, self-regulatory organizations and other nominally private institutions (such as universities, the stock exchange...churches) may in reality also perform some*

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<sup>67</sup> Sanap, S. and Bharadwaj, K, (2023), *The Executive-Judiciary Interface in Areas of Health*, RTH-UHC Working Paper II, Centre for Health Equity, Law and Policy, Indian Law Society

<sup>68</sup> *In re: Distribution of essential supplies and services during the pandemic*, Suo Moto (Civil) WP No. 3/2021

<sup>69</sup> *Union of India & Anr. v. Cynamide India Ltd. & Anr.* 1987 AIR 1802; *Vincent Panikurlangara v. Union of India*, 1987 SCC (2) 165, *Indian Pharmaceutical Alliance & Anr. v. Union of India & Ors.*, WP (C) No. 2700/2014, order dated 26.09.2016; *Healthcare Global Enterprises Ltd. v. Union of India & Anr.*, (2022) SCC Online Kar 1595; *Novartis AG & Ors. v. Union of India & Ors.*, AIR 2013 SC 1311; *Bayer Corporation v. Union of India*, AIR 2014 Bom 178

<sup>70</sup> *Andi Mukta Sadguru Shree Mukta Jeevandas Swami Suvarna Jayanti Mahotsav Smarak Trust v. VR Rudani*, (1989) 2 SCC 691

*types of public function...Non-governmental bodies such as these are just as capable of abusing their powers as is government.*

...

*A writ of mandamus can be issued against a private body which is not a State within the meaning of Article 12 of the Constitution and such body is amenable to the jurisdiction under Article 226 of the Constitution and the High Court ... can exercise judicial review of the action challenged by a party”<sup>71</sup>*

This doctrine prompted price standardization of private hospitals, nursing homes and laboratories, among other facilities, during the COVID-19 pandemic.<sup>72</sup>

The prescription in Article 15(2) of the Constitution that no citizen shall be subject to any liability or restriction in access to ‘shops’ is explicitly horizontal in application, i.e., it covers public and private actors. The Supreme Court has affirmed the validity of public service obligations on private, unaided higher medical academic institutions, in terms of granting reservation for Scheduled Caste and Scheduled Tribe (SC/ST) communities, by resorting to Article 15(2).<sup>73</sup> The court’s reliance on Dr. BR Ambedkar’s commentary on the provision, who was responding to a query in the Constituent Assembly on whether ‘shops’ covers healthcare professionals or lawyers services, is instructive:

*“To define the word ‘shop’ in the most generic term one can think of is to state that ‘shop’ is a place where the owner is prepared to offer his service to anybody who is prepared to go there seeking his service....Certainly it will include anybody who offers his services. I am using it in a generic sense. I should like to point out therefore that the word ‘shop’ used here is not used in the limited sense of permitting entry. It is used in the larger sense of requiring the services if the terms of service are agreed to.”<sup>74</sup>*

Although Article 15(1) does not explicitly prohibit discrimination on grounds of disability, courts have ventured beyond the fixed categories of grounds prescribed therein (caste, religion, sex) and evolved analogous grounds (genetic conditions, sexual orientation, gender identity) by locating the Constitution in a rights-based discourse. In cases where statutory law or regulations are inadequate, courts have routinely applied constitutional principles horizontally to foist accountability on private actors in matters of violation of patient rights in healthcare facilities,<sup>75</sup> unfair treatment towards persons with disabilities in air travel,<sup>76</sup> prevention of sexual harassment at workplaces<sup>77</sup> and women’s membership in trade unions,<sup>78</sup> among other instances. This doctrine of ensuring accountability of private actors in cases of lacuna of statutory law has reached critical consensus in Indian law<sup>79</sup> and merits articulation in the context of private health insurance markets.

