ACCOUNTABLE FACTORS OF DENIAL CASES OF CLAIMS ADJUDICATION BY INSURANCE'S IN HOSPITAL SETTING

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By

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Under the Supervision and Guidance of

Dr. Seema Mehta

2024

CERTIFICATE

This is to certify that Dr . Surjyendu Ganguli in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed his internship at Fortis Memorial Research Institute , Gurgaon during March 18 - June 20, 2024.

Place: GURGAON, INDIA
Date: 24/06/2024

Preceptor/Head of the Organization
Name of the organization : FORTIS MEMORIAL RESEARCH INSTITUTE

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **ACCOUNTABLE FACTORS OF DENIAL CASES OF CLAIMS ADJUDICATION BY INSURANCE'S IN HOSPITAL SETTING** is the Bonafede record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature) Sujjyendu Ganguli

Name of Student

Date: 29/06/2024

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled **ACCOUNTABLE FACTORS OF DENIAL CASES OF CLAIMS ADJUDICATION BY INSURANCES IN HOSPITAL SETTING** is a record of the research work undertaken by SURJYENDU GANGULI in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

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Abstract

The adjudication of insurance claims in hospital settings often faces challenges, leading to the denial of claims. This dissertation studies the accountable factors contributing to these denials within the Third-Party Administration (TPA) department of FMRI Gurgaon. The study examines 240 denied claims from six insurance organizations: Aditya Birla Capital, Niva Bupa Health Insurance, HDFC ERGO Health Insurance, CARE Health Insurance, ICICI LOMBARD Health Insurance, and STAR Health Insurance. Utilizing an analytical research design, the study employs a quantitative methods to analyze the data. Key findings indicate that pre – existing diseases , policy exclusions, Doctors denial in approving, pre-authorization issues, and information discrepancies are primary reasons for claim denials. The discussion emphasizes the need for improved documentation practices, better communication between hospitals and insurers, and enhanced training for claims adjudicators.

Objectives

1.To identify the key factors contributing to the denial of insurance claims

2.To study how these factors affect on the overall claims adjudication process

3. To study the change in claim denials with changing age group.

Methodology

Research Design:

- Cross sectional Descriptive Research Design
- Data collection through analysing claims denial cases of different Insurers collected from TPA department of FMRI Gurgaon.
- Analysis of claims data from multiple insurers

Sampling:

- Selection of insurers on the basis of availability of insurers in TPA department of FMRI Gurgaon.
- Purposive sampling of claims denial cases considering 40 samples of 6 Insurance organizations with a net count of 240 cases.

Data Analysis:

- Quantitative analysis of claims data to measure claims denial causes in Hospital Setting.

Results

The study identified several factors leading to claims denial, Pre – existing Diseases , including incomplete documentation, policy exclusions, coding errors, pre-authorization issues, insufficient query reply and discrepancies in the provided information.

Discussion

The findings highlight several reasons for claims denial cases . Possibility of pre – existing disease being the major reason among the reasons.

Conclusion

Addressing the identified factors can potentially reduce the denial rates and improve the claims adjudication process in hospitals

Keywords

Non-disclosure, claims adjudication, insurance industry

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Chapter 1. Introduction

The insurance sector plays an incredibly vital role in shielding people and businesses from Misc. financial risks—surprising events, especially in health. In that case, health insurance gives financial cover to the policyholders from medical costs incurred due to some health disorder, accident, or other illnesses. Key to health insurance, however, will be the process of adjudication of the claims—that is, the insurer evaluates and settles on the validity of the claims submitted by the policyholder.

Factors that may go against effectiveness and fairness in the adjudication of claims include nondisclosure and retrospective underwriting. By non-disclosure, it is meant failing to provide full and true information about their state of health, medical history, or on any other material fact of the contract when a policyholder purchases or renews an insurance policy. On the other hand, retrospective underwriting refers to the act of reclassifying the policyholder's risk profile at the time of filing claims rather than at the very beginning of the writing of the policy. In so doing, insurers can review the accuracy of information furnished by policyholders before reviewing their coverage decisions.

Nondisclosure and retrospective underwriting have increasingly inflated the controversy of effect on the processing of claims. This complicates the process of claiming, opens it to probable conflict between insurers and policyholders over the extent of coverage for medically related expenses, and raises ethical issues related to fairness, transparency, and treatment of policyholders who either inadvertently fail to disclose material facts or who are subjected to retroactive examination of their insurance applications.

The health insurance landscape is very wide and ranges from numerous different insurers, policies, and practices through different approaches to claims decisions. Every insurer conducts his business under the guidance of a certain legal framework, which defines what is allowed and what is not when managing claims and processing policyholders' information. Although this, variations in practices from one insurer to another can drive variations in how nondisclosure and retroactive underwriting are impacting claim outcomes.

The process of adjudication in the hospital setting has been complex and often results in claim denials, thereby putting immense pressure on the financial and operational functioning. Integrating such experience is, hence, invaluable in streamlining healthcare delivery with enhanced efficiency and effectiveness.

1.1. Research Problem

Out of all the cases that have been asked for re-imbursement there is good number of claims that are denied . The research problem of this study is to analise

1.2. Objectives

To identify the key factors contributing to the denial of insurance claims:

The foremost objective of this research is to systematically identify and catalogue the primary factors that lead to the denial of insurance claims in the hospital setting. Factors to be investigated include, but are not limited to, incomplete or incorrect documentation, discrepancies between the services provided and those covered by the insurance policy, lack of pre-authorization for certain procedures, and inaccuracies or inconsistencies in the information provided by patients and healthcare providers

To study how these factors affect on the overall claims adjudication process:

Severel of these factors lead to temporary claim denial . So a study of the above factors becomes very necessary for claims adjudication process .

