# Where Numbers Fall Short: Realities of Medical and Critical Illness Claims in Nepal's Insurance Sector

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## Abstract

Nepal's insurance sector is undergoing rapid transformation, particularly in health and critical illness coverage. However, a growing gap exists between product design and real-world claim adjudication. This article examines the inconsistencies between actuarial assumptions, medical realities, and policy interpretations within Nepal's insurance landscape. Drawing from five years of practitioner-based experience in both life and general insurance claims, the study utilizes qualitative case analysis to highlight systemic weaknesses in claim settlement, including diagnostic ambiguities, definitional rigidity, and documentation discrepancies. Six anonymized case studies illustrate recurring issues such as denial due to technical policy wording, absence of standardized medical documentation, and lack of coordination between claims, underwriting, and actuarial teams. The findings emphasize the need for localized policy definitions, standardized documentation, feedback integration, and regulatory oversight. The paper concludes that bridging actuarial precision with operational sensitivity is vital for strengthening customer trust and establishing an equitable, context-sensitive insurance ecosystem in Nepal.

**Keywords:** Insurance claims, critical illness insurance, medical indemnity, actuarial models, claim adjudication, health economics, policy design.

## 1. Introduction

Over the past decade, Nepal's insurance industry has experienced rapid diversification—both in product development and consumer awareness. Among the most notable areas of growth is the rising popularity of health and critical illness insurance, driven by increasing medical costs, a growing middle class, and expanding regulatory support (Kumara & Samaratunge, 2020). Life insurers now offer critical illness (CI) riders that promise lump-sum payouts upon diagnosis of serious diseases, while general insurers provide medical indemnity products that cover hospitalization expenses. Despite this progress, one critical component of insurance operations has not kept pace with product innovation: claims adjudication.

While actuarial science drives product pricing and benefit structure, claim departments must interpret real-life medical cases against rigid policy wordings - a task far more complex than anticipated during product design. In practice, the gap between what is covered and how

claims are assessed often results in confusion, delays, and customer dissatisfaction. This is especially evident in critical illness claims, where diagnosis, staging, and clinical documentation rarely align neatly with the policy's definition of illness.

As a professional who has worked in both life and general insurance claims departments, I have witnessed firsthand the operational and interpretational mismatches that arise in handling complex medical claims. This paper explores these mismatches by analyzing real-world scenarios in Nepal's insurance market. It aims to identify where actuarial models, medical interpretations, and policy definitions fall out of sync and what can be done to bridge that gap.

By blending academic insights with frontline claim experience, this article offers a practical framework for improving claim handling in Nepal's emerging insurance ecosystem. It contributes to ongoing conversations about customer trust, technical alignment, and insurance professionalism in South Asia.

## 2. Industry Context: Critical Illness and Medical Claims in Nepal

The insurance landscape in Nepal has experienced significant transformation over the last two decades. Spurred by economic growth, regulatory reforms, and rising health awareness, both life and non-life insurance companies have expanded their offerings to include health-related benefits. Among these, critical illness (CI) products in life insurance and medical (health) indemnity policies in general insurance have seen notable growth. These developments mirror trends across South Asia, where rising healthcare costs and increased disease prevalence have pressured insurers to innovate beyond traditional life cover or hospitalization reimbursement (World Bank, 2021).

(Nepal Insurance Authority, 2025) has actively encouraged diversification in insurance offerings. In its recent circulars, it has emphasized improving health insurance penetration and product standardization. As a result, critical illness riders—especially those covering cancer, cardiovascular diseases, and organ failure have become common in life policies (World Health Organization, 2023). Simultaneously, general insurance providers have launched variations of fixed benefit, top-up, and cashless medical policies. Yet, with this evolution comes a new set of challenges: notably, a mismatch between product design and the operational realities of claims processing.

