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Ethical and Legal Dimensions of Mental Health Insurance in India: Insights from the MHCA, 2017

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Abstract

Health insurance can act as a safeguard against catastrophic medical expenses. Under Section 21(4) of the Mental Healthcare Act, 2017 (MHCA), insurance providers are required to offer coverage for mental illnesses on the same terms as for physical illnesses. However, in practice, anecdotal reports indicate that individuals with mental health conditions frequently encounter denial or significant challenges when attempting to secure health insurance.For the year 2020–21, we systematically reviewed insurance policies listed on the Insurance Regulatory and Development Authority of India (IRDAI) website to assess their treatment of mental health conditions and to evaluate whether the policy provisions comply with Section 21(4) of the MHCA, as well as with key bioethical principles.A total of 459 health insurance policies for 2020–21 were collected from the IRDAI website. From these, 268 policies deemed relevant were examined in detail to assess compliance with the MHCA and core bioethical principles. Among the reviewed policies, six (from two insurers) explicitly excluded coverage for mental illnesses in all areas, directly violating the MHCA and IRDAI guidelines. A majority of policies excluded treatment for injuries resulting from attempted suicide or self-harm (n = 224) and those related to alcohol or substance use (n = 267). Coverage for outpatient services was offered in only 23 policies.Health insurance policies still include provisions that discriminate against individuals with mental illnesses, contravening the parity principle established by the MHCA and conflicting with fundamental bioethical standards. Ongoing advocacy is essential to ensure that insurers fully adhere to the principle of parity—both in letter and in practice—by eliminating any differential or discriminatory clauses related to mental health, in accordance with Section 21(4) of the MHCA.

Keywords: Medical insurance, Health insurance, Health financing, Mental Healthcare Act, Mental health

Introduction

Ensuring access to care for people with mental illness remains a major public health challenge in India. The National Mental Health Survey (NMHS) 2016 reported that 10.6% of the population experiences mental disorders, while treatment coverage remains low, with a gap ranging from 55% to 85% [1]. Beyond commonly studied conditions such as bipolar disorder and psychotic illnesses, researchers highlight a broader "care gap," reflecting the intertwined challenges of obtaining quality mental health services alongside adequate physical healthcare [2].

Financial barriers further exacerbate this gap. The National Sample Survey (NSS) 2017–18 (75th Round) estimated the average annual cost of hospitalization for psychiatric and neurological conditions at ₹26,843, with public facilities averaging ₹7,235 and private hospitals ₹41,239 [3, 4]. Catastrophic health expenditures—defined as spending exceeding 10% or 20% of monthly household consumption—affect 59.5% and 32.4% of households, respectively [5]. Health insurance thus plays a critical role in shielding households from financially crippling medical costs. Although private insurance often faces criticism for prioritizing profit, it covers between

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20% and 44% of the population and remains a significant player in India's healthcare landscape [6, 7], underscoring the ethical obligation of insurers to prioritize patient welfare [8].

The Mental Healthcare Act (MHCA) 2017, guided by a rights-based approach and India's obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD), explicitly recognizes insurance as a mechanism for equity [9, 10]. Section 21(4) of the MHCA requires insurers to provide coverage for mental illness on par with physical illness [9]. Implementing this provision effectively could help narrow the care gap and improve access to comprehensive treatment for mental health conditions [2].

Health insurance coverage and the mental healthcare act

In India, individuals living with mental illness have historically faced unequal access to health insurance. Until recently, treatment for mental disorders was routinely excluded from policies through standardized exclusion clauses, whereas individuals without mental illness typically had access to coverage for physical health conditions [9, 11, 12]. The principle of parity, as articulated in the CRPD and reinforced by the MHCA, requires more than merely including mental illness in insurance policies. Coverage must be equitable with respect to availability, accessibility, and quality of care, matching the standards applied to physical illness [13, 14]. In line with this, the Insurance Regulatory and Development Authority of India (IRDAI) issued a circular in 2020 mandating the inclusion of mental illness in medical insurance coverage [15].