To study the change in Claims Denial rates with Changing Age Bracket :

This study is very important as the individual premium and risk assessment deeply relies on the age bracket taking it .

1.3. Comprehensive Overview of Health Insurance Processes

Health insurance is conducted within a designed structure that covers vital operations which define the relations between insurers, policyholders, and healthcare service providers. Knowledge of the five vital operations – healthcare underwriting, healthcare claims, non-disclosure, retrospective underwriting, and claims adjudication is vital to efficient risk management, equitable treatment of policy holders, and safe financial viability for the insurers.

Healthcare Underwriting: Healthcare underwriting forms the analysis process done by the insurers to determine the risk exposure by the insurer to the individual or group being covered. This can include parameters such as health status, past medical history, lifestyle, and other related information. With such underwriting practices, insurers will establish what a standard rate would be for a person with good health and what terms should be applicable within the coverage policies for a set of policyholders. The key goal of healthcare underwriting is to incur accurate estimating costs that one can incur through the process of

providing medical services to a population of policyholders and at the same time ensuring that premiums are charged fairly and equitably to those who pose the risk concerning the magnitude linked to every policyholder.

Healthcare Claims: Healthcare claims refer to formal requests that an insured person or a healthcare provider forwards to an insurer for compensation with regard to medical expenses incurred, as agreed under the policy agreement. Healthcare claims encompass many health services, from hospitalization to outpatient treatment to prescription drugs and many others. The insurers scrutinize the claims very carefully in order to ensure the validity of the information provided, verify the eligibility of the coverage in regard to what is stated in the policy, and then make the payments due to either the policyholder or health provider. Claims processing works to achieve adjudication in a manner that is timely, fair, and nearest to what the contract agreed upon, with the minimum deviation from the regulatory framework, to effect compensation timely over the delivered medical services.

Non-Disclosure: This is a situation where applicants and policyholders fail to disclose correctly some vital information about their health status and medical history or other respective information altogether in the course of applying for their initial provisional health insurance cover. It largely affects the insurers' ability to correctly map out the associated risks and potential liabilities. In instances where non-disclosure comes to play in the event of making claims, the terms of coverage or even claim may be contested/disputed. The options available for the insurers to take are making adjustments to the terms, rejection of claims, or legal suits in an instance it factors the alleged non-disclosure as intentional or has severe effect on the risk calculation process.

Retrospective Underwriting: This is the looking back after a claim has been lodged to the medical history and the health status of the insured. Insurers do so in order to ascertain the accuracy and completeness of information supplied during the first application of insurance coverage. Fundamentally, the rationale of retrospective underwriting is to take note of material omissions and misrepresentations that bear on the validity of claims and the ascertaining of related premiums. In effect, this practice ensures the insurer does proper amendments in terms of coverage subject to the true risk level of the insured.

Adjudication of claims is the central process of an insurance company by which claims by its policyholders or rendering healthcare providers are verified, reviewed, and finally disposed of. In the adjudication process, details of the claim, policy terms, and supporting clinical documents are meticulously scrutinized by insurers to make a decision on whether the claim is covered and to determine the payable amount. It secures fair and timely settlement of claims strictly in accordance with the contract terms and regulatory requirements. Successful claims adjudication ensures the twin advantage of policyholder satisfaction and develops trust in insurance services while ensuring the financial stability of insurers.

In other words, healthcare underwriting, healthcare claims, nondisclosure, retrospective underwriting, and claims adjudication are the pillars that hold together the health insurance industry. All of these ideas coalesce into one base: it allows the insurer to provide all policyholders with risk management services on a fair and equal basis while maintaining the operational integrity of the insurance business. Insurers can strengthen this foundation by

fostering ethical standards and transparency and compliance with regulation to gain customers' trust in providing effective financial protection from healthcare spending.

Further, a short profile of the insurance organizations chosen for study : –

A short profile of the insurance organization chosen for the study is as follows :-

1. Niva Bupa Health Insurance

Niva Bupa Health Insurance is a major player in the health insurance industry of the country. The company was established in the year 2010 as a joint venture with True North, which is the leading Indian private equity firm, and Bupa, which is an expert in healthcare services based out of the UK. It designs health insurance products for Indian customer needs across various requirements. Key Features:

- All-inclusive coverage: The policies provided by Niva Bupa give in for in-patient hospitalization, pre and post-hospitalization expenses, as well as daycare treatment.

- Mobile and Web-Based Services: Used technology to elevate customer experience, which included buying policies, policy renewal, and even the tracking of claims.

- Wellness programs: Niva Bupa comes with wellness initiatives, in a bid to inculcate a healthy policyholder lifestyle, thus offering terms of health check-ups and wellness rewards.

Notable Plans:

- ReAssure Plan: The reAssure Plan with the highest Sum Insured. It aims to free you from all possible health risks. Unlimited reinstatement in Base Sum Insured. Cost of modern treatments will also be part of this plan.

- Health Premia Plan: Health Premia Insurance Plan is holistic in its approach to give you complete protection with maternity benefits, worldwide emergency cover, and health check-ups every year.

Aditya Birla Health Insurance is a subsidiary of Aditya Birla Capital, one of the dominant players in the Indian financial services business. The company commenced its operations in 2015 and has rapidly created a distinctive identity in the market focusing on health insurance by offering innovative customer-centric health solutions.

Key features.

Holistic Health Approach: Aditya Birla Health Insurance advocates preventive levels of health and wellbeing which involves programs offering incentives for those practicing healthy behaviors.

• Varied Range of Plans: The company has a diversified range of health insurance plans trying to cater to needs ranging from basic health cover to comprehensive family plans.

