FACULTY OF COMMERCE

DEPARTMENT OF INSURANCE AND RISK MANAGEMENT

AN INVESTIGATION INTO THE CAUSES OF CLAIMS MISMANAGEMENT IN MEDICAL AID SOCIETIES: CASE OF PSMAS

BY

EVELYN PRUDENCE GEMU

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SUPERVISOR: ……. DATE: ……

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DEDICATION

A lot of people run a race to see who is fastest. I run to see who has the most guts, who can punish himself into exhausting pace and then at the end punish himself even more. Thus far the Lord has taken us! This dissertation is a dedication to my parents whose love is unconditional and who have been my source strength throughout this academic journey.

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Thank you all!

ABSTRACT

Claims management is imperative for the viability of Medical Societies. This assertion is buttressed by the ever-present war among medical aid societies, their members and service providers. The main objective of the research was to investigate the causes of claims mismanagement in medical aid societies, zeroing on Premier Service Medical Aid Society and the study revealed plausible sources from which the claims mismanagement emanates, the challenges involved in claims management, the strategies which can be adopted by companies to manage them and the associated benefits of effective claims management in Medical Aid Societies.

The study adopted descriptive research design using disproportionate stratified random sampling. The primary data from structured questionnaires was then analyzed and presented using tables, graphs and charts in conjunction with secondary data. The study revealed, studies prior, focused on challenges of claims management in traditional insurance institutions and less has been done on medical insurance. The findings, exposed the existence of claims mismanagement in Medical Aid Societies, causes identified includes medical inflation, mismatch between contributions and associated benefits and fraud which is perpetrated by associated stakeholders. In this thesis, recommendations were made to try and rectify this position.

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CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter gives an insight of the failure by Medical Aid Societies in Zimbabwe to manage claims: Case study of PSMAS, zeroing in on the detrimental effects of claims mismanagement. Highlighted is the background of the research area and also laid is the foundation of the problems under investigation. Followed by the statement problem, research objectives, and significance of the study, assumptions, delimitations and limitations. Lastly, it presents acronyms used in the study as well as key definitions of terms.

1.1 Background

Premier Service Medical Aid Society is a Zimbabwe based medical insurer which was established in 1930 and has been in existence for over nine decades. The society is regulated by the Ministry of Health and Child Care (MoHCC) under the Medical Services Act Chapter 15:13 and has been registered in terms of Statutory Instrument 330 of 2000. The operations of the society are such that members pay monthly subscriptions to the society, then they access medical services from service providers using a medical aid card. Service providers then claim their fees from the society. Over and above medical insurance, the society offers its members and other people healthcare services via its investment wing PSMI. Facilities provided include hospitals, clinics, laboratories, radiology, rehabilitations, dental clinic and optometry.

Nehanda radio (2021), alleged that PSMAS launched a multi-dollar rebranding exercise at a time when PSMAS members are failing to access medication and healthcare in most private pharmacies due to the society's failure to pay on time the services rendered. Legal proceedings were once instituted against PSMAS by Dr Erasmus Dhliwayo who was suing for $208 000 in unsettled claims. The Newsday (2017), postulates that Dr Dhliwayo provided medical services to PSMAS members and submitted claims in the sum of $208 000 for payment. However, PSMAS failed, neglected and or refused to pay the said sum of money.

According to Musarurwa and Marufu (2016), doctors and other medical service providers are owed an excess of $220 million USD by health funders with PSMAS carrying the bulk of the debt at $180 million USD. This experience of delays in claims settlements has resulted in service providers requiring cash up front and the client later have to seek a refund from their medical aid. Now, members no longer have confidence in the medical aid society because the general expectation is that upon producing a medical aid card, the member is supposed to access service without any inconveniences. The Newsday (2020), quotes the Zimbabwe Medical Association president, Dr Johannes Chirisa saying medical aid societies risk losing relevance as clients are now switching from one medical aid to another or terminating their medical aid schemes outrightly.

The success of a medical aid society is based on a twin anchor comprising of timely disbursement of claims to service providers namely practitioner and assurance to potential patients that they will access medical services as and when they need it. Traditionally, PSMAS was only responsible for members' treatment after they get sick but it has added a wellness dimension in provision of wellness program such as gym access, detox, screening and periodic check-ups as a way to lower claims through lifestyle change interventions and early detection of diseases. However, while the precautionary measure lowers claims and by extension operational inefficiencies, it is also littered with hiccups in relationships between medical aid and service providers. For instance, a client goes for cervical cancer screening (papsmear) and they have to fork out cash because the medical aid has not remitted previous due payments or a client goes to a gym and they are denied access because medical aid has not yet paid.

The medical aid sector has also not been spared from malicious acts by service providers in which they connive with members of the society to make fraudulent claims. Notable example is from an article by internal auditors of Genesis Medical Aid Scheme from South Africa which articulated how they detected unusual trend in claims from a Capetown dentist. A high-level skilled audit revealed that the dentist had defrauded Genesis by filling teeth that had long been extracted, taking unnecessary x-rays. Performing root canal treatment on non-existing teeth and a whole host other irregularity. Comparably, medical aid societies in Zimbabwe have been suffering from the same fate. Shylet Sanyanga (2017), assented that medical fraud has been on the rise in Zimbabwe and medical aid societies are incurring huge losses through fraud.

Historical fraud detection methods only uncover about 10% of losses because of the post payment nature of such methods and the resulting pay-and-chase recovery process, less than 5% of losses detected are ever recovered.

By virtue of being the largest Medical Aid Society in Zimbabwe with over 950 000 members, PSMAS has been failing to settle the bulk of its claims to service providers on time. The society service approximately 87% of the total population with medical aid schemes in Zimbabwe. PSMAS therefore has the obligation to service numerous service providers at any given point because of the quantity of volumes it serves. There is no consensus that the delays in service providers claims processing is inevitable because of the checks and balances involved in the process. Therefore, the researcher intends to empirically examine the causes of claims mismanagement in medical aid societies.

1.2 Statement of the problem

The product which a consumer purchases in medical insurance is peace of mind, based on the understanding that the insurer makes to him that he will cover medical expenses that arise due to an illness. Thus, claims processing is a central service in an insurance company. The main differentiator between medical aid societies is their turnaround time in claims processing to service providers and the convenience of card acceptance when being used by customers.

In line with this view, medical aid societies are compelled to be very efficient in claims management in order to remain relevant in the market. The increased number of new entrants in the medical aid sector probed stiff competition among players and customer retention now depends on the ability to pay claims promptly. Against this background, the researcher seeks to identify the causes of claims mismanagement in the medical aid industry, paying particular attention claims processing and reasons why medical aid societies are failing to settle claims on time and a scrutiny of the risks associated with a failed claims management system in medical aid societies particularly PSMAS.

1.3 Research objectives

1.3.1 To identify causes of claims mismanagement at PSMAS.

1.3.2 To find ways of alleviating failure of claims management at PSMAS.

1.3.3 To assess the benefits associated with successful claims management.

1.3.4 To determine factors which contributes to effective claims management.

1.3.5 To identify risks associated with claim mismanagement.

1.4 Research Questions

1.4.1 What are the causes of claims mismanagement?

1.4.2 What can be done to improve claims management at PSMAS?

1.4.3 What are the expected benefits of effective claims management at PSMAS?

1.4.4 What are the factors that contributed to efficiency in claims management process?

1.4.5 What are the risks associated with claims mismanagement?

1.5 Significance of the Study

The study is important to the following

1.5.1 The researcher

This research is of paramount significance to the researcher as it will enhance the authors' ability to evaluate strategies at management level; for the good of the insurance sector as well as provide her with a depth understanding of the topic under study.

