STUDY TO IDENTIFY AND ANALYZE THE OVERRULING OF CLAIMS

BY

Dr. RIYA BANERJEE

Dissertation submitted in partial fulfillment of the requirements of the degree
MBA Hospital and Health Management

Academic Year, 2018-2020

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ABSTRACT

Health Insurance focuses on the concept of risk in health which people face. Illness often is an unpredictable phenomenon. The ability to shift the risks of illness to others is a benefit for which many are found willing to pay.

Health Insurance sector in India has grown many folds since past many years. The sector saw its growth starting from 2015 and since then it has been showing an upward trend. There was a slight increase in 2015 reaching 2.72%, it remained the same in 2016, then increased to 2.76% in the year 2017 and slightly decreased to 2.74% in 2018.

The aim of the study was to observe and analyze the overruling of claims that were recommended for denial by the Fraud and Investigation team but were paid by the claims team, strengthen the MBHI philosophy and reduce potential financial leakages in the organization.

In order to do so a secondary data was collected from the month of January, 2020 to April, 2020 (4 months) and a retrospective observational study was conducted by purposive sampling technique. The study was conducted within the Fraud & Investigation department of the organization with some inclusion and exclusion criterias.

The key results of the study are as follows:

- Majority of the claims were denied on the basis of PED/ND, the second highest being Policy exclusion followed by Misrepresentation of facts, Hospitalization not justified, Unrecognized provider/physician, Non-cooperation and Forged Documents.
- Out of all the Non-Disclosure claims that were paid a high number of cases were Related and Material facts that should have been disclosed at the time of buying policy and some PED cases were also observed that were related to the current diagnosis.
- The total amount that could have been saved from all these claims was calculated purely for the learning of both the departments.

Certificate from guide and Dean Academic and Student Affairs

TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Riya Banerjee**, student of **MBA Hospital and Health Management** from The IIHMR University, Jaipur has undergone internship training at Max Bupa Health Insurance from **February 12, 2020 to May 12, 2020**.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Professor
The IIHMR University, Jaipur

Certificate of completion of Internship/dissertation for the duration of at least three months from the organisation.

To be obtained on official stationary

The certificate is awarded to

Dr. Riya Banerjee

In recognition of having successfully completed her
Internship in the department of

Fraud & Investigation

and has successfully completed her Project on

Study to analyze the overruling of claims
February 12, 2020 to May 12, 2020
Max Bupa Health Insurance

She comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning
We wish her all the best for future endeavors

Mentor **Training & Development** **Zonal Head Human Resources**

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Study to identify and analyze the causes of overruling of claims** and submitted by **Dr. Riya Banerjee**, Enrollment No. **IIHMR-U/01/2018-20/0809** under the supervision of **Dr. Piyusha Majumdar** for award of MBA in Hospital and Health/ Pharmaceutical / Rural Management in Health and Hospitals of the University carried out during the period from **12th February,2020 to 12th may, 2020** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

(Riya Banerjee)

Signature

ACKNOWLEDGEMENTS

The success and final outcome of this project required a lot of guidance and assistance from many people and I am extremely privileged to have got this all along the completion of my project. All that I have done is only due to such supervision and assistance and I would not forget to thank them.

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I owe my deep gratitude to my mentor **Dr. Piyusha Majumdar, Assistant Professor, IIHMR University** for her help, support and guidance along the course of my dissertation work. Her spontaneity and keen interest in my work encouraged and guided me to complete my study in due time.

I would like to extend my sincere esteems to my late father Mr. Malay Kumar Banerjee for always looking over me and providing me with strength and my mother Mrs. Indra Banerjee for her constant motivation and support.

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And above all, I thank God Almighty without whose blessings nothing can come to pass.

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LIST OF SYMBOLS AND ABBREVIATIONS

1. **MBHI:** Max Bupa Health Insurance
2. **RM:** Reimbursement claims
3. **Pre-auth:** Pre-authorization/Cashless claims
4. **F&I:** Fraud and Investigation
5. **QA:** Quality Assurance
6. **PED:** Pre-existing Diseases
7. **ND:** Non-Disclosure
8. **IRDAI:** Insurance Regulatory and Development Authority of India
9. **DM:** Diabetes Mellitus
10. **CKD:** Chronic Kidney Disease
11. **HTN:** Hypertension
12. **COPD:** Chronic Pulmonary Obstructive Disease
13. **IHD:** Ischemic Heart Disease
14. **RMC:** Related Material Claims
15. **NRMC:** Non-Related but Material Claims
16. **NRNMC:** Non-related Non-material Claims

INTRODUCTION

The vision of the organization is to become India's most admired Health Insurance Company and it came into being in the year of 2010. It is a joint venture between True North, a leading Indian private equity firm, and the UK's 70-year-old healthcare services expert, Bupa.