### Theoretical Models vs. Practical Claims Handling

Existing literature on insurance product design in developing markets often emphasizes the importance of actuarial soundness, sustainability, and pricing models. These models typically rely on clean datasets, risk stratification, and medical definitions rooted in global

clinical norms (e.g., ICD-10 or WHO staging). However, very little literature from Nepal or South Asia addresses how these models hold up when confronted with local claim realities.

Studies from India and Sri Lanka (e.g., Shah et al., 2020; Fernando, 2019) point to a growing disconnect between underwriting assumptions and claim settlement decisions in health-related insurance products. These findings are echoed in anecdotal observations from Nepal, where claim rejection rates in critical illness insurance especially in cancer and heart-related claims are higher than expected. This discrepancy is often rooted in the complexity of interpreting medical evidence, staging, and terminology vis-à-vis rigid policy definitions.

Additionally, there is a scarcity of peer-reviewed research focusing on claims management practices in Nepal. Most available documentation comes in the form of regulatory reports, operational manuals, or product brochures. Academic discourse tends to emphasize insurance penetration and premium trends, with less attention given to claims adjudication, claims-related disputes, or policyholder experience post-claim -the very factors that determine customer trust and retention (Swiss Re., 2023).

**Operational Fragmentation and Policy Ambiguity**

A review of product literature from major insurers in Nepal reveals significant variation in CI definitions, claim requirements, and documentation standards. For instance, while one insurer may require a detailed histopathology report for a cancer claim, another may accept a consultant oncologist's summary. Similarly, "stroke" or "heart attack" definitions vary in terms of necessary diagnostic evidence (e.g., CT scan vs. neurological observation), creating confusion for claimants and inconsistency among adjudicators.

The absence of a centralized clinical guideline or industry-wide medical interpretation framework further exacerbates this gap. This is compounded by the fact that many critical illness definitions are adopted directly from reinsurance templates, often developed in Western markets, with limited contextual adaptation to local disease presentation, diagnostic infrastructure, or medical reporting standards in Nepal.

**Experience from the Field: A Missing Voice**

Despite the importance of claims to the insurer-customer relationship, there is a marked lack of published work that draws on the experience of claims officers and medical assessors those who work at the frontline of policy interpretation. These professionals routinely face dilemmas that are not anticipated in underwriting manuals or product prospectuses. This article seeks to fill that gap by offering a field-based perspective that combines technical knowledge with practical realities, highlighting the limitations of current models and suggesting locally informed improvements.

## 3. Methodology and Perspective

This article employs a practitioner-based case reflection methodology, grounded in real-world experience handling critical illness and medical claims in both life and general insurance sectors in Nepal. The insights presented are not drawn from a formal quantitative dataset but are instead qualitative observations based on Five years of working within claim departments in life (Himalayan Life Insurance Limited) and General (IGI Prudential Insurance Limited) : direct involvement in evaluating, approving, and rejecting claims related to cancer, cardiac events, neurological disorders, and complex medical conditions.

The dual-sector exposure-first in life insurance and now in general insurance provides a unique lens to compare the fixed-benefit model typical of critical illness policies with the reimbursement-based structure of medical insurance. While critical illness claims depend heavily on matching diagnosis to strict definitions outlined in the policy, medical claims are more dynamic, involving diverse treatment types, billing structures, and hospitalization processes (Munich Reinsurance Company, 2022). This contrast informs the comparative framework used in this paper.

To illustrate the systemic disconnects between actuarial design and claim reality, this article reflects on six anonymized cases encountered during regular operations. These cases were selected based on their:

- Diagnostic ambiguity (e.g., early-stage cancers, stroke without radiological evidence)
- Policy interpretation complexity (e.g., cardiac claims not fulfilling all CI conditions)
- Conflict between medical reality and product wording
- Overlap between life and general insurance policies

These examples are used not as isolated anomalies but as representative patterns of issues that emerge across multiple insurers and policy types in Nepal.

