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

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INTRODUCTION : -

- 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 cross sectional descriptive research design, the study employs a quantitative methods to analyze the data. Key findings indicate that pre – existing diseases , claimed within waiting period , estimate on higher side , insufficient quary reply, 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 : -

- **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 the primary factor involved behind claim denial :**
- Understanding the primary factor behind claim denial & analytically studying about its detail.
- **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 .

REVIEW OF LITERATURE : -

- **2.1. Non-Disclosure in Insurance**
- Non-disclosure within the insurance industry refers to the failure of policyholders to provide accurate and complete information during the application process. This can encompass the omission of details regarding pre-existing medical conditions, risky behaviours, or other factors crucial to the insurer's risk assessment. According to Smith and Jones (2020), non-disclosure presents a pervasive challenge that can result in substantial financial losses for insurers and lead to contentious disputes with policyholders over claim settlements.
- **2.2. Retrospective Underwriting**
- Retrospective underwriting involves the revaluation of a policyholder's risk profile after the filing of a claim. This practice allows insurers to review information that was not disclosed during the initial policy issuance. Brown (2019) underscores that retrospective underwriting may create perceptions of unfairness among policyholders. Adjustments or denials of claims based on newly uncovered information can heighten dissatisfaction and escalate the likelihood of legal conflicts between insurers and policyholders.
- **2.3. Claims Adjudication**
- Claims adjudication is the pivotal process wherein insurers assess and make decisions regarding the validity and reimbursement of insurance claims. It entails rigorous verification of claim details, evaluation of coverage terms, and determination of appropriate payouts. Studies by Green and White (2018) emphasize that efficient claims adjudication processes are fundamental for fostering trust and sustaining positive relationships between insurers and policyholders. Timely and equitable resolution of claims plays a critical role in enhancing customer satisfaction and reinforcing confidence in insurance services.
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REVIEW OF LITERATURE : -

- **2.4. Comparative Studies of Insurers**
- Comparative studies examining insurers' practices provide valuable insights into how different companies approach claims adjudication and manage issues related to non-disclosure and retrospective underwriting. Thompson (2017) conducted an extensive comparative analysis of major insurers, revealing significant disparities in their strategies and policies concerning these matters. These variations can profoundly impact claim outcomes, customer experiences, and overall satisfaction levels, underscoring the necessity for standardized practices and transparency in claims handling across the insurance industry.
- **2.5. Legal and Regulatory Perspectives**
- Legal and regulatory frameworks play a pivotal role in shaping insurers' practices concerning non-disclosure and retrospective underwriting. For instance, the Insurance Act 2015 in the UK introduced stringent measures aimed at addressing non-disclosure by mandating insurers to pose specific questions to elicit pertinent information from policyholders. Regulatory bodies such as the Financial Conduct Authority (FCA) provide comprehensive guidelines to ensure equitable treatment of policyholders and promote adherence to ethical standards in insurance practices. Compliance with these regulations is critical for insurers to mitigate legal risks, maintain regulatory compliance, and uphold the integrity of their operations.
- In summary, the review of literature underscores the intricate dynamics and critical importance of non-disclosure, retrospective underwriting, claims adjudication, comparative insurer studies, and legal and regulatory perspectives within the insurance sector. These facets collectively shape insurer-policyholder interactions, influence operational efficiencies, and uphold the credibility of insurance services. By examining these elements comprehensively, stakeholders can gain invaluable insights into industry practices, inform policy decisions, and foster continuous improvements in insurance operations and customer relations.

METHODOLOGY :-

Research Question

The central research question guiding this study is: What are the accountable factors leading to the denial of claims in the hospital setting at FMRI Gurgaon? This question aims to uncover the specific reasons behind the rejection of insurance claims, providing a clear understanding of the issues that need to be addressed to improve the claims adjudication process.

Research Design

This study employs an cross sectional descriptive research design to thoroughly investigate the cases of denied claims.

Type of Research

The research integrates predominantly quantitative methodologies. The quantitative aspect involves the use of statistical tool to analyze numerical data and identify the causes of denial.

