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INVESTIGATING THE ROLES OF CLAIMS MANAGER IN CLAIMS HANDLING PROCESS IN THE NIGERIA INSURANCE INDUSTRY

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A B S T R A C T

Claims management can be seen as an essential tool of image boosting in insurance industry. Therefore, excellence in claims handling gives an insurance company a competitive edge over its competitors. To achieve this, there must be a virile claim department headed by a seasoned technocrat whose main role is to fashion out effective claims procedures and operations. This study aims at exploring the roles of claim managers in claims handling process in insurance business in Nigeria. Using a structured questionnaire, the study adopted exploratory research design using a simple random sampling technique. Inferential statistical method of Chi-square test was used to analyze the data in order to determine if there is any significant relationship between the variables in each hypothesis. The study reveals that there is a significant relationship between claims operation and effective claims management. It also reveals that there is a significant relationship between fraud detection and effective claims management. In order to strengthen these roles, it is recommended that head of claims should be part of top management team, staff in claims department must be exposed to training and insurance companies must internalize organizational philosophy on claim handling process.

Keywords: Claims Management, Insurance, Insurance Fraud and Claims Manager.

INTRODUCTION

A claim payment is the defining moment in the relationship between an insurance company and its customer. Butler and Francis (2010) see claim payment as a chance to show that the years spent paying premiums were worth the expense. From a commercial point of view, Butler and Francis (2010) assert that claims payment represents the largest single cost to insurers and 80 percent of all premiums are spent on claims payment and associated handling charges.

Claims management includes all managerial decisions and processes concerning the settlement and payment of claims in accordance with the terms of insurance contract (Redja, 2008). However, strengthening of claims departments, according to OECD (2004), involves effective claim procedures or operations which include claims reporting, claims assessment, claim processing, fraud detection and complaints and dispute settlements. But despite the above, claim settlement has never been without some hiccups for some insurance companies.

Statement of the Problem: Managing claims effectively is a complex task. Despite its many steps and variations in each process, most Nigerian insurance companies struggle to consistently improve claims operations. This may not be unconnected with the poor claims process and non-recognition given to the staff of the department in the industry.

Given that the claims experience is a primary driver of policyholder satisfaction and loyalty, there is need to have a virile claims department headed by a seasoned technocrat who will deliver high quality experience and equally cut costs. A major way of cutting cost is by identifying genuine and fraudulent claims. Pesout and Andrle (2011) posit that frauds in insurance are one of the major sources of operational risk of insurance companies and constitute a significant portion of their losses. Dionne (2000) provides many reasons for insurance fraud such as changes in morality, poverty, behaviour of the intermediaries, insurer's attitude and nature of insurance contract. Due to these anomalies, roles of claims managers need to be expanded to

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detecting fraudulent claims and minimizing the overhead cost of the company.

In order to bring this argument into proper perspective, we seek to assess the effectiveness of the current role of the claim manager in some of insurance companies in Nigeria.

Objectives of the study: The main objective of this study is to explore roles of an insurance claims manager in claims handling process in insurance business. Other specific objectives include; assessing claims management process, to assess effectiveness and efficiency of claim management process in terms of service delivery to consumers, to determine the roles of claims manager in fraud detection and to proffer suggestions for policy and practice.

From the above stated objectives, the study proposes the following hypotheses for testing:

H_1 There is no significant relationship between claims operations processes and effective claims management.

H_2 Claims manager does not play any impact on fraud detection and prevention for effective claims management process.

Meaning and Concept of Claims Management: The word "claim" according to Kapoor (2008) emanated from the Latin word, "Clamare" which means to "*call out*". Barry (2011) defines insurance claims as all activities geared towards monitoring insured's compensation, restitution, repayment or any other remedy for loss or damage or in respect of doing their obligations. Therefore, Marquis (2011) posits that insurance claims management consists of the departmental stipulation, corporate policies and industry practices that insurance firms use to validate policyholder payment or reimbursement requests. Supporting this definition, Gallagher (2012) opines that claims management involves administration of claims arising from loss events.

Claims handling is the moment of truth for the insurance industry, an opportunity to fulfill the promise made to customers to pay a valid claim (Hewitt, 2006). The essence of its actual application is to invoke the benefit of the insurance promise (Kapoor, 2008), provided all terms and conditions of the policy are met and the insured has acted with due diligence, as if uninsured, to protect his assets from the stipulated perils (Peverett, 1993).

The main objectives of claims management, according to Redja (2008), are to verify that a covered loss has occurred for fair and prompt payment of claims and to provide personal assistance to the insured after a covered loss occurs. These objectives, according to Brooks et al (2005), are often carried out by claims personnels that include managers, supervisors, claims representatives, customer service representatives, special investigation unit personnel, in-house council and third-party administrators.

Key issues that assist the claims department in achieving its objectives include understanding the customers, choosing the right claims model for the business, developing a mutually beneficial relationship with service providers, gaining an information advantage and taking a greater control of the claims process (Butler & Francis, 2010). Krishnan (2010) singles out claims process as the most important issue. He further defines claims process as the step by step process taken by the insured individual in making the demand from the insured's company and sometimes through the broker or an agent for settlement of losses incurred from the covered risk. This process can either be manual or web – based system. In manual based system, the client has no idea as to what stage of the claims process his or her policy is into while in the web-based system, deficiencies in the forms can be pointed in a faster manner (Krishnan, 2010).