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<sup>71</sup>*Binny Limited v V. Sadasivan*, (2005) 6 SCC 657

<sup>72</sup>*Suo Moto v. State of Gujarat*, WP (PIL) No. 42/2020, orders dated 29.05.2020 and 24.07.2020

<sup>73</sup>*Indian Medical Association v. Union of India*, (2011) 7 SCC 179

<sup>74</sup>Constituent Assembly Debates – Vol. VII (29 November 1948), Parliament of India

<sup>75</sup>*Dr. Sanghamitra Acharya v. NCT of Delhi*, 2018 Del SCC Online 8450

<sup>76</sup>*Jeeja Ghosh & Ors. v. Union of India*, (2016) 7 SCC 761

<sup>77</sup>*Vishaka v. State of Rajasthan*, (1997) 6 SCC 241

<sup>78</sup>*Charu Khurana v. Union of India*, (2015) 1 SCC 192

<sup>79</sup>*Kaushal Kishor v. State of Uttar Pradesh*, 2023 SCC Online SC 6

## II. INTERNATIONAL AND COMPARATIVE PERSPECTIVES

India has ratified the *International Covenant on Economic, Social and Cultural Rights, 1966* (ICESCR), that mandates member states ‘respect, protect and fulfil’ the right to the highest attainable standard of physical and mental health for all people. The CESCR Committee obliges member states to focus on *availability, accessibility, acceptability* and *quality* (‘AAAQ’) of health services.<sup>80</sup> The obligation to ‘protect’ includes an explicit duty to regulate the private sector, whereas the obligation to ensure ‘accessibility’ includes the inextricable component of guaranteeing affordability of health services (whether publicly or privately provided). As a signatory to the convention, India has a duty to utilize the maximum of available resources to achieve progressively the full realization of convention rights. In particular, the committee observes this includes the duty of member states to provide public, private or mixed health insurance systems which are affordable for all and do not discriminate on the ground of disability.

The *Convention on Rights of Persons with Disability, 2006* (CRPD), which was ratified by India in 2007, is relied upon by the Parliament in framing the RPD Act. In particular, Article 25(e) of CRPD obliges member states to prohibit discrimination against persons with disabilities in access to health insurance, which the CRPD Committee clarifies applies to the private market.<sup>81</sup>

The UN Special Rapporteur on the Rights of Persons with Disabilities (UNSR-RPWD) notes that apart from exclusion from coverage, discrimination may also occur in the manner in which insurance plans are designed, limiting the benefits or coverage or disproportionately increasing the cost of premium. In this regard, the UNSR-RPWD recommends that states should consider adopting regulations to ensure that insurance plans and premiums are fixed in a fair and reasonable manner.<sup>82</sup>

The UN Office of the High Commissioner of Human Rights (UNOHCHR) recommends that governments should adopt legislative measures to explicitly prohibit health insurers from discriminating based on pre-existing conditions and repeal any provision excluding from or reducing coverage or otherwise providing disadvantageous insurance conditions for persons with disabilities.<sup>83</sup>

In the private market, the practice of risk classification of individuals is linked to a group’s common or generalised characteristics which are material to the individual’s profile. In the context of persons with disabilities, some insured persons placed in a risk pool might not share the average characteristics of that pool, with the result that the rate they pay or extent of insurance cover does not correspond to their lived reality – which benefits or disadvantages a person with disabilities based on their individual profile. Therefore, risk pooling becomes a difficult task for persons with disabilities, given that some can be fully functional provided they are on

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<sup>80</sup> General Comment No. 14 (GC14): *The Right to Highest Attainable Standard of Health* (2000)

<sup>81</sup> General Comment No. 6 (GC6) *on Equality and Non-discrimination* (2018)

<sup>82</sup> 2018, A/73/161

<sup>83</sup> *Policy Guidelines for Inclusive Sustainable Development Goals*, SDG-CRPD Resource Package, 2020

medication/treatment and some suffer from multiple disabilities. Private insurers often knowingly classify them into broad groupings, hence, failing to assess the risk on a personal level and refined characteristics of the disability. This violates the CRPD, as the convention's preamble enjoins member states to safeguard rights of persons with disabilities by having due regard to the diversity of the group.<sup>84</sup>

