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**THE ROLE OF LOSS ADJUSTMENT PRACTICES ON THE PERFORMANCE OF  
INSURANCE SECTOR**

Dr. Ben Kajwang PhD



## THE ROLE OF LOSS ADJUSTMENT PRACTICES ON THE PERFORMANCE OF INSURANCE SECTOR

Dr. Ben Kajwang PhD, ACII(UK), AIRM(UK), FIIU, FIIK, CPT, Chartered Insurer  
Chief Executive Officer, College of Insurance, Nairobi, Kenya  
Corresponding Author Email: [bkajwang@coi.ac.ke](mailto:bkajwang@coi.ac.ke)

### Abstract

**Purpose:** The purpose of this study was to determine the role of loss adjustment practices on the performance of insurance sector

**Methodology:** A desktop literature review was used for this purpose. , a systematic search was carried out using Google Scholar, Semantic Scholar, and Research Gate. The study included relevant sources that were published between 2015 and 2022.

**Findings:** It was found that sound loss adjustment practices are a prerequisite for optimal financial and non-financial performance of insurance firms. It was concluded that having a clear policy approved by senior management, with regards to ex-gratia claim payments reduced the financial risks. It was also concluded that insurance firms can enhance their financial performance by regularly reviewing their claims handling guidelines to factor in new developments and trends. The study further concluded that non-financial and financial performance of insurance firms in influenced by quality reviews of claims to assess whether they are handled professionally and resolved appropriately. One of the performance measures could be the number and nature of complaints against the insurer with respect to their claims settlement decisions. The performance is also influenced by monitoring the level of claims which should not have been paid or are overpaid and the severity of delays in claims registration and case reserves revision.

**Unique Contribution to Theory, Practice and Policy:** Based on the study findings, it was recommended that insurance firms should endeavor to set case reserves accurately for each claim in a timely manner, especially in respect of general insurance business. The components of case reserves should also be captured in sufficient details to provide useful statistics for in-depth analysis. For example, a single claim file could have separate components for own property damage, third party liabilities and fees payable to external parties. Another recommendation is that the insurer should have a clear policy, approved by senior management, with regards to ex-gratia claim payments. The authority to approve such payments should also be clearly specified and the rationale for the approval should be properly documented.

**Keywords:** *role, loss adjustment practices, performance, claims, insurance*



## INTRODUCTION

The insurance sector plays an important role in service economy of any country by underwriting of risks inherent in most sectors thus providing a sense of peace to most economic entities (Shaheen, Ağa, Rjoub, & Abualrub, 2020). Insurance companies are important in the role they play as they contribute to efficient resource allocation through management of risks in almost all sectors of any economy. Underwriting of these risks lessens the burden and creates stability for most entities enabling them concentrate in their core activities thus contributing to economic development (Sandada, Manzanga & Shamhuyenhantzva, 2017). In order to meet their obligations, insurers must have in place a prompt and efficient claims management (Nebo & Okolo, 2016). Good performance of the insurance sector therefore contributes to the overall prosperity of an economy. Performance of general insurance companies is expected to be related to various factors, including optimal underwriting and prompt and efficient claims management functions. Underwriting involves risk measurement and evaluation leading to determination of the commensurate cost to cover that risk (Boodhun & Jayabalan, 2018) while an insurance claim consist of a benefit paid to the insured person for a loss that may be covered under the insurance contract (Prajapati & Rane, 2018). The claims management phase gives an opportune moment for delivery by the insurers and to favourably impress the policyholder and enhance their reputation for better performance (Bates & Atkins, 2017).

Loss adjustment is the process of settling or denying a claim is called a claim settlement or a loss adjustment (Boodhun & Jayabalan, 2018). A claim on an insurance policy is a demand on an insurer to fulfill its portion of the promise, committed to while writing the contract with the insured (Jacob, 2017). Insurance claims range from straightforward domestic building and contents claims that are settled within days of notification to complex bodily injury claims that remain open for many years (Yusuf & Dansu, 2020). The loss that is insured against is referred to as the insured risk. However, an insurance company will not just pay money to the insured because of a filed claim. Otherwise, they could lose money through fraud or exaggerated claims. When presented with a claim, the insurance company either pays the claim or denies it. Most claims are paid, but a few will be denied for cogent reasons: either because the loss did not occur or because it is not covered by the policy (Ross, 2017). A loss may not be covered because it was excluded, the policy lapsed, the loss was not within the scope of the insurance agreement, or the insured violated a policy condition. There are four main steps in processing a claim, which may vary, considering the class of insurance: notice of loss, investigation, proof of loss, and payment or denial of the claim.