However, either manual or web – based system, handling of claims process varies across insurance companies because they have different business models and different supplier network (Meyricke, 2010). Generally, Brooks et al (2005) propose that claims handling process includes acknowledging and assigning the claim, identifying the policy, contacting the insured or the insured's representative, investigating and documenting the claims, determining the cost of loss and loss amount and concluding the claims, that is, claims payment. Major components necessary for effective claims management process according to AIRMIC (2009), include culture and philosophy, communications, staff or people, infrastructure, claims procedures, data management, operations, monitoring and review.

Fraud in Claims Management: Isimoya (2013), notes that insurance is based on the principle of financial compensation for the effects of misfortune. But this principle can be undermined by fraud. According to Europe Insurance (2013), insurance fraud affects this principle as fraudulent applications and claims deplete the funds paid by the many honest customers to cover genuine losses.

There is no generally acceptable definition of insurance fraud. According to Gill et al (1994), is knowingly making a fictitious claim, inflating a claim or adding extra items to the claim or being in any way dishonest with the intention of gaining more than legitimate entitlement. Insurance fraud ranges from mild overstatement of the value of an item, lost or damaged through organized criminal activity designed to obtain large sum of money. (Bates & Atkins, 2007).

From a criminal point of view, Derrig & Krauss (1994) propose that fraud can be reserved for criminal acts, probable beyond a reasonable doubt, that violate statutes, making the willful act of obtaining money or value from an insurer under false pretense or material misrepresentation of a crime. However, Artis et al (1999) are of the opinion that this definition may be too strict to match the estimation objectives of the discrete choice model applied to the Spanish Auto insurance Market.

Claims fraud can be classified into mere exaggeration of claims, systematic fraud such as staged accident, false document and misrepresentation of information at the proposal stage. Clarke (1989), classifies insurance fraudster into the opportunist, the amateur and the professional. The opportunist takes an advantage of a genuine loss to commit fraud (Morley et al, 2006). The opportunistic fraud according to Dionne & Gagne (2002) can be induced when the benefits from fraud is sufficiently large. The amateur involves committing opportunistic fraud and then takes a step further while the professional engages in systematic frauds both individually and in organized networks.

Similarly, Gill et al (1994) posit that personal circumstances and resentment of insurance companies appear to be major determinants affecting a person's willingness to commit fraud. Other circumstances are the competitive nature in the insurance industry (Morley et al 2006), perceived efficiency of procedures such as scrutiny of policy and increasing consumer awareness (Clarke, 1989).

Measures undertaken to detect fraud, according to Morley et al (1999), include the responsibility for detecting fraudulent claims in insurance companies which rest heavily with staff at the front line of claims handling process. Therefore, the staff of the claims department must possess all round skills which include technical skills, work skills and interpersonal skills (Brook et al, 2005). They further stated that technical skill includes frauds investigation, evaluation skills and negotiation skills. Work skill involves positive works ethics, organizational skills, time management skills, computer skills and mathematical skills. The interpersonal skill consists of verbal communication, effective speaking, non – verbal communication, personal appearance, listening skills, active listening, reflecting and clarifying.

To corroborate the view above, OECD (2004) releases guidelines for good practices for insurance claims management which include claims reporting, receipt of claims by the company, claims files and procedures, fraud detection and prevention, claims assessment, claims processing, timely claims processing, complainant and dispute settlement, supervision of claims-related services and market practices.

MATERIALS AND METHODS

This study adopted exploratory research design method. The rationale behind using this design is to seek new insights into the two major characteristics of the operating variables in this study that is, claims operations and fraud detection. These variables also served as indicators to investigating the roles of claim manager. Simple random sampling technique was used to select a sample of 112 staff of claims department of insurance companies operating in Lagos. The choice of Lagos was due to the fact that the city is the commercial nerve center of the nation's economy and most of the insurance companies have their head offices situated in Lagos. Four (4) questionnaires were sent to twenty-two non-life insurance companies and six life insurance companies. A set of structured questionnaires were distributed to the selected respondents who work in the claims department. The research instrument contained 23 questions with sections A and B. section A had seven (7) questions which deal with socio-demography. Section B was further divided into two parts, the first part was based on the outlook of claim department and the second part contains 4 likert index questions to address claims management drivers, organizational culture and philosophy on claims management staff, development of claims department, effects of infrastructure and technology, claims operations and fraud detection. The research instruments were validated by top executives in claims management. The response rate for the questionnaires distributed was 71.42%, though minor discrepancies in total number of respondents were observed due to respondents' inability to provide answers to some of the questions. Inferential statistical method of Chi-square test was

used to analyze the data in order to determine if there was any significant relationship between the variables in each hypothesis. Descriptive statistic of frequency and percentage was used to analyse the demographic data. Stata (version 12) Excel (version 2007) and SPSS (version 15) were used to analyze the data.