Apart from low-and-middle income countries (LMIC) like Vietnam<sup>85</sup> that provide insurance based on the social solidarity model that cover persons with disabilities (including treatments for rare diseases in Colombia),<sup>86</sup> South Africa and Kenya subsidise policyholders in private markets (by paying for coverage or granting tax deductions) where they are not covered by national health insurance schemes.<sup>87</sup> However, the problem of risk-rated premiums, inadequacy in package of benefits, de facto exclusion of persons with pre-existing conditions and policies that divert patients from affordable public providers towards high-cost private providers has compelled governments across the globe to regulate the private market, including enforcing community-rated premiums in Ireland to balance private markets' financial solvency with consumer protection.<sup>88</sup>

As national health insurance schemes are beyond the scope of this policy brief, review of law and policy frameworks is limited to foreign jurisdictions that provide explicit guidance on regulating discriminatory conduct, usage of actuarial data and reasonable accommodation in private health insurance markets:

### 3.6 Hong Kong

The Equality Opportunities Commission (EOC) of Hong Kong has urged the federation of insurance bodies to provide coverage to persons with disabilities by adopting least restrictive practices, such as ensuring coverage by charging higher premiums and/or limiting cover. However, the EOC has noted that such modified terms must also comply with the duty to prevent discrimination, by ensuring that they are actuarially justifiable. The decisions based on actuarial data derived from unreliable sources, inaccurate and irrelevant to the time and location of underwriting may not be considered reasonable in law.<sup>89</sup>

Apart from actuarial data, the *Disability Discrimination Ordinance, 1996 (DDO)* permits reliance on 'other data' –

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<sup>84</sup> Kuschke, B. (2018), *Disability discrimination in insurance*, University of Pretoria

<sup>85</sup> Banks, LM et al (2018), *Disability-inclusive social protection research in Vietnam: A national overview with a case study from Cam Le district*, London School of Hygiene and Tropical Medicine and Hanoi University of Public Health

<sup>86</sup> *IBA Healthcare and Life Sciences Law Committee: Healthcare Financing and Reimbursement Survey of Colombia* (2025)

<sup>87</sup> Axelson, H. and Goursat, MP. (2019), *Providing additional benefits coverage: A review of country experiences to inform Vietnam's revision of the health insurance law*, International Labour Organization (ILO)

<sup>88</sup> *Ibid*

<sup>89</sup> *Discussion Paper on Insurance Issues under the Anti-discrimination Legislation*, Equal Opportunities Commission, 2003

- underwriting manuals,
- local and overseas data/statistics/research,
- domestic and international claims experience, and
- medical opinion.

### 3.7 Australia

The *Disability Discrimination Act, 1992* in Australia provides a general exception for the insurance sector (general, health and life), prescribing that denial or providing the service on differential terms is acceptable in law only if such practice is based on:

- actuarial evidence (the data is applicable to the particular facts of the matter, adequate sample size, any qualifications on data, etc.), or
- other relevant factors (individual's particular circumstances, business considerations, less discriminatory options are not available etc.), and
- unjustifiable hardship to service providers.<sup>90</sup>

In *Ella Ingram v. QBE Insurance Ltd.*,<sup>91</sup> the Victorian Civil and Administrative Tribunal held that incurring any cost or effort in facilitating access to insurance for a person with a disability does not amount to unjustifiable hardship *per se*; such as, a claim for exemption due to reduction in profits must be proven by supporting evidence.

In *Xiros v. Fortis Life Assurance*,<sup>92</sup> the Federal Magistrate Court noted the law prohibits insurers from refusing coverage to persons with disabilities only on grounds that:

- the insurer does not have any data, if it would otherwise be reasonable to provide coverage having regard to other relevant factors
- the practice is supported by insurance industry's historical practice
- the insurer has based its decision on inaccurate assumptions or stereotypes of persons with disabilities.

The *Guidelines for Providers of Insurance and Superannuation under the Disability Discrimination Act 1992* (2016) state that the duty to provide reasonable adjustments/accommodation includes offers of insurance on non-standard terms that take into account the particular circumstances of the person with disabilities. If non-standard terms are offered, this may involve exclusions or higher premiums. In order to determine whether such terms and conditions meet the duty of reasonable accommodation, the following factors may be relevant:

- whether the exclusion or higher premium is reasonable given the particular circumstances of the individual,

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<sup>90</sup> Section 46 of the *Disability Discrimination Act, 1992*

<sup>91</sup> (2015) VCAT 1936

<sup>92</sup> (2001) FMCA 15

- whether there are clear and specific time limitations on the application of the exclusion or higher premium;
- the criteria the individual would have to meet to remove the exclusion or reduce the premium;
- the process involved in removing or amending the non-standard exclusion or premium.