The primary duties of the insured under the insurance contract are to pay the agreed premium and to comply with the terms of the policy while the insurer must comply with his terms and promises under the policy and to pay or settle all genuine claims promptly and equitably (Brooks, Popow, & Hoopes, 2015). A well manageable claim strengthens customer relationships amidst all odds, assists in regulatory compliance and fraud prevention and detection (Jacob, 2017). However, claims management is essential to an insurer's success. Hence, insurers have special people that investigate claimed losses (Capgemini, 2019). For life insurance companies, they are called claim



representatives or benefit representatives. In other classes of insurance, they are called claims adjusters, claims auditors, loss adjusters, or just adjusters (Brooks et al., 2015). Today, it is a common practice that the first person the insured meets after suffering a loss is the adjuster who makes the claims process flow smoothly for the parties (Akintayo, 2018).

However, losses may occur in places where it is not economically feasible for either the insurance company or an adjustment bureau to investigate. In such cases, an independent adjuster will be hired to investigate the loss. Independent adjusters bill the insurance companies for each loss adjustment (Brooks et al., 2015). When a lot of money is at stake, the insured, may hire a public adjuster, who is usually paid a percentage of the settlement, usually 10% reached with the insurance company. Public adjusters are used when claims are complex or to settle a dispute with the insurance company over the claim amount. According to Kim, Ha, Ahn, Son, and Son, (2020). The public adjuster investigates and quantifies the loss and presents evidence of that loss to the insurance company, negotiating with the insurance company to maximize payment to the insured. This will also maximize the public adjuster's own compensation, if it is based on a contingent fee.

Nowadays, most adjustment bureaus are independent companies that simply sell their services to insurance companies. Adjustment bureaus are also used when a large number of claims are filed at the same time, such as after a flood, hurricane, or earthquake (Kim et al., 2020). In geographic areas where insurance companies have many claims, loss adjusters are usually employees but where fewer claims exist, the insurers use an independent adjuster or an adjustment bureau to administer investigations to minimize cost and ensure efficiency in delivery. Note that employees of adjustment bureaus work as agents of the insurance companies that hired them, and as such, represent their interests. The National Association of Public Insurance Adjusters provides certifications that public adjusters can use to market their services. As stated by Albert (2017), thorough examination must be passed to obtain either of these certifications, to give businesses looking for a public adjuster some confidence in selecting a competent individual.

Performance is a measure of a firm's actual output or results compared to its expected outputs. It is therefore tied to the firm's general health throughout time and can be seen from several angles (Taouab & Issor, 2019). Financial performance (FP), which is measured by ratios like return on investment, return on sales, return on assets, and return on equity, is one of the indicators. Another is profit margin (Almajali, 2017; Ross et al., 2019). The surplus of revenues over costs incurred in underwriting the firm, which is how an insurer determines its profitability, is a component of total financial management, which helps to increase owner wealth to some extent (Chaudhuri, Kumbhakar & Sundaram, 2016). Non-financial metrics, some of which may be challenging to define, include operational performance, efficiency, and overall effectiveness, including increased market share, quality of service, innovation, and reputation, which help to provide greater overall performance in contrast to rivals (Lewin & Minton, 2018).

## **LITERATURE REVIEW**

According a study by Franke (2017) in Sweden, loss adjustment practice is most important in property insurance, where losses are usually partial and the amount may be hard to determine.



Payments are often paid from insurance reserves, which may have a significant negative impact on insurers' capital structures and profitability margin, therefore the proposed claims are extremely probabilistic and need a great lot of deliberation and creativity. Actuarially, insurance companies often estimate and compare their claim settlements (i.e., 5% or 8%) to the level of net premium (i.e., 95% or 92%) because the latter sets the inflows (i.e., reserves and other profits) and is anticipated to be well monitored (Brooks et al., 2015). However, the purpose of claim adjustment is to confirm the loss for which coverage is offered by the policy and guarantee fast and equitable payment. On rare occasions, the adjuster helps the insured directly. Damage adjusters are required to submit investigations in order to stop fraud and decrease inflated claims—basically, to confirm the size of the loss. Payment must be fair and made on time because that is what insurance is for. People wouldn't purchase insurance if insurance firms could avoid the majority of payments since they could never be certain that they would be reimbursed (Iqbal, Rehman, & Shahzad, 2020).