Study Setting

The study is conducted within the Third-Party Administration (TPA) department of FMRI Gurgaon, a leading healthcare institution. This setting is chosen due to its extensive interaction with multiple insurance providers and its significant volume of processed claims, providing a rich dataset for analysis.

METHODOLOGY:-

- **Study Tool**
- Microsoft Excel, is used for quantitative data analysis, enabling the calculation of inferential statistics.
- **Study Population**
- 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. 40 being collected from each insurance Organization.
- **Duration of Study**
- The duration of the study spans 3 months. This period includes phases of planning, data collection & assimilation , analysis, and interpretation of results. The timeframe allows for thorough examination and ensures that the findings are robust and reliable.

METHODOLOGY:-

- **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.

- **Data Analysis Plan**

- The data analysis plan involves quantitative approaches

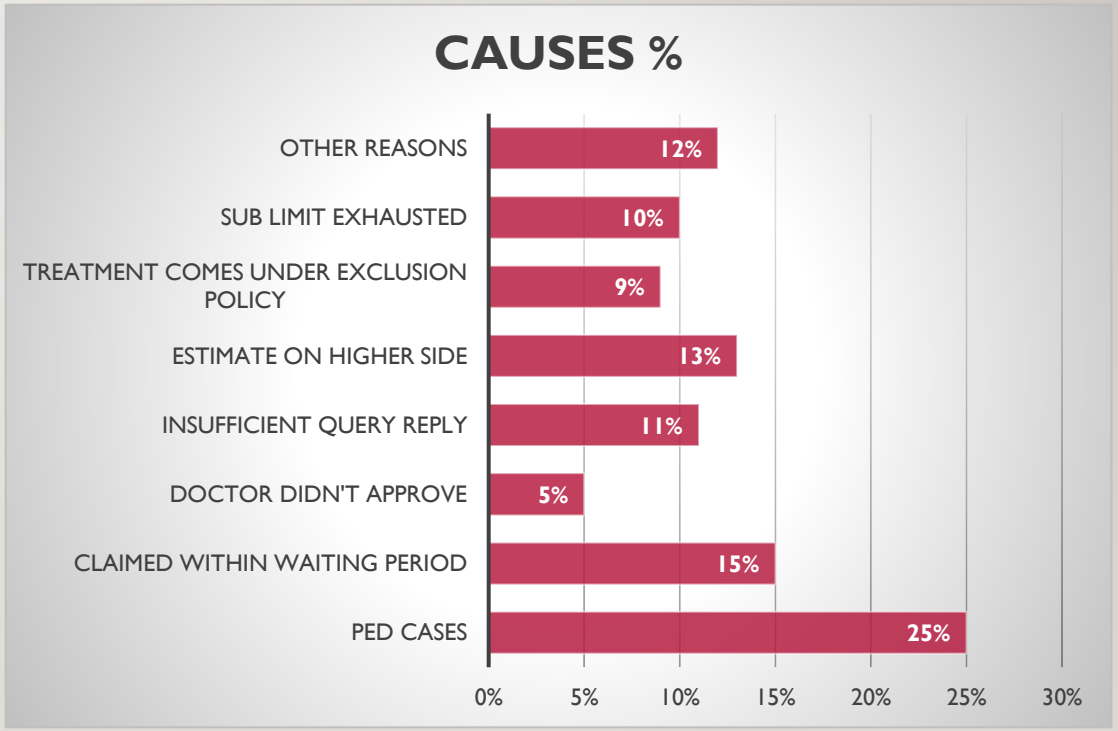
- Data analysis of the data collected from 240 claims denial cases from 6 different insurance organizations in done . Also the number of pre – existing cases detected among the denials is analysed . Also an analysis is done about the diseases which is causing claim denials due to pre – existing disease.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

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

RESULTS : -

- **STATISTICAL SUMMERY : -**
- The above statistics reveal a comprehensive breakdown of the various reasons behind health insurance claim denials, highlighting the significant impact of non-disclosure of pre-existing diseases as the primary cause. According to the data, 25% of the health insurance claim denial cases were attributed to the non-disclosure of pre-existing conditions. This percentage represents the highest among all other causes and underscores the critical importance of full and accurate disclosure of medical histories by policyholders at the time of purchasing or renewing their insurance policies. The failure to disclose such vital information creates substantial uncertainty and risk for insurers, often leading to the rejection of claims when these undisclosed conditions are later discovered.