### 3.8 Canada

In *Zurich Insurance Co. v. Ontario Human Rights Commission* (1992),<sup>93</sup> the Supreme Court of Canada was concerned with the issue of validity of reliance on prohibited grounds (age, sex, marital status) as actuarial factors in setting differential rates of premium for automobile insurance payable by young, single, male drivers, in contrast to -

- young, single, female drivers
- young, married, male driver, and
- any driver above 25 years of age.

The court noted that a fundamental tension exists between the insurance sector and human rights law, insofar as the insurance sector treats individuals on the basis of stereotypes of the group characteristics. Although there is no causal connection between age, sex and marital status with automobile accidents and insurance claims, the court found that a statistical correlation exists between such factors and the risk. In order to minimise the risk of such 'statistical discrimination' (imposing liability on an individual for the collective's actions), the 5 judge majority verdict developed a twin-test of fair use of actuarial data –

- that it is for a legitimate business activity,
- that there is no practical alternative (the data related to non-discriminatory causal actuarial factors like driving record, accident records, traffic tickets etc. were not available at the time of hearings).

The majority verdict upheld the practice of reliance on prohibited grounds as actuarial factors in so far as they complied with the standard of reasonable and bona fide usage of prohibited grounds, in accordance with Section 22 of the *Ontario Human Rights Code (OHRC), 1981*. However, in order to avoid statistical discrimination, the court suggested that the insurance sector must strive to avoid setting premiums based on prohibited grounds in the future which are correlative factors.

The OHRC's *Policy and Guidelines on Disability and the Duty to Accommodate (2009)* guidance for establishments on compliance with the principles on inclusion of persons with disabilities and the appropriate factors for the defence of undue hardship are notable. Although the policy deals with inclusion at the workplace, the

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<sup>93</sup> [1992] 2 SCR

broad principles are qualitatively similar to insurance-centric guidelines in comparable jurisdictions. For instance, the guidelines require that the onus of proof on the plea of undue hardship lies on the party raising such a claim and the evidence must be borne out by facts, figures, data or expert opinion.<sup>94</sup>

The OHRC guidelines further provide that in order to determine whether a financial cost would substantially affect the viability of the entity obliged to provide reasonable accommodation, the following parameters are noteworthy:

- ability of the entity to recover costs of accommodation in the normal course of business,
- availability of any grants, subsidies or loans from local, state or central government or non-governmental sources which can offset such cost,
- ability of the entity to distribute the cost throughout the whole operation,
- If immediate implementation of the reasonable accommodation requires substantial expenditure which can adversely impact the entity's viability, an approach of progressive realisation can be adopted,
- the ability of the entity to deduct from the cost any savings that may be available, including:
  - tax deductions or other government benefits,
  - any increase in clientele.

### 3.9 European Union (EU)

In *Association belge des Consommateurs Test-Achats ASBL & Ors. v. Conseil des d ('Test Achats')*,<sup>95</sup> the European Court of Justice (ECJ) upheld the prohibition of use of sex as a correlative factor for actuarial purposes in the private market, as mandated by Article 5(1) of the *European Council Directive 2004/113/EC* ('gender equality directive'), which seeks to implement the principle of equal treatment of men and women in access to goods and services. In particular, Article 5(2) of the directive which permitted a derogation from the general rule without any limitation was struck down and member states were required to comply with Article 5(1). Article 5(3) specifically forbids the use of pregnancy and maternity as risk factors across all lines of insurance. In order to offset any potential imbalances in the market due to cessation of sex as a correlative factor, the reconfiguration in actuarial factors was held to apply for new contracts entered into after coming into force of such directive.

