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Inside Health Insurers Through Customer Complaint

When a health insurance policy is bought, the promise is simple: the insurer will stand by the customer on their worst days.

This article asks a sharper question: which of the insurers actually live up to that promise when claims are filed, cashless approvals are needed, and hospital bills are due. The analysis is based on a broader scan of 23 health insurers and nearly 36,000 customer reviews, but for brevity, the narrative focuses on five key insurers from the 1 Finance featured list presented at the end of this magazine.

What the regulator is already seeing

In November 2025, IRDAI Chairman Ajay Seth issued a clear warning to health insurers on how poorly many customers are being treated. He stressed that the real problem is no longer just the number of complaints, but how many of them now involve serious failures at moments of real vulnerability.



His team closely reviewed how companies handle claims and grievances and highlighted a familiar list of breakdowns. Claims are taking too long, cashless approvals are delayed even in urgent hospital situations, rejections arrive

without reasons that customers can understand or contest, and partial approvals are issued without a clear explanation of what was paid and why the rest was denied. On top of this, policy documents remain too complex for most people to interpret, and complaints are often treated like routine internal paperwork rather than emergencies that demand urgency.

These are not a handful of stray cases. The same failures keep surfacing across multiple insurers and channels, forming a pattern that affects thousands of policyholders.



Ajay Seth
IRDAI Chairman

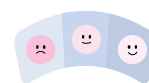
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How customer voices were analysed

Between January and November 2025, this study reviewed almost 36,000 pieces of customer feedback for 23 health insurers across X (Twitter), the Google Play Store and the Apple App Store. From this wider universe, five insurers that are part of **1 Finance's featured list—ICICI Lombard, HDFC Ergo, Bajaj Allianz, Manipal Cigna and Care Health**—were shortlisted for detailed sentiment profiling because they are the names most relevant for readers' real-world choices.

Each review was scored on three dimensions and combined into a sentiment score from 0 to 100:



Customer Emotion

How do the customers sound: calm and relieved, or angry, desperate or betrayed.



Service Reliability

Did the process work smoothly—cashless approval, documents, updates—or did things keep breaking down.



Financial Impact on Life

Did delays or rejections force people to borrow money, postpone treatment or pay large sums out of pocket.

▲ **A high score** means the insurer tends to handle crises with timely support, clear information and limited damage to the customer's life.

▼ **A low score** signals regular breakdowns—especially around emergencies, discharge, cashless approvals and follow-up communication.

What The Sentiment Scoreboard Reveals For Health Insurers

Across the full set of 23 insurers and 36,000 reviews, a clear hierarchy appears. Only a handful consistently deliver sentiment scores above 90, while several sit in the 50–70 range despite selling broadly similar products. Within the 1 Finance featured list, the five insurers covered here span that spectrum, making them a useful cross-section of how different operating models feel to customers in crisis.

The key patterns are:

- Some featured insurers run claims smoothly and on time, so customers rarely need to borrow, postpone treatment or scramble for cash because of the insurance process.

- Others process claims reasonably well but explain decisions poorly, so customers see rejections or deductions they cannot fully understand or question.

- At the weaker end of the sentiment range, many customers say they are stuck in claim loops, repeatedly asked for documents and kept waiting for approvals while interest builds on borrowed money.

All of the insurer-wise figures that follow are taken directly from the underlying sentiment analysis of the 36,000 reviews, not rounded estimates or broad impressions.

Insurer-Wise Insights From Customer Feedback

Within this broader landscape, the sentiment analysis highlights meaningful differences between individual insurers. The numbers below are illustrative summaries

of the patterns reported in the article, not product recommendations.



ICICI Lombard Health Insurance

Score Breakdown

100

Customer
Emotion

100

Service
Reliability

93

Financial Impact
on Life

Sentiment Score

Gross Health Insurance (Retail & Group) Premium
Underwritten in FY 2025-26: ₹45,247 Crs.



HDFC Ergo Health Insurance

Score Breakdown

96

Customer
Emotion

98

Service
Reliability

93

Financial Impact
on Life

Sentiment Score

Gross Health Insurance (Retail & Group) Premium
Underwritten in FY 2025-26: ₹32,695 Crs.