RESULTS AND DISCUSSION

Table 2. Test of Hypothesis 1.

Items		Frequency	VLE	LE	HE	VHE	Total	Df	X²cal	P-value
S/N	**1**	Observed	3	14	47	16	80	12	19.8	0.071
		Expected	1.4	10.2	44.6	23.8	80.0			
	2	Observed	0	7	42	31	80			
		Expected	1.4	10.2	44.6	23.8	80.0			
	3	Observed	0	6	45	29	80			
		Expected	1.4	10.2	44.6	23.8	80.0			
	4	Observed	2	11	50	17	80			
		Expected	1.4	10.2	44.6	23.8	80.0			
	5	Observed	2	13	39	26	80			
		Expected	1.4	10.2	44.6	23.8	80.0			
Total		Observed	7	51	223	119	400			
		Expected	7.0	51.0	223.0	119.0	400.0			

X2 = 19.8 (df = 12; p< 0.1).

The research hypothesis geared toward achieving the stated objectives of the study was tested using inferential statistic of Chi-square at 0.05level of significance. From the table, the X2 value of 19.8 (df = 12; p<0.05) is significant at 0.1. This indicates that, there is a significant relationship between claims operation and effective claims management. Consequently, claims operation has a positive impact in claims management.

Table 3: Test of hypothesis 2.

Items		Frequency	VLE	LE	HE	VHE	Total	Df	X²cal	P-value
S/N	**1**	Observed	5	11	39	25	80	09	80.0	0.000
		Expected	15.5	7.5	37.0	20.0	80.0			
	2	Observed	40	4	23	13	80			
		Expected	15.5	7.5	37.0	20.0	80.0			
	3	Observed	1	9	44	26	80			
		Expected	15.5	7.5	37.0	20.0	80.0			
	4	Observed	16	6	42	16	80			
		Expected	15.5	7.5	37.0	20.0	80.0			
Total		Observed	62	30	148	80	320			
		Expected	62.0	30.0	148.0	80.0	320.0			

X2 = 80.0 (df = 9; p< 0.05).

From the table, the X2 value of 80.2 (df = 9; p<0.05) is significant at 0.05. Based on this explanation, this indicates that, there is a significant relationship between fraud detection and effective claims management. Consequently, fraud detection improves effective claims management.

Discussion of Findings: From the above results, it can be deduced that there is a significant relationship between claims operation and effective claims management. The claims operations may include flow chart to record processes and levels of authority, adequately experienced and qualified senior staff to supervise operations, consistent interpretation of policy terms and conditions, minutes of meeting and other records of client discussions and outsourcing of claims process to third party (loss adjuster).

The results also show that there is a significant relationship between fraud detection and effective claims management. The fraud detection can be through the establishment of compliance programme for combating fraud, awareness of consequence of submitting a false statement by the insured, adequate

training of claims department on fraud indicators and effective communication line where claims susceptible to fraudulent are reported. Hence, the role of claims manager in claims process is crucial to the survival of insurance companies because the process of claims settlement according to Krishnan (2010) is the final point of an insurance contract.

We also found out that members of staff of claims department have relatively low work experience mostly less than 10 years, hence, more experienced staff can be deployed to the department. Because of image boosting that claims management brings to insurance companies, head of claims must be part top executive management so as to ease decision making.

Findings also revealed that motor policy has the highest claims payment. This corroborates the fact that motor vehicle policy is most sought after. The roles of loss adjuster cannot be underestimated in claims management process. To achieve efficient and effective claims management process, insurance claim drivers must be taken into cognizance. Some of the claims drivers include information technology, regulatory compliance to claim handling process, access to claims information, client complaints procedure and direct involvement of claim function by top executive management.

CONCLUSION AND RECOMMENDATIONS

The role of claims manager in claims process is crucial to the survival of insurance companies because the process of claims settlement, according to Krishnan (2010), is the final point of an insurance contract and its application is to invoke the benefit of the insurance promise (Kapoor, 2008).

The findings of this study are convergent with the view of Redja (2008) who also believes that roles of a claim manager include to verify that a covered loss has occurred, for fair and prompt payment of claims and to provide personal assistance to the insured after a covered loss occurs. However, in understanding these roles, a claim manager must possess certain qualities like understanding the customers, choosing the right claims model for the business, developing a mutually beneficial relationship with service providers, gaining an information advantage and taking a greater control of the claims process and fraud management. (Butler & Francis, 2010).

Finally, the following suggestions are given;

Head of claims should be part of management team rather than reporting to someone who then report to the management.

Staff in claims department must be exposed to training to include customer satisfaction, identification and reduction of fraud, regulatory compliance and image boasting.

Claims manager can also be trained in claims reporting process like, minimization of losses, investigation, verification of claims, loss evaluation and assessing the extent of the damage prior to any repair or replacement.

Insurance companies must have organizational philosophy on claim management to include board commitment, establishment of client complaints procedure, commitment to treating consumer fairly and direct involvement of claim by top executive management.

Insurance claims departments must improve their technology to include feedback mechanism, filing of claims process through the social media and internet and adoption of statistical data base in tracing performance of claims performance of claims settlement.

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