In the backdrop of *Test Achats*, the *European Commission Guidelines on Application of the Gender Equality Directive to Insurance in light of the Test Achats decision* (2012) provide that:

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<sup>94</sup> *Superintendent of Motor Vehicles v. British Columbia*, 1999 3 SCR 585; *Public Employee Relations Commission v. British Columbia*, 1999 3 SCR 3

<sup>95</sup> *Association belge des Consommateurs Test-Achats ASBL, Vann van Vugt, Charles Basselier v. Conseil des Ministres*, Case C-236/09

- In so far as Article 5(1) mandates the unisex rule, it means that premiums and benefits cannot be different between two individuals for the same insurance policy simply because their gender is not the same (for example, automobile insurance and pension annuities where gender bears a correlative risk to accident claims and life expectancy respectively),
- The underlying objective of Article 5(3) is to foster a solidarity mechanism for women as far as pregnancy and maternity are concerned, in general contexts and health services in particular, by proscribing differences in individual premiums and benefits arising from such costs. This policy choice proceeds on the rationale that the costs of pregnancy and maternity must be redistributed across the population as women would not bear such costs without the role of men,
- On the other hand, Article 4(5) explicitly permits insurers to offer differential premiums and benefits if such a decision is justified by a legitimate aim and the means of achieving that aim are proportionate and necessary. The physiological differences between men and women give rise to qualitatively different health concerns (such as, family history of prostate or testicular cancer, breast or uterine cancer etc.), which permit health insurers to rely on sex as a causal factor for actuarial purposes.<sup>96</sup>

In the aftermath of the gender equality directive coming into force across the EU, French and German equality bodies have respectively ruled that gender-based risk classification in pension funds (higher premiums due to longer life expectancy for women as compared to men) and maternity related exclusions in mortgage insurance warranties (only limited to grounds of illness or accident causing unemployment, which renders an insured unable to repay mortgage) constitute discrimination based on sex in delivery of goods and services.<sup>97</sup>

The effect of the ECJ's ruling is that insurers are now required to restructure current actuarial factors used for risk assessment to prevent disparate rates for men and women. These measures strike at the root of risk classification as they effectively provide that mere statistical correlation between a group and a higher risk cannot justify discrimination on prohibited grounds, as such a correlation entrenches stereotypes (dominant characteristics of a group are applied to an individual from this group), which human rights law seeks to remove.<sup>98</sup>

The European Commission is presently deliberating the *Proposal for a Council Directive 2008/0140 on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation* in access to goods, services and facilities. The probability of discriminatory (direct or disparate treatment) outcomes by usage of age and/or disability by the insurance

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<sup>96</sup> *European Commission Guidelines on Application of the Gender Equality Directive to Insurance in light of the Test Achats decision* (2012)

<sup>97</sup> *Equality Bodies and the Gender Goods and Services Directive*, Equinet (2014)

<sup>98</sup> Kuschke, B. (2012), *Gender Equality in Insurance*, University of Pretoria

sector is a major motive for this proposal, which motivated the limitation, if not outright prohibition, of using age and disability for actuarial purposes.

The latest version of the proposed directive provides that age and/or disability can be relied upon as actuarial factors for risk classification where such data is:

- appropriate (accurate, recent and relevant) in pricing a policy, and
- takes into account the individual profiles of applicants.

The directive prescribes the duty of reasonable accommodation and carves an exception with a plea of disproportionate burden for the duty bearer, which must account for:

- Size and nature of establishment,
- Resources available to the organisation,
- Possible benefits of increased access,
- Negative impact of denial,
- Amount of public funding available to the duty bearer.<sup>99</sup>

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<sup>99</sup> *Progress Report on Council Directive 2008/0140*, Council of European Union (2022)

## 4. Conclusions and Recommendations

The location of persons with disabilities in private health insurance markets necessitates balancing the collision in competing interests of financial protection for such policyholders and financial viability of insurers, given coverage in this economic model is fundamentally premised on the usage of disability as a risk factor. Although private sector actors engaged in the delivery of core public services must be amenable to stricter regulation, there is a limited margin of appreciation to seek fair terms and conditions (such as caps on insured sum, waiting period, exclusion, higher premiums, co-payments, sub-limits, deductibles etc.) in private markets.