• Chronic Management: Programs in the bucket such as those available for chronic care management of diseases such as diabetes and hypertension place Aditya Birla way apart in the market from most of its immediate competition.

Notable Plans:

• Active Health Enhanced: It comes with comprehensive wide coverage along with wellness coaching, chronic management programs, and up to 100% premium return as Health Returns™.

• Active Assure Diamond Plan: Its comprehensive coverage includes AYUSH, international emergency assistance, and high sum insured options.

3. HDFC ERGO General Insurance

HDFC ERGO General Insurance is a joint project between HDFC Ltd. - one of India's foremost housing finance lenders and ERGO International AG, the main insurance body of Munich Re Group. HDFC ERGO stands with a highly-esteemed range of insurance offerings; these consist of but are indeed not limited to health insurance.

Key Highlights:

• Extensive Network: It has a big network of empanelled hospitals all over India, which go a long way in ensuring easy access to cashless treatment for policyholders.

• Customer-Centric Approach: Known for their customer service, the company provides digital tools through which customers could check, manage policies, and claim their entitlement.

• Diverse Plans: HDFC ERGO offers different plans to befit different health insurance requirements, including individual and family floater insurance coverage, in addition to critical illness insurance plans. Ensuring savings are not liquidated for one's disease, the plans offer extensive coverage at premium rates. Notable Plans:

• stiffness This unique plan mentions of automatic reinstatement in the summative assured upon exhaustion, in addition to other medical expenditures which it provides to.

• Health Suraksha Gold This category ensures comprehensive protection inclusive of pre-post hospitalization expenses, the day care procedures and even the AYUSH treatments.

4. Star Health Insurance

Star Health and Allied Insurance Co. Ltd. was established in 2006. It is the country's 1st stand-alone health insurance corporation. Since its establishment, it has been developed with numerous policies relevant to health and customer-oriented and its innovative products.

Key Features:

• Specialized Products: Star Health has developed a broad portfolio of health insurance products that are specialized in various types. Among these products, there are health insurance for senior citizens, diabetic patients, and surgical policies.

• High Claim Settlement Ratio: The company enjoys a very high ratio for settling claims, which can speak volumes for its effective and agile claim processing system.

• Wide Network of Hospitals: It has a wide network of hospitals under its wing, ensuring that policyholders will get treatment without any hassle under a cashless facility.

Some important plans are:

• Star Comprehensive Insurance Policy: A comprehensive insurance policy, covered under maternity benefits, dental and ophthalmic treatments, and air ambulance services.

• Senior Citizens Red Carpet Health Insurance: The : This policy is specifically shaped for senior citizens, offers comprehensive coverage, and does not have any pre-medical screening.

5. ICICI Lombard

ICICI Lombard General Insurance Company Ltd. is among the top private sector general insurance companies in the country. It was incorporated in the year 2001 and promotes a broad spectrum of insurance products, including health insurance, for retail and industrial clients.

Key Features:

• Innovative Products: ICICI Lombard is involved in launching a variety of innovative health insurance products that offer wide coverage and come with added benefits.

• Robust Digital Platform: ICICI Lombard offers a robust digital platform to its customers, making the process hassle-free, right from policy purchase to renewal and claims management.

• Wellness Programs: It is focusing a lot on wellness and preventive care; it provides programs and services for its members that represent healthy living.

Notable Plans:

• CompletE Health Insurance- This is an excellent comprehensive plan. It has hospitalization coverage, both before and after, and the charges, as well as wellness services.

• Health Booster- This is a top cover plan, which provides additional coverage above the one existing. This aids in successful management in times of very high medical costs.

6. Care Health Insurance

Care Health Insurance, earlier called Religare Health Insurance Company Limited, is a Religare Enterprises Limited firm. This company has risen to the limelight with customer-centric views and highly diversifiediske health insurance products since its incorporation in the year 2012. Key features:

• Wide Coverage—Care Health Insurance offers comprehensive coverage options such as individual and family floater plans, critical illness cover, and top-up plans.

• Customer Orientation: The company is very customer-centric and ensures that the claims are processed without any glitch. Furthermore, it provides very strong customer support.

• Preventive Care: The preventive healthcare benefit extends to annual health check-ups and wellness programs under the stripe of care health insurance.

Some of Their Major Plans

• Care Plan: This is a holistic health insurance cover plan inpatient that covers hospitalization, pre and post-hospitalization besides annual health check-ups.

• Care Freedom: Tailored insurance for those suffering from diabetes, hypertension, or have a high BMI, this package caters to their special needs.

Chapter 2. Literature Review

2.1. Non-Disclosure in Insurance

Non-disclosure in insurance refers to the failure of the proposer to disclose material information concerning the risk at the time of application. This can include nondisclosure of any pre-existing conditions, hazardous activities, or any other material fact relevant for the underwriting decision of the risk. This problem of non-disclosure is particularly pervasive, according to Smith and Jones, 2020, very expensive to the insurer, and often leads to acrimonious disputes between the insurer and policyholders with respect to claim settlement.

2.2. Retroactive Underwriting

Retrospective underwriting is the revaluation of the risk profile of the policyholder at the time of claim filing. This approach allows the insurers to consider information that was not declared during policy inception. Brown, 2019, observes that retrospective underwriting can create perceptions of unfairness among policyholders. Adjustment or rejection of the claim based on newly discovered information may result in an increase in dissatisfaction among claimants. Chances of legal cases between insurers and policyholders will also be higher.