3,544

Reviews
found



2,924

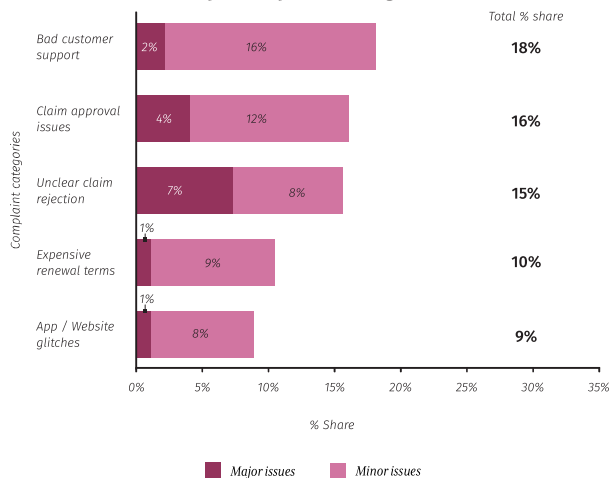


536



84

Top 5 Complaints Categories



2,435

Reviews
found



1,850

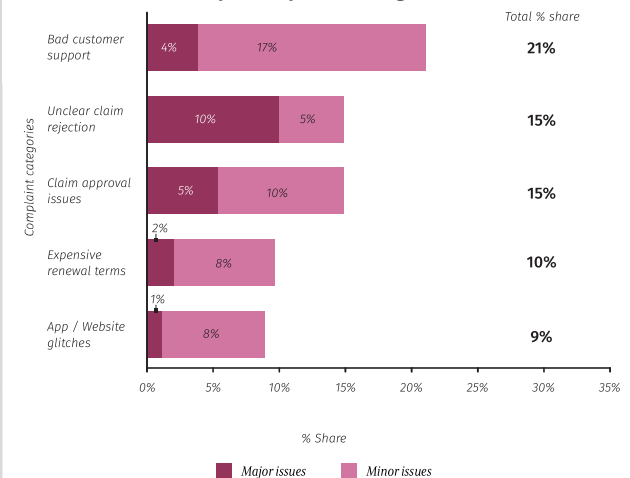


300



285

Top 5 Complaints Categories





Sentiment Score

Bajaj Allianz General Health Insurance

Score Breakdown

91

Customer
Emotion

97

Service
Reliability

90

Financial Impact
on Life

Gross Health Insurance (Retail & Group) Premium
Underwritten in FY 2025-26: ₹28,497 Crs.



Sentiment Score

Manipal Cigna Health Insurance

Score Breakdown

69

Customer
Emotion

71

Service
Reliability

67

Financial Impact
on Life

Gross Health Insurance (Retail & Group) Premium
Underwritten in FY 2025-26: ₹10,668 Crs.

2,524 Reviews found



2,127

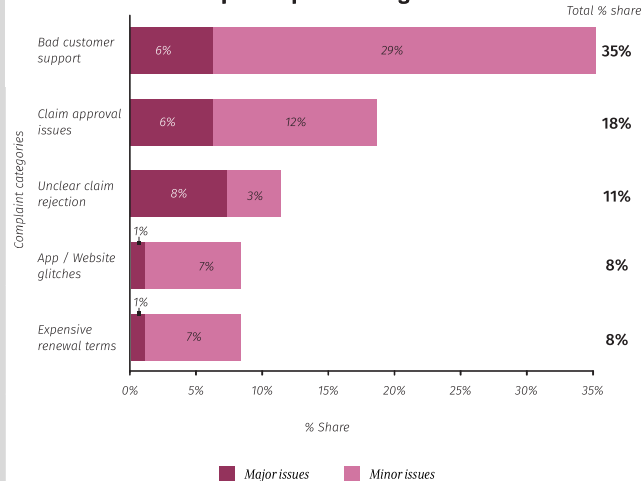


360



37

Top 5 Complaints Categories



1,250 Reviews found



1,053

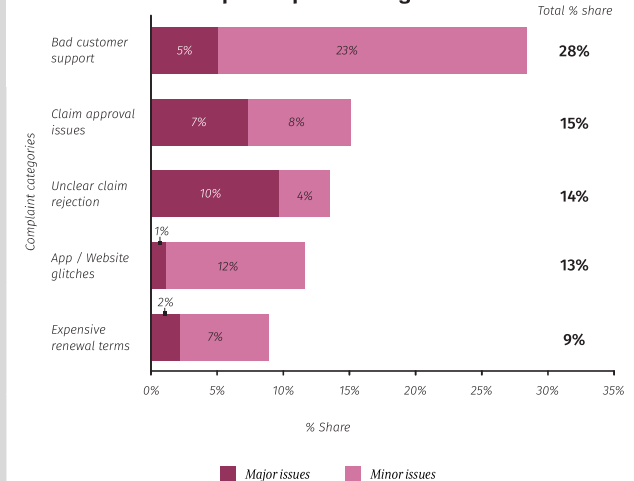


174



23

Top 5 Complaints Categories





Sentiment Score

Care Health Insurance

Score Breakdown

50

Customer
Emotion

50

Service
Reliability

50

Financial Impact
on Life

Gross Health Insurance (Retail & Group) Premium
Underwritten in FY 2025-26: ₹46,887 Crs.