At the stage India ratified the *General Agreement on Trade in Services* (GATS) in 1994, trade lobbyists pushed developing countries to transition from providers to regulators of the health services to promote competition in the private market (including via health insurance). These asymmetric international trade agreements were thrust on developing countries, despite the foresight of free markets' collapse in building more equitable risk pools that spread costs between the rich and poor, the healthy and sick.<sup>100</sup> This leads to the unavoidable conclusion that ultimately publicly financed social solidarity models like national and/or state-level health insurance schemes offer a sustainable and equitable route, for those who are not covered in employment-linked group insurance.

As India has ratified the ICESCR and CRPD, these frameworks are legally binding on the Indian government<sup>101</sup> by virtue of the *Protection of Human Rights Act, 1993*. In addition, as the norms clarified by Hong Kong, Australia, Canada and European Union with respect to actuarial fairness are consistent with the principles outlined in these conventions, Indian regulators can authoritatively rely on them to inform policy. In the absence of local laws to the contrary, Indian regulators have the power to rely on treaties, international agreements and comparative perspectives to apply local laws.<sup>102</sup>

A periodic capacity building of grievance redressal forums (internal complaints officers, insurance ombudsman, chief/state commissioners of disability, lok adalats, district consumer forums, courts) is needed to familiarise stakeholders with the prospects and limits of protecting interests of policyholders with disabilities as per the developing consensus in rights-based norms. The concerns as to whether policyholders are insured by public/private entities and insured under voluntary/group policies are especially germane for decision-making, which necessitates capacity building at the intersection of law and economics.

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<sup>100</sup> Lipson, D.J. (2001), *GATS and trade in health insurance services*: Background note for WHO Commission on Macroeconomics and Health

<sup>101</sup> *Laxmi Mandal and Ors. v. Deen Dayal Harinagar Hospital & Ors.*, (2010) 172 DLT 9

<sup>102</sup> *National Legal Services Authority v. Union of India*, (2014) 5 SCC 438

Although this policy brief deals with persons with disabilities and their interface with private health insurance markets, the risk rating of HIV-status, gender dysphoria and mental illness present similar law and policy concerns for various policyholders with pre-existing conditions. As special laws that prescribe prevention of discrimination and provision of reasonable accommodation for people living with HIV, transgender persons and persons with mental illness, the insights herein are transferable to their contexts to ensure actuarial fairness in health insurance.

The key local and comparative perspectives on regulating private health insurance markets to guarantee financial protection and delivery of health services to persons with disabilities are summarised with recommendations for stakeholders below:

## **4.1 Framing discrimination in private health insurance markets**

1. The focus of discrimination law with respect to coverage of persons with disabilities is five-fold:
  - a. The usage of disability as a correlative factor for actuarial purposes is clearly forbidden by the duty to prevent discrimination, as this practice can lead to statistical discrimination against policyholders with disabilities.
  - b. The reliance on disability as a causal factor for actuarial purposes is valid, as this serves legitimate goals of risk classification, prescription of risk shielding measures, pricing insurance and ensuring financial viability of insurers. However, a blanket exclusion is evidently discriminatory.
  - c. A disparate impact of risk shielding measures on policyholders with disabilities can be ascertained by testimonies, statistical evidence and qualitative data<sup>103</sup> that establishes unaffordability and unavailability of health services.
  - d. After a case of disparate impact is made out at the threshold, the private insurer has a duty to offer an explanation on proportionality of the risk shielding measures. This exercise is contingent on scrutinising fairness in usage of actuarial data / practice of risk classification.
  - e. Fairness in the practice of risk classification ('differential treatment') depends on:
    - i. Underwriting philosophy of insurer,
    - ii. Individual risk profile,

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<sup>103</sup> Id at 49, para. 95

- iii. Actuarial data: reliability, accuracy, relevance, geographical context and adequate sample size.