2.3 Adjudication of Claims

Adjudication of claims is a core process that involves insurance companies verifying and settling insurance claims. It will help the insured party through stringent verification of various details of the claim, reviewing the terms of the coverage provided, and quantifying reasonable payables. As studies by Green and White, 2018, reveal, an effective claims adjudication process is actually the key towards building trust and continuing a healthy relationship between the insurer and their policyholders. Fair and timely resolution of claims is demanded for high customer satisfaction and to inculcate confidence in insurance services.

2.4. Comparative Studies of Insurers

Comparative studies on insurers put forward ample evidence regarding how the 'best practice' of different companies polices its claims adjudication and management of nondisclosure and retrospective underwriting issues. A comprehensive comparison of major insurers by Thompson clearly displays that there have been huge differences among these insurance companies regarding how they functioned in the matter between their strategies and policies in this regard. These factors significantly impact the outcome of the claim, customer experience, and satisfaction levels, reflecting an urgent need for standardization of

practices where there should be transparency in the handling of claims in general within the insurance industry.

2.5. Legal and Regulatory Perspectives

The legal and regulatory frameworks bear mutually inseparable links in shaping the practices of insurers pertaining to non-disclosure and retrospective underwriting. For instance, the Insurance Act 2015 has modified the law of insurance contracts in the UK to make it much more onerous concerning the failures of disclosure, and it requires that the insurers ask specific questions sufficient to provoke relevant information from policyholders. The lead of regulatory bodies, including the Financial Conduct Authority, is comprehensive in setting guidelines that work towards treating all policyholders in an equitable, fair manner and ensuring that insurance practices are conducted with ethical standards. Compliance with the regulations is, therefore, very necessary for insurers to minimize legal risks, maintain regulatory compliance, and ensure integrity in their operation.

Literature review effectively puts into the limelight how these are complex dynamics and critical factors in non-disclosure, retrospective underwriting, claims adjudication, comparative insurer studies, and legal and regulatory perspectives in the insurance sector. These facets—with respect to RE insurers—non-disclosure, retrospective underwriting, claims processing, comparative studies, and legal and regulatory perspectives—contextualize insurer-policyholder relations, drive operational efficiencies, and institute credibility for any given insuranceservice provider. The research into all these elements enables the stakeholder to gain valuable insights into the practices in the industry, which inform their policy decisions and continuous improvements targeted at insurance operations and customer relations.

CHAPTER 3: METHODOLOGY

3.1. Research Methodology

3.1.1. Research Question

The underlying research question behind this research is: What are the accountable elements that result in the rejection of claims in the hospital setting of FMRI Gurgaon? The question is aimed at uncovering the major reasons for insurance claim denials and will present a very clear understanding of what the issues are that need to be resolved for improving the process of claim adjudication.

3.1.2. Research Design

This is an analytical design that will greatly help in studying the denied claim cases.

3.1.3. Type of Research

This research has integrated only quantitative methods. The quantitative component of this uses statistical procedures and tools to review numerical data that can lead to denial.

3.1.4. Study Setting

The research setting is set within the TPA department of FMRI Gurgaon, one of the primary institutions in healthcare. The reason for choosing this setting is that it deals with several insurance companies, and that its value, in terms of claims processed, is high, hence offering a pool of rich data for this study.

3.1.5. Study Tools

. Statistical software like Microsoft Excel for the analysis of quantitative data, which facilitates computation of inferential statistics.

3.1.6. Duration of Study

The period of study is 3 months. This includes phases of data collection, data cleaning and preparation, analysis, and result interpretation. The time allows for thorough examination and assures the findings to be robust and reliable..

3.1.7. Data Collection Management

Data collected from the TPA department is meticulously anonymized to protect patient and insurer confidentiality. The data is securely stored in a password-protected database accessible only to the research team. Regular backups are performed to prevent data loss. Data management protocols ensure the integrity and security of the information throughout the study period.

3.1.8. Data Analysis Plan

The data analysis plan involves quantitative approaches

- Data analysis of the data collected from 240 claims denial cases from 6 different insurance organizations in done . Also the number of pre – existing cases detected among the denials is analysed . Also an analysis is done about the diseases which is causing claim denials due to pre – existing disease. Also the rate of change of claim denials with increasing age is studied.

3.2. Ethical Considerations The study ensures confidentiality and anonymity of patient and insurer information, adhering to ethical guidelines for medical research.

4. Results :-

4.1 Cases Findings

Detailed Cases of Specific Claims

Cases serve as pivotal examples illustrating the practical application and impact of non-disclosure and retrospective underwriting within the insurance industry. These cases encompass:

Examples of Claims Denied Due to Non-Disclosure

These examples scrutinize instances where insurance claims were denied primarily due to non-disclosure by policyholders during the application process.

