PGDM (Insurance Business, 2014-16)

Health Insurance

INS-302

Trimester –III, End-Term Examination, April - 2015

Time allowed: 2 Hours 30 Minutes Max Marks: 50

Roll No: _____

Instruction: Students are required to write Roll No on every page of the question paper, writing anything except the Roll No will be treated as Unfair Means. In case of rough work please use answer sheet.

Section-A

There are 5 questions in this section. Attempt any 3 questions. Each question carries 5 marks and the Word limit is 200 words. [15]

A1. To what extent is Health Insurance based on the Principle of Indemnity?

A2. "Although Numerical Rating is the most prevalent practice, it is not the perfect method of judging and rating a risk" Discuss giving reasons and examples.

A3. What is the coverage under Bhavishya Arogya insurance Policy? Does it benefit a young person?

A4. Describe Daily Hopital Cash benefit cover. Is it a stand- alone policy or a rider?

A5. What is High Deductible Insurance? Is it the same as Top-up cover? How does it differ from Co-payment? Explain.

Section-B

[Note: Answer 2 out of the 3 Questions below. Each Question carries 10 marks and word limit is 500. [20]

B1. What are the factors affecting morbidity? Should the underwriter insist on medical report with each proposal? Discuss all the underwriting decisions which the insurer could take in respect of a proposal.

B2.

a) What are the standard exclusions in a Hospital Indemnity policy?
b) How does a Group Mediclaim differ from an individual policy? Discuss elaborately.

B3. Discuss how 'Customer Delight' is important for the growth of Health Insurance industry giving parameters of customer service. What are the measures available to a customer for seeking redressal of his grievances?

Contd/-2-

Section-C

Case Study ***Marks: 15***

Compulsory question-

A. Case of a hospital in Bangalore-

Type of policy: 18 Individual Policies.

Claim Type: Reimbursement.

Claim amount: Approx. 5 lacs.

Type of fraud: Fictitious Admissions

Investigation Findings: This hospital had generated admission documents and claimed in the name of non-existing insureds. On thorough scrutiny of the documents by experts, it was observed that a stereo typed pattern was followed in all the claim documents.

A team comprising of doctors, expert investigators of Medi- Assist along with the Insurer cross examined the records of the hospital and the Medical Director of the hospital and found that all these claims were fictitious and made the hospital accept in writing.

Action taken on Hospital : The entire amount was recovered and the hospital was removed from network. Alert was created for preventing any claims getting processed without investigation and was intimated to all other TPAs & Insurers.

Questions- In the light of the above real case, discuss-

1. What kind of a fraud had occurred in this case What are the other broad kinds of frauds that prevail in health insurance sector? (4)
2. What do you think in the light of the above case should have been the real role of a TPA? (2)
3. What observations can trigger suspicion of foul play in a health insurance claim? (3)
4. Can you suggest some suitable strategic measures for insurers to prevent losses to health insurers caused by various kinds of frauds? (6)