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Challenges Facing Private Medical Insurers in Claims Management: A Case of Nakuru Town

Tari Justus

Faculty of Commerce, Egerton University, Nakuru, Kenya

Abstract: **The general objective of the study was be to assess the challenges facing private medical Insurers in claims management in Nakuru town. The specific objectives were to determine the challenges facing in-patient and out-patient claims management. The study adopted a descriptive survey research design with data collected through the use of a structured questionnaire. Questions were closed ended. The data collected was arranged systematically and coded to facilitate analysis. The data was analyzed using descriptive statistics, particularly means. The main challenge facing outpatient medical insurance was falsification by medical insurance providers and fraud by members covered. For in-patient, the main challenge was falsification by service providers in relation to exaggerated billing and periods of admission longer than would be necessary.**

Keywords: **Private medical insurers, Medical insurance providers, Out-patient cover, In-patient cover.**

I. INTRODUCTION

Medical insurance is a type of insurance that covers medical expenses that are incurred by the principal member and named dependants. The cover offered by the insurance companies differs in scope, limits of coverage and the options for treatment available. Many developing countries have private medical insurance markets which are serving their middle class and also affording some degree of financial protection for the poor, particularly those that are more commonly characterized as community health insurance schemes. Developed countries use supplementary private insurance to fill gaps in their publicly funded systems offered by governments and pay for increasing health services demand, (Edebalk et.al, 1999). In Africa, private medical insurance markets continue to grow due to limited state funded schemes.

Medical insurance is an institutional and financial mechanism that helps households and private individuals to set aside financial resources to meet costs of medical care in event of illness (Kraushaar, 1994). In Kenya, there are 51 licensed insurance companies with 19 licensed to transact medical insurance products (AKI, 2016). Medical claims management is the organization, billing, filing, updating and possessing of medical claims related to patient diagnosis, treatment and medications. The medical claims management process has to strike a balance between customer expectations and maintaining cost efficiency. The customer's expectation is service without any delay, while claims manager's is to ascertain whether the claim is payable, and if so, the amount. Reliance on medical service providers may lead to a mismatch of expectations resulting to slow turnaround time and complaints from customers.

Though medical insurance is very vital to Kenya's economic development, insurers face many challenges in claims management. This class of business has been performing poorly in Kenya, registering the highest losses with loss ratios of 74.0 per cent, 80.4 per cent, 81.5 and 83.5per cent in 2008, 2009 2010 and 2011 respectively (AKI report, 2011). As per AKI (2016), only seven out of the 19 private medical insurance companies in Kenya made an underwriting profit in 2016. This class has the highest loss ratio in the industry of 83.5% with net earned premiums reaching Ksh 23,914,904,610 and net incurred claims of Ksh 17,935,754,894. The trend had been consistent for the last five years. This threatens the solvency of the insurance companies with possibility of some companies going into statutory management. While some

studies have been carried out on medical insurance companies' performance in Kenya, none has been done on the challenges facing medical insurers in claims management in Nakuru town. The sought to address this knowledge gap as well as add to the existing body of knowledge in this discipline. The general objective of the study was be to assess the challenges facing private medical Insurers in claims management in Nakuru town, with the specific objectives being to determine the challenges facing in-patient and out-patient claims management.

II. LITERATURE REVIEW

Theories relevant to the research were reviewed. The first was the neo-classical welfare economic theory, which postulates that individuals make choices to maximize their preferences over time, and the goal of society is to maximize social welfare, or aggregate preferences. It assumes that individuals make rational choices based on cost-benefit calculations under varying conditions. Neo-classical theory predicts that consumers will insure against catastrophic medical events and cover lower-cost services themselves; in reality consumers typically choose policies with low deductibles and co-payments. This approach asserts that the free market is the best way to allocate resources, as it values efficiency over equity. Risk-averse individuals are predicted to choose insurance against large risks, leaving smaller risks uncovered, thereby improving their overall welfare. As stated above, however, in empirical studies, individuals find it difficult to make such choices. Health insurance markets are also not entirely free. Insurance companies have an information advantage, which they can use to 'cherry pick', both the kinds of consumers they insure and the kinds of coverage they offer them, in order to increase their profits. In consequence, more comprehensive coverage tends to be confined to wealthier individuals, reducing the pooling of risk across the population. Conversely, poorer individuals often fail to choose coverage that meets their health needs (Ruger 2007).

