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INSURING THE MIND: THE LEGAL INEFFECTIVENESS OF MENTAL HEALTH INSURANCE IN INDIA

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I. ABSTRACT

Mental Wellbeing is an important concept of human life that goes unnoticed. Where Insurance Law has proclaimed and have clear guidelines on physical and in general medical coverage, mental wellbeing is an equally important sphere of insurable events that shall affect human life, to a dire extent, and should be insured from mishaps and needs both statutory and practicality support to progress in insurance law extremities.

The Mental Healthcare Act of 2017 has had an effect in the shift of how mental health has gone from a taboo to a mandate and in parity with physical illnesses in this country. With social help, society concerns into placement, and the regulatory directs by the IRDAI has been aiming to turn one's mental wellbeing from a benefit with discretion, to a statue mandated entitlement. Whilst the theory of how mental health is important and its dire effects on society, the absolute practical part of its enforcement still remains a big question mark. This paper examines the lack of structure and the ineffective implementation of statues in mental health insurance, and how various gaps between paper and discussion has not been in practice. It further discusses about how these implementation deficiencies have worsened the insurance mechanisms and how with the changing times, mental wellbeing if a person is one of the first things for effective output, quality of life and betterment of society as a whole.

We have explored the case of Asha Ranjan V. Max Bupa Health Insurance co. ltd to portray the growing importance of mental wellbeing and how its insurable interest market is rapidly growing, and has been an important part of our society going forward. In recent times, courts have had a rather progressive view with regard to mental health coverage, and its importance rising from a contract clause to a statue bonded mandate, showing how the importance is necessary to acknowledge, even with barriers, social taboos and low awareness from societal consumers. From historical contexts to a future of Insurance and how insurance law shall be progressed, mental wellbeing, mental coverage, and various other clauses in fields related to human health, and other forms of medical coverages are going to be an important part of

medical coverages. Once a social taboo, now it needs both societal openness and insurable interest.

II. INTRODUCTION

Mental health insurance in India remains persistently insufficiently addressed within the health insurance system. While the legal regulations governing health insurance have undergone modifications are especially after the enactment of the Mental Healthcare Act, 2017 (MHCA)[1]. The real-world experiences of those insured reflect a different reality. Section 21(4) of the MHCA mandates coverage for both physical health treatments, marking a notable shift in India's rights-based perspective on mental healthcare[2]. Nevertheless, in practice, insurance companies have frequently circumvented, diminished or limited health benefits despite legal requirements and multiple regulatory measures by the Insurance Regulatory and Development Authority of India (IRDAI).[3]

Although recent research has acknowledged India's advancements in legislation, most studies are limited to discussions on awareness, policy goals and general challenges in health financing. This creates a research gap: the deficiencies in law enforcement, execution failures and ambiguous regulations that prevent mental health insurance coverage remain insufficiently examined. This paper addresses this gap by critically analyzing the statutory design, the industry's compliance failures, judicial responses, and continuing regulatory shortcomings, with a view to understanding why mental health insurance remains legally ineffective despite clear legislative mandates.

III. HISTORICAL AND LEGAL CONTEXT OF MENTAL HEALTH INSURANCE IN INDIA

i. Pre-2017 Legal Regime

Prior to the MHCA commercial health insurance plans generally did not cover health care

[1] *Anuradha Mascarenhas, 'Mental Healthcare Act Makes It Mandatory for Insurers to Make Provisions for Medical Insurance for Treatment of Mental Illness', Indian Express (Nov. 1, 2022), https://indianexpress.com/article/cities/pune/mental-healthcare-act-medical-insurance-mental-illness- 8243141/*

[2] *PIL Alleges Bias Against People With Mental Illness in Insurance Coverage; SC Issues Notice to Centre, IRDAI, The Tribune (June 16, 2020), https://www.tribuneindia.com/news/nation/pil-alleges-bias-against-people-with-mental-illness-in-insurance-coverage-sc-issues-notice-to-centre-irda-100075/*

