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BEFORE THE MADURAI BENCH OF MADRAS HIGH COURT

RESERVED ON : 25.02.2026

DELIVERED ON : 09.06.2026

CORAM:

THE HONOURABLE MR.JUSTICE **B.PUGALENDHI**

WP(MD)No.7212 of 2023

P.Ravi : Petitioner

Vs.

1.The District Level Empowered Committee,
Rep. by the Chairman / District Collector,
New Health Insurance Scheme for Government Employees,
Madurai – 625 002.

2.The Superintendent of Police,
Madurai District.

3.M/s.United India Insurance Company Ltd.,
Rep. by its Regional Manager,
Regional Office,
Pandiyan Building,
Door No.7A, Floor No.1,
West Veli Street, Madurai – 625 001.

4.M/s.MD India Healthcare Services (TPA) Pvt Ltd.,
Rep. by its Authorised Officer,
No.27, Lakshmi Towers,
3rd Floor, Dr.Radhakrishnan Salai,
Mylapore, Chennai – 600 004.

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5.The Secretary to Government,
Health and Family Welfare Department /
Chairman of Aggregate Committee,
Chennai.

6.The Secretary to Government,
Finance Department,
Fort St.George, Chennai.

7.The Dean,
Velammal Medical College Hospital,
Madurai,
Velammal Village,
Anuppanadi Near Chinthamani,
Madurai – 625 009. : Respondents

[R.5 *suo-motu* impleaded vide order dated 17.12.2025]

[R.6, R.7 *suo-motu* impleaded vide order dated 07.01.2026]

PRAYER: Petition filed under Article 226 of the Constitution of India seeking issuance of a Writ of Mandamus directing the respondents 3 & 4 to reimburse a sum of Rs.2,72,406/- (Rupees Two Lakh Seventy Two Thousand Four Hundred and Six only) towards the petitioner's medical claim under the Government of Tamil Nadu New Health Insurance Scheme 2012 for Government Employees by considering the petitioner's representation dated 26.08.2022.

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For Petitioner : Mr.R.Rajamohan

For Respondents: Mr.Ajmal Khan,
Additional Advocate General
Assisted by
Mr.C.Venkatesh Kumar,
Special Government Pleader
for R.1, R.2, R.5, R.6

Mr.Manisankar,
Senior Counsel
for Mr.M.Keerthikiran for R.3

Mr.Isaac Mohanlal,
Senior Counsel
for Mr.L.Shaji Chellan for R.7

Amicus Curiae : Mr.B.Saravanan,
Senior Counsel

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ORDER

This writ petition has been filed seeking a writ of mandamus to direct the United India Insurance Company Limited, and the Third-Party Administrator under the New Health Insurance Scheme 2021, to reimburse a sum of Rs.2,72,406/- allegedly paid by the petitioner towards medical treatment undergone by him.

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Petitioner's case:-

2.The petitioner is serving as a Head Constable and is a beneficiary under the New Health Insurance Scheme, 2021 [hereinafter referred to as the 'NHIS 2021'] introduced by the Government of Tamil Nadu vide G.O.Ms.No.160, Finance Department, dated 29.06.2021. According to the petitioner, he underwent Aorto Bi-Iliac Bypass surgery with bifurcation grafting at Velammal Medical College Hospital, Madurai, which is an empanelled network hospital under the Scheme. The ailment for which treatment was taken is a listed disease covered under the Scheme. The coverage under the scheme extends up to Rs.5,00,000/- per employee (with enhanced limits for specified illnesses). However, despite being eligible for cashless treatment, the hospital raised a total bill of Rs.3,73,494/-. Out of this, the insurance company sanctioned only Rs.1,01,008/- as cashless coverage under the scheme. The remaining amount of Rs.2,73,494/- was allegedly collected from the petitioner by the hospital and he was compelled to make the payment in order to secure his discharge from the hospital. Therefore, the petitioner made a representation to the first respondent District Level Empowered

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Committee seeking reimbursement of his medical expenses on 26.08.2022 and the same was forwarded to the Joint Director, Rural Development Department on 27.09.2022 but no action was taken on the same. Hence, he has filed this writ petition.

Stand taken by the Insurance Company:-

3.The Insurance Company has resisted the reimbursement claim of the petitioner by contending that it has already sanctioned the admissible amount under the Scheme. The Insurance Company would state that a Memorandum of Understanding was entered into between the Insurance Company, the Third-Party Administrator and the Hospital in November 2021 prescribing the applicable package rates. According to the Insurance Company, a sum of Rs.1,01,088/- was approved strictly in accordance with the package rate applicable to the procedure undergone by the petitioner. It is their contention that the hospital has overcharged the petitioner beyond the agreed package rate. It is their claim that the hospital, having handled several thousand cases under the Scheme, cannot claim ignorance of such rates. Therefore, the Insurance Company

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contends that any liability arising out of excess billing rests solely with the hospital and not the Insurance Company.