- Following non-disclosure, the second most common reason for claim denials is related to claims submitted within the waiting period, accounting for 15% of the cases. Insurance policies typically include a waiting period during which certain conditions or treatments are not covered. This provision is designed to prevent immediate claims for pre-existing conditions that policyholders may have been aware of but did not disclose. The high percentage of denials due to claims within the waiting period highlights the importance of policyholders understanding and adhering to the terms and conditions of their insurance agreements.



Percentage of claims denied due to different reasons

STATISTICAL SUMMERY (CONTINUATION)……

- The third most prevalent cause of claim denials, at 13%, is the perception by the insurer that the claim amount was excessive. In these cases, the insurance company deemed the claimed amount to be higher than what was considered reasonable or justifiable based on the policy coverage and the nature of the treatment or service provided. This indicates a need for transparency and communication between insurers and policyholders regarding acceptable claim amounts and the criteria used to assess them.

- Insufficient response to queries from the insurer accounts for 11% of the claim denials. When insurers request additional information or clarification regarding a claim, timely and comprehensive responses from the insured are crucial. Failure to provide adequate replies can result in claim denials, as insurers may be unable to verify the validity of the claim without the necessary information.

- Another significant reason for claim denials, representing 10% of the cases, is the exhaustion of sub-limits within the policy. Many insurance policies have specific sub-limits for different types of treatments or services. Once these sub-limits are reached, any further claims for those specific services may be denied. This highlights the need for policyholders to be aware of and manage their coverage limits to avoid unexpected denials.

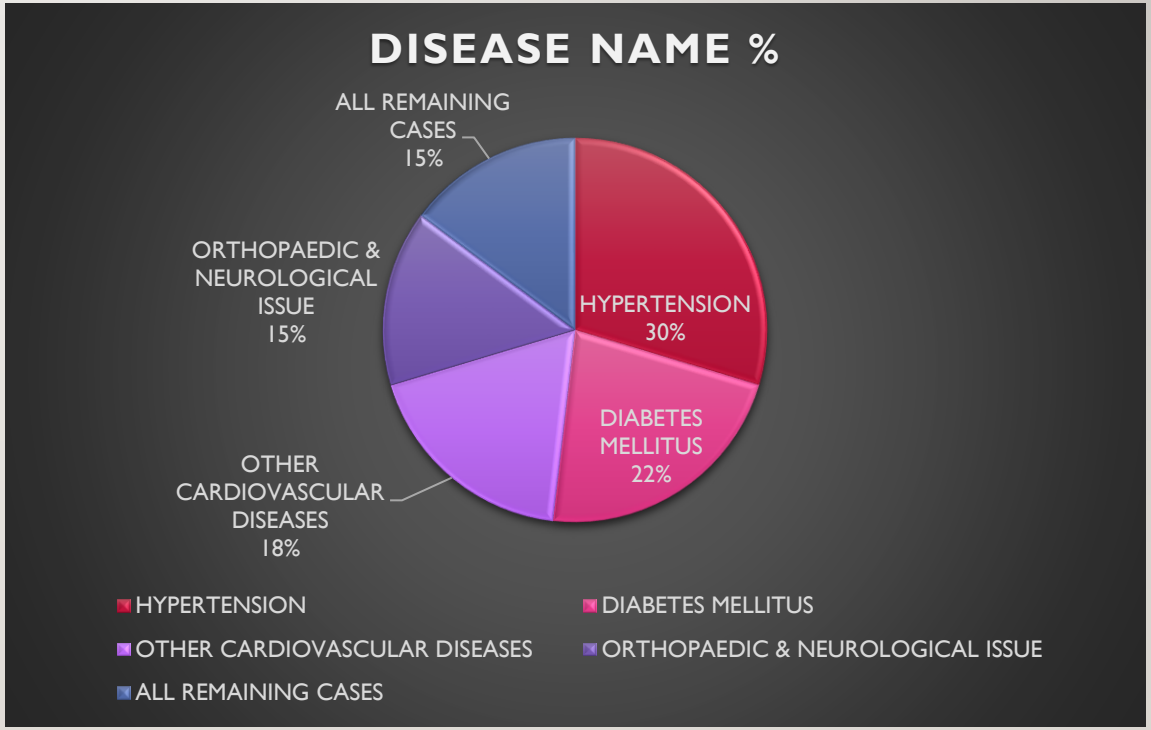
- The exclusion of certain treatments under the policy accounted for 9% of the claim denials. Insurance policies often include exclusions for specific treatments, conditions, or procedures that are not covered. Policyholders must thoroughly review and understand these exclusions to ensure they are aware of what is and is not covered under their policy.