A research in India by Blong, Tillyard, and Attard (2017) showed that loss adjustment practices play a key role in investigating the existence of a loss covered by the policy, whether policy conditions were met both before and after the loss event, and the quantum of loss. A loss will only be covered by a policy if it happened within the policy term, was brought on by a covered risk, and complies with all other insurance contract requirements. If the insurance was recently acquired or expired, it will be crucial to know if the policy was in force when the loss happened. The policyholder may also be required to provide a proof of loss, which is a sworn declaration that the loss happened, the circumstances of the loss, if any other insurance covered the loss, and the amount of loss, within a certain amount of time by the loss adjusters (Yusuf, Ajemunigbohun, & Alli, 2017). State regulators will occasionally require insurance company adjusters to provide a list of all claimants prior to a specific date following a significant disaster. The deadline may compel some claimants to provide a preliminary estimate if there are a large number of applications. Loss adjusters schedule a second visit if the initial examination is incomplete.

Another study by Karami and Pendergraft (2018) showed that loss adjustment practices improve the policyholder's customer experience. Customer service is, in fact, a key component of insurance adjusting. Every time an adjuster interacts with a policyholder, they influence how that person feels about their insurance provider and the overall insurance business. The insurer employs the adjusters to assist the insured in demonstrating their loss in order to give the finest service possible and to behave in good faith toward its insured (Ostrager, 2020). At the initial meeting, the adjuster should ask the insured to sign a non-waiver agreement if a study of the loss notification and the policy wording points to a potential issue with coverage. The parties to the policy agree in a non-waiver agreement that none of their rights or responsibilities will be waived as a result of the examination of the claim. If the insured declines, the adjuster ought to send the insurer a reserve of rights letter on the same day, giving it the same protection. The adjuster shall inform the insured of their need to give a sworn statement as evidence of loss within 60 days of the loss or within 60 days of the request for a proof of loss if there is any doubt about coverage (Levin et al., 2019) The loss adjuster should state that if more time is needed, both he or she and the insurer, whom he or she represents, will offer the insured any reasonable extension of time. All of this fundamental



behavior is necessary to uphold the duty to treat an insured with the highest good faith. In order to constantly operate in good faith, the adjuster must refrain from taking any actions or failing to take any actions that might deprive the insured of the benefits of the insurance policy, according to Levin et al. (2019).

A study by Doherty, Tinic, and Seha (2016) in Canada stated that loss adjustment practices plays a key role in determining the liability of the insurance company and the amount of the payment. In some circumstances, the claims committee determines the quantum after the adjusters have evaluated the insurers' responsibilities, depending on the situation (Doherty et al., 2016). Additionally, the insurance companies frequently grant draft power to agents, enabling them to make payments up to a certain amount in order to expedite, reduce adjustment costs, and improve the policyholder's goodwill (Putra, & Dharma 2017). In order to maintain a competitive price for its insurance, an insurer must balance the needs of its clients with the need to limit payouts for claims. Furthermore, equitable remuneration are often required by state regulations. A process for settling a payment dispute may be specified in the insurance contract. For instance, a home owner's insurance policy may stipulate that the property be subject to separate evaluations by the policyholder and the insurer. The appraisers may choose an umpire to decide which assessment is the most accurate if the differences between them are significant (Kim, 2015). An umpire will be chosen by the court if the parties are unable to agree on one. There are various choices available to a client who is displeased with an insurance settlement. The insured may file an appeal with the state insurance department if the claim is denied because the loss event was determined to be exempt from coverage under the policy. If the settlement is judged ineffective, the insured must challenge the amount in court or, if required by the insurance policy, arbitration. The insured may also use the forms on the state insurance department's website to submit a complaint (Iqbal et al., 2020).