Stand taken by the Hospital:-

4.The Hospital, on the other hand, submits that the petitioner was initially admitted with Aorto-Iliac disease and that a cashless pre-authorisation request was forwarded to the Insurance Company estimating the cost of treatment as Rs.2,50,000/-. The Insurance Company initially granted authorisation for a sum of Rs.20,000/- and directed the hospital to submit the final bill and discharge records for approval of the remaining claim under the NHIS 2021. According to the hospital, the petitioner subsequently developed complications necessitating prolonged hospitalisation, intensive care treatment and consultation by multiple specialists. The petitioner underwent Aorto Bi-Iliac Bypass surgery with bifurcation grafting on 26.05.2022 and, owing to the complications that arose during the post-operative period, remained hospitalised until 07.06.2022.

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5.It is further contended that the prolonged ICU stay, specialist consultations and additional treatment substantially increased the cost of medical care. Consequently, the total expenditure incurred towards the petitioner's treatment amounted to Rs.3,73,494/-. Though an enhanced cashless authorisation request was submitted to the Insurance Company, only a sum of Rs.1,01,088/- was approved by the Insurance Company under the scheme. Therefore, the balance amount necessarily had to be collected from the petitioner by the hospital. According to the hospital, the petitioner was informed about the risks of the treatment and the nature of expenses incurred on the same. The hospital also contends that despite the coverage available under the NHIS extending up to Rs. 5,00,000/-, the Insurance Company approved a substantially lesser amount without assigning any reasons for the same and therefore any grievance of the petitioner must be directed against the Insurance Company and not the hospital.

6.Further, the Hospital has also disputed the contractual arrangement fixing package rates which was relied upon by the

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Insurance Company. According to the Hospital, no such concluded Memorandum of Understanding exists between the parties. It is their specific stand that though the Dean of the Hospital had signed an undated agreement, the same was never executed by the Insurance Company and consequently no package rates were ever mutually agreed upon between the Hospital and the Insurance Company.

7.This Court has given its anxious consideration to the rival submissions advanced on either side and carefully perused the materials available on record.

8.The issue in the present case arises out of the fact that the petitioner, despite undergoing treatment in an empanelled network hospital for a disease covered under the New Health Insurance Scheme 2021, was required to incur substantial out-of-pocket expenditure. The Insurance Company attributes the shortfall to the package rates applicable under the Scheme, whereas the hospital contends that the expenditure incurred was necessitated by complications arising during

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the course of treatment and that the amount approved by the Insurance Company was grossly inadequate.

9.The rival stand taken by the parties gave rise to certain broader questions concerning the manner in which the Scheme operates. These include the nature of the coverage provided under the Scheme, the relationship between the ceiling limit prescribed under the Guidelines to the scheme and the package rates arrived at by way of contractual arrangements, and the extent to which such package rates can affect the promise of cashless treatment provided to the beneficiaries. In order to effectively adjudicate the grievance projected by the petitioner, it therefore becomes necessary to briefly examine the object behind providing medical reimbursement to government servants and the clauses under the guidelines to the NHIS 2021.

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Evolution of the Health Insurance Scheme for government employees:-

10.The Constitution of India envisions the State not merely as a sovereign authority exercising governmental power, but as a welfare State committed to securing the well-being and economic security of its citizens. This constitutional philosophy finds expression in the Directive Principles of State Policy contained in Part IV of the Constitution. Article 47 casts a duty upon the State to promote public health, while Article 43 obligates the State to endeavour to secure a decent standard of life for all workers, including Government servants. Further, the right to life guaranteed under Article 21 has been consistently interpreted to encompass the right to health and access to adequate medical care.

11.These constitutional obligations assume greater significance in the case of Government servants, who constitute the backbone of public administration and through whose efforts the policies and programmes of the State are implemented. It is in recognition of the invaluable services rendered by them that the State has introduced various welfare

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measures, including health insurance schemes, to ensure timely and quality medical treatment to Government servants and their dependants without exposing them to financial hardship during medical emergencies.