1.5.2 Midlands State University

The university will be granted intellectual property rights to the research which can be added to the university' library and may be used by other scholars with interest in this area of study. The research may also fortify between Midlands State University and Premier Service Medical Aid Society.

1.5.3 Premier Service Medical Aid (PSMAS)

The study will assist PSMAS to have better perspective and approach to claims management so as to significantly gain competitive advantage over other medical aid societies

1.6 Assumptions

The research is based on the following assumptions

1.6.1 There will be no major changes in the operations of PSMAS for a considerable time.

1.6.2 Information to be accessed from respondents is free from errors, misstatements and bias.

1.6.3 The respondents have an appreciation of the concept of claims handling procedures and are willing to participate.

1.7 Limitations

1.7.1 Time

Time might be a limiting factor to the successful gathering of information required for the compilation of this project.

1.7.2 Resources

The researcher requires financial resources which may be in short supply. Financial resources will be required for surfing the internet and travelling to Harare which is the oasis of information as the company's head office re located there.

1.7.3 Holding of confidential information

There is some information required to fully complete the research which is very sensitive, private and confidential hence the researcher may not be able to access it. Assurance will be guaranteed to the respondents that the information will be purely used for academic purposes and anonymity will be maintained.

1.8 Delimitations

The research will concentrate specifically on one medical insurer, PSMAS. The research was limited to only 5 years of the entity's life span, 2016-2020.

1.9 Definition of terms

Medical Aid Society- An organization that administer medical insurance and where applicable, renders a relevant health service to its members, either by itself, or by any suppliers of a relevant

health service or by any person, in association with or in terms of an agreement with a medical aid (Mcleod,2001).

Service provider-refers to an individual or an entity that delivers or execute the health care service or product.

Claims-demand made by the insured's beneficiary, for payment of the benefits as provided by policy. Claim is a formal request that is made either by a plan participant or his or her healthcare provider to the insurance company, asking for payment for a procedure the member received. Vaughan and Vaughan (2008) also define claim as a notification to an insurance company that payment of an amount is due under the terms of a policy.

Claims management- claims management also referred as claims handling covers all the necessary steps starting from notification of incident by the customer all the way to settlement. The claims management process, while requiring to pay all claims per the policy terms fairly and promptly, guarding against fraud, minimizing costs and assuring customers satisfaction (Tajudeen and Adebowale, 2013).

1.10 Acronyms

MoHCC - Ministry of Health and Child Care

PSMAS - Premier Service Medical Society

1.11 Summary

This chapter gave an introduction to the study area in order to give basic understanding of the research. It discussed the background of the study, defined the problem which prompted the research question. Following the statement of the problem, sub research questions, study objectives, assumptions, limitations faced, delimitation and justification of the study were discussed. Lastly key terms in this study were defined.

CHAPTER TWO

LITERATURE REVIEW

1.0 Introduction

The objective in this chapter is to reveal the pertinent literature reviewed, airing what other authors and researchers have observed with respect to claims and claims management in the context of insurance business. The chapter provides a broader view of the impartation of claims as an operational risk to the overall performance of medical insurance. More so, the researcher discussed the causes of claims mismanagement, as well as assessing the areas of improvement which promotes expedition of claims settlements whilst promoting cost efficiency for the success of the organization.

2.1 The medical insurance concept

Kasule (2012), defined medical insurance as a component of social security and social justice which may be provided by state, by the community, by private for profit entities or a combination of all these. It serves two main functions psychological and financial. According to Kasule (2012), psychologically, insurance gives reassurance that a person is safe in any catastrophe that will occur in the future. On the other hand, financially it ensures that help in the form of services or money will be provided and the insured or family will not be financially ruined by catastrophic payments. Policybazaar (2008) defined, medical insurance as a type of insurance that covers the whole or part of the risk of a person incurring medical expenses. As with other types of insurance, risk is shared among many individuals by estimating the overall health risk and health system expenses over the risk pool. An insurer can develop a routine finance structure such as monthly premium or contribution to provide the money to pay for the benefits specified in the insurance agreement.

2.2 Claims as a core competence

According to Johnson, Scholes and Whittington (2005), core competencies can be defined as those activities or processes that critically underpin an entity's competitive edge. Hussey (2012), viewed core competencies as a bundle of skills and technologies which create and sustain the ability to meet critical success factors of specific customer segment in ways difficult for competitors to imitate. Core competencies are usually intertwined with the organization at operational level as well as with the work routines of an organization. Viljoen and Dann (2003) asserts that core competencies are represented by skills, resources, systems and technologies that an organization can utilize to give an edge on market opportunities. Hamel and Prahalad (1994) believes that a core competence is not an individual skill, but is an integration of skills and technologies which transcend any particular product or service to the entire organization.

The performance of an insurance companies is mostly determined and rated in accordance to its speed and efficiency in settlement of claims. Hence, most companies in their advertisements do not fail to mention that they pay customers claims promptly. A company that wishes to attract and retain customers must develop its skills around effective management of claims. On the other hand, a company that is unable to fulfil its promises to its policyholders in relation to prompt and efficient management of claims is likely to lose goodwill of not just the current policyholders, but also of prospective customers. Thus, it is not a wonder that the Claims Department receives considerable attention at corporate and board levels. Having said that, it is goes without saying that the claims' function is critical for the success of any insurance company. Therefore, if the company intends to be competitive in the market place, it must address the factors which may hinder the effective performance of the claims function.

2.3 1 Medical Insurance Claim

Policybazaar (2008) defined health insurance claim as a request that a health insurance provider submits to the insurance company in order to obtain services that are covered in their health insurance scheme. Providing healthcare when needed is the true utility of a medical insurance scheme. To ensure timely and easy settlement of all medical expenses, one need to initiate a health insurance claim process. Kasule (2012) asserts there are two types of claims under health insurance, which are cashless claims and reimbursement claims. Kasule (2012) defined 'cashless claims' as a claim in which, the insurer settles all the hospitalization bills and other related

medical expenses directly to the service provider. However, the insured needs to access the medical services from networked service providers only to get the benefits of cashless services. On the other hand, in reimbursement claims, the policyholder pays for hospitalization and other related expenses upfront and requests for reimbursement by the insurance provider later. One can get reimbursement facility at both network and non-networked hospitals in this case.

2.3.2 Claims procedures in medical insurance

2.3.2.1 Claims Submission

The general procedure to avail cashless claim in medical insurance policy is a client contact the insurance help desk at the point of service. On a National Medical Aid or Dental claim form, details of the client are availed such the patient's name and date of birth, membership number, name of employer, dates of treatment and signature, the details of the tariff code, diagnosis and treatment given and fees charged thereof and the provider's signature.

2.3.2.2 Pre-authorization

After verification of the identity of the insured, the service provider contacts the insurer to obtain approval form the plan before it will cover the costs of a specific medicine, medical device or procedure and this process is referred to as a pre-authorization or a prior authorization (PA).

2.3.2.3 The authorization process for health insurance

As soon as the insurer receives the intimation from the attendant of the policyholder and is contacted by the hospital (network) about the same, the insurer verifies the validity of policy and the policy coverage of that policyholder. Then, a field doctor is assigned to facilitate the request for the pre-authorization document to cross check the claims settlement. After verification, the medical team from the insurance company approves the cashless claim for the policyholder according to the terms and conditions of the policy.

2.3.2.4. Generation of an invoice

On a recognized drug claim form, there should be a narration of the doctor's prescription, tariff code, drugs supplied with quantity thereof and charge and the official stamp of the supplying pharmacist. The service provider then must generate an invoice, the invoice must provide

sufficient details of treatment, service or supply enable the managers to determine the award from a scale of awards.