A research in Germany by McMillan and Lowhurst (2017) indicated that loss adjustment practices increases or reduces customer retention. Each month, a policyholder pays an insurance premium in exchange for the chance to be made whole again or, in certain situations, as near to whole as their insurance policy permits. Additionally, they are paying for the customer support and claim support that an adjuster offers when things go wrong. Additionally, insurance providers understand that paying claims promptly, fairly, and politely is a fantastic way to keep clients and maintain a competitive edge in the insurance industry (Bhatia & Bansal, 2018). Because of this, insurance firms employ specific personnel that look into reported losses. Because customer retention, customer happiness, and bad faith exposure matter, it is crucial for loss adjusters to offer a high level of customer care along with a ton of justice. Every insurer is aware of their own policyholder retention costs, thus everyone's satisfaction is important when discussing those expenses. When an insurer loses a policyholder, they lose more than just the premium; they also have to pay to find a replacement and deal with any reputational harm that results. Ideally, insurance companies want consumers to visit their neighbors and rave about how great their adjuster was (Isimoya & Olaniyan, 2020). Insurance companies want clients to mention how knowledgeable, kind, and professional the agent was. The goal of the insurance industry is to always build a relationship of



trust with their clients, which benefits everyone involved. A patient, calm, and empathetic adjuster is just what a policyholder needs when they have experienced a loss.

A study conducted by Adhikari (2021) in Nepal showed that loss adjustment practices have a direct relationship with insurance firm's public image. Verifying the loss and confirming that it was covered by the policy, paying the claim quickly and equitably, and, in certain situations, offering direct help to the insured are the goals of any loss adjustment. Investigations are required to stop fraud, lessen overstated claims, and ultimately to confirm the size of the loss. Payment must be fair and made on time because that is what insurance is for. People wouldn't purchase insurance if insurance firms could avoid the majority of payments since they could never be certain that they would be reimbursed (Huddleston, 2019). Because insurance plays a crucial role in every society, nations have laws that forbid unfair claim practices, such as: rejecting any claim without a thorough investigation; delaying payment when liability is obvious; and routinely underpaying claims, which forces many insured people to file lawsuits to recoup the underpayments. If an insurance provider consistently loses these underpayment actions, then is strong proof that the provider systematically underpays claims (Capgemini, 2019).

Another study conducted in Kenya by Angima (2017) showed that loss adjustment practices helps insurance companies in minimizing claims expenses. Insurance firms may incur the biggest financial burden from claims, thus no insurer can afford to play about with the claims handling process (Angima, 2017). Loss adjusters are employed by the insurer to manage claims effectively and take preventative or mitigating actions. Loss adjusters must comprehend the terms and circumstances of the contract between the insurer and the insured in order to do this. The adjuster must study and thoroughly examine a first-party property insurance policy in order to comprehend it. The specifics of each individual claim help to define and enliven the meaning of the policy contract and give the language of the policy new dimensions. According to Jerry (2019), the adjuster has to be aware of the coverage that the insured is eligible for, the liability limits, the territorial restrictions, and the exceptions, restrictions, and overlays that are attached. The loss adjuster's report assists the insurance company in confirming that the insured did what was necessary to minimize loss when the insured event happened before claims are paid. An insurance company's bottom line is significantly impacted by effective claims processing since it affects expenses, client acquisition, and retaining customers.

A research conducted in Russia by Doherty et al. (2016) indicated that loss adjustment practices directly affects insurer's profitability and persistent sustainability. The adjuster is required to inform the insured of their duties under the policy, such as the need to provide a sworn evidence of loss within 60 days of the date of the loss or, in accordance with the terms of the policy, as soon as possible. The sworn declaration of the insured that is needed by the terms of the insurance policy is referred to as a proof of loss. It includes information on encumbrances on the property, parties having an interest in the property, the value of the property, the amount of loss, and the amount of the claim, as well as the date, time, and cause of the loss, according to the insured's knowledge and belief (Ostrager, 2020). The main goal of a proof of loss is "to inform the insurance company of particular facts and circumstances relating to the loss, establishing the foundation for future action



to be taken by the business, ranging from complete settlement to ultimate repudiation of obligation." The adjuster should always request a sworn evidence of loss where fraud is suspected. By making the insured swear under oath, the adjuster assists the insurer in fending off a possibly fraudulent claim. If the proof of loss is falsely declared under oath, the insured forfeits all claim to any insurance benefits as well as the associated penalties for perjury. The claim should be swiftly reimbursed if the proof of loss provided is correct and there is no evidence to support fraud. Loss adjustment procedures increase insurers' profitability and long-term viability by assisting them in thwarting possibly fraudulent claims (Yusuf & Dansu, 2020).