[3] *Anuradha Mascarenhas, 'Mental Healthcare Act Makes It Mandatory for Insurers to Make Provisions for Medical Insurance for Treatment of Mental Illness', Indian Express (Nov. 1, 2022), https://indianexpress.com/article/cities/pune/mental-healthcare-act-medical-insurance-mental-illness- 8243141/*

services. Insurance providers frequently rejected claims for treatment by citing exclusion clauses like "disorders" "conditions," or "behavioral disorders." This aligned with the environment then: IRDAI did not mandate coverage for mental health allowing insurers to classify mental health problems as uninsurable conditions such, as "lifestyle-related," "self-inflicted" or "non-physical. Therefore, the Mental Health Act, 1987 (the predecessor to the MHCA) lacked any statutory obligation for insurers to treat substantial mental health on par with physical health and overall being. Thus, as a result, mental health financing was dominated by out-of-pocket expenditure, making psychiatric care inaccessible for the majority of the population[4].

ii. The Mental Healthcare Act, 2017

The MHCA marked a transformation. Section 21(4) mandates that "each insurer shall provide insurance coverage for illness treatment on par with physical illness." This equality clause was inspired by legislation such as the U.S. Mental Health Parity and Addiction Equity Act (2008) demonstrating India's commitment, to health equity.

The Act also introduced rights-oriented claims, including the right to mental health services, prohibition of inhumane treatment and the right to reside in the community. From the insurance perspective the MHCA sought to make mental health coverage a legal entitlement, then an optional benefit.

iii. IRDAI's Regulatory Framework

In accordance with the MHCA the IRDAI issued circulars (, in 2018 and 2020) directing insurers to comply with Section 21(4) and explicitly prohibiting the exclusion of mental illnesses. The regulator also carried out product-level assessments to ensure the coverage of disorders, psychiatric conditions, neurodevelopmental disorders and mental health crises[5].

However, the IRDAI's role has remained largely supervisory, with limited emphasis on enforcement or penalties for non-compliance, which has weakened the practical impact of these regulatory reforms.

[4] *PIL Alleges Bias Against People With Mental Illness in Insurance Coverage; SC Issues Notice to Centre, IRDAI, The Tribune (June 16, 2020), https://www.tribuneindia.com/news/nation/pil-alleges-bias-against-people-with-mental-illness-in-insurance-coverage-sc-issues-notice-to-centre-irda-100075/*

[5] *Insurance Regulatory & Dev. Auth. of India, Circular No. IRDAI/HLT/MISC/CIR/128/07/2018, Coverage of Mental Illness Under Health Insurance Policies (Aug. 16, 2018).*

IV. PERSISTENT COMPLIANCE GAPS AND LEGAL INEFFECTIVENESS

i. Narrow Interpretation of Coverage

Despite the mandate insurers have consistently imposed interpretations on "mental illness." Some insurers confine coverage to term psychiatric hospitalization leaving out services like outpatient counselling, psychotherapy, rehabilitation substance use disorder treatment and neurodevelopmental disorders. Such exclusions conflict, with the MHCA's definition of illness but persist because regulators fail to enforce a standardized coverage framework.

ii. Continued Use of Exclusion Clauses

Several policy documents continue to feature exclusions such, as " self-harm " "stress-related disorders," or "personality disorders," enabling insurers to reject legitimate claims. Substance-use problem are protected under the MHCA—are often left out by insurers because of risk concerns. These exclusions contradict the goal of achieving parity[6].

iii. Inadequate Coverage Design

When mental health is included, if it is, it usually represents only hospitalisation. But, for most people with psychiatric illness, treatment happens in context settings through therapy and medication[7]. So, by taking outpatient treatment out of the schedule, the coverage is toothless since T-Pysch admissions are really few and far between; in fact, most times not even necessary. As a consequence, insurance products don't really line up with what your mental healthcare needs are.[8]

iv. Lack of Product Standardisation

Though IRDAI's standard health cover (Arogya Sanjeevani is one of these) carries mental illness in the bracket, non-mandatory generalisation of it means insurers can lay out benefits

