

THE MOMENT OF TRUTH: CLAIMS MANAGEMENT IN MICROINSURANCE

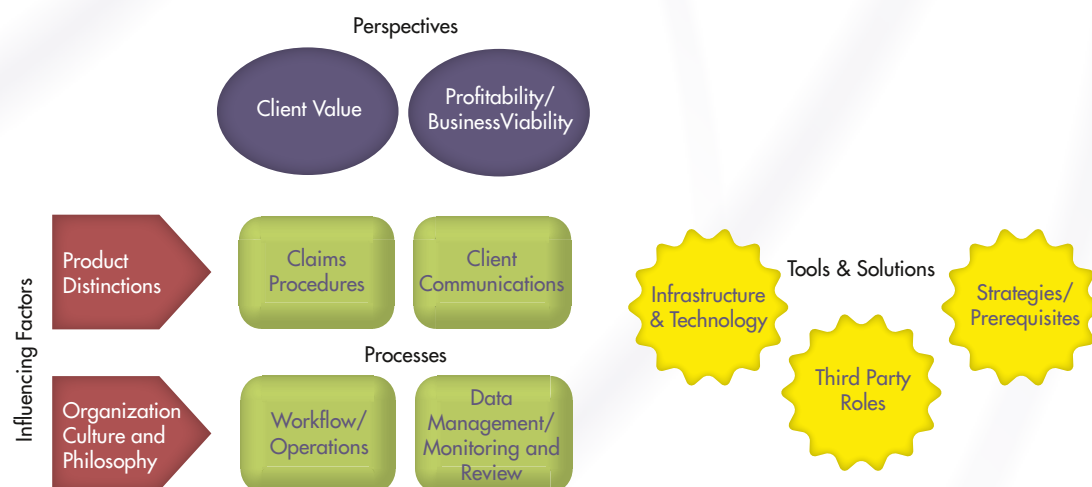
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The reputation and financial stability of insurers depends on their ability to manage claims efficiently and transparently. Claims management is particularly challenging for microinsurance providers, who must deliver similar products and services as mainstream insurers, while working with smaller margins. Client satisfaction in the microinsurance market hinges on receiving the insured benefit or service. Furthermore, low-income households with limited resources rely on timely receipt of insurance benefits to recover from a loss. Consequently, the client value of many microinsurance products, and trust in the principle

of insurance itself, is often reinforced or diminished based on how a claim is managed.

This note summarizes eight guiding principles for microinsurance practitioners to improve their claims management practices. The principles were identified using a framework to analyse processes in four components: claims procedures, client communications, workflow operations, and data management and monitoring (see Figure 1). The framework was used to evaluate specific tools, solutions or strategies for claims management that were implemented by at least one of the twelve schemes reviewed in the study.

FIGURE 1. Analytical framework



¹ This brief is excerpted from Microinsurance Paper no. 28. The paper is available at <http://www.ilo.org/microinsurance>. Kelly Rendek is an independent microinsurance consultant. Jeanna Holtz and Camyla Fonseca are part of the ILO's Microinsurance Innovation Facility.

GUIDING PRINCIPLES FOR CLAIMS MANAGEMENT

1. Leverage existing social capital and distribution channels

A community-based approach to claims management can leverage the impact of existing social networks and

create proximity of the microinsurance provider to the client, whether directly or through local representatives. If managed well, local claims support can improve overall claims processing time. The ICICI Prudential case in Box 1 demonstrates that local assistance to obtain and complete claims documentation improves accuracy and reduces the need for follow-up investigations by the insurer.

BOX 1. ICICI Prudential: community based assistance with claims submission

ICICI Prudential's Amnol Nivesh was designed in partnership with tea company McLeod Russell India Limited to provide a unit-linked savings product with life insurance benefits to workers employed in tea estates in Assam state.

Service centres are set up in the tea estates, and staffed by sales representatives (SRs) hired from among the educated youths in the local tea worker tribes. The SRs are closely involved in the programme, particularly enrolment, and are known in the community. In the event of the death of an insured person, the SR is notified by members of the family. The SR explains the claim process to the family and assists with collecting the necessary documents and completing forms, and in some cases paying for documents such as the death certificate. The SR submits the claim by post to the nearest branch office of ICICI Prudential.