Additionally, references are made to product documents, claim guidelines, and underwriting manuals used by leading insurers in Nepal to highlight where ambiguities arise. Although these materials are not quoted verbatim due to confidentiality, their essence is retained to demonstrate the typical structures used in local policy design and their influence on claims decisions.

The interpretative framework used in this analysis is drawn from the intersection of:

- Actuarial science principles (particularly assumptions embedded in product pricing and risk stratification)
- Health economics (specifically moral hazard, adverse selection, and information asymmetry)

- Operational claims management (focusing on real-time decision-making and medical documentation interpretation)

By situating the analysis within this blended framework, the article seeks to bridge the academic understanding of insurance product performance with the on-ground realities of claims adjudication. It aims to highlight that even technically sound insurance products can underperform in customer satisfaction and fairness if practical challenges in claims are not factored into their design.

## 4. Real-World Challenges in Claim Adjudication in Nepal

Claims adjudication is the moment where the insurer's promise is tested. In Nepal, this process is frequently challenged not only by limited documentation or infrastructure but by inconsistencies between policy wording, underwriting expectations, and medical realities. Based on firsthand experience across life and general insurance claims, several recurring patterns emerge that expose systemic weaknesses in how critical illness (CI) and medical insurance claims are handled. These issues are not isolated to specific insurers but appear across the industry suggesting a structural need for reform.

**Critical Illness Claims in Life Insurance: Definitional Rigidity vs. Clinical Complexity**

Critical illness policies in Nepal typically follow templates provided by global reinsurers, defining claim eligibility in strict, binary terms. However, medical conditions rarely present themselves in such clear-cut stages.

Cancer claims are frequently disputed due to classification issues- especially when diagnosed as carcinoma in situ, low-grade tumors, or borderline malignancies (Shah, et al., 2013). While policy definitions clearly exclude non-invasive cancers, confusion arises when diagnostic language in pathology reports does not neatly state “invasive” or when treatment (e.g., mastectomy and chemotherapy) suggests severity that policy wording doesn't technically acknowledge.

Cardiovascular claims such as myocardial infarction or coronary artery disease face problems when the required evidence (e.g., elevated cardiac enzymes, ECG changes, or angiographic proof) is only partially present. In some cases, CABG surgery is performed based on clinical judgment, yet claims are denied because certain diagnostic thresholds are unmet.

Neurological claims involving stroke or coma also demonstrate the issue. Policies often demand radiological evidence of permanent brain damage or specific durations of unconsciousness. Yet, in practice, patients may show severe functional impairment without fully satisfying these narrow definitions.

Another issue is the binary nature of CI benefits either full payment is made or none at all. This lack of proportionality leads to frustration among policyholders and limits the insurer's ability to act fairly in ambiguous cases.

**Medical Claims in General Insurance: Documentation, Definitions, and Discretion**

Medical insurance in Nepal generally follows a reimbursement model, which introduces its own set of challenges:

Pre-existing condition disputes are among the most common. In many cases, diagnoses made during hospitalization are retrospectively interpreted as pre-existing based solely on assumptions or indirect references in old prescriptions. Without standardized underwriting and claim-linked medical coding, such decisions can appear arbitrary.

Diagnostic ambiguity is also a problem. For example, a case diagnosed as "viral fever with suspected encephalitis" may lead to a denial if encephalitis is not confirmed- even though treatment aligns with the suspected condition. This reveals a gap between clinical judgment and claims criteria.

Cashless claims often face issues when hospitals provide incomplete documentation or omit key tests. In such cases, the insurer bears the cost of assumption or delays, creating tension between the customer, the provider, and the insurer.

In pediatric claims, insurers often struggle with rare diagnoses or undefined disease presentations, leading to conservative interpretations and increased rejection rates despite the presence of severe symptoms.