While on the one hand, Bupa brings its vast and varied experience, on the other hand, True North adds the insights and understanding of the Indian healthcare market and its capability of transforming business. Together, they strive to make the company one of the best medical insurance companies in the country.

The organization always believes in adapting to newer lifestyle by promoting healthy habits through rewards, covering new-age treatments and coming up with quick digital solutions like AnyTimeHealth(ATH) Kiosks and Health App.

At the organization, the mission is to help customers live healthier and more successful lives by providing expertise as healthcare partners. And they have made this possible by constantly raising the standard of medical insurance by keeping the promises made to ourselves, to our customers, and caring for them, for life. For the company, it is always about building a long-term relationship with the customers, and providing them the trust they need and expect from the best health insurance company in India.

Bupa, the global experts in health insurance plans, has built a customer-base of over 29 million in over 190 countries with their six decades of experience in the healthcare industry.

True North is a leading Indian private equity firm, with a focus on investing in and transforming mid-sized profitable businesses into world-class industry leaders. In the last 20 years, True North has invested in more than 50 Indian businesses and has successfully guided these companies in making the transition into well-established and large businesses that are valuable, enduring and socially responsible.

Health insurance can be defined as a contract where an individual or group purchases in advance health coverage by paying a fee called “premium”. Health insurance refers to a wide variety of policies. These range from policies that cover the cost of doctors and hospitals to those that meet a specific need, such as paying for long term care.

The penetration of non-life insurance sector in the country has gone up from 0.56 in 2001 to 0.97 in 2018 (0.93 in 2017).

The health insurance industry in India is the fastest growing segment in the non-life insurance sector. The market witnessed a robust double digit growth of 24% in FY 17, with a market share of 24%, in the entire non-life insurance sector. It has been the fastest growing market segment, registering a CAGR of 23%, for the past 10 years. This phenomenal growth may be attributed to the liberalization of the economy and growing general awareness among the public on healthcare.

The health insurance industry is at an embryonic stage, with roughly 25% of the population under its coverage. There exists a huge potential for growth and penetration of health insurance to a larger population. The launch of National Health Protection Scheme under Ayushman Bharat, in September 2018, in order to provide coverage of up to INR 500,000 (USD 7,723) to more than 100 million vulnerable families, holds heavy expectations, which increases penetration of health insurance in India, from nearly 34% to 50%.

Healthcare providers, such as pharmacies and private hospitals, are the leading health insurance providers, with a coverage share of more than 55%.

According to the Annual Report 2018-19 of IRDAI, during the FY 2018-19, General & Health Insurance Companies collected 44873 crore as Health Insurance Premium registering a growth of 21.2% over the previous FY 2017-18. Health insurance premium continues to grow over 20% year on year during the past four financial years.

There is a marginal dip in the market share of public sector insurers from 58% in FY 2017-18. On the other hand, the share of private sector general insurers has increased marginally from 21% in FY 2017-18 to 24% in FY 2018-19 and the share of stand-alone health insurers in health insurance premium has gone up from 21% in FY 2017-18 to 24% in FY 2018-19.

Health insurance business is classified into Government Sponsored Health Insurance, Group Health Insurance (Other than Government Sponsored) and Individual Health Insurance.

Health insurance in India typically pays for only inpatient hospitalization and for treatment at hospitals in India. Outpatient services were not payable under health policies in India.

1. PROJECT BACKGROUND

The claims team intimates or triggers a claim to the F&I for investigation and a report is submitted by the investigator to the F&I team which then does the QA and submits the report by adding their remarks in the claim recommendations section. The claims team then studies the report and comes to a conclusion of whether to approve the claim or not.