This claims facilitation process provides local and immediate assistance to beneficiaries through a trusted intermediary, and improves both the accuracy and timeliness of claims submission. It minimizes the costs to the beneficiary of making a claim, such as paying postage or taking time off from work to deliver a claim to the branch in person.



A community approach may also increase the visibility of the claims process – other policyholders and even non-insured community members are more likely to know when someone receives a claim payment. Since the actual payment or benefit is the most tangible demonstration of the value of insurance, increasing the visibility of the claims process can improve understanding and awareness of the value of the insurance programme in the community overall. This in turn may have a positive impact on demand and viability.

Claims expenses can also be minimized by hiring local personnel rather than recruiting full-time claims staff at the head office and having them travel to microinsurance sites. Using a community representative in place of a professional loss assessor may be cost-effective as well as reduce the time needed for loss assessment.

2. Claims notification and submission processes are simple and easily understood by clients, intermediaries and claims managers

Long turn-around-times (TAT) are frequently caused by challenges in the claims submission process, rather than by the time required to process a claim once it has been submitted. Simplified and streamlined procedures for claims notification and submission can help to ensure that the claim enters the insurer's processing system more quickly. Good product design with easy-to-understand benefits and appropriate training for intermediaries and claims managers can also help to speed up claims settlement.

The use of standard claim forms, including fixed options for responses to claims questions (for example, "yes or no" questions, or standard codes), can not only shorten the time required to complete and submit claims, but also improve the speed and accuracy of data entry and claims processing.

3. Claims documentation requirements are reasonable

Claims documentation requirements need to be sufficient to manage fraud, but should not be excessive. The time and cost to acquire documentation and make a claim, especially if it involves travel or taking time off from work, can often outweigh the expected benefit. Simplifying requirements for clients to claim can improve the accuracy of claims submissions and minimize the number of claims requiring follow up or extra assessment. This in turn improves efficiency and controls claims assessment costs.

Fraud control measures can be incorporated into product design, rather than implementing checks and controls after the claim event. Collecting sufficient data at enrolment and ensuring they are available when settling claims also facilitates the process. Additional technology-supported solutions, such as biometric cards, facilitate improved claims processes even further. Finally, permitting alternative methods for claims validation minimizes the documentation burden on clients at the time of claim. Alternative Insurance Company (AIC)'s approach in Haiti illustrates how a service provider can support documentation of claims (see Box 2).

BOX 2 . AIC: A streamlined claims process lessens the burden on clients and increases efficiency and accuracy

The claims submission process for AIC's microinsurance products is simple and straightforward for beneficiaries. Although the documentation requirements are greater than for many other microinsurance products, the process is streamlined so that most of the documentation is automated or provided by third parties.

The beneficiary does not have to complete a claim form: she or he notifies AIC in person or by telephone, and the AIC claims agent receives the information verbally and enters the claim directly online into AIC's claim system. The system generates a unique claim number and a declaration form, which the beneficiary must sign using an electronic tablet at the nearest branch office.

The funeral home checks the identity of the deceased using his or her insurance card and confirms eligibility for benefits with AIC. The AIC claims agent has access to an online, integrated system that includes enrolment and premium data, so that approval for funeral benefits can be provided in real time.

The beneficiary must provide a copy of one of four approved forms of government-issued identification, and must also sign a document to confirm that funeral services were provided. The funeral home collects all the documents and submits them to the insurance company for reimbursement.

4. Pay attention to turn-around-time (TAT)

The need for fast access to funds or insurance benefits is often highlighted as a distinguishing characteristic of the low-income market, recognizing that this population frequently has limited savings or other financial resources to turn to in the period immediately following a loss. In order to alleviate this financial burden many microinsurance programmes provide cashless or in-kind benefits, although non-cash benefits come with their own complications and trade-offs. From the client's point of view, it is not the internal claim processing speed that matters as much as the total time elapsed from loss to payment. Monitoring the total claim TAT, from date of loss to receipt of benefit, can help to improve client satisfaction with the claims process.