4.2. Statistical Summary

Here is a brief statistical overview of the summed-up findings of the study: -

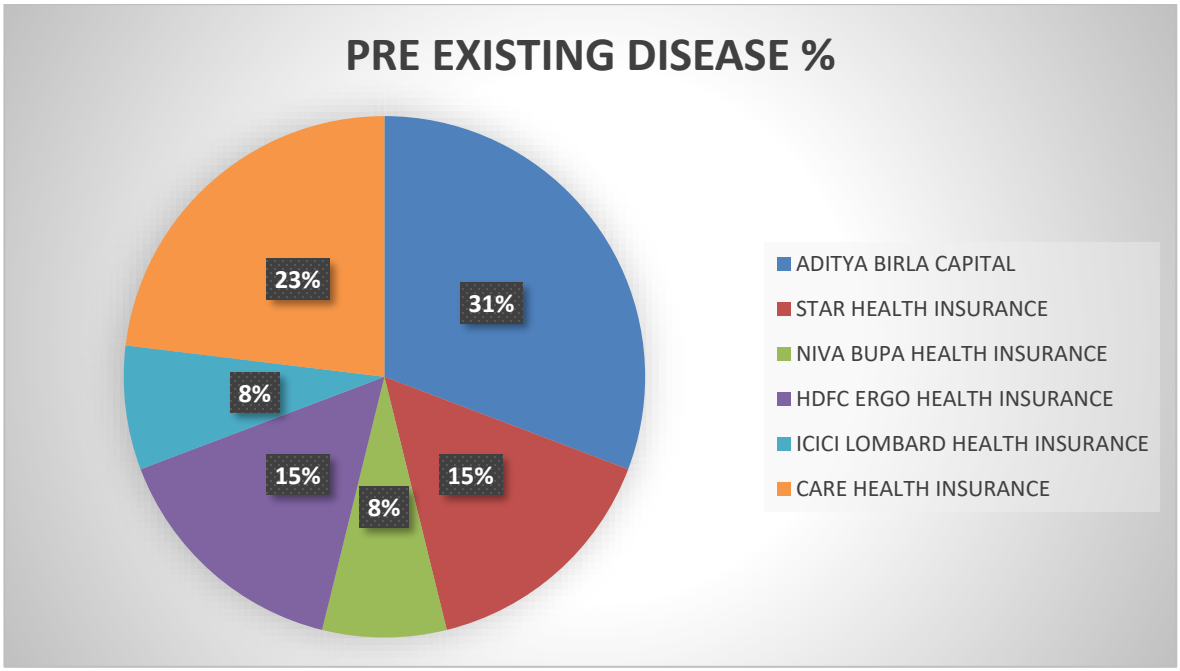

Fig 4.1 Comparative overview of claims denial % of different insurers because of PRE-EXISTING DISEASE.

The findings of the report highlights the pre-existing disease cases in different insurers revealing that a substantial number of these denials are due to policyholders failing to disclose their pre-existing medical conditions or intentionally hiding the extent of their illnesses during the initial application process for health insurance policies. This lack of transparency often results in claim denials when insurers later discover these omissions or discrepancies, which are critical to accurately assessing the risk and determining the eligibility for coverage.

Aditya Birla Capital stands out with the highest percentage of such claim denial cases, with 31% of their denials attributed to non-disclosure of relevant medical information by policyholders. This indicates that nearly one-third of the denied claims were due to applicants either not revealing their existing medical conditions or underreporting the severity of their health issues at the time of policy enrolment..

Following closely, Care Health Insurance reported 23% of their claim denials being related to non-disclosure.

In contrast, ICICI Lombard and Niva Bupa exhibited the lowest percentages of claim denials due to non-disclosure, with each insurer reporting only 8% of such cases.

HDFC Ergo and STAR Health Insurance occupy an intermediate position with each reporting 15% of their claim denials resulting from non-disclosure

The variation in the percentages of claim denials due to non-disclosure among different insurers underscores the importance of clear and strong underwriting guidelinesThe findings suggest that insurers like ICICI Lombard and Niva Bupa, with their lower rates of non-disclosure-related denials, could serve as benchmarks for best practices in underwriting and risk assessment.

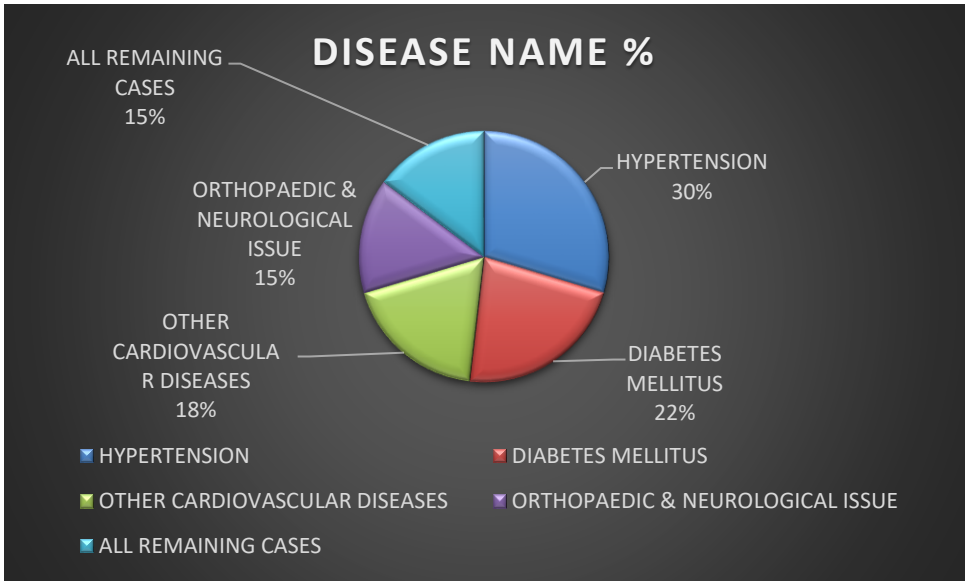

Fig 4.2, Disease name percentage among all the cases rejected due to Pre-Existing Disease.