The process flow for fraud investigations in case of reimbursement claim is as follows:

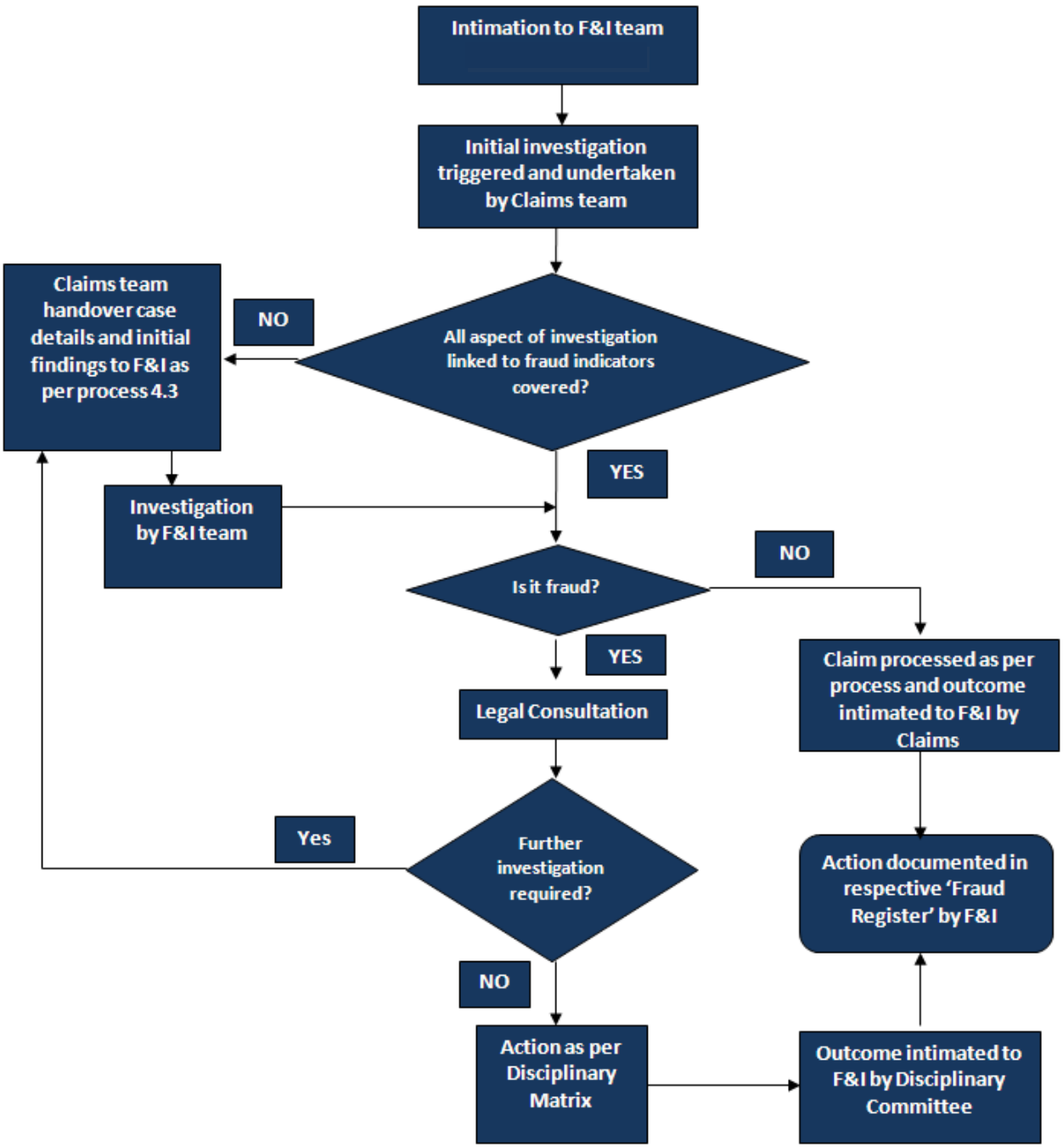

Figure 1: Process of fraud investigations of Reimbursement claims

In some instances, the opinions differ, which is termed as overruling.

There are two types of overruling:

1. **Deny to pay:** wherein the F&I recommend to deny the claim but the claims team decides to pay.
2. **Pay to deny:** wherein the F&I recommend to pay but the claims team denies.

As the philosophy of MBHI to pay every genuine claim and to deter every fraudulent claim, the philosophy needs to be developed, accepted and implemented across.