12.Support for this principle can be drawn from the decision of the Hon'ble Supreme Court in ***State of Punjab v. Mohinder Singh Chawla*** [***(1997) 2 SCC 83***], wherein it was held that the right to health is an integral facet of the right to life and that the Government is under an obligation to provide health facilities to its employees. The said principle was reiterated in ***Shiva Kant Jha v. Union of India*** [***(2018) 16 SCC 187***], wherein the Hon'ble Supreme Court observed that it is a settled legal position that a Government employee, during his lifetime as well as after retirement, is entitled to the benefit of medical facilities and that no fetters can be placed upon such entitlement.

13.It is in furtherance of these constitutional and welfare obligations that the Government has framed various rules and

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introduced schemes to provide accessible and affordable healthcare facilities to Government servants, pensioners and their dependants.

14.Initially, medical assistance to government servants was extended under the Tamil Nadu Medical Attendance Rules which was introduced with the object of ensuring access to quality health care and mitigating the financial burden incurred by the government servants due to medical expenses. Under these rules, free treatment was provided in Government medical institutions and limited reimbursement for emergency treatments undergone in private hospitals. However, the reimbursement was available only in the case of treatments certified to be emergency in nature by the competent authority and they had to be undergone beyond the conscious capacity of the government servants or pensioners concerned.

15.Therefore, recognising the need for wider access to quality healthcare and enhanced financial protection, the Government introduced dedicated health insurance schemes for its employees and

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pensioners. The Tamil Nadu Government Employees Health Fund Scheme was launched in 1992, followed by a similar scheme for pensioners in 1995. As these schemes were found inadequate to meet the growing healthcare requirements of government servants, the State introduced a comprehensive Health Insurance Scheme in 2007 vide G.O.Ms.No.174, Finance (Salaries) Department, dated 28.04.2008 wherein it decided to enter into an agreement with a private insurance company selected by way of a tender for the implementation of the scheme. Under this scheme, cashless insurance coverage of up-to Rs.2 lakh was provided to the government servants and their dependents.

16.The scheme has thereafter undergone periodic renewals and the insurance coverage provided to the government servants has been increased. At present, Government employees and their dependants are covered under the New Health Insurance Scheme 2021 and the guidelines for implementation of the same are provided under G.O.Ms.No.160, Finance Department, dated 29.06.2021. The scheme is implemented by an Insurance Company selected by the Government

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through a competitive tender process. The United India Insurance Company was selected as the Private Insurer for the scheme by way of tender. Subsequently, the Government, represented by the Principal Secretary to Government, Finance Department and the Insurance Company have entered into an agreement dated 30.06.2021 for the implementation of the scheme.

Salient features of NHIS, 2021:

17.The NHIS 2021 is a contributory health insurance scheme under which Government employees are provided insurance coverage through a cashless treatment model. The premium payable is fixed under the government order and recovered from the salaries of Government employees and remitted towards implementation of the scheme. The scheme is compulsory for all government employees and the Annual Premium payable by the government is fixed at Rs.3,240/-. This amount is recovered from the government employees at the rate of Rs.300/- per month (Rs.295/- for subscription to NHS and Rs.5/- employees' contribution).

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18.The scheme aims to provide coverage of up-to Rs.5 lakh in a block of 4 years in cashless model for the approved treatments/ surgeries listed in Annexure 1 and up-to Rs.10 lakh in case of specified illnesses listed under Annexure 1-A.

19.The main object of the scheme is the assurance of cashless treatment to the beneficiaries. The cashless coverage is provided for the specified treatments undergone in empanelled hospitals upto the ceiling prescribed under the Government Order and the eligible medical expenses include all admissible expenses incurred during hospitalisation upto the date of discharge, excluding only those expenses specifically classified as non-admissible.

20.Clause 4(g) of the guidelines defines "Cashless Service by Network Hospital" and provides that the beneficiaries should receive treatment without having to make deposits from the time of admission till discharge for procedures covered under the Scheme. Therefore, the

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scheme thus envisages that a beneficiary should enter a network hospital, undergo treatment and leave the hospital without making any payment towards covered procedures, except for non-admissible expenses specifically excluded under the Scheme.

21.Clause 17(5) of the Scheme specifically provides that the Insurance Company shall ensure that Government employees and their eligible family members are treated without having to make any cash payment for eligible medical expenses, subject to the ceiling criteria prescribed under the Scheme. The said clause reads as under:-

> *"Clause 17(5): The Insurance Company shall ensure that the Employees of Government Departments etc., and their eligible family members defined in these Guidelines are treated without having to make any cash payment for any of the Eligible Medical Expenses subject to the Ceiling Criteria upto a limit of Rupees Five Lakh in respect of treatments taken and surgeries undergone listed in the Annexure-I to these Guidelines and upto Rupees Ten Lakh in respect of specified treatments taken and surgeries undergone listed in the Annexure-I A to these Guidelines in the empanelled Network Hospitals."*

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22.In order to ensure the same, the scheme also mandates the Insurance Company / Third Party Administrator to appoint nodal officers under clause and these nodal officers shall compulsorily be present in the hospitals to assist in the claim settlement process.