**Shared Challenges Across Both Sectors**

Several systemic issues affect both CI and medical insurance:

- Ambiguous documentation from hospitals or treating physicians makes it difficult to match real cases to policy definitions. Discharge summaries often use vague terms like "lesion," "provisional diagnosis," or "rule out," which lack the specificity needed for clean claim approvals.
- Lack of standard medical coding (e.g., ICD-10) across insurers prevents consistency. One claims team might accept a CT report as proof of stroke, while another may demand neurological certification.
- Misalignment between underwriting and claims: Many policies are sold based on optimistic interpretations of coverage. When customers discover exclusions or requirements at the time of claim, it results in dissatisfaction and reputational risk.

Resource gaps in claims teams: Many adjudicators lack a clinical background and rely solely on documentation rather than clinical reasoning. This can lead to overly rigid or overly lenient decisions -both of which can harm the insurer.

**Operational Pressures and Moral Hazard**

In some cases, moral hazard and fraud also complicate claim adjudication:

Fabricated medical bills or inflated treatment costs, particularly in general insurance, place claims teams in an adversarial position with customers and hospitals.

Multiple policy stacking (e.g., critical illness cover with overlapping benefits) creates difficulty in assigning liability and interpreting the scope of payout.

Agent-driven expectations lead to misrepresentation at the point of sale, where policyholders are led to believe that any "serious disease" will result in an automatic payout contradicting the legal definition embedded in the policy.

## 5. Bridging the Gap: Actuarial Assumptions vs. Practical Realities in Claim Handling

Actuarial science forms the foundation of modern insurance design. Actuaries define benefit structures, set premiums, and determine risk exposure based on mathematical models and historical data. In Nepal, where health and critical illness insurance are still maturing, actuarial models often rely on reinsurance templates, global disease prevalence, and assumed patterns of illness progression. While this provides a technical backbone for product development, the experience in claims departments reveals a significant gap between model assumptions and real-world complexity.

**Theoretical Risk Stratification vs. Clinical Ambiguity**

Actuarial pricing assumes a rational categorization of diseases: cancer is either invasive or not; a heart attack either occurred or didn't; a stroke is confirmed or excluded. In reality, medical conditions often lie in gray zones. For instance:

A biopsy may suggest "atypical ductal hyperplasia" rather than clear carcinoma.

A patient may undergo angioplasty for unstable angina with elevated markers, yet lack the full ECG pattern of an infarction.

Neurological deficits may persist without confirmatory imaging due to delays or limitations in rural diagnostic centers.

Such ambiguity is not factored into actuarial pricing, which assumes policyholders will either cleanly meet or miss the defined criteria. This oversimplification causes friction in claims,

especially when customers argue that the intent of the policy has been fulfilled, even if technical definitions are not met.

**Claim Frequency and Severity: A Misaligned Expectation**

CI products are priced assuming a low frequency, high severity model. In practice, claim departments are now witnessing:

- Increasing frequency of early-stage diagnoses, especially in cancers (due to better awareness and screening)
- More borderline cardiac procedures (angioplasty without full MI)
- Complex multi-morbidity claims, where one illness triggers investigation of another

These cases may not result in payout but require full claims investigation, thereby increasing operational cost, turnaround time, and customer dissatisfaction. Yet, actuarial loadings for administrative strain are often not sufficient, especially in low-premium CI riders.

**Static Product Design in a Dynamic Medical Landscape**

The definitions embedded in most CI policies in Nepal are often imported from international reinsurer guidelines with minimal localization. They reflect medical knowledge from a point in time, while medical science evolves rapidly. Examples:

Cancer classifications have expanded, with terms like “borderline malignancy” and “pre-invasive carcinoma” becoming more clinically relevant—but not yet reflected in policy wordings.

Neurological and cardiac conditions are increasingly diagnosed using biomarkers and advanced imaging, which may not be required or accessible in Nepal’s public hospitals.

Treatments like targeted therapy, hybrid cardiovascular surgeries, or daycare chemotherapy challenge the traditional assumption that hospitalization or full surgical intervention is a claim trigger.