The study focuses on identification of reasons of overruling. Some of the reasons are as follows:

- Hospitalization only for evaluation purpose or Hospitalization not justified
- Absence of mandatory documents
- PED/ND
- Misrepresentation of facts
- Policy Exclusion
- Unrecognized provider
- Non-cooperation

Majority of the deny to pay claims are because of some Pre-existing disease or Non-Disclosure of material facts (PED or ND) which is the main focus of the study.

Pre-existing disease is a condition, ailment or injury that already exists at the time of buying a health insurance policy. Conditions such as DM, Epilepsy, CKD etc. are some of the pre-existing health conditions.

Non-Disclosure refers to that situation where a customer fails to reveal a relevant fact when applying for or renewing an insurance contract.

1.1 AIM:

The aim of this study is to identify and analyze the causes of overruling of claims, strengthen the philosophy of MBHI and achieve decrease in existing rate of overruling.

1.2 OBJECTIVES:

1. To strengthen the philosophy of MBHI for F&I and claims.
2. To identify potential financial leakages.
3. To establish an understanding of overruling decisions of claims and F&I

1.3 OUTLINE OF THE STUDY PREFORMED:

This study was performed using secondary data of past four months from 1st January, 2020 to 30th April, 2020. Firstly, categorization of the claims was done on the basis of fraud categories to find out the most common category under which claims were denied but were paid. All the Group Health Insurance (GHI) claims were excluded from this study. After the categorization it was identified that majority of the claims were denied under the PED/ND category (56%).

All the PED and ND cases were then separated and were categorized into Related/Non-Related and Material/Non-Material respectively. The cases which were related to the diagnosis and were proven fraud under PED and were paid instead of getting denied were filtered in Excel and the sum amount of those claims was calculated. The same was done for all Related Material ND cases to fulfill the objective of prevention or reduction of financial leakages in the organization.

2. LITERATURE REVIEW

i. The article titled "**Misrepresentation and Non-Disclosure on applications for Insurance**" was published in the year 1995 and talks about the process of Application in Insurance among man (Misrepresentation and Non-Disclosure on applications for Insurance , 1995)y other processes such as renewals, issuance of policy, settlement of claims etc. In this article the author focuses on only one stage of the Insurance process i.e. the Application for insurance. The article discusses the nature of the problems addressed by applications from the point of view of both the insurer and the insured. The author also suggests some precautions to ensure that an insured is not innocent with respect to a misrepresentation or a Non-disclosure.
Authors and Co-authors: **Roderick S.W. Winsor and Gil Lan**

ii. The journal article titled "**The Revised Statements of Insurance Practice**" was published in the year 1986 in the Journal called **The Modern Law Review Vol. 49**, No. 6 (Nov., 1986), pp. 754-767 (14 pages) and is an attempt by the insurance industry in Britain to meet some of the criticisms against it. Few of the case studies were discussed and studied in the article to better understand the problems faced by the insured.
Authors: **Forte, A. D. M.** "The Revised Statements of Insurance Practice." The Modern Law Review, vol. 49, no. 6, 1986, pp. 754–767.

iii. The article titled "**Pre-Existing conditions and Medical underwriting in the Individual Insurance Market prior to the ACA**" was published in the year **2016** to review the medical underwriting practices by private insurers in the individual health insurance market prior to 2014, and estimates how many American adults could face difficulty obtaining private individual market insurance if the ACA (Affordable Care Act,2014) were repealed or amended and such practices resumed. They examined

data from two large government surveys: The National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS) and consulted field underwriting manuals used in the individual market prior to passage of the ACA as a reference for commonly declinable conditions. It was estimated that at least 52 million non-elderly adult Americans (27% of those under the age of 65) have a health condition that would leave them uninsurable under medical underwriting practices used in the vast majority of state individual markets prior to the ACA. While most people with pre-existing conditions could have employer or public coverage at any given time, many people seek individual market coverage at some point in their lives, such as when they are between jobs, retired, or self-employed.

Authors: **Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt, Karen Pollitz**

iv. The study titled "**Pre-existing condition coverage post-health reform**" was published in the year **2010** and talks about the role of Private Insurance sector, System Organisation/ Integration, Funding / Pooling, Access. According to the article Preexisting conditions were previously used as cause for exclusion from private insurance coverage on the individual insurance market in the United States. Congress changed this with the passage of the Patient Protection and Affordable Care Act (PPACA), which offers a two-phase solution for these patients: a temporary insurance plan for uninsured individuals with pre-existing conditions from 2010-2014, and a prohibition against denying coverage for such individuals after 2014.