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[6] *Insurance Regulatory & Dev. Auth. of India, Health Insurance (Amendment) Regulations, 2020, No. IRDAI/REG/1/2020.*

[7] *Anuradha Mascarenhas, 'Mental Healthcare Act Makes It Mandatory for Insurers to Make Provisions for Medical Insurance for Treatment of Mental Illness', Indian Express (Nov. 1, 2022), https://indianexpress.com/article/cities/pune/mental-healthcare-act-medical-insurance-mental-illness- 8243141/*

[8] *Newsletter, Nov. 25–Dec. 1, 2023, Insurance Institute of India, https://www.insuranceinstituteofindia.com/documents/d/college-of-insurance/newsletter-25th-november- 1st-december-2023 (last visited Nov. 25, 2025)*

and claims history uniquely.[9] Some provide it as an optional rider, consequently some cover within sub-limits and many restrict to specific diagnostic categories. This sort of patchwork is unfair to policyholders and unreliable for them as well[10].

V. ENFORCEMENT CHALLENGES AND REGULATORY AMBIGUITIES

i. Weak Regulatory Enforcement

The IRDAI frequently issues compliance directives it seldom enforces penalties for breaches. Yet the lack of enforcement tools—like audits, financial penalties or withdrawal of offerings, permits insurers to regard mental health parity as an optional duty instead of a mandatory legal obligation[11].

ii. Ambiguity in Definitions

However, the MHCA utilizes a definition of illness, with WHO standards; nevertheless, authorities have not specified if neurodevelopmental disorders, addiction therapy or prolonged psychotherapy are included under the coverage[12]. Insurers take advantage of this uncertainty by limiting coverage to mental health conditions.

iii. Lack of Clear Parity Regulations

Herein the contrast to the U.S. Parity system, which establishes standards, for both -quantitative treatment restrictions India does not have clearly defined regulations regarding:

- permissible gaps
- pre-authorization requirements
- exclusions
- Limitations, on therapy sessions

[9] *Anuradha Mascarenhas, 'Mental Healthcare Act Makes It Mandatory for Insurers to Make Provisions for Medical Insurance for Treatment of Mental Illness', Indian Express (Nov. 1, 2022), https://indianexpress.com/article/cities/pune/mental-healthcare-act-medical-insurance-mental-illness- 8243141/*

[10] *Anuradha Mascarenhas, 'Mental Healthcare Act Makes It Mandatory for Insurers to Make Provisions for Medical Insurance for Treatment of Mental Illness', Indian Express (Nov. 1, 2022), https://indianexpress.com/article/cities/pune/mental-healthcare-act-medical-insurance-mental-illness-8243141/*

[11] *Newsletter, Nov. 25–Dec. 1, 2023, Insurance Institute of India, https://www.insuranceinstituteofindia.com/documents/d/college-of-insurance/newsletter-25th-november- 1st-december-2023 (last visited Nov. 25, 2025)*

[12] *Newsletter, Nov. 25–Dec. 1, 2023, Insurance Institute of India, https://www.insuranceinstituteofindia.com/documents/d/college-of-insurance/newsletter-25th-november- 1st-december-2023 (last visited Nov. 25, 2025)*

- co-pay structures

Thus, the regulatory vacuum enables insurers to apply restrictive conditions that would be impermissible for physical illnesses, undermining the parity mandate.

VI. JUDICIAL DEVELOPMENTS AND EMERGING CASE LAW

Although the legal principles related to health insurance in India are still developing, the cases that have emerged play a role in shaping the legal landscape. Courts and quasi-judicial bodies have increasingly recognized health as a component of the right to health and have begun scrutinizing insurance policies that unjustly exclude individuals, with mental health issues. The following cases illustrate how judicial interpretation is gradually strengthening the equality mandate set forth by the Mental Healthcare Act, 2017 (MHCA) and endorsed by IRDAI.

1. Asha Ranjan v. Max Bupa Health Insurance Co. Ltd. (Delhi High Court)[13]

In this judgment the Delhi High Court concluded that excluding illness from a health insurance policy violated Section 21(4) of the MHCA, which mandates equal treatment, for mental and physical health issues. The court therefore concluded and also referenced IRDAI's circulars directing insurers to eliminate exclusions and provide coverage.