Despite this regulatory directive, non-compliance persisted, prompting a landmark judgment by the Delhi High Court in 2021. The Court directed all insurance providers to comply with Section 21(4) of the MHCA, ensuring that mental illnesses are covered without discrimination [13, 16]. The judgment emphasized that there can be no distinction between coverage for physical and mental health conditions and placed a supervisory responsibility on IRDAI to guarantee enforcement across insurers [13]. Following this, the Bombay High Court referenced the Delhi precedent to stay an insurer's rejection of a policy application by an individual with bipolar disorder [17]. These rulings underscore that insurance companies and their representatives may face accountability for violating Section 21(4). However, while legal recourse can secure coverage, it remains inaccessible for many due to the expertise, time, and financial resources required.

Health insurance coverage and the lens of bioethics

Beyond the provisions of the MHCA, the universally recognized principles of bioethics emphasize the necessity of fair, equitable, and ethical care, including in mental health. Core bioethical principles—autonomy, beneficence, and non-maleficence—offer a valuable framework for evaluating the practices of insurance providers regarding mental health coverage from an ethical and equity-focused perspective [18].

Despite updated IRDAI guidelines, individuals with current or past mental illnesses—similar to those with other pre-existing conditions—continue to encounter barriers to obtaining health insurance in India [11, 12]. Given that people with mental illness are at increased risk for a range of physical conditions, including cardiovascular and respiratory diseases, diabetes, and infections, such exclusions raise concerns about unethical practices and violate the principle of beneficence, which obliges providers to act in the best interest of their patients [19].

The principle of non-maleficence, which requires healthcare and insurance providers to avoid causing harm, is also compromised when access to mental healthcare coverage is selectively restricted. The for-profit structure of private health insurance in India often prioritizes the financial interests of insurers over the health needs of consumers, creating inherent tension with both beneficence and non-maleficence [8, 20].

Transparency and autonomy are similarly undermined, as policy language is frequently vague, claim rejection processes opaque, and third-party administrators influence decisions, all of which limit consumers' ability to make informed choices. These challenges are not unique to India; inadequate mental health coverage has been reported internationally [21]. This paper explores these issues within the Indian context, examining the ethical and practical dimensions of insurance coverage for mental illness.

Research objective

We analyzed all health insurance policies issued or revised during 2020–2021 to examine how mental health conditions are addressed and the range of services covered. This study highlights key observations and underscores the necessity of providing mental illness coverage equivalent to that for physical illness, offering

insights that could guide policy development and regulatory practices in India's insurance sector.

Materials and Methods

For this study, all health insurance policies were obtained from the IRDAI web portal, which annually publishes a comprehensive list of newly introduced or revised policies. Given IRDAI's regulatory authority, this approach was considered the most reliable method to capture all relevant and updated policies. Using the 2020–21 list as a reference, complete policy documents were retrieved from individual insurance providers' websites and examined for their coverage language. Policies not directly related to mental health treatment—such as travel insurance, accident-only policies, or critical illness-specific plans (e.g., cancer, COVID-19, vector-borne diseases)—as well as those for which the full policy document was unavailable, were excluded. State-level government insurance schemes were also beyond the scope of this analysis.

To guide data extraction, a template was developed following an initial review of policy wording to identify relevant features. The template was informed by the principle of parity outlined in Section 21(4) of the MHCA and the IRDAI's 2020 Master Circular on Standardization of Health Insurance Products, which prohibits listing mental illness as an exclusion criterion [9, 15]. Each policy was evaluated for parity by examining: (i) explicit references to mental illness in the policy text, (ii) features applicable to mental health coverage, and (iii) a comparison of these features with those available for physical health conditions. Keywords used to identify relevant clauses included: suicide, self-harm, self-injury, psych*, mental health, mental illness, counseling, addict*, substance, alcohol*, OPD, IPD, inpatient, outpatient, and sublimit.