2.3.2.5 Claims adjudication

According to Policybazaar (2012), claims adjudication is a process by which the insurer's claim processing area determines that an insured is eligible for payment and establishes an amount payable in relationship to the contractual benefits. The adjudication of a claim may involve several steps, beginning with the insured's initial filling of a claim and concluding with a determination by the insurer of the amount that will be paid or a denial of the claim.

2.3.2.6 Claims settlement

Where the liability is not in dispute, and both the insurer and the service provider are in agreement on quantum, settlement follows immediately. However, in situations were either liability claims, they are determined in court.

2.4 Claims management defined

Reija (2008), postulates the claims management is a combination of all managerial decisions and processes concerning the settlement and payment of claims with accordance to the terms of the insurance contract. Claims management is broad in scope and involves not only processing but also the strategic role, cost monitoring role, service aspect and the role of people handling the claim. Yusuf et al (2014), summarized a good claims management as being proactive in recognizing and paying legitimate claims, assessing exactly the reserves associated with each claim, reporting regularly, minimizing, unnecessary costs, avoiding protracted legal disputes, dealing with claimants courteously and handling claims expeditiously. Wedge and Handley (2003) believes claims management involves carrying out the entire claims process with a particular emphasize upon monitoring and lowering claims costs. The definitions combined

together suggested that the claims management process has to strike a balance between exceeding customer expectations and maintaining costs efficiency.

2.4.1 The claims management process

According to Lalithchanadra and Kumari (2015), claims management includes claims processing and pay-out, which should be a core element of insurance practises, so as to ensure smooth operations. Keeper (2010), gave a comprehensive claims management process as articulated below:

2.4.1.1 Settling claims

According to Keeper (2010), settling claims is just one aspect of the claims management process. The time it takes to process a claim involves several stages beginning with a person filing a claim. The stages that follow determine if a claim has merit as well as how much the insurance company will pay. Insurance customers expect a company to settle claims quickly and to their satisfaction levels can give a company a competitive edge, reducing the time it takes to settle insurance claims is one way to decrease the number of customer complaints and improve service. The use of claims management system software that speeds the process and minimizes costs offers a practical solution. Simplifying the claims process through automation helps reduce expenses for smaller companies that operate with smaller budget (keeper, 2010:167).

Assefa (2014) asserts that, the basic purpose of insurance is to provide for the group who suffer losses. This is accomplished in the claim settlement process, but it is sometimes a great deal more complicated than just passing out. The payment of losses that have occurred is a function of the claims department.

2.4.1.2 Detecting fraud

Paying fraudulent claims costs insurance companies money, a cost which the insurance industry then passes on to its customers. Consequently, underwriting guidelines become tougher and insurance premiums consumers pay increase. Software tools designed to examine payment history and evaluate trends in claim payoffs can help insurance companies to detect fraud, according to Wipro, a global IT business. For example, how often the same individual files an insurance claim can be a warning that a person might be filing a fraudulent claim.

Unfortunately, settling claims too quickly increases a company's chances of paying out a greater number of fraudulent claims. Unlike large companies that can absorb some losses as part of doing business, small companies quickly suffer the negative effect on net earnings when paying fraudulent claims. Then again, processing insurance claims too slowly increases the risk of losing dissatisfied customers. In a highly competitive insurance market, small companies can't afford to lose customers (Keefer, 2010)

2.4.1.3 Lowering costs

Monitoring claims costs throughout the claims management process determines how much of a customer's premium rate goes towards paying for the insurance company's administrative costs. Generally speaking, when settling a claim is delayed, it costs the insurance company more money. The higher claim costs reduce profitability. For small and large insurance companies alike, automation of the claims management process can help decrease a company's operating costs. One example is the increased cost in investigating a claim manually. Information technology systems though, improve efficiency by decreasing the number of claim errors, detecting fraud early and reducing the time it takes to process and settle a claim all factors that cut costs an insurance company's costs and increase profitability. Even in a healthy economy, running a small business can be tough. Other essential functions of claims management process that can reduce costs include developing programs directed at preventing claims before they occur and avoiding future claims (Keefer, 2010)

2.4.1.4 Avoiding Litigation

In most cases involving insurance claims disputes, the insurance company eventually agrees to pay an equitable amount if a customer has a legitimate claim and can present evidence supporting it. Although quickly settling a claim can avoid chances of litigation, accurate liability assessment is crucial to achieving a quick solution a claim dispute. Insurers work to evade litigation because it substantially increases the company's cost of settling a claim. For instance, one-time cases where a person misrepresents information, he provides on an insurance application can be expensive for an insurance company to prove legally. Causing a company financial loss is another reason to avoid litigation. Small insurance companies are not an immune but rather are increasingly exposed to potential litigation involving claim disputes (Keefe, 2010).

2.5 Causes of claims mismanagement

2.5.1 Cash flow constraints

Cash flow management is the process of monitoring, reviewing and regulating a company's cash flows. Reeve, Warren and Duchac (2009), asserts that, the statement of cash flow reports a company's cash inflows and outflows for a period and provides a company's ability to generate cash from operations, maintain and expand its operating capacity, meets its financial obligations and pay dividends

For a medical aid fund, cash inflows include subscriptions from members, investment income, deferred income, unrealised and realised exchange gains and replacement of membership cards. Cash out flows include claim pay-outs, investments made in establishment of medical services infrastructure, income tax to the government and statutory accruals. Cash flow constraints emanates from various reasons, including outstanding premiums, competing priorities, high operating costs, medical inflation and rate of premium increase lower than rate of medical costs among others. Claims take the lion's share of payments, so cash flow constraints affect timely claims disbursements most.

Failure or delay in meeting financial obligations when they fall due negatively may affect a company's reputation. Further, the Statutory 330 of 2000 stipulates that no society shall fail to reimburse a health care provider for expenses incurred in respect of medical or dental treatment by a member or dependants of a member within the maximum settlement period which is sixty days from the date of the lodging of the claim. Failure of which results in the society liable to a fine and or, to pay an interest rate which is calculated from the last day when the claim should have been met to the day when the claim is actually reimbursed to the health care provider, however if the society fails to comply an additional order suspending the registration of the society is issued. Inability to pay claims and accrued interest are among grounds that can be used to petition the courts to wind up a medical aid society.

2.5.2 Medical inflation and changes in claims patterns

Aggarwal and Buckle (2020), defined medical inflation as the change in average healthcare expenditure per person from year to year assuming the risk profile of the person in question remains the same and the benefits entitlements remains unchanged. In their writing, they argued that drivers of medical inflation can be split into two broad categories which are: changes in cost per service and changes in utilisation cost per person.

According to Aggarwal and Buckle (2020), changes in costs per service refers to the change in unit costs of a specific existing medical treatment or procedure. These changes in cost are primarily driven by changes in consultation fees and hospital staff salary, change in costs of hospital consumables and increases in the overheads of the hospital for example rent or property costs, utilities and technology. On the other hand, changes in utilization costs per person refers to changes in the overall utilization of a service but also captures that the distribution may be different over time. Aggarwal and Buckle (2020), goes on to say that change in overall utilisation per service become more skewed towards newer, more expensive treatment and drugs. The change in utilization is primarily driven by change in healthcare availability and access that is supply and demand, consumer behaviour which is attributed to changes in awareness about health in general or a general willingness to consume more healthcare than other options.