This decision is significant because it was among the court affirmations that insurers cannot evade their responsibilities by relying on outdated policy terms. Forecasting the court's reasoning definitively established that compliance with the parity principle is compulsory. It represents a duty. Furthermore, it shaped the trajectory of cases by recognizing health coverage as a legal entitlement rather, than a contractual concession[14].

2. Neeraj Arora v. Max Bupa (Insurance Ombudsman)[15]

Herein, this case brought before the Insurance Ombudsman the insurer rejected a claim for care arguing that the policyholder had a -existing mental health condition. The Ombudsman disagreed with this position emphasizing that insurers must evaluate claims in accordance, with both MHCA guidelines and IRDAI regulations.

The decision highlighted that pre-existing mental illness cannot be used as a covering and safeguard reason to deny coverage without following the parity requirements and fair

[13] *Asha Ranjan v. Max Bupa Health Ins. Co. Ltd., W.P.(C) No. 2347/2021 (Del. HC Apr. 2021).*
[14] *Asha Ranjan v. Max Bupa Health Ins. Co. Ltd., W.P.(C) No. 2347/2021 (Del. HC Apr. 2021).*
[15] *Neeraj Arora v. Max Bupa Health Ins. Co. Ltd., Complaint No. HNHL-030-2021-0050, Order of the Insurance Ombudsman, New Delhi (Dec. 2020).*

underwriting standards. It also emphasised and noted that insurers have a duty to treat mental illness with the same seriousness and legitimacy as physical health conditions. Although the forecastation of Ombudsman orders do not create binding precedent, they reflect a growing regulatory stance against discriminatory denial practices.

3. Supreme Court's Observations on Mental Health Rights

While the Supreme Court has yet to decide a case directly related to health insurance, it has consistently highlighted and taken into account the importance of mental health[16]. In its sensory judgments on Articles 14 and 21, the Court has concluded that dignity, autonomy and healthcare availability are components of the right to life[17].

Thereby broader constitutional statements indirectly strengthen the argument that discriminatory insurance exclusions breach rights. Recognizing health as part of the right to health solidifies the legal basis, for demanding equal insurance coverage and reinforces the idea that equality is not merely a regulatory issue. It is a matter[18].

4. Overall Judicial Decision

Taken together these decisions indicate an increasing willingness to enforce health parity in insurance. Judges and Ombudsmen are increasingly scrutinizing insurer behaviours. Acknowledging the rights, to health care.

However, the small number of cases also reveals an issue: most policyholders do not have the knowledge, resources or legal support needed to challenge improper insurance denials. This minimal amount of litigation reflects a lack of access to justice, then a lack of grievances.

As awareness grows, the judiciary is likely to play an even more crucial role in shaping a mental-health-inclusive insurance regime.

VII. THE RESEARCH GAP: INEFFECTIVENESS DESPITE LEGAL MANDATES

While mental health has attracted focus in medical and policy-related research in India there is still a significant research gap in comprehending why mental health insurance coverage

[16] *PIL Alleges Bias Against People With Mental Illness in Insurance Coverage; SC Issues Notice to Centre, IRDAI, The Tribune (June 16, 2020), https://www.tribuneindia.com/news/nation/pil-alleges-bias-against-people-with-mental-illness-in-insurance-coverage-sc-issues-notice-to-centre-irda-100075/*

[17] *PIL Alleges Bias Against People With Mental Illness in Insurance Coverage; SC Issues Notice to Centre, IRDAI, The Tribune (June 16, 2020), https://www.tribuneindia.com/news/nation/pil-alleges-bias-against-people-with-mental-illness-in-insurance-coverage-sc-issues-notice-to-centre-irda-100075/*

[18] *Ministry of Health & Fam. Welfare, Gov't of India, National Mental Health Survey of India, 2015–16 (2016).*

remains insufficient despite clear legal and regulatory mandates requiring parity with physical health coverage. Existing research mainly concentrates on stigma, treatment accessibility, public health concerns and the social dimensions of illness. However, there is less emphasis on the ongoing systemic shortcomings, within the insurance system. A flaw that undermines the rights granted by the Mental Healthcare Act, 2017 (MHCA) along, with the regulations prescribed by the Insurance Regulatory and Development Authority of India (IRDAI)[19].