The second theory is the expected utility which emphasizes the mathematical equivalence between Nyman (2003) model and expected utility theory, it objects risk aversion as the basis for buying insurance. Nyman explores briefly into prospect theory, where the consumer's value function is assumed to be concave over gains and convex over losses. Framing the consumer's decision in terms of losses, that is, comparing the sure payment of an insurance premium to the uncertain expense of medical bills, Nyman (2003) concludes, 'insurance should not be purchased according to this specification." In addition, it is observed that the consumer's decision is a choice between two gains, and reconciles the purchase of insurance with the concave portion of the value function; but this seems to show that it is the concavity of the objective function (that is risk aversion) rather than prospect theory per se that drives the purchase of insurance. The concept of risk aversion need not be limited to wealth fluctuations, however, and the access motive may even be viewed as a reflection of the consumer's aversion to health risks. If the consumer knew with certainty that they would never need medical treatment, the consumer would presumably not be willing to pay for health insurance. It is the risk of becoming ill at an uncertain time and with unpredictable severity and duration that prompts a desire for access to medical care. More so, claims processing procedures also affect the purchasing level of medical insurance products. Especially, the delays in meeting claims obligations by medical insurers, contribute highly to their unwillingness to purchase medical cover.

Outpatient care is medical care provided on none admission basis including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of the hospital (Osler, 2011). Settling of outpatient claims by medical insurers may be subject to fraud. A claim is said to be fraudulent if its settling process relies on false statements of facts either intentional, unintentional or which may be as a result of not taking prudent care. The insurer has a right to decline a claim if fraud is proved as it amounts to breach of one of the basic principles of insurance, the principle of Utmost Good Faith (Bennett, 1992). Wedge and Handley (2003) note that fraud can take a variety of forms, including the inflation of a genuine claim, creating an entirely fictitious event, and causing deliberate as opposed to uncertain diagnosis. The main motive of fraud is financial gain. Medical insurance companies have had to undergo very tough times and incur huge payouts in medical claims, some of which have proved to be fraudulent. This forced medical insurance companies to rethink the way they handle medical claims (Karau, 2008). Fraud is perpetrated by a cartel of crooks, through non-existent or exaggerated claims. Fraud has been cited as one of the causes of the collapse insurance companies in the last decade (Wahome, 2010). As much as genuine customers need to be paid promptly, the claims must be separated from the fraudulent ones through investigations, which is time consuming and a major cause of customer dissatisfaction. If a fraudulent claim is paid, the insurer loses

money to fraudsters. The insurer may resort to increasing premiums, which affects both the good and bad customers. In addition, if a fraudster gets away with it, there is temptation to continue this practice in the future (Roff, 2004).

In a service industry such as insurance, contact employees are the face of the organization, and can directly influence customer satisfaction (Zeithaml&Bitner, 2003). Employees in the claims department are in close contact with the customer and intermediary from the time a claim is reported, throughout its processing, until it is eventually settled or rejected. The difference between one service supplier and another often lies in the attitude and skills of their employees (Lovelock &Wirtz, 2007). Further, the best defence against claim fraud is well-trained claims staff. As Brown (1997) observed the process of uncovering and battling fraud begins in the claims Department. It is the responsibility of the claims manager to recruit, train and retain intelligent and competent staff. Delegation of responsibilities within the department should be in a way where a substantial proportion of claim advice does not have to be referred to the claims manager but decisions with serious ramifications on the business should not be left to inexperienced or incompetent staff (Wedge & Handley, 2003). However, due to various factors, some of which are not within the manager's control, claims staff leave employment and have to be replaced. Whereas direct costs associated with loss and replacement of employees is measurable, there are also indirect costs associated with loss of employees, including loss in customer service and customer satisfaction. The company also suffers loss of specific job skills and disruption of service (Mwangi, 2008). If the insurance company is not an attractive employer, retention of competent and qualified staff may be a major challenge. Medical insurers mostly rely on medical practitioners and medical institutions to ascertain whether to pay a medical claim, and if so the amount of compensation. Whereas some medical insurers employ full time employees to perform these functions, others outsource the function to independent service providers. Insurers expect their service providers to adhere to the set customer service benchmarks, while at the same time exercising a high level of integrity. In addition, they are expected to assist the insurer reduce claim costs. Usually, this may not happen, either due to lack of the necessary skills to perform the task assigned or due to lack of integrity. The external service provider may also not attach as much importance to customer retention as the insurer and as a result, service to the customer may be compromised.