23.Clause 11 of the guidelines provide that medical assistance shall be extended on a cashless basis subject to the ceiling criteria prescribed under the government order. The clause contemplates reimbursement from the Insurance Company in cases where a beneficiary is forced to incur out-of -pocket expenditure towards eligible medical expenses. It is important to note that this clause does not make any reference to any package rate arrived at between the Insurance Company and the Hospitals.

24.The Scheme further contains a penalty clause under Clause 22 empowering the Government to impose penalties upon the Insurance Company for failure to provide services in accordance with the terms of the Scheme.

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25.The Scheme provides a structured mechanism for dealing with the reimbursement claims. Claims are initially scrutinised by the Grievance Redressal Officer and thereafter approved by the District Level Empowered Committee. Appeals against the decisions of the District Level Empowered Committee lie before the State Level Empowered Committee headed by the Commissioner of Treasuries and Accounts and having the Director of Medical and Rural Health Services or his nominee as Member Secretary and an official representative nominated by the Insurance Company as members.

Ceiling Criteria and Package Rates:-

26.The ceiling criteria forms a part of the Government Order providing guidelines for implementation of the Scheme and therefore derive their authority from executive instructions. They are publicly notified and constitute the limits of coverage assured to beneficiaries under the Scheme.

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27.On the other hand, the practice of entering to agreements fixing package rates appears to arise from Clause 12 of the Scheme. Under the said provision, an empanelled hospital is required to obtain pre-authorisation from the Insurance Company or the Third Party Administrator before undertaking treatment under the Scheme. The purpose of the same is to verify if the beneficiary is eligible under the scheme. This clause also provides that the hospital shall act in accordance with the rates agreed upon under the tripartite arrangement between the Insurance Company, the Third Party Administrator and the hospital concerned.

28.Thus, it is clear that the package rates are not fixed under the Government Orders. They arise from separate contractual arrangements entered into between the Insurance Company and the empanelled hospitals. These package rates are neither incorporated in the Scheme guidelines nor made known to the beneficiaries as part of the Scheme framework.

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29.Clause 11 of the scheme dealing with cashless treatment refers only to the ceiling criteria governing medical assistance under the Scheme and clause 15(10) dealing with medical reimbursement also refers only to the ceiling rate. Therefore, it is the ceiling criteria prescribed under the Government Orders which constitutes the governing benchmark recognised under the Scheme, whereas the package rates owe their existence to subsequent contractual arrangements entered into by the Insurance Company and hospitals.

Litigations:-

30.The government servants, under the impression that the government has promised cashless treatment and without knowing the limitations under the scheme, have taken treatment in hospitals and claimed medical reimbursement, which has led to multiple litigations before this Court.

31.In ***Star Health and Allied Insurance Co. Ltd v. A. Chokkar*** [***2010-2-LW 90***], a Division Bench of this Court while dealing with a

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batch of writ petitions on this issue held that the Insurance Company is bound by the agreement between the Insurance Company and the State Government, which is nothing but a contract. It further held that if reimbursement was not possible under the Health Insurance Scheme, then the government would have to reimburse the medical expenses of the government employees under the Medical Attendance Rules.

32.In ***S.Marimuthu v. Government of Tamil Nadu*** [***2019 SCC OnLine Mad 1764***], a learned Single Judge of this Court held that a welfare State bears a heightened obligation to protect the health of its employees and that the responsibility of the Government cannot be completely washed away merely because the Scheme is implemented through an Insurance Company. The Court also recorded the stand of the Government that they would add more listed diseases; reimbursement amount would be enhanced; that the eligible medical expenses would be reimbursed either by the Insurance Company under the Scheme or by the Government under the Medical Attendance Rules and has held as under:-

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"38.In this context, the Government has come forward to add more diseases as listed disease and in so far as Annexure II A is concerned, for some of the surgeries and treatment, the medical reimbursement has been allowed to the maximum of Rs. 7.5 lakhs notwithstanding the cap of Rs.4 lakhs provided under the Scheme for the whole block period of four years.

... ...