Authors: **Krista Harrison and Gerard Anderson**

3. RESEARCH METHODOLOGY

This study was conducted as a part of the dissertation programme at the organization and the whole process was operational under the F&I department.

This study included secondary data followed by identification and analysis of the causes of overruling of claims, strengthening the philosophy of MBHI and achieving reduction in existing rate of overruling.

- **Study Design:** Observational
- **Study Duration:** February, 2020 to May, 2020 (3 months)
- **Sample Size:** 194 cases of PED/ND out of 345 total cases
- **Sampling Technique:** Purposive sampling
- **Data Period:** 4 months (January 1,2020 to April 30,2020)
- **Data type:** Secondary
- **Inclusion criteria:** Reimbursement and Deny to Pay claims
- **Exclusion criteria:** Pre-auth, Pay to Deny, Spot RM and GHI claims
- **Study Setting:** F&I Department of MBHI

The data is entered and analyzed in Excel itself. The data is visually represented in the form of pie charts to show the percentage of cases which were denied under different fraud categories and to identify the most common fraud parameter.

The pie diagram is also used to show the percentage of Related/Non-Related and Material/Non-material PED and ND cases respectively.

Ethical Considerations:

It is understood that the data used in the study contains sensitive and confidential information of the organization and must not be used inappropriately in any manner. Appropriate measures should be incorporated to ensure data security, privacy and confidentiality.

4. RESULTS AND DATA ANALYSIS

DIFFERENT CATEGORIES OF INSURANCE FRAUD:

- Pre-existing Disease or PED is defined as a condition, ailment or injury that already exists at the time of buying a health insurance policy. Conditions such as DM, Epilepsy, CKD etc. are some of the pre-existing health conditions.

- Non-Disclosure or ND refers to that situation where a customer fails to reveal a material fact when applying for or renewing an insurance contract.

- Policy Exclusion is a provision that eliminates coverage for some type of risk. The insurers make policy exclusions to narrow down what is covered and what is not covered in the policy. There are some waiting periods applicable in the policies such as 30 day waiting period, PED waiting period in which if the insured has a pre-existing condition then he has to wait for a specific time to claim for that condition after which it will get covered in the policy, a specific waiting period and a personal waiting period. There are some permanent exclusions also that are not paid under any circumstances.

- Misrepresentation of facts, as its name suggests, is the discrepancy in the information provided to the insurer by either a customer or a provider.

- When an insured is admitted in a Hospital just for the purpose of evaluation and investigations and does not undergo any form of treatment then it is said that the Hospitalization is not justified.

- Non-cooperation can be from a customer in the form of not providing information or not answering the investigator's questions or it can be from the provider in the form of not providing the investigator the complete set of ICP and investigation reports required for investigation.

- Unrecognized providers are those providers that do not fulfill the criteria set by the organization.

The result of the study is depicted in the form of Tables and Pie diagrams and the analysis was done in Excel.

Categories	Number of cases	Percentage
Misrepresentation of facts	41	11.88
Hospitalization not justified	42	12.17
Non-cooperation	8	2.32
PED/ND	194	56.23
Policy Exclusion	52	15.07
Unrecognized provider	6	1.74
Forged documents	2	0.58
Total	345	

The table shows the number of cases from different categories of Fraud under which claims are denied. It is clearly shown that the highest numbers of cases, that is, **194 cases out of 345** are denied under the PED/ND category where PED stands for Pre-existing diseases and ND stands for Non-Disclosure.