According to a research by Afolabi (2018) on the performance of insurers and their claims administration processes, underwriting is done by grouping comparable risks for rating, and the resulting rates are then adjusted to account for the group's experience. Then, this is modified to account for inflation, uncertainty, and costs. Actuaries employ stochastic models, complex regression analysis, and data mining technologies to account for the frequency and severity of claims in order to adequately price the risk (Mahlow & Wagner, 2016). A significant amount of an insurer's expenses come from claim costs, and according to Barth and Eckles (2015), claim costs have a significant impact on an insurer's profitability. Claims also degrade earnings. Therefore, correctly assessed and fair claims administration practices that are in line with optimal underwriting policies play a key role in enhancing better performance of insurers.

According to a similar study conducted in Nigeria by Oyedokun and Gabriel (2018), there are a variety of factors that can have an impact on an insurer's total claims, including underestimating liabilities from unpaid (expired) past policies or underpricing current business, incorrect or inaccurate underwriting, incorrect or inaccurate assumptions about the frequency and severity of losses, or factors that are entirely out of the insurer's control. It's also possible that a large portion of the total written premiums are uncollectible and stay unpaid for a long time (Oyedokun et al., 2018). The ratio of claims to premiums (loss ratio) for a property and casualty insurance partly reflects underwriting outcomes, indicates the caliber of business covered, and is a crucial sign of the firm's pricing strategy's accuracy. Loss ratio is important to an insurer's primary claim management initiatives and is therefore crucial to the long-term financial success of the insurance company (Mahlow & Wagner, 2016).

According to Mwangi (2017), effective underwriting procedures are essential to an insurance company's profitability, including the best possible evaluation of risk exposures and the proper pricing of those exposures for coverage. The majority of businesses aim to accept the vast majority of risks at standard rates, but they nonetheless impose modified premiums for risks that don't fit normal norms that take into account loss experience and other considerations. Although cost-cutting through selective underwriting may boost profitability, market share may be lost to rivals (Eling, Jia & Schaper, 2022). Higher claim expenses brought on by lowering pricing and lowering underwriting requirements might result in declining/poor underwriting outcomes (Mwangi, 2017). The relationship between an insurer's underwriting strategy and claims management program is that if more of the insurance products are sold result in moral hazard, adverse selection, and high





outstanding premiums, this will result in high claims and have a negative impact on both the underwriting profit and the total net profit (Kaijage & Ogutu, 2017).

According to Njegomir (2018), claim expenditures make up the majority of an insurer's costs; as a result, insurers must treat their claim management responsibilities seriously. An efficient claims management program includes loss prevention via taking preventative action as a crucial component in lowering risks and as a crucial factor in profitability (Hashem, Mehany & Grigg, 2016). A strong claims management program should be proactive in handling legitimate claims, maximizing prospects for recovery through salvage, subrogation, and third parties, reporting on a regular basis, limiting needless costs, and lowering loss adjustment costs. It also includes handling claims expeditiously, reviewing of costs associated with litigation, and monitoring expenses and, future payments plans in order to reduce on disputes and delays so as to reduce the insurer's expense (Njegomir, 2018). Njegomir notes that claims management also involves giving good service to claimants, who should be treated courteously. This will result in higher customer satisfaction, retention and policy renewals that are fundamental to profit and better financial performance. Poor handling of claims may lead to lose of confidence by policyholders leading to damaged reputation and poor performance (Collie et al., 2019).

In India, a study by Benyoussef and Hemrit (2019) on optimal loss adjustment practices and insurance firm efficiency showed a positive relationship between the two variables. The study demonstrated that an accurate assessment of the reserves connected with each claim, which reflect liabilities and potential future financial responsibilities for the insurer, is necessary for optimum loss adjustment. An insurer is required to save a specific amount of reserves to protect itself against unearned premiums, both financially and legally. The necessary reserves increase in tandem with premium growth. Therefore, before it can calculate losses, the corporation must estimate its future payments, which includes an estimates of the payments for claims that have already occurred but have not yet been recorded (IBNR). This necessitates the growth and availability of expertise in loss reserving and claim prediction, as well as the creation of the best reinsurance plans possible to minimize the requirement for contingent increases in loss reserve.