55. Assuming that, the treatment has been taken in non network hospital, it is the duty of the District Level Empowered Committee or at least at the State Level high power committee to go into the claim of such employee / pensioner and to see whether the treatment had been taken in a non network hospital for any plausible reason like emergency or immediate non-availability of the network hospital in the locality. ..."

33.Subsequent to the decision of this Court in ***S.Marimuthu***'s case (supra), the Principal Secretary to the Government has issued guidelines for the implementation of the New Health Insurance Scheme 2016 (upto 30.06.2018) which was communicated by way of Letter No.37012/Fin. (Salaries)/2019-1 dated 01.11.2019. These guidelines under clause 6(I)(e) stated that the package rate is a bilateral agreement between the

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Insurance Company and Network Hospitals and therefore, does not hold as a ceiling for reimbursement, in case the hospital charges beneficiaries more than this package rate. This guideline also specifies that the Insurance Companies are liable to pay in case the hospitals have charged in excess of the package rates, subject to the ceiling criteria. The same is extracted as under for easy reference:

> *"6(I)(e)- The Committee must note that the package rate is a bilateral agreement between the Insurance Company and the Network Hospital and therefore, it does not hold as a ceiling for the reimbursement in case such hospital has charged the beneficiary higher in cash and the beneficiary has appealed or claimed against such higher charges. As such, Insurance Company is liable to pay in case hospitals have charged in excess of package rates, subject to the ceiling criteria."*

Sadly, this clarification is found to be missing in the subsequent Health Insurance Schemes.

34.Be that as it may, it is important to note that clause 11 of the guidelines to NHIS 2021 provides that medical assistance shall be provided only subject to the ceiling criteria and no reference is made to

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the package rates. The government has also previously issued guidelines reiterating the binding nature of the ceiling rate fixed under the scheme.

35.Therefore, this Court is of the opinion that in case of a clash between the ceiling rate which is an amount fixed under the government orders and the package rate which is a private arrangement between the Insurance Company and the Hospitals, it is the ceiling rate which would prevail and the medical reimbursement should be made as per the ceiling rate. To be noted, the rights of the beneficiaries flow from the scheme framed by the State. Therefore, the executive instructions issued by the government have the force of law and cannot be defeated by way of the private agreements.

Deficiencies in the Implementation of the Scheme:-

36.During the course of these proceedings, this Court found that the grievance projected in the present writ petition is not an isolated incident but reflects larger concerns regarding the implementation of the Scheme itself.

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37.The foremost issue relates to the existence of package rates fixed through separate arrangements between the Insurance Company and empanelled hospitals. While the Scheme assures insurance coverage upto the prescribed ceiling limits and promises cashless treatment, the actual settlement of claims appears to be governed by package rates determined through private contractual arrangements. In several instances, such package rates are lower than the coverage assured under the Scheme, resulting in the beneficiaries being forced to incur out-of-pocket expenditure for treatment.

38.A further concern is the complete lack of transparency surrounding such package rates. While the ceiling limits prescribed under the Scheme are publicly known and form part of the Government Orders, the package rates that ultimately govern the settlement of claims are not made available to the beneficiaries.

39.The materials placed before this Court reveal that the Commissioner of Treasuries and Accounts has requested the Insurance

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Company to host the package rates in the website of the finance department and also on the New Health Insurance Scheme portal by letters dated 12.07.2023 and 18.07.2023. However, the Insurance Company has taken a stand that the package rates cannot be displayed without the approval of the government. Though proposals appear to have been exchanged between the Government and the Insurance Company regarding the display of package rates, they have not been uploaded on any website and they continue to remain outside the public domain. Therefore, the beneficiaries, whose contributions sustain the Scheme, remain unaware of the package rates that determine the settlement of their claims.

40.Therefore, this Court attempted to understand from the Insurance Company as to the manner in which the package rates are being being fixed for each treatment. However, this Court found that the Insurance Company was evasive in providing a response and only after directing the Managing Director of the United India Assurance Company to appear before this Court, some clarity was provided.

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41.The Deputy General Manager of the Insurance Company has filed a counter affidavit on 25.02.2026 explaining the manner in which the package rates are being arrived at. The stand of the Insurance company regarding the fixation of package rates and the functioning of the New Health Insurance Scheme is summarised hereunder:

(i)The Insurance company being the underwriter, modifies the package rates from time to time and the same is given to the empanelled hospitals as a part of the MOU signed with the hospitals. It is the government which fixes the premium payable and also provides accreditation for the empanelled hospitals.