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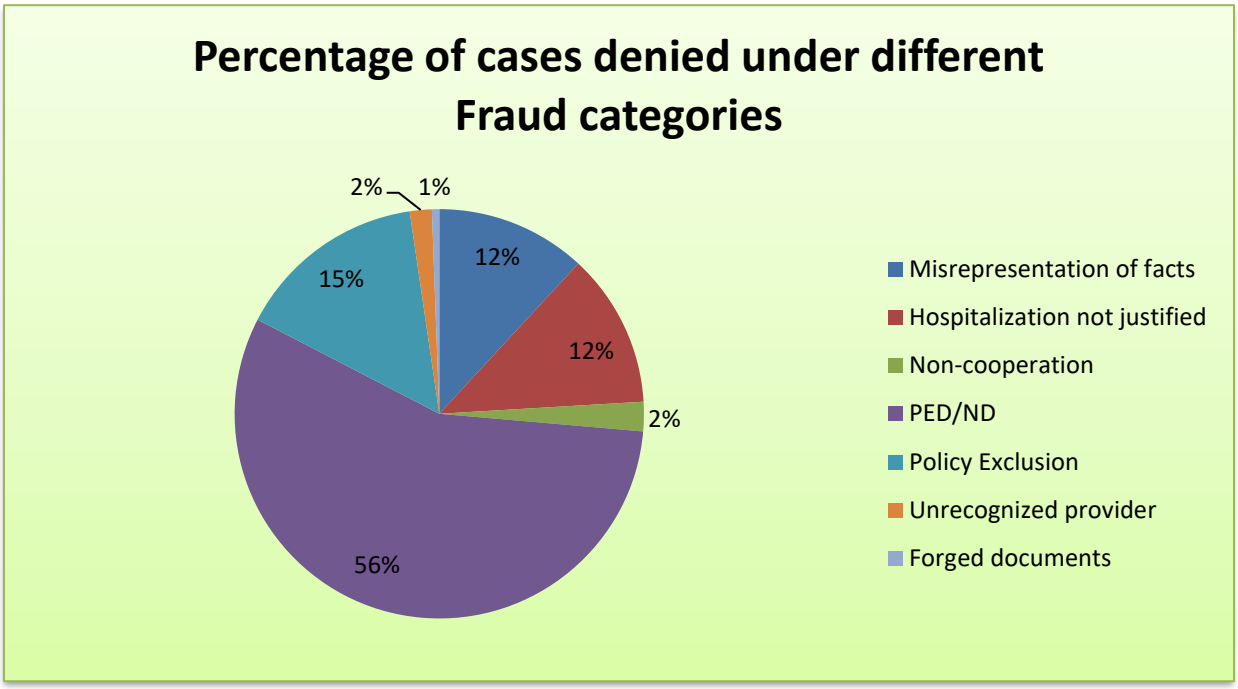

Figure 2: Percentage of cases denied under different Fraud categories

The above Pie diagram shows the percentage of the different fraud categories under which claims are denied. The findings of the above diagram are as follows:

- 56% of the total cases are denied under the PED/ND category.
- 15% of the cases are denied under Policy Exclusion.
- 12% cases each are denied under Misrepresentation of facts and Hospitalization not justified.
- 2% cases each are denied under Non-Cooperation and Unrecognized Provider
- Only 1% of the total cases are denied under the Forged Documents category.

PED	No. of cases	Percentage
Related	20	90.91
Non-related	2	9.09
	22	

The above table shows the number of Related/Non-related PED cases.

Out of the 20 cases in which the pre-existing condition was related to the current diagnosis, 10 cases were such that were either covered in the policy or were cases of acute conditions and 10 cases were such which should have been denied instead of being approved.

The amount of money that could have been saved if those 10 claims had not been paid was calculated in Excel and it came out to be **Rs. 9,75,294/-**

Non-disclosure	No.of cases	Percentage
Related Material	45	26.16
Non-related but material	109	63.37
Non-material non-related	18	10.47
	172	

The above table shows the number of Related/Non-Related Material/Non-Material non-disclosure cases.