Society of Actuaries in Ireland (2016), supports that the emergency of new technology such as biologic medication, Hepatitis C anti-viral drug which is used to treat liver diseases, robotic surgeries, intense modulated radiotherapy and blood products such as immunoglobulin which is used to treat neurological diseases, contributes to higher prices and higher utilization. They reiterated that if it replaces existing treatment options, new technology is more expensive, although it may also expand treatment options. That being said, medical inflation is a key driver of health care insurance costs and as such directly impacts on the claims costs of an insurance company. Kapumha (2020) believes that medical inflation costs will result in contributions of the past financing claims incurred in the future leading to premium inadequacy.

2.5.3 Mismatch between contributions and associated benefits

Contributions are set in advance before the insurer knows the cost of the service it is pledging to deliver. Economists calls this an inversion of the normal production cycle. It may be that even

the most reasonable forecast with regards to expenditure on claims (number, costs and assessment of damages by the courts at the date of judgement rather than on the date of the event) and overheads (e.g. salary increases etc.) are out of date and because a very long time can elapse between payment of premium by policyholder and performance of promised service by the insurer, an insurer may in fact be in a state of failure even if it is experiencing no cash flow problems, with new premiums being used to pay out past claims. To avoid this, premiums must be sufficient to cover the insurer's total costs including claims and acquisition costs and administration costs, given the contributions of financial income.

Experience in health insurance indicates that the stricter forms of rate regulation can reduce the capacity of insurers to make changes consistent with changes in underlying claims pattern. As a result, an insurer may be forced to draw down its capital to support claims, possibly impairing the solvency strength in the process.

2.5.4 Loss reserve estimation errors and its effects on claims management

They are two main reasons why reserve errors may occur: non-discretionary misestimating and manipulation (discretionary). Non-discretionary errors may occur for variety of reasons these includes but they are not limited to delays in reporting of claims , changes claims patterns, increases in claims settlement costs due to inflation, the effects of new regulatory, or judicial decisions on loss amounts and limitations in actuarial modelling techniques.

2.5.4.1 Over-reserving errors

Petroni (1992) believes that, with over reserving error**,** the estimated future liability is higher than the actual ultimate claim, which reduces the reported policy holder surplus, tax payment and profit level. Petroni (1992) postulated that, subscription surplus is an indicator of a medical aid society's financial strength. Therefore, if the insurer over reserves during prosperous years, the over-reserve may not materially impact a regulator's assessment of its financial strength bit if it over reserve in lean years a resulting low surplus level may draw a regulator's attention an action.

2.5.4.2 Under- reserving errors

According to Bellando (2005), technical provisions account for more than 80% of an insurance undertaking. They an organisation's contractual obligations to its customers and other contract beneficiaries. Bellando (2005) postulates that, these obligations cannot be known exactly and they must be estimated, and the person estimating them can make mistakes.

Bellando (2005) believes that technical provisions for long term obligations are subject to wide variations over time, some of which are unpredictable and are hard to quantify. These includes but not limited to, interest rate fluctuations, changes in inflation trends which have an impact on the costs of claims and relative administration costs. Bellando (2005) postulated that, in some line of insurance, there can be a long interval between the times a claim is incurred and when it is settled in full; the information needed to assess a case is gathered only gradually and this is essentially true of liability insurance involving medical care. Lastly, Bellando (2005), identified the inventory date as a causative to under reserving. She stated that, in this instance an insurer is not yet aware of a number of claims that have been incurred but not yet reported (IBNR).

Pretonia (1992), asserts that under reserving increases the insurer's level of policyholders surplus and reported profits which varies from the profit which would have been actually made. This extra profit may then be unavailable when claims are required to be paid. Pretonia (1992) believes that, under provisioning harms a firm's position in two way: liabilities that should have been recognized during the year in question are deferred and will impair earnings in future years. Chamberlin et al (1989), supports that under estimating provisions for claims distorts an insurer's judgement concerning the equilibrium of its underwriting.

2.5.5 Medical loss ratio

The medical loss ratio (MLR), according to Cope, Garrett and Wissoker (2015), considers loss from an insurer's perspective, as the amount an insurer pays out for the covered health care expenses of its members expressed as a share of the premium revenue it collects from (or on behalf of_ members. Ungar (2011), argues that, there is no way in which profit health insurers are going to learn how to get by and still make a profit while being forced to spend at least 80% of their receipts providing their customers with coverage for which they paid. An increased MLR can be attributed to higher growth in claims spending relative to trend. Increases in claims could

occur in different ways: less aggressive utilization review, fewer claims denial, high payments to providers, or increasing reserves counted as claims.

Cope, Garrett and Wissoker (2015, supports that by increasing the number of claims paid for health care, while holding premium growth in check, the MRL increased value that many consumers received for their health insurance premium dollar. However, higher growth in claims spending may benefit consumers today but could ultimately contribute to higher premium costs in the future. The increase in claims costs depreciates the claim reserves of the insurer and the profitability subsequently and in turn affects the claims pay out by the insurer.

2.5.6 Claim lag and its effects on claims settlement.

A claim lag is defined as the time between the incurred date of a claim and the date on which a claim payment is made. This time can be broken into two parts: (i) the time between the incurred date and the date upon which it is received for consideration by the insurer and (ii) the time between the insurer's initial consideration date and the claim payment date. The different intervals in claims lag contributes significantly to the delays in claims settlements.

2.5.6.1 Components of claims lag

Lamers and Sgrosso (2019), presented four phases in which a claim passes through until it gets to a point of settlement.

2.5.6.2 Accrual lag- A claim lag cannot be reported until it is completed or has been accrued. An example is a hospital confinement in process. Another example, if liability is defined by when an accidental injury occurs, services that define the liability amount may be performed for a few days to a few weeks later depending on when the insured member seeks treatment for the injury.

2.5.6.3 Reporting lag – Once a claim is completed it must then be reported to the carrier before it can be processed and then paid. Some claims: drugs submitted on a paper is a basis as an example, may be put in a shoe box and only submitted once a year. Conversely claims submitted electronically have very quick report lags.

2.5.6.4 Processing lag- Once a claim has been reported it must be processed in order to determine the amount of the carrier's obligation. This claim turnaround time is usually one to three gays through a C O B or subrogation settlement, a longer processing lag can be expected. Incomplete information on the claim's submission will also lead to process delays.

2.5.6.5 Payment lag- once a claim has been processed, a check may be not immediately issued. Perhaps checks are only written on Fridays, or every other week, thereby creating a payment lag

2.6 The role of Claims reserving in claim management

The Institute of Actuaries (1997), states that the delay between event and settlement dates means that the insurer must set up "reserves" in respect of those claims still to be settled. It therefore implies that, reserves required at any time are the resources needed to meet the costs, as they arise, of all claims finally settled at that time. The insurers must be able to quantify this liability if it is to assess its financial position correctly both for statutory and internal purposes.

Claims reserving now means that the insurance company puts sufficient provisions from the premium payment aside, so that it is able to settle all claims that are caused by thee insurance contracts. The main issue is how to determine or estimate claims reserves which should be held by the insurer.

Baranoff, et al (2009), alluded that optimal claims management process includes accurately assessing reserves associated with each claim as they represent liabilities and financial future obligations of the insurer. The Institute of Actuaries (1997), points out that reserves are essential element of claims management in that they influence pricing insurance business in the sense of estimating the costs of claims on risks yet to be taken (by extrapolation of past paid and reserved claim cost). Reserves assist as well in assessing the solvency of an insurer in terms of its ability to meet its liabilities (the upper limit of outstanding costs), thus claims reserving remains a crucial element of the claims management process. When there is deficiency in reserves it is inevitable that the insurer fails to settle claims as the fall due.

2.6.1 Important reserves in claims management

The claims manager need to take note of the important reserve to promote efficiency in claims management so that the company will not be found wanting when need arises to settle claim.