This ***research gap is intricate***. At first the MHCA explicitly requires equality mandating insurers to treat health issues equally. Yet despite this obligation insurers continue to apply restrictive policy clauses, narrow definitions and exclusionary underwriting techniques. Such conculsive actions include imposing waiting periods excluding psychiatric conditions and rejecting claims citing vague reasons that consist of futile reasons such, as "behavioural disorders" or "pre-existing mental illness." [20]The disparity between concepts and real-world application remains inadequately explored in academic research and even though it is crucial, to the matter, it elucidates the applicability to insurance and mental well being as intersecting pointers[21].

Education has always been one of the mainstays of our society, providing both knowledge for individual minds and a prop to personal growth. It gives people the tools, information, skills that they require to thrive and live full work lives in society. Besides book knowledge, education helps people develop complex ways of thinking that can solve problems and create things; that make up what we call creativity. Education facilities all provide people of all ages with information and skills to enable them to cope with future challenges. In this way education supports the idea of lifelong learning, while immersing our people in the habits necessary to attain success at work and personal life. Because when we invest in education, we are laying a cornerstone for both personal and professional success in the future. And by investing in the future of society, we grant talented people an opportunity to realize their full potential evasion. ***The judicial landscape remains sparse***. A handful of significant decisions—such as Asha

[19] *Nat'l Hum. Rts. Comm'n, India, Report on Mental Health Systems in India (2019).*

[20] *Anuradha Mascarenhas, 'Mental Healthcare Act Makes It Mandatory for Insurers to Make Provisions for Medical Insurance for Treatment of Mental Illness', Indian Express (Nov. 1, 2022), https://indianexpress.com/article/cities/pune/mental-healthcare-act-medical-insurance-mental-illness-8243141/*

[21] *Anuradha Mascarenhas, 'Mental Healthcare Act Makes It Mandatory for Insurers to Make Provisions for Medical Insurance for Treatment of Mental Illness', Indian Express (Nov. 1, 2022), https://indianexpress.com/article/cities/pune/mental-healthcare-act-medical-insurance-mental-illness-8243141/*

Ranjan v. Max Bupa—assert mental health parity, yet judicial action remains largely reactive. Courts intervene only after the policyholder's challenge to denials, which itself requires time, legal literacy, and financial resources. Academic attention has yet to consider why litigation in this area is so limited, how access-to-justice barriers shape the outcomes, or how judicial silence contributes to systemic regulatory inefficacy.

The ambiguity and exportability in the wording of insurance policies create uncertainties that insurers frequently exploit. Terms such as "disorders," "personality disorders," and "psychosomatic conditions" are not clearly defined, allowing insurers to arbitrarily exclude mental health issues[22]. Scholarly studies have not yet examined how these uncertainties operate in practice or how they act as loopholes for coverage[23].

There is an ***absolute absence of empirical data concerning non-compliance***. No comprehensive academic studies relevant to testament have explored trends in denial rates, for psychiatric care claims underwriting discrimination or the financial challenges faced by clients[24]. Without concurrent and conclusive evidence, the debate remains theoretical and fails to represent the real experiences of policyholders.

In the end there is no mended evaluation of how equality is enforced among insurers, whether private or public. There is a low form of studies examining policy language, compliance mechanisms or the essential systemic adjustments required to bridge the gap, between law and real-world implementation[25].