Oyedokun and Gabriel (2018) suggests that for optimal financial prosperity, every insurer should have a sound strategy to manage risks arising from its core activities. According to Oyedokun et al. (2018), an insurer should first assess its risk tolerance, or the amount of risk that it is willing and able to take into account its operational goals and resources. The insurer should think about the current and anticipated economic and market circumstances and their influence on the risks inherent in its core activities when developing its risk management plan. The insurer should also take into account the knowledge that is available to meet its business objectives in particular market categories as well as its capacity to recognize, monitor, and manage the risks in those market sectors. Additionally, the insurance provider should think about the types of business it writes and the risks associated with concentration that might result in profit volatility (Mahlow & Wagner, 2016). Additionally, Mwangi (2017) adds that the insurer should reevaluate its risk management plan on a regular basis while taking into consideration its own financial performance and market changes. When the insurer's operations or business plan undergo significant changes,



the insurer should examine its risk management strategy and make the necessary adjustments to account for the new circumstances. The plan has to be adequately written and successfully shared with all concerned staff members. Proposed deviations from the agreed-upon approach should go through an approval procedure, and there should be processes and controls in place to catch illegal deviations (Mwangi, 2017).

Another research by Diacon, Starkey and O'Brien (2017) in Sweden showed a direct relationship between claims handling patterns and insurance firm financial performance. The researcher came to the conclusion that an insurance company's financial performance may be enhanced by having a clear procedure in place for the notification of claims by intermediaries or policyholders. The procedure should make sure that all claims are reported to the insurer as soon as possible and that pertinent data is timely entered into the insurer's information system. These rules are very important for general insurance companies. According to a related study conducted in Spain by Cummins and Rubio-Misas (2016), insurance companies that regularly review the claims form to ensure that the questions are still reasonably clear, unambiguous, and pertinent to allow the claims staff to make an accurate assessment of the claim's validity perform better and make more money. The researchers also discovered that insurance companies that update data gathered in relation to claims enable management to keep track of how the claim handling procedure is going and verify the accuracy of the claim settlement judgments. According to Cummins and Rubio-Misas, insurance companies should implement measures to identify the risks associated with subpar claims handling and case reserving, which may include making claim settlement decisions that are against the terms and conditions of the policy, thereby incurring liability that is not taken into account in the pricing or breaching its contract agreements to insureds. Poor claims handling could also involve inefficient handling of claims leading to slow responses or higher cost overheads, thereby impeding its market competitiveness. Ineffective claims processing may also result in sluggish replies or greater overhead costs, which would hurt a company's ability to compete in the market. Poor claims processing, according to Collie et al. (2019), also includes setting insufficient reserves, delaying modifying case reserves for reported claims, underestimating claim liabilities, and delaying adjusting premiums for new policies in the case of general business.

In another research, general insurance companies in Ghana were the subject. In order to adequately direct the claims employees, Akotey and Abor (2016) stated that superbly performing insurance organizations have well defined claims processing rules for each of the major categories of claims. The claims handling guidelines cover the paperwork needed to verify the claim, references to promises made or conditions put in place at acceptance (such as keeping the car in drivable condition for a motor policy and a payout cap, exclusions, and lien for life policy), a formula for determining the settlement amount, available settlement options, and rules for large or ex-gratia claims. When claims should be directed to the reinsurer or other parties, such as attorneys, for claims support or adjudication, well-performing insurance businesses have defined rules in place (Hashem, Mehany & Grigg, 2016). Additionally, the top-performing insurance companies periodically examine their policies for managing claims in order to take into account recent advancements and trends. In Morocco, Mouatassim and Ibenrissoul (2017) found that the



performance of insurance companies is positively impacted by having a clear control mechanism for the payment of significant claims, such as receiving an official sign-off from a member of the management team and the reinsurer. Additionally, Mouatassim and Ibenrissoul pointed out that the insurance companies' efforts to precisely and promptly create case reserves for each claim, particularly in regard to general insurance business, improve financial performance. Additionally, the elements of case reserves must be recorded in sufficient depth to produce helpful statistics for in-depth examination. A single claim file, for instance, can have distinct sections for own property damage, third-party obligations, and fees owed to outside parties (Akotey & Abor, 2016).

### **Theoretical framework**

#### **Ruin Theory**

The study was anchored on The Ruin Theory. The theory was developed by Lundberg (1932). Ruin theory, often referred to as collective risk theory, is a branch of actuarial science that employs mathematical models to show how vulnerable an insurer is to going bankrupt. The stability of an insurer is described by the ruin model. It addresses issues such as the premium rates to charge so that there are sufficient reserves to pay upcoming claims, the anticipated number of claims, their severity, and how frequently they will occur (Paulsen & Gjessing, 1997).

