

CLAIMS PROCESSING: SOME GENERAL COMMENTS

Claims are *the* most important aspect of insurance since their settlement is when the insurers can fulfill their promises and prove to the insured that they are trustworthy. Without efficient and effective claims processing, it will be impossible to offer affordable real value products to low-income households.

The claims process involves the occurrence of an insured event, collection of required documents, presentation of the claims applications to an intermediary or the insurer, claims adjustment and settlement.

Claims processing – from notification to settlement – is often a costly and time-consuming activity for insurers. For microinsurance to be successful, **operational and fraud costs must be minimized** to preserve affordable premiums.

A strategy to minimize costs involves **tiered claims requirements**. Claimants with the smallest claims would be required to present a limited number of documents through a relatively simple process, while more stringent controls would be in place for larger claims.

Claims notification and application

Insurers usually leave the responsibility of initiating claims to the beneficiary. However, by approaching the beneficiaries themselves, microinsurers can **enhance their credibility and strengthen the insurance culture**. For instance, with life insurance it is important for microinsurers to make sure the claims are initiated – not only collect on a possible outstanding loan, but to build client trust in their programmes.

Because the low-income market is unfamiliar with insurance, some microinsurers actively encourage them to submit claims. For example, VimoSEWA (India) realized that its claims rates were much lower than they should have been, so it increased efforts to educate policyholders about the claims process. The microinsurer also gave its members stamped postcards to make it easier for policyholders to contact their agents if they needed assistance.

Health insurance claims are more complicated than life insurance because a third party, the healthcare provider, is involved and claim assessment is subjective, requiring medical expertise. With health insurance, the ideal arrangement is to keep the policy-

holder out of the process completely. In this cashless system, the insurer pays the healthcare provider directly.

Claim forms that require a significant amount of formal documentation can lead to a higher rate of claims rejection due to incomplete claims applications. The objective is to find a balance between confidence that the insured event has occurred and accepting less than complete documentation. For example, in some countries it can be very time consuming and costly (relative to the size of the sum insured) to secure an official death certificate. To overcome this, Card MBA in the Philippines, for example, requires certified copies of a birth certificate or marriage license to be on file at branch level. When someone in the family dies, claims payment is much quicker as a result.

Delayed submission of claims to the insurer can be due to a variety of causes, such as:

- Claims **paperwork is too demanding**
- Local officials not being readily forthcoming with **official documents**
- Intermediaries **delaying premium payment**

To combat such delays, microinsurers must take the initiative in facilitating the claims process and adjusting their requirements where needed.

Settlement

When the low-income market experiences an insured event, it is critical for insurers to pay claims quickly or within the agreed upon period. Otherwise the poor may be required to borrow money or sell off assets to cover losses while they wait for the claims settlement.

On average, settlement times can be anywhere from seven to sixty days, or even longer if the claimant experiences snags in the process. It should be kept in mind that even though the insurer has paid an intermediary promptly, this does not mean that client payouts are equally timely, so risk carriers may want to consider monitoring the performance of their delivery channels. To combat client dissatisfaction, some microinsurers have instituted an additional **monetary compensation** payable to the client if they experience excessive delays.

Although some MFIs and credit unions have been known to delay the settlement process, others pay all

or part of the claims almost immediately upon being notified of the claim. For example, in Guatemala, Columna's cooperative partners give partial payouts when beneficiaries provide the initial documentation, and then settle the balance when the paperwork is completed and properly processed. This arrangement provides better customer services, but can only be implemented if intermediaries are properly trained.

As underwriting requirements are frequently applied to claims submissions rather than initial policy applications, **rejections** can be an issue for microinsurance. In the case studies, claims rejection rates, where available, were generally between 5 and 22 per cent. Claims rejections often occur on several levels, leaving the actual rejection rates ambiguous. For example, a claim can be rejected by the field officer, branch manager, head office management, or the actual claims department – since only the latter tracks rejections, the final figure most likely does not represent the total amount of rejections.

Health claims are largely rejected due to policy exclusions that fail to cover medical procedures or medications and the client not being aware of such exclusions. Another common reason for claims rejections is the failure of policyholders to understand that they must pay premiums every year in order to keep their policy in force.

To reduce rejection rates, policyholders must be fully knowledgeable about the product that they are buying. A simple policy document (e.g. brochure) that explains the entirety of their coverage and benefits should be given to clients. In addition, insurers need to deal with the root causes behind lapses in premium payment and develop alternative payment options that are sensitive to low-income families.

Controls

For insurers to be successful, they must ensure that the claims are legitimate and correspond with the policy requirements. Policyholders, and even intermediary agents, are motivated to try to cheat this system and **insurers must maintain strong yet sufficient controls** to stay in business.

Microinsurers use various controls to combat claims fraud. They may use **professional claims adjusters** (e.g. physicians) when dealing with more complicated

valuations stemming from health or disability claims. Still, health insurance tends to be the most vulnerable to fraud. Insurers must be vigilant against these common fraud problems:

- Physicians submitting invoices for care never provided
- Policyholders obtaining cover for persons not covered by the policy
- Over-treatment by providers
- Submission of fraudulent invoices by policyholders

Other controls relate to the structure of deductibles and co-payments, which limit the volume and value of claims, and can help limit the incentive for fraud by policyholders. Certain microinsurers' staff members frequently interact with clients and get to know families personally, which works as a moral deterrent against fraud.

Insurers employ controls that are built into the system to stop fraud before it occurs. Still, controls must reflect both practicality and the market situation. Too often, controls can cost more to implement than the likely cost of the aggregate loss.

Claims considerations for design

Claims processes and costs must be recognized in the product development process. A **simplified product design will greatly aid the claims process**. But, the greater the number of exclusions, the more complex the settlement process will be. For example, some microinsurers offer a range of benefits for life insurance, giving additional benefits if the death was accidental. Accidental death policies create a lot of ambiguity surrounding the definition of an accident and incentives to convert a death due to illness into an accidental death. A simple death policy where any death leads to a common settlement eliminates this problem.

An excessive claims rejection rate (over 5 percent in most instances) is a clear indication that either the product is too complex, or the underwriting is inadequate, or the claims' procedures are too difficult, or some combination of these. In any case, it should cause the insurer to undertake an investigation into improvements in one or more areas so that the claims rejection rate can be reduced.

The International Labour Organization (ILO) and the Munich Re Foundation recently published **Protecting the Poor: A Microinsurance Compendium** on behalf of the CGAP Working Group for Microinsurance. This authoritative book analyzes the experiences of more than 40 microinsurance providers and is based on the **Good and Bad Practices in Microinsurance** project led by the Operation Subgroup and funded by DFID, GTZ, the ILO and SIDA. The translations into French and Spanish are financed by ADA.

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