- In 5% of the cases, claim denials were due to the lack of approval from the attending doctor. Insurance companies may require confirmation from a medical professional that the treatment or service is necessary and covered under the policy. Without such approval, claims can be denied, emphasizing the importance of medical validation in the claims process.

- The remaining 12% of claim denials were attributed to various other reasons. This diverse category includes a range of potential issues, such as administrative errors, discrepancies in documentation, or other policy-specific criteria not met by the claim. These varied reasons underscore the complexity of the claims adjudication process and the multitude of factors that can influence the outcome.

RESULTS : -

- STATISTICAL SUMMERY :-
- The above statistics reveal a detailed breakdown of health insurance claim denials attributable to the possibility of pre-existing diseases.
- Hypertension emerges as the leading cause among the pre-existing disease-related claim denials, accounting for 30% of these cases. This statistic indicates that nearly one-third of all denied claims in this category are linked to policyholders who had hypertension, a condition characterized by consistently high blood pressure. The prevalence of hypertension as a primary factor in claim denials highlights the critical nature of accurate and comprehensive health disclosures during the insurance application process.



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

STATISTICAL SUMMERY (CONTINUATION)……

- Following hypertension, Diabetes Mellitus stands as the second most common reason for claim denials related to pre-existing diseases, representing 22% of such cases. This considerable percentage reflects the widespread nature of diabetes and its significant implications for health and healthcare costs. Diabetes Mellitus, which involves elevated blood sugar levels due to insulin resistance or deficiency, poses substantial risks that insurers must consider when evaluating coverage eligibility and claims.

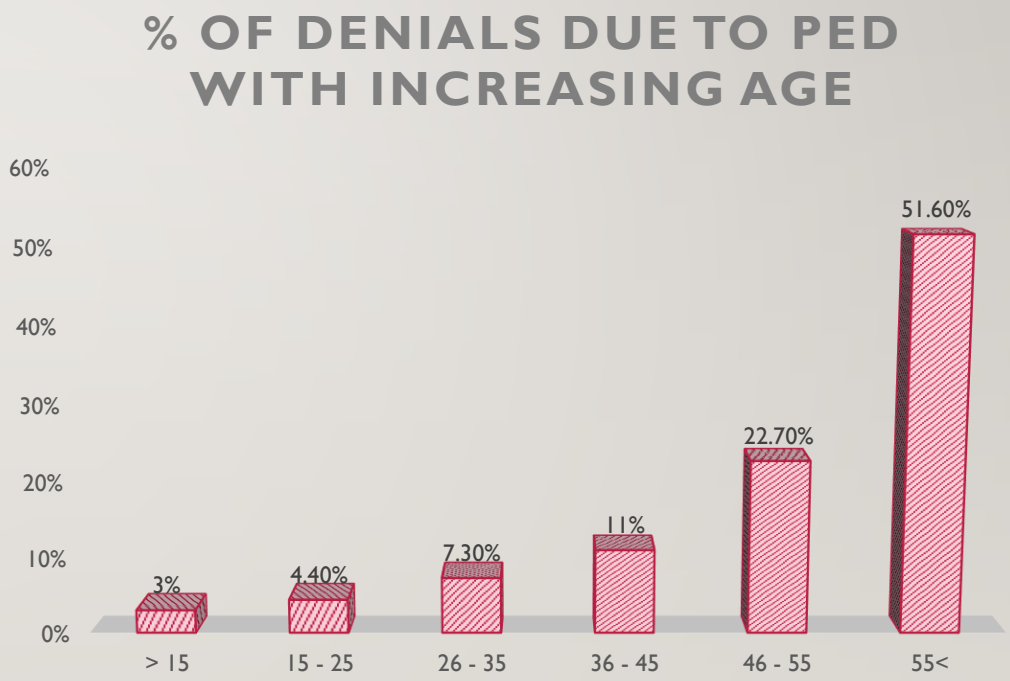
- Cardiovascular diseases other than hypertension also contribute notably to claim denials, comprising 18% of the pre-existing disease-related denials. This category includes a range of heart-related conditions, such as coronary artery disease, heart failure, and arrhythmias. The substantial proportion of denials due to these conditions underscores the importance of thorough medical evaluations and disclosures for individuals with a history of cardiovascular issues.