Results and Discussion

A total of 459 health insurance policies for 2020–21 were retrieved from the IRDAI website and individually screened for relevance to mental health coverage. Policies not directly addressing mental health treatment—such as travel insurance, accident-only plans, critical illness, and vector-borne disease coverage (n = 191)—were excluded during screening. The remaining 268 policies were examined in detail to evaluate the scope of mental health coverage and compliance with Section 21(4) of the MHCA, using features identified through a structured data extraction process **(Figure 1)**. Among these 268 policies, the majority (n = 262) did not explicitly exclude mental illness; however, six policies from two insurers specifically excluded mental health coverage across all areas of the policy **(Table 1).**

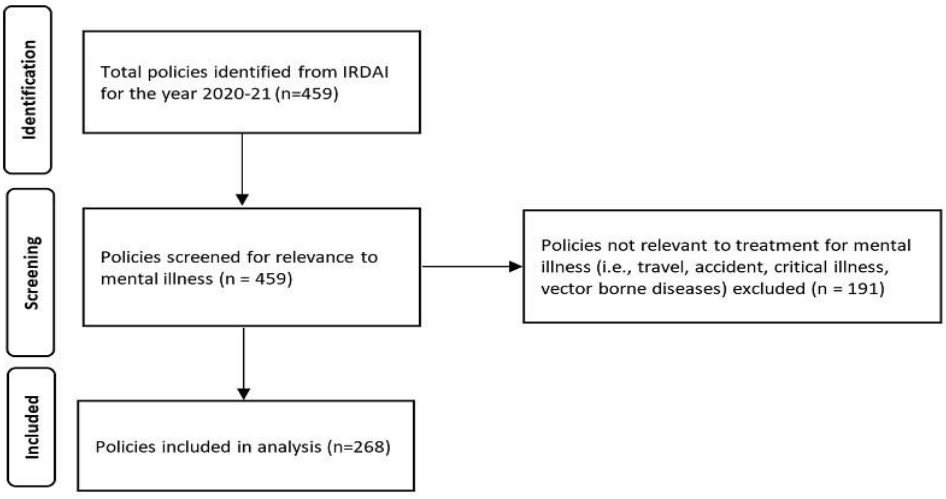

Figure 1. Overview of health insurance policy documents sourced and analyzed.

Most of the policies examined offered coverage for costs incurred before and after hospitalization, as well as associated services such as ambulatory care, medications, and second-opinion consultations. Despite this, significant limitations were noted in mental health coverage. Several policies excluded treatment related to

attempted suicide or intentional self-harm, addiction, and substance use. Additional constraints included sub-limits specifically applied to mental health services and restrictions on domiciliary and outpatient care for mental health conditions.

Table 1. Types of private insurance policies addressing mental health.

Coverage Feature	Providers (n = 30)	Policies (n = 268)
Policies entirely excluding mental health, in violation of MHCA Section 21(4)	2 (7%)	6 (2.2%)
Policies limiting the insured sum specifically for mental health treatment	7 (23%)	35 (13.1%)
Policies excluding care for attempted suicide or self-inflicted injury	29 (97%)	224 (83.6%)
Policies excluding treatment for addiction or substance-related disorders	30 (100%)	267 (99.6%)
Policies not covering home-based (domiciliary) mental health treatment	15 (50%)	32 (11.9%)
Policies extending coverage to outpatient mental health services or consultations with mental health specialists	12 (40%)	23 (8.6%)

Exclusion of attempted suicide or intentional self-injury

The majority of policies analyzed (n = 224) omitted coverage for treatment related to intentional self-harm or attempted suicide, despite the fact that the 2020 IRDAI Master Circular does not permit such standardized exclusions [15].

Exclusion of addiction and substance use

All but one policy (n = 267) explicitly excluded coverage for treatment of addiction and substance use, including medical care for physical conditions resulting from alcohol or substance use.

Exclusion of domiciliary hospitalization

Domiciliary hospitalization refers to providing medical care at home when inpatient treatment is not possible. Our analysis found that 32 policies explicitly excluded coverage for domiciliary hospitalization related to mental health conditions.

Restrictions via sub-limits for coverage

Sub-limits are restrictions set by insurers on the amount payable for specific treatments or illnesses. In our review, 32 policies from seven providers imposed sub-limits on mental health claims. These limits ranged from 5% to 25% of the total sum insured, or INR 50,000 to 300,000 in absolute terms, which were comparable to sub-limits applied for certain other medical procedures.

Coverage for out-patient services

A small number of policies (n = 32) provided coverage extending beyond inpatient hospitalization. Among these, 16 policies specifically included outpatient services, such as consultations with specialists, counseling sessions, and psychological rehabilitation, either as a standard part of the policy or as an optional add-on requiring an additional premium.