2.6.1.1. Outstanding claims reserve

Outstanding claims can be defined as claims which have been approved by the financial guarantee insurer for payment but not yet paid, and include expenses associated with the settlement of such claims bit does not include such claims that are already included in policy liabilities. Outstanding claim reserve comprise of the following categories:

(a)In course of Settlement (ICOS)

Chadick, Campbell and Knox-Seith (2009), asserts that ICOS refers to the reserve amount attributed to claims already known and identified by the insurer but noted adjudicated, settles and paid by the insurer. Comparably, in course of settlement reserve contrasts with claim liabilities which have not yet been identified by the insurer (IBNR), also can be described as reserves for claims that are on the file in the company at the time the valuation is done, by have not yet been approved or paid.

(**b) Incurred but Not Paid (IBNP)**

According Chadick, Campbell and Knox-Seith (2009), incurred but not paid liability reserve amount, sometimes used formally in lieu of the more informal acronym "IBNR", refers to an insurer's total claim.

2.6.1.2 Incurred but Not Reported Claims (IBNR)

It goes without saying that, inaccurate IBNR reserves will lead to non-optimal management decisions. It is not only prudent discounting practice to have proper IBNR provisions, but it is required by law. It is, for example stated in Article 72 of the New York Insurance law that: "every insurer shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims incurred on or prior to the date of settlement whether reported or unreported which are unpaid as of such date and for which such insurer may be liable, and also reserves in an amount estimated to provide for the expenses of adjustments or settlement of such claims".

2.6.1.3 Reserves for loss adjustment expenses

According to NAIC Health Reserve Manual of 2007, reserves for loss adjustment expenses (the administrative expenses associated with adjudicating unpaid claims) should be established based on the level of claims reserves for all contract types. This assertion is based on the assumption that the liability for adjudicating the claim is incurred at the same time the claim is incurred. Loss adjustment expense reserve are generally held as a percentage of the unpaid claim reserve. The percentage should be the carrier's own expense of processing claims, typically expressed as a percentage of claim dollars paid.

According to the Accounting Practices and Procedures Manual, the liability of unpaid loss adjustment expenses should be established regardless of any payments made to third-party administrators, management companies or other entities. This includes any loss adjustment expenses on mom-capitated payments under those contracts.

2.6.1.4 Premiums deficiency reserve

According to National Association of Insurers Commissioners (NAIC) (2017), a premium deficiency reserve is a reserve that is established when future premiums and current reserves are not sufficient to cover future claim payment and expenses for the remainder of a contract period. Considerable judgement must be exercised in determining the "contract period" when circumstances exist that artificially shorten the contract period (such as the likelihood of causation) or extend it (such as regulatory limitations on rate increases).

Premium deficiencies that are likely to occur only for a few months or for part of a rating period usually need not to recognize because premiums are anticipated to be sufficient over the entire year or rating period. Premium deficiency reserve are also not needed when contract reserves have already been set up to recognize the deficiency, such as for issue-age-rated individual policies. Deficiency reserves should closely correspond to the anticipated risk to the insurer.

2.6.2 Factors that affect health insurance claims reserves and patterns

2.6.2.1 Changes in claims patterns

Large claims can distort claims patterns or historical per unit claim levels that is considered when developing claims estimates. Abnormal large claims settlements amount affects estimated claims reserve.

2.6.2.2 Claims administration disruption/Backlogs

Claims inventory or claims adjudication processing changes a special example of real-world disruptions to a health actuary's IBNR calculations. Staffing changes, missed work days due to weather or other unexpected events, administration system hardware/software changes and changes in how providers file claims are just few of the types of situations that cause disruption or backlogs. It is the job of the actuary to recognize these disruptions as they occur and make use of the available data (e.g. claims inventory reports) to make certain that the reserve estimate is accurate.

2.6.2.3 Seasonality

According to Chadick, Campbell and Knox-Seith (2009), states that seasonality is a term that actuaries use to refer to the consistent change in claims over time during the course of the year due to the utilization of services by the insured population. There are many different ways in which seasonality is introduced. The most common is due to the benefit design, plans with annual deductibles and other cost sharing elements see claims increase later in the year. Once the deductible has been met, more claim dollars are payable by the insurance company.

Measuring seasonality is a challenge of its own. Since seasonality patterns are measured over the course of the year, it takes analyses of several years of data in order to develop a stable history from which to draw results. This is further complicated by the fact that benefits and plan provisions often change from year to year. This tends to distort the data, making it hard to determine what changes are due to benefit design. Thus, it is unusually only feasible to attempt to measure seasonality on mature blocks with several years of historical data that have not had any major changes to benefit plan design.

2.6.2.4 Claims cost trends

Claims costs trends is one of the primary external influences on claims payments. Chadick, Campbell and Knox-Seith (2009), mentions that this trend is made up of two pieces: unit cost trends, the increase in per service unit costs for a particular service over time and utilization trends which is the tendency by people to utilize more services over time. Due to the factor that these trends can run at more than three times the average inflation rate, they are very important to consider when establishing reserves.

Lloyd (2009), believes that it is important to note other factors that distort trend values, resulting in understating or overstating the true claims trend. He noted that, changes in benefits, provider reimbursement and demographics can all affect the costs of services, which compound the effective trend when analysing historical data. When making trend analysis, adjustments should be made to account for these.

2.6.2.5 Changes in benefits

As opposed to issues with premium changes described before, the loss ratio method is the only method that is mostly unaffected by benefit changes, with the exception that over time it is expected that premiums will change relative to claims changed in response to a benefit change. However, the majority of the remaining methods have to make adjustments for changes in benefit levels.

The level of effect benefit changes has on the different lag methods depends upon the type of benefit changes implemented. If the changes are in the form of cost sharing, benefit limits or other monetary type changes, the lag methods should not be affected since the underlying payment pattern will not change. However, if the changes result in a shift of covered charges from the one type of service or to another (e.g. more outpatient services, fewer impatient services), this could affect the lag method since the payment patterns would be altered due to the differing lag times between types of services. Continuing to use older completion factors on the new claims would result in misestimating the claim reserve.

2.7 Challenges in claims management

2.7.1 Fraud

Nyemba (2017), postulates that fraud involves a deception or misrepresentation that an individual or entity makes, knowing that the misrepresentation could result in some unauthorized benefit to the individual or to the entity or some other party. The most common fraud involves false statement or a misrepresentation or deliberate omission that is critical to the determination of benefits. Fraud amounts to the breach of one of the basic principles of insurance, the principle of Uberrimae fidei (Utmost Good Faith), the insurer has a right to decline a claim if fraud is proved (Bennet, 1992). Wedge and Handley (2003) note that fraud can take a variety of forms

including the inflation of genuine claims and creating an entirely fictions event. The main motive of insurance fraud is financial gain.

Insurance companies have had to undergo very tough times and incur huge pay-out in claims, some of which have proved to be fraudulent. This has forced insurance companies to rethink the way they handle 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 major causes of collapse insurance companies in the last decade. Wahome (2010), sited that, as much as genuine customers need to be paid promptly, they must be separated from fraudulent ones through investigations, which is time consuming and a major cause of customer dissatisfaction. If a fraud claim is paid, the insurer loses a lot of moony to fraudsters. The insurer may resort to increasing, which affects both good and bad customers. In addition, if a fraudster gets away with it, he may be tempted to continue this practise in the future (Roff, 2004).