In-patient cover is the insurance of patients whose condition requires admission to a hospital. Progress in modern medicine and the advent of comprehensive out-patient clinics ensure that patients are only admitted to a hospital when they are extremely or have severe physical trauma (Wachter, 1996). Monitoring admission rates and diagnosis statistics of individual inpatient service providers proves to be a great challenge to medical insurers. Inpatient services are usually characterized by high medical expenses and as a result they lay heavy financial burden to medical insurers. Cash flow management is important. The statement of cash flows reporting a company's cash inflows and outflows for a period, provides a company's ability to generate cash from operations, maintain and expand its operating capacity, meet its financial obligations and pay dividends (Reeve et al, 2009). For a medical insurance company, cash inflows include premium, investment income, capital injections, policy excess, and reinsurance recoveries while cash outflows include claim payouts, costs, investments made in securities and bonds, distribution payments to owners and creditors of the insurer, tax to the government and payment of reinsurance premiums.

A company may experience cash flow constraints due to various reasons; including outstanding premiums, competing priorities, failure or delay of reinsurers to pay their share of claims, huge claims among others. Claims payment usually takes the largest percentage of a company's payment and is the one most affected when a company has cash flow constraints. Therefore, if a company has cash flow constraints, the item likely to be affected most is claims payments. Failure or delay in meeting financial obligations when they fall due may negatively affect a company's reputation. Further, the Insurance Act Cap 487 stipulates that where the claimant has submitted all required documents, and the insurer has admitted liability, the claimant must be paid within ninety (90) days of the date of reporting the claim, or if liability is determined by court, within ninety (90) days of such determination (Insurance Act, Cap 487). Failure to comply leads to a penalty being imposed. Inability to pay claims and accrued interest are among grounds that can be used to petition the courts to wind up an insurance company.

Underwriting is the process of evaluating a proposal that comes for insurance and making a decision of whether to accept the proposal or not and if the proposal is accepted, at what price and on what terms, conditions and scope of cover (Brown, 1997). The underwriter also has a responsibility to ensure that there is no adverse selection against the insurer, and that the proposer is not a moral hazard. The underwriter must ensure that the premium charged is commensurate with the risk exposure. To a large extent, the quality of underwriting has a bearing on claims eventually made as well as detection of

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moral hazard proposers and adverse selection. Such proposers lodge claims which would have been avoided if they were detected at the underwriting stage. Unissued policy documents pose a major challenge to a claims handler. The insured feels unjustly treated, if the claims manager relies on breach of a policy condition to decline a claim. Other challenges include wrongly worded policy documents, incomplete or no proposal forms, agents completing proposal forms on behalf of the insured among others. The claims manager ends up paying claims which would otherwise not have been paid if proper underwriting was done. The underwriting standards in Kenya's insurance companies have been wanting, in that most companies do not adhere to internationally accepted underwriting standards. As a result, underwriters underestimate the level of risk, and charge premium which is less than the risk exposure (Karau, 2008). When the level of claims exceed premiums received, the insurance company is unable to meet its obligation to policyholders, and this may result to insolvency.

III. RESEARCH METHODOLOGY AND DATA ANALYSIS

The research adopted a descriptive survey research design with the population of interest being all medical insurers in Nakuru. The total population was nineteen medical insurers with questionnaires administered to heads of claims. Since the population was small, a census was be used. Primary data was collected by use of structured questionnaires. Data was collected, edited to ensure completeness and accuracy and analysed using descriptive statistics.

Data was analyzed with the aid of Statistical Package for the Social Sciences (SPSS) and findings presented in form of tables. Interpretation was done using descriptive tools such as the frequencies and percentages as well as measure of central tendencies. The respondents were heads of claims or their assistants in their absence. Out of the nineteen medical insurance companies, sixteen responded positively, by completing the questionnaires and returning in time, making the response rate to be 84 percent. This was considered satisfactory, as according to Mugenda and Mugenda (1999), a response rate of 50 percent or more is sufficient for statistical analysis.