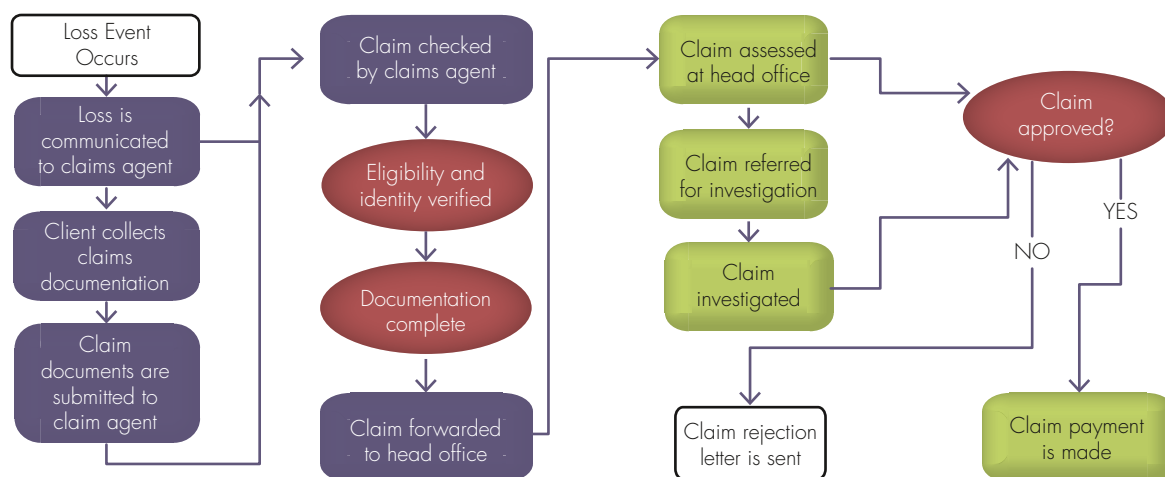
In terms of client value, client satisfaction with settlement time also depends as much or more on client expectations as on absolute measures of TAT. This includes the client's experience with other forms of insurance, whether formal or informal. For example, in South Africa, services provided by burial societies typically include fast TAT in order to meet the need for a funeral. Any insurance product needs to meet or exceed expectations arising from this standard. It is important, therefore, for microinsurers to evaluate the financial impact on clients of claims TAT reflecting local circumstances and expectations, and to collect adequate feedback on client satisfaction as a way of improving claim practices.

5. Implement efficient internal procedures and streamline workflow

Internal procedures refer to the insurer's procedures to process and pay a claim once notification has been received. Workflow analysis evaluates not each step in the process, but the movement from one step to the next. In addition to considerations such as efficiency, accuracy and speed, internal procedures and workflow should be designed to ensure traceability and accountability for claims transactions, especially in environments where compliance with client protection regulations is monitored.

Workflow analysis is less about the technology that is used, than about how the process fits together. For example, claims data may need to be reviewed by different people during the process: an agent who receives the claim from the client, a claims officer who enters the data into a system, a claims assessor who evaluates the claim for validity and determines the benefits payable, a manager who approves the claim, etc. As the number of reviews rises, the complexity of the process increases, and often, settlement times grow longer. If data are transferred manually, or entered into different systems more than once along the way, the potential for errors increases, and again, TAT suffers. Workflow analysis and process maps can help to identify areas where standardization may improve operations (see Figure 2).

FIGURE 2. Illustrative claims workflow





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Updating processes is necessary as the programme evolves or as claims volumes increase. Standard processes and claims coding, as well as a claims decision hierarchy, are especially important considerations for products that generate high volumes of complex claims. Claims decision flowcharts or assessment protocols are also useful tools for streamlining the process, as well as for improving the consistency of results. Automated processes for low-risk claims are also an option.