2.7.2 Capacity of claims personnel

According to Zeithhaml and Bitner (2003), people are core to the delivery of a promise, employees in the service industry, are the face of the organization, and can directly influence customer satisfaction. Sheth and Malhotra (2010), believes that service employees ought to have two complementary capabilities: service competencies (the skills and knowledge required to execute the job) and service inclination (passion in doing service-related work). During claims service encounter, the customers and or external service providers interacts with employees in claims department from the time a claims is reported, throughout its processing, until it is eventually settled or rejected. According to Lovelock and Wirtz (2007), it is the attitude and skills of employees which differentiates one service supplier from the other. More so, Brown (2007) asserts that, the best defence against claim fraud lies in the competence of a well trained staff and the process of uncovering and battling fraud begins in the claims department.

Zeithhaml, Bitner and Glemler (2009) revealed that the performance gap in service delivery can closed through aligning the human resources strategies around service delivery. The organisation is obliged to recruit the right people, train and retain intelligent and competent staff. Wedge and Handley (2003), recognized that delegation of responsibilities within the department must be performed in such a that whereas material proportion of claim advices do not have to be referred

to his office, decisions with serious implications on the business are not left in the hands of inexperienced and incompetent staff.

However, if the insurance company is not a lucrative employer it is difficult to retain competent and qualified personnel. In some case claims employees due to reasons beyond management's control, will leave the organisation and have to be replaced. According to Mwangi (2008), the company may suffer loss of specific skills and service disruption. Although direct costs associated with loss and replacement of employees is measurable, indirect costs associated with loss of employees, such as loss in customer service and customer satisfaction are also incurred.

2.7.3 Incompetent and corrupt service providers

Medical insurers relies on various medical service providers such as pharmacies, hospitals, specialist doctors such as dentist, paediatrician, dermatologist, general practitioners, obstetrician and gynaecologists, physicians and surgeon to ascertain medical treatment and if so the medical expenses. Whereas some medical aid companies have in house medical service to perform these functions, the law prohibits them to restrict their member to their medical services only and allow members to access medical service from their preferred medical practitioners of choice, hence others outsource the function to independent service providers.

It is a general expectation of insurers that service providers must adhere to set customer service benchmark, concurrently excising a high level of integrity. More so, service providers are expected to assist the insurer in reducing claim costs. Practically, this might not be the case, either due to lack of the necessary skills to perform the task signed or due to lack of integrity. Wedge and Handley (2003), recognizes that external service provider may also not attach as much importance to customer retention as the insurer, as a result, service to the customer may be compromised.

2.7.4 Weak underwriting standards

Brown (1997), defined underwriting as a process of evaluating a proposal that come for insurance and making a decision of whether to accept the proposal or not. If the proposal is to be accepted, at what price and on what terms, conditions and scope of cover (Brown, 1997). The underwriter also has an obligation to ensure that there is no adverse selection against the insurer

and the proposer is not a moral hazard. The underwriter must ensure that the premium charged is commensurate with the risk exposure.

However, unlike the other forms of insurance, health insurers are required by the law to provide health insurance for all Zimbabweans regardless of their health status and cannot charge higher premiums based on whether a person is more likely to require treatment. This condition gives health insurers little control over their underwriting standards

2.7.4.1 Waiver of waiting period and pre-existing conditions.

A waiting period is an initial period of health insurer membership during which no benefit is payable for certain procedure or services. Waiting period can also apply to any additional benefits when a member change (upgrade) their health insurance policy. Then, pre-existing conditions are conditions, illness or ailment that a member had signs or symptoms of during the six months before they joined a medical aid scheme.

Waiver of a waiting period and fore-going pre-existing conditions increases the inherent risk associated with the portfolio and should there be mass claims from this category of policyholders, the claims ratio rising might place the company in financial distress. The underwriting standards of medical insurer have been found wanting, in that most companies in a bid to increase the clientele base overlook vital component when underwriting health insurance policies. As a result, underwriters underestimate the level of risk and charge premiums which are less than the risk exposures (Karau, 2008). When the level of claims exceeds premiums received. The insurance company is unable to meet its obligation to policyholders, and this may result to its closure.

2.8 Risks which emanates from claims mismanagement

2.8.1 Reputation risk

According to Suren (2016), reputation risk arise when a company fails to meet stakeholders' expectations and they change their behaviour. A customer's expectation during a claim, is to be

paid without any delay while a claim manager will have to ascertain whether the claim is payable and if so, the amount payable.

Insurance services lacks ownership intrinsic, thus when regarding the quality of insurance services, it depends not so extensively on just how well the insurance service is structured, but above all on the perception of quality by the clients that is, the insured. This perception is most strongly influenced by word of mouth and due to the characteristics of services, people are inherently cautious, often acting under the advice of friends experience (Ehrlich and Fanelli, 2004) . In the case of the insurance sector, the insured's experience regarding the settlement of claims is crucial in determining their perception of the quality of the service and thus the subsequent spreading of their positive opinion and likely recommendations, thereby creating a competitive advantage for the insurer in attracting new insurance customers and retaining the existing ones.

Unchecked reputation risks can undermine corporate standing and financial performance in a multitude of ways over both short and long term.

2.8.2 Insolvency risk

According to Zeitlow and Seidner (2007), solvency is the financial soundness of an entity to discharge its monetary obligation as the fall due. The Insurance and Pensions Commission, when it considers an insurer insolvent, it takes legal action to place the insurer into liquidation, rehabilitation or curatorship. In most states, when an insurer is placed in curatorship, the state commissioner of insurance is appointed its statutory receiver. Failing to settle claims on time or to settle claim at all can result in the insurance company being declared insolvent.

2.9 Strategies which can be implemented to enhance efficient claim management

2.9.1 Actuarial valuations

The insurance company should consistently carry out actuarial valuations to ensure that there is never a mismatch between premiums charged against benefits offered. This should be done on prescribed times during a financial year and should there be any major economic shifts within the market, which may include but not limited to inflation, currency volatility and policy change. According to Sander (2012), actuarial valuations can be conducted using information obtained

from claim and medical evaluations together with appropriate assumptions regarding inflation and interest rates.

Sunder (2012), postulates that claim evaluation consist of gathering accurate and current data concerning the amount and timing of medical expenditures and the medical condition of the underwritten portfolio based on the most current information available. On the other hand, the medical evaluation consist of using the medical information obtained from the claim evaluation to estimate the effect on the claimant's life span.

2.9.2 Contingency buffer

The loss reserve estimates should be informed by accurate historical record, together with industrial benchmarks. Additionally, it should have a contingency buffer to cater for any extreme scenarios.

2.9.3 Clampdown fraudulent claims by creating controls

Chartered Global Management Accountant (2012), had suggested effective anti-fraud strategy to include: prevention, detection, response and deterrence. Meanwhile, a combination of prevention, detection and response measures can assist to create an effective fraud deterrent. For further submission, while fraud prevention strategy is said to be composed of: sound ethical culture and sound internal control systems; the key tools for detecting fraud include: training and experience combined with necessary mind-set that fraud is always a possibility.

Lexis-Nexis (2004) suggested that tactics to preventing insurance fraud must be integrated with insurer operating activities to guaranteeing the following: ensuring secure information management, enhancing operational efficiency, improving investigative efficiency, minimizing false-positive results and promoting compliance with global regulations. Therefore, taking an assessment technique, according to IBM (2012), insurance companies are guaranteed of the following, preventing fraud at the time of policy submissions, predicting fraud at the intake of claims, identifying fraud during adjudication, discovering fraud by examining patterns in data, investigating fraud more efficiently by reducing false positives and accelerating the investigation process and visualising trends to continuously enhance antifraud efforts.