(ii)When the scheme was introduced in 2008, package rates were determined by the private insurer at that time. Thereafter, this company has been the successful tenderer in 2012, 2016 and 2021. There was increase in premium paid by the government for each period and based on the same, the package rate was also revised. Further, the rate is also

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determined based on the number of empanelled hospitals, claims ratio, administrative costs and premium received.

(iii)The package rates are lower than the General Insurance Public Sector Association (GIPSA) package rates and that the premium paid by government employees under this scheme is less than the premium paid in normal private insurance policies.

(iv)Overall, revision of package rates is made on the basis of the following factors:

(1)Increase in Premium paid (from previous to current scheme)

(2)Claims made and costs ratio

(3)Historical data

(4)Market Benchmarks

(5)Based on scheme comparison to other schemes.

42.However, no materials have been placed before this Court to demonstrate the existence of any transparent, objective or scientifically evolved mechanism for the fixation of such package rates. There is

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absolutely no record of any meeting or group being constituted to arrive at such package rates. It is not known as to whether doctors and medical experts are involved in the fixing of package rates. It is highly doubtful as to whether the interests of the patients who are the ultimate beneficiaries under the scheme is being considered by the Insurance Company and Hospitals when fixing these package rates. Even though the fixation of package rates directly impacts the healthcare entitlements of lakhs of Government employees, there is no clarity regarding the individual components taken into account for fixing the package rate.

43.The consequence of such an arrangement is that a parallel system has emerged alongside the Scheme itself. While the Government Orders assure coverage upto the prescribed ceiling limits, the actual benefits available to employees are often controlled by package rates fixed through undisclosed contractual arrangements. This parallel mechanism substantially dilutes the promise of cashless treatment and defeats the very object for which the Scheme was introduced.

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44.The concerns of this Court are further reinforced in view of the stand taken by the Hospital disputing the very existence of the Memoranda of Understanding relied upon by the Insurance Company. However, the Hospital has continued to accept claims under this scheme. When the agreement and package rate itself is under dispute, this Court is unable to understand as to why the Hospital concerned has continued to accept claims under the scheme.

Stand of the Government on the fixation of package rates:-

45.When this Court posed a query as to the stand of the Government in this regard, a counter affidavit was filed by the Deputy Secretary to Government, Finance Department dated 18.02.2026, that the fixation of package rates is a matter between the Insurance Company and the empanelled hospitals under the tripartite arrangements contemplated by the Scheme and that verification of such package rates by the Government is not warranted. The Government has further taken the stand that the implementation of the Scheme has been entrusted to the Insurance Company selected through the tender process and that

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any overcharging by hospitals can be addressed through the mechanisms available under the Scheme. The Government has also assured that they are prepared to incorporate any of the suggestions provided to improve the implementation of the scheme.

46.While this Court appreciates the assurance of the Government that any suggestions provided would be considered, their overall stand that the State has no role to play in the fixation of package rates cannot be accepted. The Scheme is not a private insurance arrangement voluntarily entered into by individual employees. It is a welfare measure conceived, introduced and administered by the State itself. The Scheme is funded through mandatory deductions from the salaries of Government employees. All Government employees are mandatorily enrolled in the Scheme. The Insurance Company is selected by the Government through a tender process. Therefore, the State cannot outsource its responsibility. While the operational aspects of the Scheme may be entrusted to an Insurance Company, the State must ensure that the Scheme functions in a fair, transparent and effective manner. The

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State cannot claim credit for introducing welfare measures, while simultaneously disclaiming responsibility for their failure in implementation.

47.The issue assumes particular significance since the package rates directly impact the extent to which the promise of cashless treatment is fulfilled. If the package rates are fixed at levels that substantially fall below the actual treatment costs or the ceiling limits fixed under the Scheme, the burden ultimately falls upon the beneficiaries. Consequently, the Government cannot remain a mere spectator to the process by which package rates are determined and applied.

48.The present case itself furnishes an illustration of the practical consequences arising from the manner in which the New Health Insurance Scheme is operating. The petitioner underwent treatment for a listed illness in an empanelled network hospital under the Scheme. The treatment admittedly falls within the scope of coverage available under

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the New Health Insurance Scheme. Yet, despite the promise of cashless treatment and the overall medical expenditure being within the ceiling limits available under the Scheme, the petitioner was compelled to incur an out-of-pocket expenditure of Rs.2,73,494/-. The Insurance Company attributes the shortfall to the package rates applicable for the procedure, whereas the hospital claims that the treatment involved additional complications and the expenses were not covered by the amount approved by the Insurance Company. The Nodal Officer of the Insurance Company ought to have settled the issue at the initial stage itself by referring to the ceiling rate and referring the hospital to the government for overcharging. But it was not done in the present case.