Actuarial models, unless frequently updated, fail to capture these nuances placing pressure on claim adjudicators to interpret outdated definitions against modern clinical realities.

**The Feedback Gap: Lack of Experience-Driven Product Evolution**

In an ideal system, claims data and real-world experiences should loop back into actuarial pricing and underwriting design. However, in Nepal’s insurance industry, this feedback mechanism is weak or nonexistent. Some reasons include:

- Siloed operations: Claims, underwriting, and actuarial teams rarely collaborate post-product launch.

- Lack of standardized claims reporting across the industry, making it difficult to aggregate meaningful trends.
- Agent-driven distribution focuses more on sales volume than claim quality, reducing focus on feedback integration.

The result is a system where products continue to be priced and sold with assumptions that are divorced from how claims actually unfold- increasing friction, rejections, and reputational damage.

**Claim Outcomes as a Risk Management Tool**

Ironically, claim adjudication often becomes the de facto risk control mechanism, instead of better underwriting or pricing. Rather than refining products to reflect what is medically and operationally feasible, insurers depend on technical rejections or ambiguous interpretation to protect margins. This approach may provide short-term cost containment, but undermines long-term trust, market development, and regulatory goodwill.

## 6. Case-Based Illustrations from Nepal's Claims Landscape

The following anonymized case studies, drawn from real claim files handled across both life and general insurance companies in Nepal, illustrate the operational, medical, and interpretational complexities discussed earlier. These cases are not outliers- they represent common, recurring dilemmas that highlight the gap between insurance product assumptions and medical reality.

**Case 1: Cancer Diagnosis and the "In Situ" Confusion**

A 45-year-old female policyholder underwent a mastectomy after being diagnosed with ductal carcinoma in situ (DCIS) of the right breast. She submitted a claim under her critical illness rider for "Cancer of Specified Severity." Despite the severity of her treatment—surgery, radiation, and extended recovery-the claim was rejected on the grounds that DCIS is excluded under most CI definitions, as it is technically non-invasive.

✓ Key Issue:

Policy definition required histological confirmation of invasion beyond the basement membrane. The treating oncologist's report described the lesion as "DCIS, high grade," but without explicit mention of invasion, making it inadmissible - even though the clinical impact and cost of treatment were substantial.

✓ Insight:

This case demonstrates how strict adherence to pathology wording can override clinical severity, frustrating policyholders and damaging insurer credibility.

**Case 2: Stroke Without a Scan**

A 58-year-old man suffered a sudden loss of motor function and was diagnosed by the attending neurologist with a right hemispheric ischemic stroke. CT scan facilities were unavailable at the time, and he was referred to a government hospital days later, where imaging failed to capture definitive infarction due to delay.

The claim was filed under CI for stroke. Despite physician certification and obvious clinical symptoms, the claim was rejected because the policy required radiological evidence of brain tissue damage and neurological deficit lasting at least 96 hours.

✓ Key Issue:
In rural or resource-limited settings, radiological confirmation is not always feasible in time. Policy definitions assume access to modern diagnostics, which is not the reality for many in Nepal.

✓ Insight:
Standard definitions built for advanced clinical environments need local adaptation, or at least discretionary clauses for medically justified exceptions.

**Case 3: heart disease – Treated but Not Covered**

A 49-year-old male was diagnosed with double vessel coronary artery disease and underwent coronary artery bypass grafting (CABG). The claim under his CI policy was rejected due to lack of angiographic documentation and failure to meet the specified >70% stenosis threshold per the policy wording.

Ironically, the surgery itself should have signaled severity - but because the pre-op angiogram report was not attached (the hospital only provided a surgical note), the insurer could not validate whether the surgery met the technical trigger criteria.

✓ Key Issue:
Claims teams rely heavily on pre-specified test results, even when treatment decisions (and clinical severity) are clear.

✓ Insight:
Over-reliance on documentation - particularly when medical action already proves severity-results in technically defensible but ethically questionable rejections.