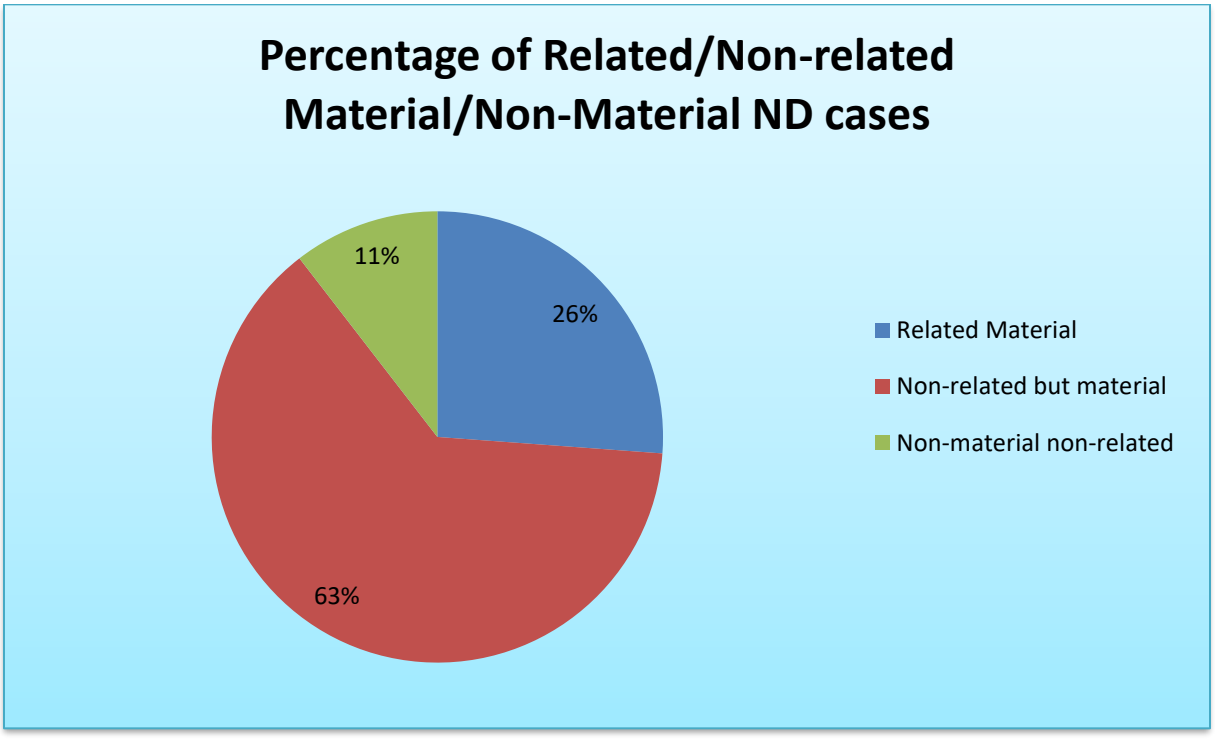

Figure 3: Percentage of Material/Non-Material Non-Disclosure cases

Material facts are those conditions that can have a long term effect or an increased morbidity in the health status of an individual. Some of the conditions that are material non-disclosures are HTN, DM, Hypothyroidism, COPD/Asthma, IHD etc.

The above pie diagram shows that **26%** of the total Non-Disclosure cases were Material non-disclosures and also were related to the current diagnosis of the insured.

Here also, the amount that could have been saved was calculated and recorded in Excel and it came out to be **Rs. 9,752,778/-**

The total financial leakage which could have been saved under the PED/ Non-Disclosure category alone was **Rs. 10,728,072/-**

5. DISCUSSION

The purpose of the study was to understand the overruling of claims decisions, strengthen the philosophy of MBHI and prevent or reduce the financial leakages that happens because of this.

A secondary data of all Reimbursement claims that were overruled in the past 4 months from January to April was collected and observed. All the GHI claims and the negative overruling claims (pay to deny) were filtered and the total sample size became 345.

Out of the total sample percentage of the different taggings or categories under the Fraud Proven category was found which showed that almost 56% of the cases under Fraud Proven were tagged under PED/ND. The second most common category was Policy Exclusion with 15%. The others that followed were 12% cases under Misrepresentation of Facts and Unjustified Hospitalization each, 2% of cases under Non-cooperation and Unrecognized Provider/Physician and only 1% of the cases were tagged under Forged documents.

This step was important so as to identify the most common criteria under which claims were denied and focus on that criterion for the study as it was difficult to review all 345 cases altogether.

The next step in the study was to review all the PED and ND cases and then identify them as Related/Non-Related and Material/Non-Material respectively as per the philosophy of Max Bupa Health insurance (MBHI).

The total number of PED and ND cases was 194 out of which 22 cases were that of PED and 172 were of ND.

It was found that out of 22 cases of PED, 20 of them were related and only 2 were non-related. And out of 20 of the related PED claims 11 claims were such that were covered in the policy i.e. they had already crossed the pre-existing disease waiting period as per the policy T&C but still were wrongly tagged under fraud proven category. So the overruling decision of those cases was justified. However, the remaining 9 claims out of 20 related PED claims may have been denied instead of getting paid. The amount of such claims was calculated to get an idea of the saving that could have been possible.