Demographic dimensions based on the position of respondents in their respective organizations were captured, like the number of years of experience in the position as well as their departments. These were important to determine the respondents experience, capacity and knowledge in medical insurance. From the findings, 70 percent of respondents were claims heads and their assistants were 30 percent. Hence the majority of respondents were those heading the departments. On the average working experience of the respondents, 76 percent had more than ten years while 24 percent had less than ten years. Hence the majority of respondents had good experience in medical insurance claims management. In terms of the highest level of academic qualification, 90 percent had university degree with a paltry 10 percent without university degree level. The majority had the required academic qualifications in tandem with the requirements of their work.

The first objective of the study was to assess the out-patient challenges facing private medical insurance claims management. A 5-point likert scale was used to rank the challenges to out-patient private medical insurance, where responses with 'very frequently' were coded 5, 'frequently' coded 4 and 'sometimes' coded 3, 'rarely' coded 2 while 'never' was coded 1. Table 3.1 below presents the results of the challenges in outpatient medical insurance claims management.

Table 3.1: Challenges in out-patient medical claims management

	N	Mean
Falsification by medical service providers	16	4.8
Fraud by members covered	16	3.8
Incompetence of claims personnel	16	1.4

From table 3.1, falsification by medical service providers had a mean of 4.8, fraud by members covered 3.8 and incompetence of claims personnel had 1.4. The majority of respondents indicated falsification by medical service providers to be the main challenge, followed by fraud by members covered and incompetence of claims personnel was the least challenge. This was consistent with the literature reviewed which indicated that moral hazard on the part of medical service providers was a big challenge. Table 3.2 below presents the in-patient medical claims management challenges.

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Table 3.2 Challenges faced by in-patient medical claims management

	N	Mean
Falsification by medical service providers		4.9
Exaggeration of medical costs	16	4.2
Fraud by members covered	16	3.0
Incompetence of claims personnel	16	1.6

From table 3.2, falsification by medical service providers had a mean of 4.9, exaggeration of medical costs 4.2, fraud by members covered 3.0 and incompetence of claims personnel 1.6. Thus, the majority of respondents reported falsification and exaggeration of medical by medical providers as the main challenges, this was followed by fraud of members covered and incompetence of claims personnel as the least challenge. This is consistent with literature reviewed which showed that moral hazard from medical service providers was the biggest challenge in medical claims management.

In addition, there were challenges of prompt payment to service providers who are quick in suspending cover, thus not allowing room for any scrutiny of the claims submitted. Private medical insurers are often faced with the dilemma of quick settlement of claims at the expense of validation of the same. The exclusion of pre-existing conditions in most medical policies also leads to dissatisfaction by members where they are denied cover or have to foot the medical bills themselves when they seek treatment.

IV. CONCLUSION

The first objective of the study was to assess the challenges facing out-patient private medical insurance claims management. The main challenge is falsification by medical insurance service providers, this not only includes exaggerated billing but also providing treatment under the card to non-covered members. While many medical insurers have attempted to address this through employment of medical personnel to validate treatment and use of biometric identification, cases of leakage are still reported. Fraud by members covered was also evident but takes collusion between the member and the medical service provider. Largely many private medical underwriters employed qualified personnel but the urgency in claims settlement as well as threats to suspend cover by the medical providers in case of delayed settlement, leaves them with little room for scrutiny. The insurers should work closely with the providers association like the Kenya Medical Association among others in harmonizing fees as well as standard practice. Also the regulatory bodies should play an active role in monitoring and checking any unprofessional practices by the service providers to ensure full compliance with the law and professional ethics.

The second objective was to establish the challenges facing in-patient private medical insurance claims management. The main challenge remained falsification by medical insurance service providers. This included, some outpatient cases being billed as in-patient to escape the low limits under outpatient, longer periods of admission than what is required and in some cases undertaking surgical procedures that are not medically essential. Just like with outpatient, the urgency in settlement of claims as well as threats of suspension of cover by providers negates any validation from the insurance companies. Employment of qualified staff in medicine, frequent surveillance of admitted cases and delisting some of the providers involved in fraud are some of the interventions adopted but with very little success. The future would require a joint effort between the insurers and associations as well as professional bodies for the providers in coming up with sustainable long term solutions. This is necessary since medical insurance continues to report poor loss ratios consistently over the years with the resultant exposure to insolvency and eventual collapse of insurers.

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