When a business's revenue, given its original riches, is insufficient to pay its bills, it is in ruin (Dickson, & Waters, 1995). Akotey and Abor (2016) assert that the majority of insurance firms want to turn a profit and prefer that their ruin probability be close to zero. To do this, they will consequently modify their models and take into account competition. By assuming specific assumptions and applying different methodologies from probability theory, the severity and frequency of claims are taken into consideration when modeling the risk in non-life insurance. Calculated claims totals are broken down into frequency and severity along with their mean and variation (which represent uncertainty). The insurer next chooses the appropriate premiums to charge, and attention then turns to the mathematical models' projections of the insurer's long-term bankruptcy vulnerability. The financial excess of the insurer may be tracked over time thanks to stochastic processes. Ruin theory is then used to determine how likely it is, given the model, that the insurer would go bankrupt (Biard, & Sausseureau, 2014).

If yearly premiums and the claim-generating process stay unaltered, the likelihood that this will ever occur is a strong indicator of how well the insurer's assets and obligations match. To prevent disaster, they may accomplish this by raising the premiums they charge, raising the beginning capital, or changing their portfolio in some other way by using models that employ approximations of probability (Akotey & Abor) (2016). By predicting the frequency of claims and so addressing an insurer's susceptibility to bankruptcy, the ruin theory is significant as a risk management tool for insurance businesses aiming to succeed in the long run. As a result, businesses will only provide non-life insurance if they can turn a profit or at the very least remain solvent. However, they may also be in fierce rivalry with other companies and may be ready to take a chance, for instance by lowering premiums and so raising the likelihood of failure in order to increase their marketability (Coad, Frankish, Roberts & Storey, 2013). Ruin theory, however, can not account



for subpar models that might cause catastrophe in the actual world. When conditions change, it is probably best to avoid using the same model year after year or continually. Instead, it is preferable for users to be able to adjust these models to address a larger variety of insurance issues at hand (Biard, & Saussereau, 2014).

This theory is relevant to the study because it forms the basis for estimating expected claims while taking into account frequency and severity, reserves to cover claims, the amount of reserves to invest, and underwriting risk, which manifests itself in sporadic occurrences of losses and causes fluctuations in insurers' underwriting results. These activities in turn lead to risk mitigation efforts which should focus on reducing claims risk as it is directly related to the long-term profitability of an insurer.

## **CONCLUSIONS AND RECOMMENDATIONS**

### **Conclusions**

From the above reviewed literature, it is concluded that sound loss adjustment practices are a prerequisite for optimal financial and non-financial performance of insurance firms. It was concluded that having a clear policy approved by senior management, with regards to ex-gratia claim payments reduced the financial risks. It was also concluded that insurance firms can enhance their financial performance by regularly reviewing their claims handling guidelines to factor in new developments and trends. The study further concluded that non-financial and financial performance of insurance firms is influenced by quality reviews of claims to assess whether they are handled professionally and resolved appropriately. One of the performance measures could be the number and nature of complaints against the insurer with respect to their claims settlement decisions. The performance is also influenced by monitoring the level of claims which should not have been paid or are overpaid and the severity of delays in claims registration and case reserves revision.

### **Recommendations**

Based on the study's findings, it was advised that insurance companies make an effort to properly and promptly create case reserves for each claim, particularly with regard to general insurance business. Additionally, the elements of case reserves must be recorded in sufficient depth to produce helpful statistics for in-depth examination. A single claim file, for instance, can have distinct sections for own property damage, third party responsibilities, and fees owed to outside parties. Another suggestion is that the insurer have a clear policy on ex-gratia claim payouts that has been authorized by top management. Additionally, the power to make such payments must be indicated explicitly, and the justification for the decision must be adequately documented. In order to adequately direct the claims employees, the insurance companies should also have clearly written claims handling rules for each of the major categories of claims. The rules for managing claims may include information on the paperwork needed to validate the claim, warranty references, or acceptance-related limits. A clear control procedure for the payment of big claims was also advised for insurance companies, such as obtaining the appropriate formal approval from the reinsurer and a member of the management team. In addition, insurance companies have to



conduct quality evaluations of claims to see whether they are handled expertly and settled properly. The quantity and kind of grievances lodged against the insurer in relation to claim settlement decisions may be one of the performance indicators. The amount of claims that should not have been paid or that have been paid excessively, as well as the severity of delays in claim registration and case reserve modification, should all be closely monitored by the insurer. Last but not least, it was suggested that insurance companies set up frequent claims reporting to senior management to increase knowledge of major claim exposures and losses, particularly when a single claim, loss event, or series of losses might have an impact on its balance sheet.

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