

Claims Management in General Insurance - Issues & Concerns

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Underwriting and claims settlement are the two most important aspect of the functioning of an insurance company. Out of any insurance contract, the customer has the following expectations:

- i. Adequate insurance coverage, which does not leave him high and dry in time of need, with right pricing.
- ii. Timely delivery of defect free policy documents with relevant endorsements / warranties / conditions / guidelines.
- iii. Should a claim happen, quick settlement to his satisfaction.

For the purpose of this article, we shall be concentrating on (iii), as (i) and (ii) relate to underwriting, though proper u/w facilitates claim settlement. Unlike life insurance, where all policies necessarily result in claims – either maturity or death – in general insurance not all policies result in claim. Approximately around 15% policies in general insurance result in claim. The claim settlement in general insurance thus have their own peculiarities and therefore need proper handling. Also how 15% policy holders are attended is of great importance. The services being rendered will determine the attitude of the customers. How the services being rendered is perceived by the customer? That also needs to be kept in mind. Do we have a mechanism to find out the same?

The insurance companies have hitherto been handling the claim rather than managing them. Typically this process involves –

- i. As soon as a claim is reported, the insurance company checks as to whether the cover was in force at the time of loss and whether the peril is covered under the policy.
- ii. A surveyor is appointed who visits the spot, do the assessment and submits the report.
- iii. Insurance company examines the report, calls for relevant supporting documents.
- iv. On receipt of survey report and documents, the same are examined. The claim file is processed and settlement is offered.

The claims handling is thus more process oriented and does not pay adequate attention to the monitoring and claims cost aspect as also to the service parameters.

In the present liberalized scenario, with cut-throat competition being the order of the day, the insurance companies have to go much beyond the handling of claims. The following aspect needs to be kept in mind.

- I. General insurance being a market driven service industry, the customer has to be kept satisfied. With so many options available, a customer once lost is most likely a loss forever. Claim settlement can be used as a marketing tool. Brining in a new customer is much more costly than retaining the existing ones.

- II. In a de-tariffed market, pricing will be the key factor. Proper claims management - quick settlement at optimal cost will help keep the price competitive.
- III. A dissatisfied customer is a bad publicity. It has all the potential to damage the reputation of the company. It is an accepted fact that most of the customers complaint relate to claims. It should be the endeavour of any insurance company to ensure that such complaints do not occur in the first place and in some cases if they do occur it is attended promptly, efficiently and transparently.
- IV. IRDA guidelines on 'protection of policyholders' interest' stipulates certain obligation on the part of insurance company including time limit for claim settlement. This is a regulatory requirement and insurance company personnel at every level must understand its implication.
- V. Delayed claim settlement generally result in higher claims cost. Claims cost is a very important factor vis-à-vis profitability. Why do delays take place in claim settlement? Nobody will buy the excuse that the claimant is not forthcoming with documents and other requirements for settlement of claim. Is it because of the delay in submission of survey reports? If so, who is responsible for this. Are we undertaking necessary follow up steps for timely submission of report. The surveyors are duty bound as per IRDA regulations to submit report within a stipulated time. Even after submission of report and completion of other requirements how much time does it take to finally issue settlement cheque and its delivery to the claimant. Do we have a system to monitor it? How about our accounts department people meeting the claimants for a change to understand "the sensitivity of the client" so that they are better sensitized on the issue.
- VI. Claims files must be monitored as they progress. A little time spent thinking clearly right from the beginning will avoid lot of unnecessary and time consuming patch-ups and straightening out later on. Unpleasant decisions conveyed timely with proper justification of the decision is better than procrastination which is bound to create more problems and unpleasant situations.
- VII. Proper u/w is essential as defective u/w results in complication at the time of settlement of claims. U/w and claims department should not work in isolation. There has to be a coordination between them. Defective U/w may saddle the companies with unwanted claims. Various court judgments and consumers forum awards bear testimony to the same. Any defect / ambiguity in the documents issued invariably goes against insurance companies. It is therefore of utmost importance that the client is made aware in very clear terms about what exactly is covered and what is not. There should be a strong system of audit for examining the documents being issued.
- VIII. Lot of time / energy / money is spent when claim cases go to Ombudsman / Consumer Forum/ Court. Besides, adverse comment bring bad name, when we are held liable. Insurance companies are invariably at the receiving end. The "watch and wait" attitude must change. There is a need to find out why so many cases go to consumer forum or the ombudsman and what should be done about it.
- IX. Claims-settlement have social service angle which must be met. In times of natural calamity lot of bad publicity comes to insurance company for delay in settlement of claims. This is in spite of the fact that in such situation insurance