49.The petitioner has also lodged a complaint to the first respondent / District Level Empowered Committee seeking reimbursement of his medical expenses on 26.08.2022 and the same was forwarded to the Joint Director, Rural Development Department on 27.09.2022. The guidelines under clause 4(1)(p) provide that the the Joint Director of Medical and Rural Health Services Department is the

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grievance redressal officer under the scheme and this grievance redressal officer is required to verify the reimbursement claim under clause 15(7). However, the same was not considered, which forced the petitioner to file this instant writ petition.

50.It is a matter of serious concern that the very employees, through whom welfare measures are delivered to the public, are compelled to approach Courts for enforcement of the benefits promised to them under a Scheme introduced by the State itself. A welfare State cannot stay silent when a scheme specifically designed for the welfare of its employees fails to achieve its stated objective.

Suggestions for improvement of the scheme:-

51.The promise underlying the Scheme is one of cashless treatment. An employee who contributes towards the Scheme is entitled to legitimately expect that, in times of medical necessity, he would receive the benefit assured under the Scheme. However, in view of the aforesaid deficiencies, the beneficiaries are being compelled to incur

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substantial expenditure from their own resources. Therefore, this Court has been compelled to examine certain larger issues concerning the implementation of the Scheme.

52.Since the State Government has expressed its willingness to examine improvements to the Scheme while formulating future health insurance schemes and guidelines, this Court deems it appropriate to place certain suggestions for consideration so that the object underlying the Scheme is more effectively achieved:

(i) When the New Health Insurance Scheme, which is a welfare measure intended for the benefit of Government employees and their dependants, is implemented, the object and purpose of providing cashless treatment must be ensured at every stage of the treatment process. Every effort shall be made to ensure that beneficiaries are not compelled to incur out-of-pocket expenditure. Even in cases where such expenditure is incurred, reimbursement should be facilitated, at least up to the ceiling limits prescribed under the Scheme.

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(ii) The Commissioner of Treasuries and Accounts functions as the Administrator of the Scheme under the Scheme guidelines. Therefore, the stand of the Government that it has no role to play in matters concerning fixation of package rates runs contrary to the very structure and object of the Scheme. Clause 22 of the Scheme empowers the State Government to impose penalties for violations and non-compliance. Once such supervisory powers are vested with the Government, it cannot remain detached from the manner in which package rates are fixed and the Scheme is implemented. It would therefore be desirable for the State Government to review and oversee the package rates fixed through arrangements entered into between the Insurance Company, Third Party Administrator and empanelled hospitals so as to ensure that the objectives of the Scheme are not defeated.

(iii) The present functioning of the Scheme reveals a disconnect between the ceiling limits prescribed under the

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Scheme and the package rates fixed through contractual arrangements. While the Government prescribes the extent of coverage through ceiling limits, package rates are determined independently by the Insurance Company and hospitals. Such an arrangement creates a situation where package rates may fall substantially below the actual treatment costs, thereby compelling beneficiaries to incur out-of-pocket expenditure. While fixing package rates, due regard should therefore be had to the anticipated cost of treatment as well as the ceiling limits prescribed under the Scheme. Otherwise, the promise of cashless treatment would remain largely illusory despite the existence of substantial insurance coverage under the Scheme.

(iv) Greater transparency is required in the process of fixation of package rates. The deliberations leading to fixation or periodic revision of package rates should be appropriately documented. The process should involve medical experts, Government representatives and other stakeholders. The

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relevant factors such as prevailing treatment costs and medical inflation should be taken into consideration and not merely the premium received or claim ratios, so that the Scheme effectively achieves its intended purpose.

(v) No doubt, the government is paying the premium amount in advance and thereafter, deducting the same from the monthly salary of the employees. But, it is to be noted that though this scheme has been implemented with a welfare objective, the government is not contributing any amount towards the insurance premium. Therefore, this Court expects the Government to improve its participation in the future health insurance schemes by contributing some portion of the insurance premium, while enhancing the premium amounts depending upon the need. The same can be determined after consultations with all the stake-holders, including the trade unions of government employees and in line with the financial position of the State.

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(vi) The package rates fixed pursuant to agreements entered into between the Insurance Company and empanelled hospitals should be placed in the public domain. Appropriate provision may be incorporated in future Scheme guidelines requiring such package rates to be published on the website of the Insurance Company or on a dedicated portal accessible to beneficiaries. Such information should be made available in both Tamil and English. Transparency in this regard would enable beneficiaries to make informed choices, reduce uncertainty and minimise the possibility of exploitative practices.