The above statistics represent granular data of health insurance claim denials attributing to the possibility of pre-existing diseases.
Attention to the fact that hypertension dominates the array of denials relating to pre-existing diseases and represents 30% of the same. This simply means that nearly one-third of the denied claims in this category can be wholly attributed to a single health condition: the presence of hypertension—a health condition characterized by high blood pressure—in the policyholder. It is thus very important that all relevant health information should be disclosed accurately and in full when applying for insurance.
Accounting for 22%, Diabetes Mellitus is the second most common cause for claim denials on grounds of pre-existing diseases, after hypertension. This big percentage is indicative of the fact that diabetes is a very common condition with important implications for morbidity, mortality, and costs to the healthcare system. Diabetes Mellitus represents a metabolic disorder characterized by high blood sugar levels caused by either resistance to or lack of

insulin, and is a risk quite high to be therefore a factor that the insurers take serious regard to while considering eligibility for their coverage and settlement of claims.
The next 18% of the pre-existing disease-denied claims come from cardiovascular diseases, excluding hypertension. This category includes a host of conditions pertaining to the heart, such as coronary artery disease, heart failure, and various types of arrhythmias. The large percentage of denials resulting from coverage of this nature therefore shows the requirement for injudicious medical checkups and their disclosure by persons with a history of cardiovascular problems.
Orthopedic and neurologic cases combined account for 15% of pre-existing condition-based claim denials. This category encompasses a very wide range of disorders or conditions in the musculoskeletal apparatus and nervous system, including certain nervous diseases such as epilepsy and multiple sclerosis and all forms of arthritis and disorders in the spine. For those, in which during claim adjudication the presence of a pre-existing condition is relevant to a high degree, optimum gathering of the medical history and assessment is required at the phase of underwriting.
Of the remaining 15%, other pre-existing conditions are not mentioned above. This broad classification includes all other medical conditions pre-existing at the time a policyholder applied for insurance coverage and that were not fully disclosed at the time of application. While individually less frequent themselves, they nevertheless make up a material portion of the pre-existing disease-related denials and further illustrate the very broad range of medical issues that may impact claims outcome.

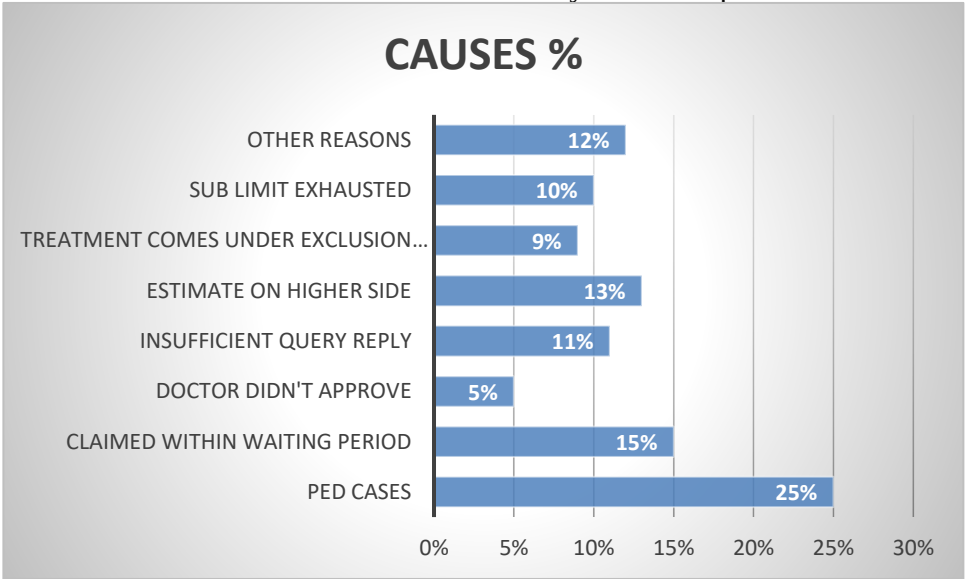

Fig 4.3 Percentage of claims denied due to different reasons.

The above statistics represent a comprehensive break-up of the various reasons of heath insurance claim denials and clearly indicate the high impact of non-disclosure of pre-existing diseases as the main cause. According to the data, 25% of health insurance denial cases were attributed to nondisclosure of pre-existing conditions. This represents the highest percentage compared with all other causes and points out the critical necessity for complete and truthful disclosure of medical history by policyholders at the point of application and/or at the time of policy renewal. Otherwise, it creates a lot of uncertainty and risk for an insurer if not disclosed, and in most instances, such claims are later rejected if discovery of those conditions occurs.

The next 15% cases of claim denial, after non-disclosure, are claims submitted within the waiting period. Most insurance policies have an indistinguishable part called a waiting period during which some conditions or treatments are not covered. This prevents the policyholders from claiming immediately for pre-existing conditions of which they could have been aware but failed to declare. This high percentage of the denials emanating from claims falling within the waiting period stresses the need for policyholders to understand and adhere to terms and conditions of insurance agreements.

The third is that where an insurer feels that the claim amount is excessive, accounting for 13%. These cases had the insurance company view the claimed amount as being higher than what could be construed as reasonable or justifiable by the policy coverage and the nature of the treatment or the service rendered. This shows that, in these cases, there is transparency regarding the acceptability of the amount claimed and, more importantly, its assessing criteria from the part of the insurers to the policyholders.

Poor response or reply to the queries made by the insurer is the reason for 11% of claim denials. For example, if an insurer asks for some more details or seeks clarification regarding a certain claim, then it is necessary that the insured responds quickly and in a proper manner. If proper replies are not provided, then it can lead to denial of claims because the insurer will not be able to verify the authenticity of the claim 因为lack of information.

Another major reason that accounts for 10% of the cases for claim denial is that the sub-limits within the policy have been exhausted. Most often, there are specific sub-limits in many insurance policies for different treatments or services. Once such sub-limits get consumed, all subsequent claims pertaining to those particular services could be denied. This again brings home the fact that the policyholder needs to be aware and manage his coverage limits to avoid such denials.

9% of the denial of claims is due to the exclusion of certain treatments under the policy. This refers to some treatments, conditions, or procedures that are specifically noted as being excluded from the policy. In such cases, the policyholder needs to read and understand them very properly in order to know what is covered and what is not.