- Orthopaedic and neurological issues collectively account for 15% of the claim denials related to pre-existing conditions. This category encompasses a variety of conditions affecting the musculoskeletal and nervous systems, such as arthritis, spinal disorders, and neurological diseases like epilepsy and multiple sclerosis. The impact of these conditions on claim adjudication highlights the need for detailed medical histories and assessments during the underwriting process.

- The remaining 15% of the claim denials are attributed to other pre-existing conditions not specifically mentioned above. This diverse category includes various other medical conditions that were present before the policyholder applied for insurance coverage and were not adequately disclosed at the time of application. These conditions, while less frequently cited individually, collectively represent a significant portion of the pre-existing disease-related denials, further emphasizing the broad scope of medical issues that can influence claim outcomes.

RESULTS : -

- STATISTICAL SUMMERY :
- 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%.



% OF DENIALS DUE TO PED WITH INCREASING AGE

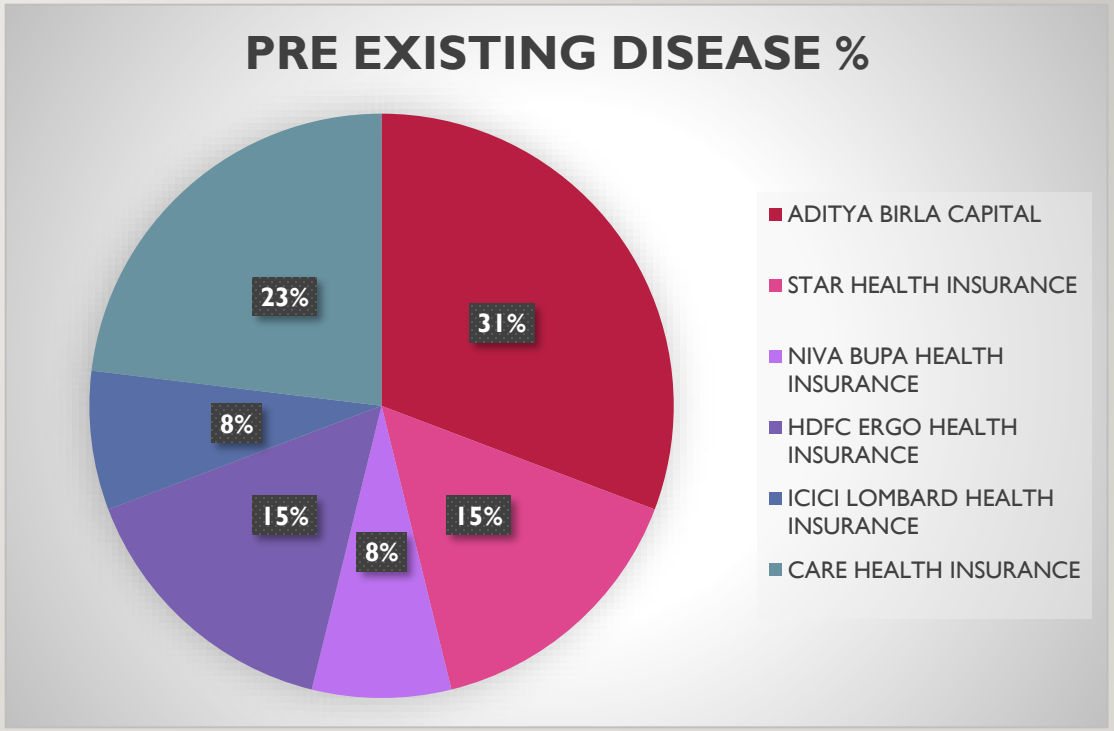
STATISTICAL SUMMERY (CONTINUATION)……

- 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%..