6,755 Reviews
found



5,505

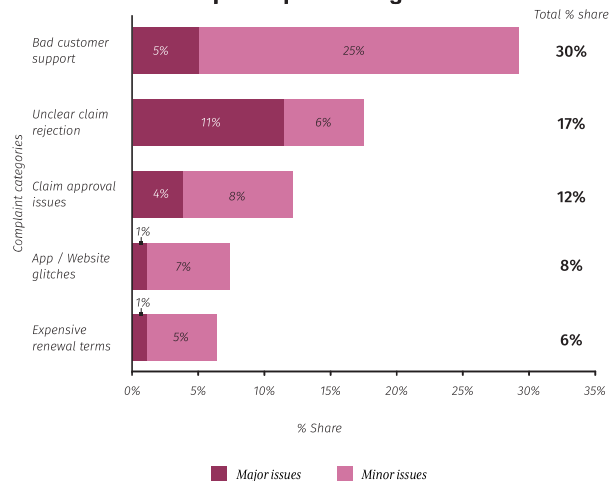


1,104



146

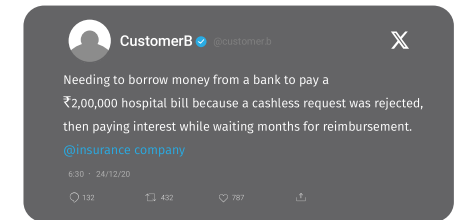
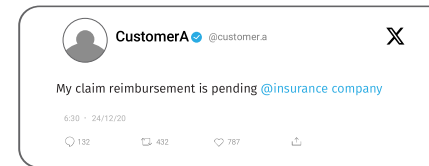
Top 5 Complaints Categories



Beyond the scores what customers actually go through

Numbers only tell part of the story. The words customers use show how deeply these failures cut into daily life.

A simple line such as the one on the left does not convey the strain of arranging funds in an emergency. By contrast, a typical detailed review might read more like the right one.



When the analysis tags such feedback, it reflects more than irritation; it records that the safety net failed in a tangible way. Likewise, when dozens of customers across insurers complain that hospital cashless desks refuse to accept their policy despite being listed as network hospitals, the problem is no longer isolated—it is structural.

The categorisation into experience buckets—bad support, unclear rejection, claim approval issues, expensive

renewals, policy misrepresentation, cashless network problems, app or website glitches and miscellaneous others—helps show where firms are most likely to break down. For many, the biggest damage is not in the policy wording but in how call centres, TPAs, hospitals and apps behave when a claim is in motion.

What this means for policyholders and insurers

For policyholders, the main lesson is that claim ratios and product brochures are not enough. An insurer can have a strong formal record yet still leave customers chasing responses and borrowing during emergencies. Monitoring sentiment scores and the types of complaints customers share online offers a complementary lens on how an insurer behaves when tested.



For insurers, the data points to a different priority list. Fixing basic service experiences—answering calls, providing clear written explanations, speeding up cashless approvals,

and reducing repeat document requests—could improve sentiment more than adding new product features. Customers do not expect zero disputes, but they do expect to be heard, updated and treated fairly.

For regulators and industry observers, sentiment analysis can act as an early-warning system. When thousands of detailed reviews point to the same high-impact failures at the same institutions, it signals where closer supervision and targeted reforms may have the greatest benefit. In a sector built on trust, understanding how customers actually feel is not a soft metric; it is a direct measure of whether health insurance is doing the job it was created to do.

DISCLAIMER

This research analyses customer sentiment toward health insurance providers. Recognising that sentiment is subjective and varies by individual perception, this study does not measure the objective reality of specific complaints. Rather, it is a method to identify and compare broader service feedback patterns across companies. This analysis is for understanding customer experiences, not a final verdict on company performance or policy validity. Individual circumstances always matter, and personal assessment is encouraged.