5% of the cases of claim denials were attributed to non-availability of approval from the attending doctor. Sometimes, the insurance companies need confirmation from a medical professional regarding the necessity of the treatment or the service which he/ she intends to provide to the patient and whether such treatment is covered under the policy. This also proves the essence of medical validation in the whole claims process.

The other 12% of the claim denials were for a variety of other reasons. This very heterogeneous category includes flaws in the administrative process, documentation errors, or other policy-specific criteria that might not have been met by the claim. The many different reasons represent, therefore, how complicated the process of adjudication is and

the many factors at play in such decisions.

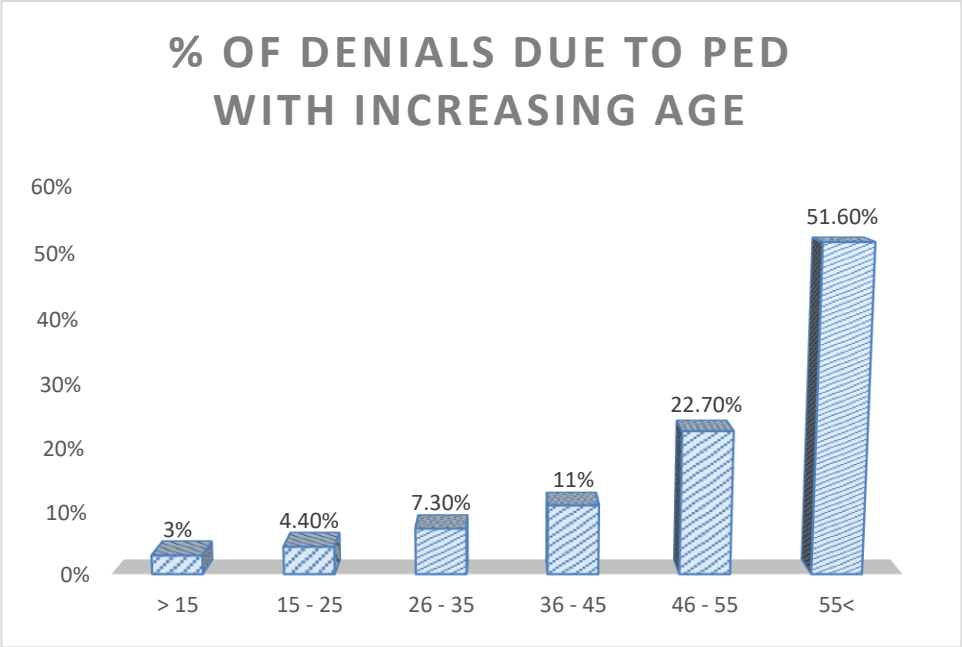

FIG 4.4. % OF DENIALS DUE TO PED WITH INCREASING AGE

The above study presents a detailed analysis of the correlation between the age of insured individuals and health insurance claim denials due to pre-existing disease cases. The findings indicate increase in claim denials as the age of the insured increases, highlighting the heightened risk perception by insurers for older policyholders.

In the youngest age bracket, those aged 15 and under, the percentage of claim denials due to pre-existing conditions is relatively low, at just 3%.

As we move to the age bracket of 15 to 25 years, the percentage of claim denials increases slightly to 4.4%.

In the next age range, 26 to 35 years, there is a noticeable rise in the percentage of claim denials, reaching 7.3%.

The age range of 36 to 45 years sees a further increase, with 11% of claim denials attributed to pre-existing diseases.

A substantial increase is observed in the 46 to 55 years age bracket, where the percentage of claim denials due to pre-existing conditions rises to 22.7%.

The most dramatic increase occurs in the oldest age group considered in this study, those aged 55 and above. In this group, the percentage of claim denials due to pre-existing conditions soars to 51.6%..

In summary, the study illustrates a clear trend: as the age of the insured individuals increases, so does the likelihood of health insurance claim denials due to pre-existing conditions. Starting from a low of 3% in the youngest age group, the percentage gradually rises across

successive age brackets, culminating in a steep 51.6% for those aged 55 and above. These findings highlight the critical impact of age on the adjudication of insurance claims, emphasizing the importance of thorough and accurate disclosure of health conditions by policyholders and the need for insurers to develop nuanced underwriting guidelines that take into account the increased risks associated with aging.

CHAPTER: 5 DISCUSSIONS

5.1. Interpretation of Results

The results of this research on a few salient points are focussed : -

A .Non-Disclosure & It's role in Claims Adjudication Process :-

Non-disclosure crops up as an important parameter of claims adjudication process in the parlance of insurance. The inability of the policyholder to disclose, fully, the pre existing medical conditions or dangerous habits, adequate and full disclosures regarding risk profiling has a vital bearing upon the decision -making process of the Insurer. This can result in claim denials or adjustments based on newly disclosed information during a process of claims. The discussion highlights the contribution of nondisclosure to complicating the assessment of risks, exposing insurers to financial losses that may result in disputes and litigations with policyholders. B. Pre – Existing Disease the leading cause for Health Insurance Claims Denial Statistics clearly underline the points of the highest and chief order that may be a cause for denial: concealment of pre-existing diseases, claims within the waiting period, excessive claim amounts, lack of sufficient query respondents, exhausted sub-limits, policy exclusions, lack of approval from doctors, and other such factors. The findings underpin why transparency, proper understanding of policy conditions, and communication between policyholders and insurers are of great importance to the ultimate goal, that is, confirming a transparent and efficient settlement process.

C.The major diseases that is leading to ' Pre – Existing Disease Named Claims Denial'

The statistics depicts that hypertension and Diabetes Mellitus are the maximum pre-existing conditions which is leading to rejection of health insurance claim. Other cardiovascular diseases and orthopaedic and neurological problems come next in the list .