companies goes out of their way to settle claims. In any case claims relating to the assets of weaker section needs to be attended on priority. So do the health / medical related claims.

In view of the above, it is necessary that

- Insurance companies manage the claims rather than handling them.
- Insurance companies have a corporate claims management philosophy

Managing claims involves not only claims processing but goes on to cover the entire gamut of claims management – strategic role, cost monitoring role, service aspect as also the role of people handling the claim.

Out of the total outgo on account of claims it is estimated that around 10 to 15 % is because of leakages, frauds and inflated claims. In absolute terms this will be a quite substantial amount. If this can be effectively checked, the benefit can be passed on to the customer by way of reduced premium rates.

Claims reserving is also an important part of the overall claim management process. Adequacy of claims reserving is important for any insurance company to meet its claim obligation. In fact in a study in USA of the insurance companies going “bust” 34% (highest) was on account of insufficient reserve / premium. The analysis of reserve and the process that goes into making the same and its comparison with past experience can help address such important concerns as

- Company’s likely future obligations on account of claims and its ability to meet them.
- Solvency aspect and assessing the true picture of the financial health.
- Analysis of claims trend can help to timely initiate remedial action. e.g. restricting a particular class of business.
- Effectiveness of loss control measure.
- Average time being taken for the settlement of a claim and the claim settlement ratio and how it compares with other operators in the market.

The claims management philosophy involves, the company having written corporate philosophy on claims management setting out the broad approach aiming to provide high quality service. It should specify the nature of claim service at each stage of the claim process, the speed of the claim service and also the IT enabled interactive process to know the status of the claim. Without visiting the office. In fact with web-enablement of claims processing, services from submission of claims to queries on claims status can be effected on line. Automation of claims processing will result in seamless connectivity of all personnel involved e.g. client, agents, brokers, surveyors, etc. The present low productivity paper intensive system must be replaced to keep up with the modern day requirement. It should also specify grievance redressal procedure. It should be ensured that claim department which has to deal quickly and fairly with all the claims have competent and well trained staff with right attitude. The claimant should not be treated as an intruder. In fact he is reason for our

existence. The time-gap between reporting of claim and its ultimate settlement needs to be reduced to the bare minimum. System of time-audit for self check may be introduced. Lastly a few words on “attitude”. The attitude of people handling claims is important. You can not face emerging challenges with past mind set and approaches. The personnel of insurance company should therefore change their present attitude, behaviour and must show flexibility to effectively respond to the requirements of the markets. They should thus exhibit empathy. Mere ‘sympathy’ will not do. Let’s settle the claim gracefully. Let’s enjoy good image on that count. Let’s enjoy the confidence and good will of our customer for that is the ultimate litmus test for our service. In the likely changes that are going to take place as can be visualized, the differentiating factor amongst the various players in the market will be the pricing, innovative product lines and the quality of service in general and more particular the claims service. Let it be understood very clearly, if the customer does not get good service everyone is going to pay the penalty.

Insurer’s procedure for handling claims are coming under closer scrutiny by the regulators as well as the consumer forum or courts. If recent judgments are any indication, in so far as retail customers are concerned, in the absence of any frauds the insurers may not be able to repudiate the claim on the ground of innocent, non-disclosure or misrepresentation of facts and non-causation of breaches of warrantee and get away with it.

Let’s see the writing on the wall and let’s responds to the needs of the hour positively. We are capable of that -- there is no doubt about it. Our capability commitment must be reflected in our conduct and behaviour so as to change the prevailing perception about us and our service.