The same thing was done for all the Non-disclosure cases. The ND cases were categorized into three categories:

- RMC: Related Material Claims
- NRMC: Non-Related but Material Claims
- NRNMC: Non-Related Non-Material claims

Out of the three categories the highest percentage was of Non-Related but Material Claims (NRMC) with 63% of the cases i.e. more than half of the total ND claims. The reason for this may be that the investigator thinks that the fact is a material fact and should have been disclosed at the time of buying policy so he rejects the claim on the basis of ND and does not pay attention to the fact that whether the ND was related to the final diagnosis of the patient or not. In this case, the overruling becomes justified.

The second highest percentage was that of Related Material claims (RMC) with 26% of such cases. Again the total claim amount of these cases was calculated to calculate the saving that could have been made.

The savings which could have been made on the PED cases was **Rs. 9,75,294/-** and the savings which could have been made on the Non-Disclosure cases was **Rs. 9,752,778/-**

The total financial leakage that could have been saved came out to be **Rs. 10,728,072/-**

Therefore, this study was conducted to:

- ✓ Better understand the philosophy of MBHI
- ✓ Strengthen the philosophy of MBHI
- ✓ Prevent/Reduce the financial leakages for the growth of the organization
- ✓ Gain a learning to both departments Claims as well as F&I

6. CONCLUSION

The denial of claims in Health Insurance in no way means the denial of treatment. Approval of claims is a multi-step process and requires time, money and manpower. Claims are triggered for investigation in order to verify the admission and insured details. The F&I department has a responsibility to do a complete review of a claim after the investigator shares his/her report and provide recommendations or remarks in the report before sending it for a final review to the claims team. The recommendation may be to reject a claim if fraud is proven during investigation or to raise a query if certain documents are not provided by the provider or to approve a claim if no discrepancy found and the claim seems genuine.

However there often arise some instances where there are differences in opinions of the claims and F&I team which is usually called Overruling. Both the departments have a different point of view and different philosophies regarding claims processing.

This study was done to understand those differences in opinions so that the philosophy of the MBHI as a whole is strengthened and both the departments have a clear understanding of each other's decisions.

The implications of the study are as follows:

- This study will help understand the reasons for which claims might have decided to pay when F&I recommended the claims team to deny.
- The study will also help establish an effective communication between the departments i.e. F&I and Claims.
- The study can help reduce or prevent financial leakages which in turn will help the organization gain profits and continue to grow.

7. BIBLIOGRAPHY

https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=AR&mid=11.1

https://www.maxbupa.com/

https://www.mordorintelligence.com/industry-reports/india-health-and-medical-insurance-market

https://www.actuariesindia.org/downloads/gcadata/10thGCA/Emerging%20Health%20Insurance%20in%20India-An%20overview_J%20Anitha.pdf

https://en.wikipedia.org/wiki/Health_insurance_in_India

https://www.thebalancesmb.com/insurance-exclusions-462464

https://www.myinsuranceclub.com/articles/are-pre-existing-diseases-covered-in-your-health-insurance-policy

https://heinonline.org/HOL/LandingPage?handle=hein.journals/jlac15&div=19&id=&page=

https://www.blaney.com/sites/default/files/article_misrepresentations.pdf

https://www.jstor.org/stable/1094136?seq=5#metadata_info_tab_contents

https://www.jstor.org/stable/1095968?seq=13#metadata_info_tab_contents]

https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/KFF_Pre-existing-Conditions-and-Medical-Underwriting-Prior-to-the-ACA_Dec-2016.pdf

http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.443.1924&rep=rep1&type=pdf

http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=1&sid=4c53be83-32eb-463f-97e7-5d578036af21%40sessionmgr4006

https://economictimes.indiatimes.com/wealth/insure/health-insurance/certain-illnesses-in-1st-3-months-of-health-insurance-policy-to-be-treated-as-pre-existing-disease/articleshow/71534306.cms

8. REFERENCES

Works Cited

Misrepresentation and Non-Disclosure on applications for Insurance . **Lan, Roderick S.W. Winsor and Gil. 1995.** 1995.

Pre-existing condition coverage post-health reform. **Anderson, Krista Harrison and Gerard. 2010.** s.l. : Bertelsmann Stiftung, 2010.

Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market prior to the ACA. **Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt, Karen Pollitz. 2016.** 2016.

The Revised statements of Insurance. **Forte, A.D.M. 1986.** 1986, The Modern Law Review, pp. 754-767.