Discussion and recommendations

Our review of health insurance policies approved in 2020–21 indicates that most no longer explicitly exclude mental illnesses, aligning with Section 21(4) of the MHCA and the IRDAI's 2020 Master Circular on Standardization of Health Insurance Products [9, 15]. According to Section 3 of the MHCA, mental illnesses are determined based on nationally or internationally recognized medical standards, such as the WHO's ICD. Therefore, insurance providers should cover all conditions recognized under the ICD, regardless of specific diagnostic labels. However, our analysis identified practices that may be discriminatory, leaving uncertainty about the extent to which individuals with mental illnesses are supported by private insurers [12].

A notable concern is the exclusion of treatment for attempted suicide/self-injury and substance use disorders by the majority of insurers, in violation of the MHCA's intent [9]. Section 115 mandates that the government provide care, treatment, and rehabilitation for individuals who have attempted suicide, highlighting the necessity of insurance coverage for both physical and psychological care in such instances. Similarly, although alcohol and substance use disorders are recognized as mental illnesses under Section 2(s) of the MHCA and ICD-11, treatment for these conditions—and for physical illnesses resulting from them—is commonly excluded. Unlike the

exclusion of self-injury or suicide, this is a standard exclusion permitted by IRDAI under Code Excl12 [22].

We also observed exclusions for physical conditions stemming from psychiatric causes, such as speech disorders resulting from mental health conditions. Coverage for such conditions should ideally be determined on a case-by-case basis by attending physicians, rather than automatically excluded. The same principle applies to domiciliary hospitalization.

Regarding sub-limits, the IRDAI Master Circular permits insurers to impose monetary or hospitalization-day limits for specific diseases, provided they are based on objective and actuarial principles [15]. However, restrictive sub-limits for mental illness can adversely affect insured individuals, especially when these limits are not transparently communicated or are disproportionately low relative to the total sum insured, given the episodic and recurrent nature of mental illness. Currently, the legality of such sub-limits is under review in the Delhi High Court [23].

A positive finding is that a few insurers now recognize outpatient services for mental illness, including therapy and counseling, which is a significant shift from traditional practices that focus solely on hospitalization [24]. Limited availability of usage data for mental health services has been cited as a barrier to expanding coverage [25]. Until more insurers provide such services, costs will continue to fall on individuals.

Although our study focused on policy wording rather than implementation, anecdotal evidence indicates that individuals with mental illness still face denial of coverage and claims, including for services typically accessible to those without mental illness. This contradicts the ethical principles of beneficence and non-maleficence [26]. The lack of publicly available data on rejected insurance applications prevents a full assessment of Section 21(4) compliance [27]. Future research should compare policy entitlements with actual claim experiences to evaluate real-world adherence.

Ultimately, insurance providers must treat mental illness on par with physical illness and uphold the ethical principles of beneficence, non-maleficence, and autonomy. Some initial uncertainty is expected given the novelty of these provisions [12, 14].

Based on our findings, we recommend the following actions:

- Insurance companies should implement the principle of parity fully, removing all discriminatory or differential terms for mental illness in compliance with Section 21(4) of the MHCA.
- The IRDAI should proactively supervise insurers, identify discriminatory terms, and ensure their removal, including the elimination of restrictive sub-limits.
- The IRDAI should remove addiction as an exclusion criterion from its guidelines, prompting insurers to remove exclusion clauses for alcohol and substance use disorders.
- Insurers should eliminate exclusions for intentional self-injury and attempted suicide, ensuring these treatments are covered.
- More insurers should recognize the need for coverage beyond hospitalization, including outpatient services like counseling and therapy, to address the broad spectrum of mental health care needs.
- Finally, the IRDAI should publicly release annual data on insurance applications and rejections, including reasons for denial, to promote transparency and enable informed decision-making by consumers.

Conclusion

Our study highlights significant gaps in health insurance coverage for mental illnesses, revealing that many policies still include discriminatory provisions, in breach of the parity principle mandated under Section 21(4) of the MHCA. We emphasize the need for ongoing advocacy to drive reform within the insurance sector and underscore the IRDAI's supervisory responsibility to ensure full implementation of the MHCA across all insurers. Ultimately, both public and private insurance providers have an ethical and legal obligation to deliver equitable, high-quality, and affordable mental healthcare to all policyholders.

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