2.9.4 Risk adjusted inflation pricing

In high medical inflation markets such as Zimbabwe, it is important for the sustainability of the insurer to be able to include risks adjusted inflation pricing at least on an annual basis. This will require robust methodologies and mechanisms to track medical inflation closely and design of internal processes for standardizing reprising exercise. According to Aargawal and Buttle (2012), in such strategy will be initially difficult to implement due to the nature of the price competitive pricing but with the right communication strategy, the benefits far outweigh the risks

Alternatively, a market medical index or similar, could provide the industry with credible n=bench marks against which to judge the proposed premium increases. Such index would be extremely useful in providing solid robust benchmark and would allow the organization to compare their own experience against the market.

2.9.5 Containing operational cost by leveraging on technology

According to Bowling (2018), insurers can leverage on technology to improve claims processing and customer service. While it is evident that many insurers are rolling out customer interface apps that better accommodates the new digital buyer, there remains significant opportunity within insurers own organisations to streamline processes, reduce redundancy and drive administration costs out of operations through effective use of technology

To help automate claims process and optimize scheduling, some insurers are turning to Microsoft Dynamics 265 Field Service, which contains out of the box capabilities that all improve the quality and consistency of custom care.

2.9.6 Implement cash flow risk management strategies

The availability of optimal level of cash is the life blood of an organisation. Keown and Martin (2005) believes that an organization can be operating at a profit but suddenly go insolvent if it runs out of cash in course of business and cannot obtain cash. Therefore, to curb, cash flow volatility, it is imperative that medical aid societies adopt cash flow risk management strategies which includes but not limited to making consistent follow ups with policyholders in arrears. There has to be conscious effort to follow up on those policyholders in arrears, in the form of

text or call or even Whatsapp. Additionally, prepayments must be encouraged when dealing with those entities with an appetite and ability for it.

In order to improve the cash flow medical aid societies, the insurer must keep majority of its investments in short term financial instruments to enable them to meet unexpected future obligations such as medical insurance claims. Also, the medical insurers must device methods and strategies to encourage the conduct of internal forecasting and analysis of future cashflow to enable them to manage the inherent cashflow risks. This will help stakeholders' interests and prevent the risk of insolvency.

2.10 Benefits of efficient claims management

Claims expenses constitute the bulk of the costs incurred by medical insurers hence the need for insurers to take their claims handling functions seriously. According to Bates and Akins (2007), the claims management phase gives an opportune moment for delivery by the insurers and to favourably impress policyholders and enhance their reputation for better performance. Capgemini (2011), mentioned that building an efficient case management capture substantial operational efficiency and substantial value, the benefits of which includes but not limited to the following:

2.10.1 Improved customer service

Horovitz (1994), opined that customer services are complex of promises which are expected from the product by a customer, such as function of price or image. Amiko and Zikmund (2001), outlined that services present company activities created to increase value of selling products to strengthen customer satisfaction. Capgenimi (2011), purports that a purpose-built and well-designed claims platform directly results in better service throughout the entire claim lifecycle from a highly responsive First Notice of Loss (FNOL) process (prepopulated with all applicable policy, coverage and information and the capacity to align insured customers with appropriate services) to enabling customer service access options. Therefore, an efficient claims management must have a high degree of flexibility intended to respond to significant challenges posed by critical loss events and catastrophes.

2.10.2 Improved Enterprise Risk Management

Paape and Spekle (2012), supports the observation which asserts that Enterprise Risk Management framework is gaining substantial momentum as a potentially effective response to managing risks and related challenges. Beasley, Pagach and Warr (2008), believes that ERM takes a holistic approach of risk management which enables organisations to deal with risks and opportunities more effectively, enhancing the organization's capability to create and preserve value for stakeholders.

Capgenimi (2011), opined that by leveraging all the advantages of an advanced modern claims system, the claims team can increase its focus on fraud, risk control mechanics, reserving, vendor management, brand positioning, and compliance and regulatory issues. Tourben (2009) argues that, effective risk management systems equip organizations to withstand adverse effects caused by various environmental risks resulting in a steady stream of business opportunities that could potentially reduce variability in corporate earnings.

2.10.3 Core branding differentiation

Settling claims on time separates an insurance organisation from its competitors and plays a major role in building a brand. Romaniuk et al (2007), believes that differentiation in brand strategy has the power to influence customer purchase behaviour. The arguments of Romaniuk et al (2007), were recognised into marketing concepts such as perception of customers about brand differentiation that drive customer loyalty through purchase preferences and purchase decision in a competitive market. Effective claims management has the potential to increase the market share of an organisation as it builds a level of confidence with regards to the significance of medical insurance. Capgenimi (2011), supports that competitive differentiation which resulted from enhanced customer claims experience leads to increased customer advocacy and retention.

2.10.4 Enhanced business agility

Capgenimi (2011) asserts that, the claims system architecture needs to be designed to support a range of anticipated changes from process movements to the launching of new lines of business or assimilating acquisitions. The ability to make quick and appropriate responses to important environmental and business shifts, enables insurers to solidify customer relationships, grab market share from competitors and achieves sustained strong performance.

2.10.5 Profitability/Surplus

Yusuf and Dansu (2012), conducted a similar research on the effects of claims management on profitability of insurance companies. Their study revealed that strategic claims management will aid the profitability of a firm through reasonable costs control, suitable key staff and developing analytical framework to detect and reduce excesses in order to enhance performance.

2.10.6 Improve customer experience and retention

Insurance is a highly competitive industry and customer satisfaction is vital to staying ahead of competition. With many insurance companies using technology to streamline the claims management process, consumers have become used to seamless customer experience and customer expectations are all-time high. Policyholders expect hassle-interaction with their provider, rapid settlement of claims and transparency policy information. Firms who use technology to improve sufficiency of their claims handling can make it easy for customers to file claims and receive settlements, improving their overall satisfaction. User friendly mobile applications or online portals offer customers an easy way to interact and communicate with their provider and claims management software can quickly move claims through various settlement stages while automating communications with the customer.

With increased levels of customer satisfaction, claims companies can benefit from improved customer loyalty, positive reviews, recommendations and fewer complaints

2.10.7 Reduce the cost of claims management.

An effective claims management process will utilise software to automate payment and communication tasks, saving the company time and money. By reducing the number of employees needed for administrative tasks, the company can cut back on costs and make better use of skilled personnel.

Claims management processes that use software can reduce the costs associated with human error and fraudulent claims. Human error during claims handling can create time consuming and expensive problems that can be difficult to fix and may lead to the settlement of fraudulent claims. The use of software can take over and automate these manual tasks, limiting the risk of human error compromising claims.

2.12 Summary

In this chapter, the researcher analysed the theoretical and empirical literature from various authors pertaining claims management. Various aspects of claims management process were elaborated, indicating their relevance to the study and possible contributions on effective claims management and timeously payment of claims to service providers. The benefits of efficient claims management have been divulged in this chapter, as well as challenges which counters successful implementation of efficient claims management.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter explains and demystify the research methods that were used by the researcher in carrying out the study. The chapter presents. The research design, data sources that were used, research instrument, population and the sampling technique that was carried out together with validity and reliability of the research and summary.

3.1 Research design

A research design is a plan, structure and strategy of investigations conceived as to obtain answers to research questions or problems. The plan is to the complete scheme or programme of the research. It includes an outline of what the investigator will do from writing the hypothesis and their operational implications to the final analysis of data (Kerlinger, 1986). It provides the basis of a coherent plan on which the entire research was carried out. Howell (2013) is of the opinion that research designs are the backbone of every research as they support researchers at every stage of the research and ensures that the reliability and validity of the data that is collected is analysed.