## 4.2 Private health insurer's duty to modify policies

1. Persons with disabilities can demand reasonable accommodation to modify terms and conditions (exclusions, waiting period, caps on insured sum, higher premiums, co-payments, sub-limits, deductibles, etc.) in private health insurance. In arriving at a decision, insurers must:
  - a. Take into account benefits to the concerned party and similarly placed policyholders,
  - b. Take into account facts and circumstances of every case,
  - c. Consult the concerned party.
2. If the private health insurer counters the demand for modifying terms and conditions by claiming financial unviability or undue burden, they bear an onus of supporting this claim with appropriate evidence on record, including:
  - a. Estimated financial costs,
  - b. Availability of resources with the entity (including public subsidies, tax benefits, incentives, corporate social responsibility fund),
  - c. Overall assets of the duty bearer must be accounted for, rather than resources available only to a unit/department of the entity,
  - d. Size of the accommodating party,
  - e. Beneficial impact of the accommodation on the requesting party as well as collective benefits to third-parties,
  - f. Adverse impact of denial on requesting party,
  - g. Ability of the entity to recover costs of accommodation in the normal course of business,
  - h. Ability of the entity to distribute the cost throughout the whole operation.
3. In LMIC settings, the duty of reasonable accommodation goes beyond ensuring universal design (for instance, renovation of buildings) to positively facilitating disability-responsive health services like coverage of assistive devices and rehabilitative services in health insurance.<sup>104</sup>

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<sup>104</sup> Phan, H. et al (2020), *Reviewing Vietnam's law on Persons with Disabilities in comparison with the Convention on Rights of Persons with Disabilities and international best practices*, United Nations Development Programme

### 4.3 The government's duty to ensure financial protection and provide health services

1. As insurance policies do not cover outpatient services, drugs, medical devices and diagnostics – that are known to inflict catastrophic OOPe on poor families<sup>105</sup> - the Central and State governments must adopt price control measures<sup>106</sup> to promote affordability as healthcare goods, services and facilities are material resources of the community.<sup>107</sup>
2. The IRDAI must consider constituting a National Disability Insurance Data Repository, that can yield evidence on claims and utilisation of health services by policyholders with disabilities. This can contribute to a reliable actuarial database and lead to precision in risk pricing.
3. The global evidence on private sector delivery of core public services like water, sanitation, health and education has compelled inter-governmental bodies to recommend that national governments must prescribe public service obligations on private actors to guarantee access.<sup>108</sup> In particular, the World Health Organisation (WHO) recommends to “*conscript private insurance to serve the public goal of equitable access*” by incentivising them to provide group insurance with compulsory enrolment at community-rating in LMICs.<sup>109</sup> Central and State governments must accordingly ensure that insurers are incentivized to provide group health insurance policies.<sup>110</sup>
4. Central and State governments must undertake all efforts to allocate maximum available budgetary resources<sup>111</sup> at their disposal to support inclusion of policyholders with disabilities in private health insurance markets, wherever appropriate. This proposal stems from precedents that supports the view that governments routinely invest in development concerns that maximize collective well-being, such as:
  - a. The government provides extensive ‘viability funding gap schemes’ to support economically desirable but commercially unviable development

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<sup>105</sup> Samir Garg et al. (2021), “*Comparing the average cost of outpatient care of public and for-profit private providers in India*”, BMC Health Services Research

<sup>106</sup> Entry 33 (trade, commerce, production, supply, distribution) read with Entry 34 (price control) of List III (Concurrent List) of Schedule VII, Constitution of India

<sup>107</sup> *Property Owners Association & Ors. v. State of Maharashtra* (2024) SCC Online SC 3122, paras. 225, 229(e)

<sup>108</sup> General Comment No. 24 (2017): *State obligations under the ICESCR in context of business activities*, E/C.12/GC/24

<sup>109</sup> Id at 27

<sup>110</sup> *Promoting an inclusive workplace for persons with disabilities in Thailand* (2022), United Nations Development Programme (UNDP)

<sup>111</sup> Id at 80

projects by public-private partnerships (PPP).<sup>112</sup> The proposal to provide financial support for inclusion of policyholders with disabilities in private health insurance markets in order to address the 'financial viability' concern is therefore not controversial.