The remaining denials are due to a wide array of other pre-existing conditions.

The findings underline the paramount needs of the public with respect to applicants making a comprehensive statement of their medical history and insurers must perform potent underwriting practices in order to precisely evaluate and mitigate risks for pre-existing diseases. Offering fair and lucid procedures for processing the claims boosts trust and dependability in health insurance. D.Increase in Age Bracket is Directly proportional to Increase in Claims Rejection Count The clear trend emerging from this study is that the chances of rejection of health insurance claims on the grounds of pre-existing conditions rise due to an increasing age of insured persons. The percentage increases from as low as 3% in the youngest age group to a steep 51.6% for those above 55, rising successively through age brackets.

The findings reiterate that age is an important factor in determining insurance claims and, consequently, the necessary full and accurate disclosure of the policyholders' true health status and for the insurers to design underwriting guidelines that address nuancedly with increased risks associated with aging**.**

5.2. Limitations of the Study

It is important to consider the limitations of the study in order to broaden the context within which to consider the findings and their overall implications. There were a number of key limitations: Potential for Sampling Bias

The first notable limitation is that there is potential sampling bias in the choice of insurers and policyholders included in this study.

The focus on a purposive sample of insurers itself may mean that it cannot include the diversity of practices and experiences across the whole insurance industry, considering especially large multinational companies.

This may include studies that are based only on some of the biggest insurers, which again have certain characteristics or operational frameworks that may differ from smaller or regional insurers. Therefore, results based on this sample cannot be fully representative of industry-wide practices and dynamics. A serious consideration is required in the interpretation of findings and generalization of study outcomes with respect to the broad insurance sector. Generalization of the findings Another limitation pertains to the challenges associated with generalizing the findings across the entire insurance industry. The insurance landscape is one characterized by high variability in regulatory environments, market dynamics, and operational practices among insurers.

Regional or jurisdictional variations in the regulatory framework, market competitiveness, and cultural factors may prevail and influence how non-disclosure, retrospective underwriting, and procedures are adopted at claims adjudication by insurers.

Therefore, findings from this study might not translate to all other insurers or jurisdictions. Such results of the study should be contextualized in light of the unique contexts and boundaries of the insurers and markets investigated, bearing in mind the diversity and inherent complexity of the insurance business. Data Reliability and Availability Another set of limitations pertains to data reliability and availability. The findings are based on the fact that claims datasets, policy documentation, and ancillary information provided by the respective insurers are complete and accurate.

The differing levels of quality, accessibility, and transparency of data across insurers may thus impact the strength and scope of analysis undertaken as part of this research. Accordingly, meaningful insights that can be drawn from some insurers or particular claim cases will be limited due to limited access to information that is proprietary or otherwise sensitive. In light of such data-related challenges, tacking them will thus involve cautious navigation and collaboration with the insurers to ensure adequate access to and reliability of information for stringent analysis. Temporal and Contextual Constraints Temporal and contextual constraints also place some limitations on the scope and applicability of the study.

The insurance market is considerably dynamic, with changing regulatory frameworks, market trends, and consumer behaviors. Continuous scanning and updating of research methods are warranted.

The findings that emerge from such a study are basically a snapshot in time and under certain contextual conditions.

Hence, with regard to the construct and relevance, it is possible that the longitudinal validity of the study outcomes might change as industry practices and other extraneous variables continue to evolve over some time. Although this paper gives valuable insight into the intricacies of non-disclosure, retrospective underwriting, and claims adjudication in the insurance sector, one must never forget the presence of these intrinsic limitations. Only with recognition will researchers, policy makers, and industry stakeholders be in a very good position to appreciate the challenges and opportunities facing the insurer, which shall inform targeted strategies and initiatives designed to improve industry practice and regulatory frameworks effectively**.**

6. Conclusion

Hence, the study concludes that if the major factors identified by the research are taken seriously, then it will drastically reduce the incidence of denial in insurance claims from a hospital setting. First recommendations pertain to improving the accuracy and completeness of documentation to be submitted along with the claim. Giving adequate information properly and completely documented helps in reducing errors and omissions, which normally are the causes of denial.

Another key recommendation at this juncture is the improvement in the communication structure between all stakeholders in this claims adjudication process. At this stage, it involves the establishment of better interactions between healthcare providers, insurance companies, and patients. This clear, consistent, and timely communication will solve, clarify doubts, and be very beneficial in keeping all concerned parties on the same page pertaining to coverage, requirements, and processes. Improved communication channels can enable the resolution time for issues that may crop up during the course of an adjudication to occur at a much faster clip.

This should also include focused training and continuing education regarding healthcare providers, administrative staff, and claims adjudicators. Updated topics of the training programs should always include current coding standards and preferred documentation practices, changes in regulatory requirements, and new policies affecting generally the processing of claims. In this regard, the knowledge and skills of personnel will be enhanced and errors and misunderstandings will be reduced. The staff shall have increased capabilities for processing claims accurately through regular updates and refresher courses on policy and procedure changes.

Implementation of these recommendations will yield an effective and transparent process of claims adjudication.

Better documentation, improved communication, and appropriate training to staff can significantly reduce the frequency of claim denials.

This not only helps hospitals by reducing administrative burdens, improving cash flow, but also empowers patients to avoid all hassle involved in claiming the cover they are entitled to.

Better accuracy and hence, efficiency in processing such claims should also result in better customer satisfaction and hence, increased customer loyalty for the insurance companies. In sum, the study can be concluded by stating that systematic improvements in documentation, communication, and training are of much relevance to mitigate some of the challenges associated with insurance claim denials. These strategies would help the hospital progress toward a more streamlined and effective claims adjudication model and might improve the health care delivery system as a whole.

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