6. Remember that a loss event is a difficult time for the client

Uncertainty about the timing and amount of the benefit may cause more anxiety than the settlement time itself. Transparency, in this context, is vital; it means that claims activities are conducted in an open way so that stakeholders, including clients, can be confident that procedures are fair and honest. Focused client communications, via local branches, call centres, online claims applications, and including mechanisms for resolving complaints and disputes can be incorporated to enhance the transparency of claims processes.

It is also important to make sure that benefits are provided in a convenient form. In many cases, logistical challenges, such as remote locations, lack of bank accounts and technology limitations, may necessitate alternative arrangements to ensure that the benefit reaches the beneficiary in a reasonable

amount of time. Providers need to appropriately balance meeting client needs with existing limitations. Options for claim payments include cheques issued to the beneficiary, electronic fund transfer to a beneficiary's bank account, mobile phone transfers, and payments in cash or in-kind through a third party, among others.

7. Maintain control over data and processes

A key component of claims management is the collection of claims data. For a microinsurance provider, the most immediate requirement is to ensure that sufficient data are collected during the claims submission process to evaluate and pay the claim. This may include ensuring that the enrolment data are not only sufficient, but are easily available at the time of claim. If the benefit is provided on a cashless basis, then required information needs to be collected and/or verified at the time the service is provided, and be in a format suitable for transmission from the service provider to the insurer. Similarly, if the benefit design includes annual or lifetime limits, then previous claims history needs to be available.

In addition to the data needs for claims processing, it is important to consider the value that good data collection can add to the microinsurance programme as a whole. Detailed historical claims data are essential to evaluate trends in the underlying claims drivers, including utilization and unit claim costs, and to improve the product design. Microinsurance

providers should capture and digitize claims data in a way that is easy for analysis and reporting of key performance indicators such as claims ratio, as well as for data mining.

Evaluating process data, such as claims settlement times, or other workflow productivity measures pertinent to claims management is equally important in order to improve efficiency and manage growth. External assistance provided by objective experts can be invaluable to evaluate and improve the claims process.

A good information technology system improves data collection and analysis. A well-designed system can serve to collect and integrate enrolment and claims data, which can be leveraged for better analysis of the programme as a whole. These benefits are further multiplied if third party partners are involved. However, the development and implementation of new technology can be complicated by challenges along the way. Given limited resources, microinsurance providers need to perform a careful and thorough cost-benefit analysis prior to making the investment.

8. Balance business and client perspectives, present and future

The case studies illustrate various trade-offs between client value and business viability such as balancing transparency with TAT; fraud control with simplified documentation requirements; and accessibility of services with the costs of maintaining a local presence. Technology solutions are often considered when evaluating trade-offs; more and better use of technology may improve results, but investments in

technology are costly. There is no single or perfect solution to balance the business perspective and the client value perspective. A microinsurance provider must decide how to achieve the best results, considering factors such as the programme design, and the regulations in effect.

The time frame for which results are measured matters, as neither costs nor benefits are static; investments in process improvements today may pay off significantly in the future. However, even if eventually investments translate into business viability, it is important to define expectations and estimate implementation and operating costs of options before choosing an approach.

CONCLUSION

The eight guiding principles noted above can support microinsurance providers to improve claims management, with benefits for both the scheme and clients. Using a community-based approach insurers can leverage social networks to improve TAT and the visibility of the claims process. Simplicity of product design, document requirements and internal procedures, as well as transparency of the claims process can improve overall performance. Innovative technologies can help, but their costs and benefits must be carefully evaluated.

Claims are the moment of truth in insurance. While many microinsurance providers are working hard to improve implement better practices and improve their results, there is clearly scope to do more.

Housed at the International Labour Organization's Social Finance Programme, the **Microinsurance Innovation Facility** seeks to increase the availability of quality insurance for the developing world's low income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with generous support from the [Bill & Melinda Gates Foundation](#) to learn and promote how to extend better insurance to the working poor. Additional funding has gratefully been received from [several donors](#), including the [Z Zurich Foundation](#) and [AusAID](#). See more at www.ilo.org/microinsurance



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