RESULTS : -

- STATISTICAL SUMMERY : -
- 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..



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

STATISTICAL SUMMERY (CONTINUATION)……

- 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

DISEASE CAUSING PED DENIALS PUT UNDER AGE BRACKET

		DISEASE CAUSING PED DENIALS				
		HYPERTENTION	DIABETES MALLITUS	OTHER CARDIOVASCULAR DISEASE	ORTHOPAEDIC & NEUROLOGICAL ISSUE	ALL REMAINING CASES
AGE BRACKET IN YEARS	< 15				1	1
	15 - 25	0	0	1	1	1
	26 - 35	0	1	0	1	2
	36 - 45	1	1	2	2	1
	46 - 55	5	4	2	1	2
	> 55	12	7	6	3	2

INFERENCE FROM THE ABOVE TABLE

- The table depicts the distribution of diseases causing PED (pre-existing disease) denials across different age brackets. Here are some detailed inferences:

1. **Prevalence of Hypertension**:
    - Hypertension is mostly found in individuals over 55 years old, with 12 cases.
    - The 46-55 age bracket also shows a good number of hypertension cases (5 cases).
    - There are no cases of hypertension in the younger age brackets (15-35 years).
2. **Incidence of Diabetes Mellitus**:
    - Diabetes Mellitus is most common in the age bracket over 55 years, with 7 cases.
    - The 46-55 age bracket also has a considerable number of cases (4).
    - Diabetes is not present in individuals younger than 26 years.
3. **Other Cardiovascular Diseases**:
    - Other cardiovascular diseases are most prevalent in individuals over 55 years, with 6 cases.
    - The 36-45 age bracket also shows a higher number of cases (2).
    - These diseases are not present in individuals younger than 26 years, except for one case in the 15-25 age bracket.

CONTINUATION……

1. **Orthopaedic & Neurological Issues**:
   - Orthopaedic and neurological issues are more common in the age brackets 36-45 (2 cases) and over 55 (3 cases).
   - These issues are also present in younger individuals, though less in number, with 1 case each in the <15, 15-25, and 26-35 age brackets.
2. **All Remaining Cases**:
   - The extent of all remaining cases is relatively even across most age brackets, with a slight increase in the 26-35 age bracket (2 cases).

DISCUSSION

- **. Interpretation of Results**
- The interpretation of results from this study focusing on several key points:
- **Non-Disclosure & It's role in Claims Adjudication Process : -**Non-disclosure emerges as a critical factor influencing the claims adjudication process within the insurance industry. Policyholders failing to disclose accurate and complete information, such as pre-existing medical conditions or risky behaviours, significantly impact insurers' risk assessments. This omission can lead to claim denials or adjustments based on newly disclosed information during the claims process. The discussion underscores non-disclosure's role in complicating risk evaluation, potentially resulting in financial losses for insurers and disputes with policyholders.
- **Pre – Existing Disease the leading cause for Health Insurance Claims Denial**
- In summary, the statistics demonstrate that non-disclosure of pre-existing diseases is the leading cause of health insurance claim denials, followed by claims within the waiting period, excessive claim amounts, insufficient query responses, exhausted sub-limits, policy exclusions, lack of doctor approval, and a range of other factors. These findings highlight the critical importance of transparency, thorough understanding of policy terms, and effective communication between policyholders and insurers to ensure a fair and efficient claims process.
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- **The major diseases that is leading to ' Pre – Existing Disease Named Claims Denial'**
- The statistics illustrate that hypertension and Diabetes Mellitus are the most prevalent pre-existing conditions leading to health insurance claim denials, followed by other cardiovascular diseases and orthopaedic and neurological issues. The remaining denials are due to a wide array of other pre-existing conditions. These findings highlight the critical importance of full disclosure of medical histories by applicants and the necessity for insurers to implement rigorous underwriting practices to accurately assess and manage the risks associated with pre-existing diseases. This approach ensures a fair and transparent claims process, ultimately fostering trust and reliability in the health insurance system.

CONTINUING…….