VIII. COMPARATIVE INSIGHTS

Comparative models offer understanding for India.

i. United States

The Mental Health Parity and Addiction Equity Act mandates terms and treatment limitations with stringent penalties, for violations. Federal agencies conduct inspections, issue compliance

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[22] *Mental Health Programme in India: Has the Tide Really Turned?, Indian J. Med. Res., https://ijmr.org.in/mental-health-programme-in-india-has-the-tide-really-turned/ (last visited Nov. 25, 2025).*

[23] *PRS Legislative Research, The Mental Healthcare Bill, 2016: PRS Analysis (2017), https://prsindia.org/billtrack/the-mental-healthcare-bill-2016.*

[24] *Mental Health Programme in India: Has the Tide Really Turned?, Indian J. Med. Res., https://ijmr.org.in/mental-health-programme-in-india-has-the-tide-really-turned/ (last visited Nov. 25, 2025).*

[25] *Mental Health Programme in India: Has the Tide Really Turned?, Indian J. Med. Res., https://ijmr.org.in/mental-health-programme-in-india-has-the-tide-really-turned/ (last visited Nov. 25, 2025).*

reports and impose fines.

ii. United Kingdom

The NHS in the UK provides health care to everyone reducing reliance on private insurance. Private insurance companies must adhere to coverage guidelines. Cannot randomly refuse coverage, for mental health issues.

iii. Lessons for India

India lacks:

a. Detailed parity regulations,
b. Enforcement audits,
c. Penalties for violations, and
d. Transparent reporting.

Adopting these features could significantly strengthen compliance and reduce loopholes.

IX. RECOMMENDATIONS FOR REFORM

i. Mandate Standardised Mental Health Coverage

IRDAI should set regulations requiring every health insurance policy to cover consultations, psychotherapy, medication management and rehabilitation without applying biased limitations.

ii. Enforce Parity Regulations

India needs rules specifying equality in:

a. Sub-limits
b. Co-payments
c. Waiting periods
d. Exclusions
e. Therapy session caps
f. Pre-authorization rules

iii. Strengthen Regulatory Enforcement

This includes:

a. Routine audits,
b. Mandatory compliance reporting,

c. Public disclosure of coverage details, and

d. Penalties for non-compliance.

iv. Expand Judicial Review

Courts and Ombudsmen should adopt a rights-centred approach ensuring that insurance contracts comply with the standards established by the MHCA.

Promote Consumer Awareness

Mental health coverage remains poorly understood. Public awareness campaigns and transparent policy documentation are essential[26].

X. CONCLUSION

The mental health of the people in India portrays that the insurance system reveals a challenge in regulatory law, and the progressive statutes are undermined by ineffective implementation. However, even though the MHCA mandates equal treatment of physical health insurance, regulatory enforcement has been inconsistent insurers continue with restrictive interpretations and policy structures fail to sufficiently meet genuine psychiatric care needs[27].

The nerfed ineffectiveness of health insurance stems not from deficiencies in the law itself but from structural shortcomings in regulation, failures, in enforcement and industry practices that undermine legislative objectives[28]. Addressing these challenges requires a reform strategy featuring improved regulatory oversight, explicit parity regulations, judicial accountability and the reinforcement of consumer protections[29].

Until such reforms are implemented, the promise of mental health parity under Indian law will remain largely unrealised, perpetuating inequity in access to essential mental healthcare services and undermining the transformative spirit of the Mental Healthcare Act, 2017[30].

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[26] *Ministry of Health & Fam. Welfare, Gov't of India, National Mental Health Survey of India, 2015–16 (2016).*

[27] *Mental Health Programme in India: Has the Tide Really Turned?, Indian J. Med. Res., https://ijmr.org.in/mental-health-programme-in-india-has-the-tide-really-turned/ (last visited Nov. 25, 2025).*

[28] *Newsletter, Nov. 25–Dec. 1, 2023, Insurance Institute of India, https://www.insuranceinstituteofindia.com/documents/d/college-of-insurance/newsletter-25th-november- 1st-december-2023 (last visited Nov. 25, 2025)*

[29] *Mental Health Programme in India: Has the Tide Really Turned?, Indian J. Med. Res., https://ijmr.org.in/mental-health-programme-in-india-has-the-tide-really-turned/ (last visited Nov. 25, 2025).*

[30] *Mental Healthcare Act, No. 10 of 2017, INDIA CODE (2017).*