**Case 4: Medical vs. CI Policy Overlap - Who Pays?**

A 55-year-old policyholder had both a medical insurance plan and a CI rider. He was hospitalized with hypertensive heart disease and underwent a combination of diagnostic and stabilization procedures but no surgery. His medical insurer covered part of the cost. He then claimed the CI benefit, arguing the illness was severe enough.

The CI claim was denied, as the condition did not meet the strict definitions of "Heart Attack" or "Heart Failure" under the policy. The customer felt betrayed, believing that two separate covers should ensure broader protection.

✓ Key Issue:
Customer expectations often conflate medical and CI benefits, especially when agents oversell without clarifying distinctions.

✓ Insight:
There is a pressing need for better sales training, policyholder education, and policyholder-friendly CI definitions to reduce this confusion.

**Case 5: Pediatric Neuroblastoma – Covered but Unclear**

A 7-year-old boy was diagnosed with neuroblastoma and treated with chemotherapy and supportive care. His parents filed a CI claim. The policy included pediatric cancer but used adult-oriented definitions (requiring "histologically confirmed malignancy with evidence of metastasis or severe bone marrow suppression").

The histopathology report confirmed neuroblastoma, but did not specify metastasis. The claim was initially put on hold due to ambiguous staging. It was only after direct clarification from the oncologist that the claim was approved.

✓ Key Issue:
Pediatric conditions are often underrepresented or poorly defined in policy wordings, leading to delays or denials.

✓ Insight:
CI policies must explicitly define pediatric conditions, use clear staging standards, and recognize real-world treatment protocols.

**Case 6: Reimbursement Denied Due to Documentation Errors**

A woman was admitted to a private hospital for severe abdominal pain, later diagnosed as ovarian torsion, and underwent laparoscopic surgery. She filed a medical claim under her general insurance policy.

The hospital failed to submit the intra-operative findings and complete histopathology on time. The insurer rejected the claim for "insufficient documentation," despite multiple attempts by the claimant to supplement missing papers.

✓ Key Issue:
Hospital documentation practices vary widely and directly affect claim outcomes.

✓ Insight:

Standardized documentation templates, hospital tie-ups, and insurer training can reduce these unnecessary rejections.

## 7. Recommendations for the Nepalese Market

The recurring disconnects between policy design, actuarial assumptions, and real-world medical claims in Nepal signal an urgent need for systemic improvements. Based on professional experience, observed case patterns, and comparative regional practices, the following recommendations aim to improve fairness, clarity, and operational efficiency in Nepal's critical illness and health insurance claims ecosystem.

### A. Local Adaptation of Policy Definitions

Many of Nepal's critical illness (CI) and medical insurance products are based on global reinsurer templates, which may not reflect local healthcare realities. These definitions often assume:

- Universal access to advanced diagnostic tools (e.g., MRI, histopathology)
- Standardized medical documentation
- Clinically uniform disease progression

**Recommendation:**

Insurers, guided by the Insurance Board and relevant medical associations, should develop localized CI definitions that consider:

- Common diagnostic practices in Nepal
- Resource variability between urban and rural hospitals
- Region-specific disease presentations (e.g., tuberculosis-related complications, late-stage diagnoses)

This will reduce unnecessary rejections and better align policies with the healthcare environment policyholders actually face.

### B. Integrated Feedback Loop Between Claims, Underwriting, and Product Design

Currently, claim decisions in most companies are not systematically fed back into underwriting or actuarial teams, leading to repetitive product blind spots.

**Recommendation:**

- Establish a formal feedback mechanism where rejected, disputed, or complex claims are reviewed quarterly.
- Use anonymized case studies to update underwriting manuals, pricing models, and sales training materials.

- Consider forming a multi-disciplinary task force involving claims officers, underwriters, actuaries, and medical advisors to review emerging medical claim trends and their implications on policy design.