53.The Government should also consider the schemes being framed in the other States for the welfare of government servants. In fact, the State of Kerala has introduced a legislation mandating the public disclosure of package rates and baseline rate of treatments for all types of medical treatments. A Division Bench of the Kerala High Court in

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Kerala Private Hospitals Association and Another v. State of Kerala ***[2025 SCC OnLine Ker 13042]*** has upheld the validity of the same. It was held by the Court that unforeseen complications and high-end consumable may be billed separately provided that there is disclosure and clinical justification for the same.

54.This Court is of the opinion that the same requirements can also be incorporated when the New Health Insurance Scheme is implemented in the future. The baselines rates for each treatment should be billed separately and a separate bill can be raised for the add-ons and unforeseen expenses and also the non-covered items so that the patient has clarity regarding the same.

55.This Court hopes and trusts that the above suggestions will receive fair consideration, while formulating future Health Insurance Schemes and the guidelines governing their implementation. These observations are made solely with a view to strengthening a welfare measure intended for the benefit of Government employees and their

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dependants. Being a welfare State, the Government bears a continuing obligation to ensure that such schemes are implemented in their true spirit and are not rendered ineffective by operational deficiencies or avoidable loopholes. It should not be forgotten that the success of a welfare scheme is measured not merely by the benefits it promises on paper, but by the relief it actually delivers to the beneficiaries for whom it is intended.

Directions:

56.In view of the foregoing discussions and observations, this Court, insofar as the present case is concerned, holds as under:-

(i) The Cashless Scheme introduced under the NHIS 2021 is a beneficial scheme introduced for the welfare of the government employees and their dependents and the coverage provided under the government orders cannot be defeated by referring to the individual package rates arrived at by way of private agreements.

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(ii) The executive instructions issued by way of government orders would prevail over the private agreements between the hospitals and the Insurance Companies.

(iii) It is the ceiling rate and eligible medical expenses provided under G.O.Ms.160, Finance Department dated 29.06.2021 that should prevail when considering the cashless claims under the scheme.

(iv) If the patients are forced to make out-of-pocket expenditure, then they have a right to receive medical reimbursement from the Insurance Company. Even while considering such reimbursement claims, it is the ceiling rate fixed under the scheme which should be considered and not the individual package rates arrived at between the Hospitals and the Insurance Company.

(v) The patients cannot be punished for the failure of the hospitals and the Insurance Company to rationalise and fix appropriate package rates.

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57.Coming to the relief sought for in the case on hand, this Court directs the State Level Empowered Committee, headed by the Commissioner of Treasuries and Accounts, to consider the case of the writ petitioner for medical reimbursement, in line with the above directions, decide the eligible reimbursement and ensure its disbursal, within a period of three months from the date of receipt of a copy of this order. While fixing the reimbursement amount, the State Level Empowered Committee shall also order for payment of interest in terms of Clause 11(1) of the guidelines for wrong denial / restriction of cashless facility.

58.This Court places on record its appreciation to Mr.Ajmal Khan, learned Additional Advocate General and Mr.B.Saravanan, learned Amicus Curiae for the valuable assistance extended by them, which has greatly aided the Court in rendering this decision.

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In fine, this writ petition stands disposed of. There shall be no order as to costs.

Internet : Yes **09.06.2026**
gk

Note:
Mark a copy of this order to

1. The Chief Secretary to Government,
   State of Tamil Nadu,
   Secretariat, Chennai.

2. The Secretary (I) to Hon'ble Chief Minister,
   State of Tamil Nadu,
   Secretariat, Chennai.

3. The State Level Empowered Committee,
   Headed by the Commissioner of Treasuries and Accounts,
   Integrated Finance Department Complex,
   Nandanam, Chennai – 35.

4. The Commissioner of Treasuries and Accounts,
   Integrated Finance Department Complex,
   3rd Floor, Anna Salai,
   Nandanam, Chennai – 600 035.

5. The Director of Medical and Rural Health Services,
   DMS Complex, Teynampet, Chennai – 6.

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To

1.The District Level Empowered Committee,
Rep. by the Chairman / District Collector,
New Health Insurance Scheme for Government Employees,
Madurai – 625 002.

2.The Superintendent of Police,
Madurai District.

3.The Secretary to Government,
Health and Family Welfare Department /
Chairman of Aggregate Committee,
Chennai.

4.The Secretary to Government,
Finance Department,
Fort St.George, Chennai.

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B.PUGALENDHI, J.

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