- **Increase in Age Bracket is Directly proportional to Increase in Claims Rejection Count**

- 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.

- **Increase in age group shows a remarkable no of PED Denials Due to Hypertention & Diabetes Mallitus**
  - There is a clear increase of all the listed diseases with age, particularly evident in the age bracket over 55 years.
  - The age bracket 46-55 also shows a high overall number of diseases leading to PED denials, especially hypertension and diabetes.
  - Younger age brackets (15-25 and 26-35) have lower number of these diseases, with a notable absence of hypertension in these groups.

- These observations underscore the impact of aging on the prevalence of various diseases that can lead to PED denials.

LIMITATION OF THE STUDY

- Acknowledging the limitations of this study is crucial to contextualizing its findings and implications. Several key limitations include:
- **Potential for Sampling Bias**
- One notable limitation is the potential for sampling bias inherent in the selection of insurers and policyholders included in the study. The study's focus on a purposive sample of insurers, particularly large multinational companies, may not fully capture the diversity of practices and experiences across the entire insurance industry. Insurers included in the study may exhibit specific characteristics or operational frameworks that differ from those of smaller or regional insurers. As such, findings derived from this sample may not be entirely representative of industry-wide practices and dynamics. Recognizing this sampling bias underscores the need for cautious interpretation and generalization of study outcomes to the broader insurance sector.
- **Challenges in Generalizing Findings**
- Another limitation pertains to the challenges associated with generalizing findings across the entire insurance industry. The insurance landscape is characterized by considerable variability in regulatory environments, market dynamics, and operational practices among insurers. Factors such as regional regulatory frameworks, market competitiveness, and cultural norms can significantly influence how insurers approach non-disclosure, retrospective underwriting, and claims adjudication processes. Therefore, findings from this study may not universally apply to all insurers or jurisdictions. The study's findings should be interpreted within the specific contexts and parameters of the insurers and markets under investigation, acknowledging the inherent diversity and complexity of the insurance industry.
- **Data Reliability and Availability**
- The reliability and availability of data represent additional limitations that warrant consideration. The study's findings rely on the accuracy and completeness of claims data, policy documentation, and other relevant information provided by insurers. Variations in data quality, accessibility, and transparency among insurers may impact the robustness and comprehensiveness of the study's analysis. Moreover, limitations in access to proprietary or sensitive data may restrict the depth of insights that can be gleaned from certain insurers or specific claim cases. Addressing these data-related challenges requires careful navigation and collaboration with insurers to ensure sufficient access and reliability of information for rigorous analysis.

CONCLUSION

- The study concludes that addressing the key factors identified in the research can substantially reduce the incidence of insurance claim denials in hospital settings. One of the primary recommendations is to improve the accuracy and completeness of documentation submitted with claims. Ensuring that all necessary information is correctly and thoroughly documented can help in minimizing errors and omissions that often lead to denials. This includes accurate patient records, detailed treatment plans, and comprehensive billing information.

- Enhancing communication between all stakeholders involved in the claims adjudication process is another crucial recommendation. This involves fostering better interactions between healthcare providers, insurance companies, and patients. Clear, consistent, and timely communication can help in resolving discrepancies, clarifying doubts, and ensuring that all parties are on the same page regarding coverage, requirements, and processes. Improved communication channels can also facilitate quicker resolution of issues that may arise during the adjudication process.

- Underwriting team need to focus on more cases of Hypertension & Diabetes Meletus cases specially while registering candidate of higher age group. Proper investigation of the cases need to be done while providing policy tso that they don’t face problems later while retrospective underwriting.

- Implementing these recommendations can lead to a more efficient and transparent claims adjudication process. With better documentation practices, enhanced communication, and well-trained staff, the frequency of claim denials can be significantly decreased. This not only benefits the hospitals by reducing administrative burdens and improving cash flow but also benefits patients by ensuring that they receive the coverage they are entitled to without undue hassle. Insurance companies also stand to gain through improved accuracy and efficiency in claims processing, potentially leading to higher customer satisfaction and loyalty.

- In conclusion, the study highlights that systematic improvements in documentation, communication, and training are key to mitigating the challenges associated with insurance claim denials. By adopting these strategies, hospitals can create a more streamlined and effective claims adjudication process, ultimately enhancing the overall healthcare delivery system.