- b. The government proposes to offer financial assistance to the private sector in bridging the 'viability' gap to guarantee paid maternity benefits to women.<sup>113</sup> The government clearly recognises that investment to promote women's role at workplaces contributes towards individual well-being and strengthens the economy via the metric of labour workforce participation rate.
  - c. The healthcare sector promotes individual well-being as well as collective goals of social cohesion by guaranteeing fair access to health services, economic resilience by developing a healthy workforce and sustainable development by promoting climate-adaptable measures.<sup>114</sup>
  - d. The government incentivises the private sector to ensure that at least 5% of their work force is composed of persons with benchmark disability.<sup>115</sup> Thus, the government must adopt corresponding measures to promote inclusion of policyholders with disabilities in private health insurance markets, including but not limited to:
    - i. Tax benefits to insurers,
    - ii. Offer partial or full subsidy towards costs of higher premiums,
    - iii. Utilise the National/State Funds for Persons with Disability to defray expenditure towards the goal in (b).
5. Strengthening the social solidarity models of ABPM-JAY and/or state-level health insurance schemes:
- a. The prohibition of risk rating race in the United States of America<sup>116</sup> and pregnancy/maternity (not sex *per se*) in Europe is based on the fundamental premise that democratic societies must not allow personal characteristics to be treated as poor risks and deny benefits of insurance. In order to avoid the unfair consequences of risk rating disability, coverage under AB-PMJAY and/or state-level health insurance schemes is vital to facilitate a comprehensive package of health services<sup>117</sup> for persons with disabilities.

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<sup>112</sup> *Scheme for financial support to public private partnerships in infrastructure (Viability gap funding scheme)*, Department of Economic Affairs, Ministry of Finance. Available at: <https://www.pppinindia.gov.in/vfguidelines>

<sup>113</sup> Unstarred question No. 2020 (Rajya Sabha), Maternity Leave Incentive Scheme, Ministry of Labour and Employment, Government of India

<sup>114</sup> Greenely, R. et al (2024), *How health systems contribute to societal goals*, Perspectives; Economic Survey (2020-21), Vol. I, Ministry of Finance, Government of India

<sup>115</sup> Section 35 (incentives to employers in private sector) of the *Rights of Persons with Disabilities Act, 2016*

<sup>116</sup> *Linton v. Tennessee Commissioner of Health*, United States Court of Appeal, 1990

<sup>117</sup> Patel, V et al (2015), *Assuring health coverage for all in India*, Lancet

- b. The government currently spends 1.43% of India's gross domestic product (GDP) on health financing,<sup>118</sup> whereas India needs to increase spending on health up to 6%<sup>119</sup> to realize the goal of universal health coverage for all. In order to accomplish this, India must institute a progressive taxation framework where wealthy taxpayers contribute a higher share of their income than poorer taxpayers,<sup>120</sup> to ensure availability of adequate resources to scale-up ABPM-JAY.

#### **4.4 Option to remove waiting period by paying additional premium survives (2016-2019)**

1. Although the 2024 IRDAI Regulations allow policyholders to contest the fairness of terms and conditions, the 2017 Regulations (repealed) authorized removal of exclusions and waiting period on payment of additional premium.
2. In spite of their repeal, this option is 'saved' with respect to policyholders with disabilities who purchased health insurance between 22 July 2017 and 24 March 2024. As a general rule, the repeal of any law or regulation does not affect any right or remedy acquired under that framework.<sup>121</sup>
3. However, in order for such policyholders to benefit from this, they must have taken action to exercise this right during the aforesaid period of subsistence of the 2017 Regulations.<sup>122</sup>

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<sup>118</sup> Union Health Ministry releases the National Health Accounts Estimates for India (2022-23). Available at: <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2265816&reg=3&lang=1>

<sup>119</sup> Reddy, KS et al (2011), *Towards achievement of universal health care in India by 2020: A call to action*, Lancet

<sup>120</sup> *Report of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health*, (2012), A/67/302

<sup>121</sup> Section 6 (Effect of repeal), *General Clauses Act, 1897*

<sup>122</sup> *Ravinder Kumar Dhariwal v. Union of India*, 2021 SCC Online SC 1293, paras. 20-30

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