Available online @ www.iaraindia.com
RESEARCH EXPLORER-A Blind Review & Refereed Quarterly International Journal
ISSN: 2250-1940 (P) 2349-1647 (O)
Impact Factor: 3.655 (CIF), 2.78 (IRJIF), 2.77 (NAAS)
Volume VII, Issue 23
April - June 2019
Formally UGC Approved Journal (63185), © Author

CLAIM SETTLEMENT MECHANISM AND INDIAN HEALTH INSURANCE SECTOR: A CRITICAL INSIGHT

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Abstract

A customer spends premium annually which will cover his medical expenses but there's always a concern in his mind about the claim settlement. So, choosing a good health insurance provider is an important step in choosing the right policy for health insurance needs. Knowledge of claim data will not only help to understand the history of claim handling process but also to earn higher amount of trust on insurers. In this backdrop, the objective of the paper is to undertake a critical insight of the performance of health insurance industry in India with reference to claim settlement mechanism and its impact on profitability. Findings reveal that the health insurance sector is facing severe headwinds on account of increased number of repudiation and pending claims over the years. On an Average 83.26% of claims had been honoured. Out of unsettled claims, 56% were repudiated and 44% were lying pending in claim processing.

Keywords: Premium, Headwinds, Repudiation, Pending, Lagging, and Promptness.

Introduction

"To all intents and purposes, the claim department can be seen as the shop window of the insurance company. It does not matter how cheap an insurance company's premium is, or how efficiently they conduct their underwriting administration if a claim is not properly and fairly dealt with. This is where an insurer will be judged."-**Roff, 2004.**

In this era of intense competition and market share, the timely and efficient management of claims is very imperative for the achievement of both large and small companies operating within the insurance industry. It is one aspect of insurance practice, the handling, which can make or mar the image of an insurance company in terms of profitability and long-term sustainability. It is not just a legal obligation but also a strong public relations instrument and a marketing strategy that has a lot of bearing on client's satisfaction and the sale of insurance products. It plays an important role in differentiating a company from its competitors by handling claims in a proactive and positive manner. Done right, it solidifies customer relationships, aids in regulatory compliance and prevents frauds.

Claims are the moment of truth for insurance (Rendek et al.,2014).Claims make insurance tangible and deliver client value because they can reduce out-of-pocket expenses and decrease reliance on burdensome financing strategies such as sale of productive assets(Dalal et al., 2014).

An efficient claim management not only has to monitor costs and provide claims services to customers to restore normalcy but

also at the same time to operate within budget. Secondly, the speed and promptness with which the claims are settled and paid within the framework of stipulated rules and regulation of IRDA is an important in ensuring consumer centric insurance solution deep impact on the policyholders' willingness to recommend insurance to others as well as on the re-purchase by word of mouth advocacy of insurance products. In other words, delay in handling and settlement of claims not only earn bad name for the company but also increases claim costs making it more expensive for the company.

According to Lalithchanadra and Kumari (2015), claim management includes claims processing and payout, which should be a core element of insurance practices, so as to ensure smooth operations.

A successful claim settlement shall strive to achieve;

1. High customer satisfaction.
2. Sufficient premium growth.
3. Low incurred claim ratio.
4. Profitable Underwriting.
5. Detection and prevention of fraud.
6. Management of adverse selection & moral hazard by clients.
7. Avoidance of litigation & decreasing number of claim errors.

In this backdrop, the objective of this paper is to undertake a critical insight of the performance of Indian health insurance industry with reference to claim settlement mechanism and its impact on profitability.

Review of Relevant Literature

According to Irukwu (2000), claim settlement needs to be done expediously and equitably as it is the best form of advertisement for insurance companies.

According to Productivity Commission (2002), a good claim management program should be proactive in dealing with genuine claims, maximizing on recovery opportunities from salvage, subrogation and third parties, reporting regularly, minimizing unnecessary costs and reducing loss adjustment expenses.

According to Braers (2004), a prudent claim administration strategy promotes customer loyalty by developing a perception of membership or belongings within a particular group of customers. It provides the company with opportunities to retain existing customers while attracting new ones and profitable ones.