REFERENCES: -

- Disclosure in Insurance law , a comparative analysis . Available from : - https://link.springer.com/article/10.1007/s10657-012-9355-y
- The Insured's Non-Disclosure in The Formation of Insurance Contracts: A Comparative Perspective. Available from : - https://www.cambridge.org/core/journals/international-and-comparative-law-quarterly/article/abs/insureds-nondisclosure-in-the-formation-of-insurance-contracts-a-comparative-perspective/17AFBF1A64EB0F6C2F43C1B7C6F54050
- Non-disclosure to insurers. Available from : - https://www.addleshawgoddard.com/en/insights/insights-briefings/2021/litigation/the-brief-case-summer-2021/non-disclosure-to-insurers-pre-insurance-act-2015/
- When can an insurer repudiate a claim on the basis of non-disclosure. Available From : - https://www.cliffedekkerhofmeyr.com/en/news/publications/2015/dispute-resolution/insurance-matters-16-november-when-can-an-insurer-repudiate-a-claim-on-the-basis-of-non-disclosure-.html
- Understanding claims adjudication. Available from: https://www.medvision-solutions.com/blog/understanding-claims-adjudication-how-does-it-work
- Underwrite retrospective risk in Insurance policy. Available from https://anziif.com/professional-development/skills-units/li20014-20
- Knowledge & Research. Available from https://www.scor.com/en/life-knowledge-and-research
- Official portals of the 6 selected Health Insurance Organizations. They are as follows :- Niva Bupa : -https://www.nivabupa.com/health-insurance-plans/get-quote.html?cid=S_Brand_E_NB_Health_Insurance&utm_source=Bing&utm_medium=cpc&utm_campaign=Bing_Search_Niva_Brand_Exact_New&msclkid=a4f1e97f4e7f1138238a8f045626a020
    - HDFC Ergo Health Insurance :-https://www.hdfcergo.com/campaigns/health-insurance-detail-new?&utm_source=bing_search&utm_medium=cpc&utm_campaign=Health_Search_Brand_Exact&utm_adgroup=Brand_Exact&adid=&utm_term=hdfc%20ergo%20health%20insurance&utm_network=o&utm_matchtype=e&utm_device=c&utm_location=1658&utm_sitelink={sitelink}&utm_placement=&ci=bingsearch&SEM=1&msclkid=f2fddcd921ca180d47bbbaa2391958b6

REFERENCES : -

- Star Health Insurance :- https://www.starhealth.in/lp/health-insurance/?utm_source=bing&utm_campaign=GS_Brand_PanIndia&utm_agid=1330411471492592&utm_term=star%20health%20insurance&creative=&device=c&msclkid=14c6d8d6aa2517ccaf50beadb3a6b665
- Aditya Birla Capital: https: https://www.adityabirlacapital.com/
- ICICI Lombard : https://sme.icicilombard.com/employee-benefit-insurance/group-health-insurance?utm_source=bing&utm_medium=cpc&utm_campaign=IL_Bing_GHI_Generic_Phrase_12Apr24&utm_adgroup=GHI_company&utm_term=health%20companies%20insurance&utm_matchtype=p&utm_device=c&utm_content={getquote}&msclkid=40fea477deca1ce9f1eac20cc5cfcd74
- CARE Health : https://www.careinsurance.com/health-insurance/cr/chi-health-insurance-plans-new.html?agentId=20027297&utm_source=bing&utm_medium=cpc&utm_campaign=ht_ind_new-101_AD_CR_DT&utm_content=rta&utm_keyword=care%20health%20insurance&s_kwcid=AL!10397!3!!e!!o!!care%20health%20insurance&utm_term=433232151&utm_adgroup=1209463287171442&msclkid=7075ef1bc07215e3e40c8960db994d86&utm_source=bing&utm_medium=cpc&utm_campaign=Health_Brand-CHI_Desktop-LP_India_Exact_Care&utm_content=Care%20HI
- Retrospectively Rated Insurance: What it Means, how it Works. Available from
- https://www.investopedia.com/terms/r/retrospectively-rated-insurance.asp

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