### C. Standardized Medical Interpretation Guidelines

One of the key bottlenecks in claim adjudication is the inconsistent interpretation of medical documents, especially when terminology varies by doctor, hospital, or diagnostic lab.

**Recommendation:**

- Develop an industry-wide medical interpretation guideline- an internal document aligned with ICD-10/11 codes, WHO standards, and adapted for Nepal.
- Train claim adjudicators and panel doctors in standard diagnostic triggers and how they relate to policy wording (e.g., what counts as “invasive cancer” vs. “in situ”).

This would also support newer claims staff and reduce internal decision variance.

### D. Clarity and Simplicity in Product Wording

Claim disputes often arise not from medical disagreements, but from ambiguity or complexity in policy wording.

**Recommendation:**

- Simplify CI definitions using layperson-friendly explanations in policy brochures.
- Include example scenarios in policy documents (e.g., “This policy does not cover Stage 0 breast cancer, but does cover Stage 1 and above”).
- Provide pre-claim checklists for common illnesses (cancer, heart disease, stroke) to help policyholders prepare documentation accurately.

### E. Strengthen Agent and Intermediary Education

A significant proportion of claim dissatisfaction originates at the point of sale, where agents may oversell or misrepresent coverage.

**Recommendation:**

- Introduce a mandatory CI and medical product training module for agents and brokers.
- Include real claim scenarios in sales training to highlight limitations and responsibilities.
- Encourage agents to deliver "benefit vs. limitation summaries" at the time of sale.

This improves policyholder understanding and reduces future disputes.

### F. Digital Integration for Claims and Medical Records

In many rejected claims, missing or incomplete documentation is a technical, not medical, issue.

**Recommendation:**

- Promote partnerships between insurers and major hospitals for direct medical data sharing (e.g., e-reports, diagnostic access).
- Pilot digital claim portals with document validation features and auto-flagging of missing sections.

This will reduce paperwork, speed up turnaround time, and improve claim quality.

### G. Role of the Insurance Board and Industry Bodies

Finally, regulatory support is critical to drive consistency across the industry.

**Recommendation:**

- The Insurance Board of Nepal (Nepal Insurance Authority) could initiate a central guideline for CI definitions, documentation standards, and adjudication timelines.
- Promote annual cross-company claims benchmarking reports to monitor claim ratios, rejection trends, and customer satisfaction.

Such transparency would improve public trust and industry performance alike.

## 8. Conclusion

The promise of insurance lies not just in the design of products, but in their performance when it matters most- at the time of a claim. In Nepal's fast-evolving insurance landscape, the rise of critical illness and health insurance products represents a positive shift toward greater risk protection. Yet, this progress is hindered by a persistent and often overlooked gap: the disconnect between actuarial and underwriting assumptions versus the practical realities of claims adjudication.

As shown through both analytical observations and real case experiences, this disconnects manifests in multiple ways: overly rigid claim definitions, medical documentation mismatches, diagnostic ambiguities, and unmet customer expectations. These issues are not simply operational inefficiencies they are points of tension that can undermine trust, satisfaction, and market credibility. When a cancer patient undergoes life-altering treatment yet fails to qualify for a payout due to narrow wording, or when a heart disease claim is denied for lacking a specific enzyme report, the industry loses more than just money it risks losing the public's confidence.

For insurers in Nepal, the path forward requires a fundamental shift in how product design, underwriting, claims, and customer communication are integrated. Relying solely on imported policy templates and rigid benefit structures is no longer sufficient. As claims become more medically complex and policyholders more informed, the insurance sector must evolve into a more adaptive, data-informed, and empathetic system.

This article has argued that claims handling must be repositioned not as a back-office task but as a strategic feedback loop into the very structure of insurance products. With thoughtful regulatory support, localized policy frameworks, and a commitment to fairness, Nepal's insurance industry has the opportunity to lead a regional example in aligning numbers with needs- and turning policy promises into practical protection.

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