According to Harrington &Niehaus (2006), Bates & Atkins (2007) and SAS (2012), claim expenses constitute the largest proportion of an insurer's expenses and hence there is a need for insurers to take their claim handling activities seriously.

According to Bates and Atkins (2007), the claim management phase gives an opportune moment for delivery to the insurers and to favourably impress the policyholders along with enhanced reputation and better performance.

According to Baranoff et al. (2009), an optimal claim management practices include assessing accurately the reserves associated with each claim as they represent liabilities and future financial obligations for the insurer.

According to Association of Insurance and Risk Managers in Industry and Commerce (2009), claims monitoring and review are key components in achieving excellence in insurance claims handling.

According to Banjo (1995); Butler & Francis (2010), poor handling of claims may lead to loss of confidence among the policyholders leading to damaged reputation and poor performance.

Asikhia (2010) is of the opinion that until and unless companies are able to deliver their services with technology as key determinant, financial institutions may not be able to retain their customers.

TIBCO (2011) is of the opinion that for insurers to significantly enhance their claims management and promptly adapting to changing situations, they are required to make more profound infrastructural changes for better customer service, operational cost and risk management.

According to Capgemini (2011), a highly effective claims practice can be a vital contributor for attracting new customers and strengthening loyalty with valuable customer experience.

According to the Organization for Economic Co-operation and Development (2004), a good insurance claim management process should involve: claims reporting; receipt of claims by the company; claims files and procedures; fraud detection and prevention; claims assessment; timely claim process; complaints and dispute settlement; and supervision of claims-related services.

Objectives of the Study

1. To study the performance of Indian health

insurance sector with reference to claim settlement mechanism and its impact on profitability.
2. To make a comparative analysis of settlement of claims by TPAs Vs In-House.
3. To suggest policy prescriptions necessary for an equitable and rational claim settlement.

Data and Methodology

The study is descriptive, explorative and at the same time analytical in nature. It is mainly based on secondary data collected from published IRDA annual reports, articles, books, national & international journals, Government reports and publications from various websites related to insurance industry in India and abroad. After collection of the required information, findings have been interpreted and the conclusions arrived there from have been structured as required. The study has covered a total of 30 non-life insurers, among which 4 are public sector companies and the rest 26 are private companies. Among these private insurers, there are 6 standalone insurance companies whose core business is health insurance and 2 specialised insurance companies.

The study covers the period of 6 years from **2012-13** to **2017-2018.**

Significance of the Study

The outcome of this study will help the insurance providers to understand the existing inefficacies in the claim settlement mechanism and to redesign and implement more effective measures to handle claims that will meet better customer satisfaction as well as to encourage more efficient use of services, yet remaining within sustainable operating limits. This in turn will help to earn higher amount of trust on insurers. Increased demand for insurance products, premium income generation/sales, marketing figures and larger capital formation will bestow prosperity to insurance companies in terms of profitability and long-term sustainability.

Details on Year-wise Claim Settlement, Repudiation & Pending.

Particulars	2014-15		2015-16		2016-17		2017-18	
	No of Claims	Avg. Claim Size(Rs)	No of Claims	Avg. Claim Size(Rs)	No of Claims	Avg. Claim Size(Rs)	No of Claims	Avg. Claim Size(Rs)
Claims Paid	**92,35,780**	**0.10**	**80,34,711**	**0.27**	**110,39,074**	**0.25**	**145,44,736**	**0.21**
Claims Repudiated	8,67,194	0.38	10,39,349	0.42	13,66,978	0.31	12,14,616	0.44
Claims Pending	6,49,671	0.73	7,08,290	0.35	10,33,319	0.30	13,44,419	0.24
	15,16,865	**1.11**	**17,47,639**	**0.77**	**24,00,297**	**0.61**	**25,59,035**	**0.68**

Source: IRDA Reports. (Numbers in Actual)(Amount in Lakh)

It is evident from the table above that the number of claims paid over the years seems to be greater than the number of claims repudiated and claims pending taking together.

If these are looked in terms of monetary values, it shall be observed that the average value of claims repudiated and claims pending **(Rs 1.11, Rs 0.77,Rs 0.61 and Rs 0.68)** are more than the claims paid **(Rs 0.10, Rs 0.27,Rs 0.25 and Rs 0.21)** in all the subsequent years.

This implies that claims of higher values are either prone to repudiation and/or pending in the health insurance industry.

This may result in policyholders' losing confidence in the insurance claim management, leading to poor customer satisfaction and low retention and policy renewals.

All these can be attributed to companies' poor underwriting practices or following stricter norms in the process of claim settlement.

Low earnings, availability of insufficient claim reserves or maintenance of higher solvency margin with insurers can be a strong cause to this effect.

However, the effort should be made to gear up the volume of claim settlement.

Claim Settlement by Third Party Administrators Vs In-House.

Years	% of Claims Settled			% of Claims Repudiated			% of Claims Pending			% of Claims Settled within 1 Month		
	In-House	TPAs	Diff.	In-House	TPAs	Diff.	In-House	TPAs	Diff.	In-House	TPAs	Diff.
2014-15	87.50	84.64	2.86	07.95	8.15	(0.2)	04.55	7.21	(2.66)	85.72	78.53	7.19

2015-16	77.77	83.89	(6.12)	14.07	9.23	**4.84**	08.16	6.88	**1.28**	93.07	80.85	12.22
2016-17	84.15	81.53	2.62	08.82	10.58	(1.76)	07.03	7.89	(0.86)	92.87	81.14	11.73
2017-18	85.80	84.73	1.07	06.91	7.18	(0.27)	07.29	8.09	(0.8)	87.68	61.74	**25.94**

Source: IRDA Reports. Figures in %.

In reference to the table above, the following observations have been made:

The rate of claims settled by TPAs over the years is lesser than the In-House except the F.Y 2015-16, where the settlement has increased by 6.12%.The overall claims settlement performance of In-House is diminishing which can be visualised by the decreasing rate of differences between In-House and TPAs Claim settlement.The rate of claims repudiation and claims pending by TPAs is greater than the In-House except the **F.Y 2015-16** where the rate has decreased by 4.84% and 1.28% respectively, signifying TPAs are tight –fisted while passing on the benefits to the claimants.

TPAs have been lagging behind In-House consistently in terms of speed and promptness in settlement of insurance claims. The highest resolving difference (25.94%) was found in the **F.Y 2017-18** where the TPAs settlement rate decreased to the level of 61.74%.Lengthy turnaround time points to bottlenecks and poor processes, which can erode value and add both direct costs (additional staff time) and indirect costs(lower client retention) to an insurance product.

These irregularities and mismanagement in claim settlement may affect consumers' centric insurance solution and confidence of the policyholders thereby increasing the risk of losing dissatisfied customers which can be visualised through the profit after tax statement (PAT) as mentioned below:

Suggestions

The underwriting and claims personnel should be provided with state-of-the -art training mechanism in order to appreciate the sensitive nature and the role claims play in the insurance industry. The cost of claim settlement increases with the multiple stages in the process.

Since, repudiation of a claim is subject to legal implication involving cost, the insurers should be cautious in denying liability under a policy which requires the insurers to decide the purview of inclusion under the covered peril. Moreover, the claim settlement should be more transparent and customer oriented. The action to repudiate the claim must be completed promptly and courteously.

The higher claim costs reduce profitability.Streamling the claim settlement process through automation (Claim Management System Software) will help to reduce expenses especially for smaller companies that operate with smaller budgets. Moreover; it will help to maintain low percentage of claim settlement in a period exceeding 30 days, leading to decreased number of customer complaints.

Conclusion

In conclusion, it can be inferred that the performance of the Indian health insurance sector in terms of claim management remains unsatisfactory with fast depleting profitability. There have been almost no significant change/improvements in the percentage of claims settled by the insurers over the years. Industry is tight-fisted when it comes to passing on the benefits to the claimants. The claims of higher values are either prone to repudiation and/or pending by the insurers. Moreover, unwarranted delays in payoutsby TPAs have created hassling experience for the individual thus, earning a bad name for the sector besides increasing the claim costs. This has become a matter of serious concern amongst policyholders' losing confidence in the insurance claim management, leading to poor customer satisfaction and low retention and policy renewals. Hence; the insurance sector is required to expedite the handling and claims settlement mechanism proactively and promptly.

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