In this study, the researcher used descriptive research design and interpretive case study to acquire data on the causes of claims mismanagement in Medical Aid Societies through the use of quantitative data. Primary and secondary sources were used together with interviews and questionnaires as the main research instrument.

3.1.2 Descriptive research design

According to Onwuegbuzie et al (2012), quantitative research is about collecting and gathering numerical data in order to provide an explanation on a particular question or phenomena. The researcher used quantifiable research data to obtain reliable statistics that were used to measure trend and generalize findings (Madrigal and McClain, (2012).

A descriptive research was used by the researcher to obtain a clear picture on claims management at Premier Service Medical Aid Society (PSMAS). The data was collected through detailed questionnaires and interviews which were descriptive in nature. Furthermore, descriptive research was used by the researcher because it poses an opportunity to use both qualitative and quantitative research data about the population in the study (Murphy and Media, 2025). The researcher implemented descriptive research design as a way to accurately collect data from Premier Service Medical Aid Society in the research under study.

3.1.3 Case study

The case study design is based upon the assumption that the case being studied is atypical of cases of a certain type and therefore a single case can provide an insight into the events and situations prevalent in a group from where the case has been drawn. According to Bums (1997), in a case the focus of attention is the case in its idiosyncratic complex, not of the whole population of cases. The researcher focused on a case study of Premier Service Medical Aid Society. A case study is a recognised as a relevant research tool which addresses areas of most significance. The advantages associated with a case is that, they facilitates the researcher to examine data within the context of its use and also focuses on both qualitative and quantitative researches which enables the researcher to have a holistic approach. In spite of the advantages of a case study, it is often denounced because it lacks validity and produce massive documentation.

3.1.4 Quantitative research data

According to Maye (2016), the use of data that is collected using quantitative measurements enables the researcher to have appreciation of the root causes of the occurrence or non-occurrence of certain events in a research area due to its flexibility. Rajasekar (2013), believes that qualitative approach in data collection is non-numerical, descriptive and uses reasoning and logic in understanding the observable idea behind a research area which cannot be numerically measured. Medley (2013), states that qualitative approach deals with understanding, explorations, opinions, meaning and motivations of individuals towards a particular problem which cannot be measured, but can only be observed.

3.1.5 Qualitative research data

Onwuegbuzie et al (2012) believes that, quantitative research is about the collection and gathering of numerical data in order to give an explanation on a particular phenomenon or question. Madrigal and McClain, 2012, believes that the use of quantitative data assist in obtaining reliable and objective statistics which can be used to measure trend and generalize findings.

3.2 Population

Philipov et al (2014), refers 'a population' to the total number of all the individuals who poses certain characteristics which is of interest to a researcher. Eldredge et al 2014 postulates that, target population is the entire group of individuals, which is of interest to the researcher in order to generalize the conclusion. Newby (2012), states that a research target population can be viewed as a cluster of similar elements from which a sample for a research can be realistically drawn.

The researcher used Premier Service Medical Aid Society as a case study as it possesses much of the attributes of medical insures in Zimbabwe, and has own medical services facilities under

PSMI. The researcher considered 23 employees from the claims department of PSMAS as the targeted population. The distribution of the population is as follows:

Table 3.1 Population Distribution

Target respondents	**Number of employees**	**Population**	**Interviews**	**Questionnaire**
Claims manager	1	1	1	1
Assistant claims manager	2	2	1	2
Supervisors	4	4	1	2
Claims adjudicators	4	4	2	4
Claims assessors	8	8	2	4
Claims clerk	4	4	1	2
Total	23	23	8	15

Source: primary data (2021)

3.2.1 Sampling Techniques

The researcher has to make a choice between using a census or a sample research. According to Australian Bureau of Statistics (2013), a census is a study of everyone or everything in a population (complete enumeration) and a sample means choosing few elements to represent the entire research under investigation. Practically, it difficult to conduct a census. According to Hair (2003), sampling is a process of selecting a relatively small number of elements from a larger group so as to obtain information from that smaller group which permits one to draw a conclusion or to make judgement about a larger group.

Castillo (2009), believes that the sampling concept arises from the inability of the researcher to investigate all the individuals in a given population. Therefore sampling is a process of selecting group(s) of subjects for research in such a way that the individuals represents a significant proportion of the group from which they were selected.

3.2.2 Non-random sampling technique

According to Kumar (2012), non-random sampling designs do not follow the theory of probability in the choice of elements from the sampling population. Non-random sampling designs are used where the number of elements in a population is either unknown or cannot be individually identified in such situations the selection of elements is dependent upon considerations. Wheeler (2002), defined non-random sampling as judgmental selection of the subjects to be included based on the knowledge of the phenomena. There are five commonly used nonrandom designs each based on a different consideration, which are commonly used in both qualitative and quantitative research. These are:

(a)Quota sampling

Stimpson (2002), asserts that in quota sampling, participants are chosen according to the different proportions that certain groups of consumer make of the whole survey population. Similarly, just like in stratified random sampling, some elements in quota sampling also has 0% chances of being selected (Field (2005). McClave and Sinach (2013), reiterates that quota sampling involves dividing the population into stratums and then the researcher has to use his or her own judgment to select the elements from the strata. Alvi (2016), postulates that in this sampling method every element of the population does not match all the idiosyncratic of the predefined criteria. The technique, therefore, deals with sub groups that are homogenous and is usually used in street interview questions.

(b)Judgemental/ Purposive sampling.

The primary consideration in purposive sampling is the judgement of the researcher as to who can provide the best information to achieve the objectives of the study. According to Kumar (2012), the researcher will only consider those people who in their option are likely to have the requisite information and are willing to share the information. Judgemental sampling is extremely useful when the researcher intends to construct a historical reality, describe a phenomenon or develop something about which only a little is known (Kumar (2012). This sampling strategy is more common in a qualitative research, a predetermined number of people must be selected, who in the judgement of the researcher, are in the best position to provide the relevant information about the study.

(c)Accidental/ Convenience sampling

According to Allison (2010), convenience or accidental sampling technique, only considers those subjects that are immediate to hand. Kothari (2004), states that it includes drawing a sample from a part of the population that is immediate or readily available thus the name convenience sampling. According to Kumar (2012), accidental sampling does not include people possessing obvious visible characteristic. This method of sampling is mostly used in market research and newspaper reporters. In convenient sampling, you stop collecting data when you reach the required number of respondents you decided to have in your sample. It has more or less the same advantages and disadvantages as quota sampling but in addition as the researcher is not guided by any obvious characteristics, some people contacted may not have the required information.

3.2.3 Random sampling techniques

Kumar (202), articulated that, for a design to be called random sampling or probability sampling, it is imperative that each element in the population has an equal and independent chance of selection in a sample. Equal implies that the probability of selection of each element in the population is the same, that is the choice of an element is not influenced by other consideration such ad personal preferences. There are four methods of sampling under random sampling.

a) Simple random sampling

Wagner (1993), revealed that in a simple random sampling technique, there is a potential each and every variable element of the population has an equal chance of being selected to become part of the sample. Teddline and Yu (2009), defined a simple random sample as a sampling technique in which every unit in the accessible population has an equivalent chance of being incorporated into the sample and the probability of a unit being picked is not impacted by the choice of various units from the open population. Numerous ways can be implemented to come up with a simple random sample which includes but not limited to picking names or numbers out of a hat or by the use of a computer to generate a sample using random numbers.

b) Systematic sampling

Allison et al, (2001), postulates that, in a systematic random sample, the selection of elements uses a fixed or systematic interval until the desired sample is reached. Allison et al, (2001), goes

on to say, systematic sampling does not differ much from simple random sampling except that the only random selection involved relates to which subject is selected as the first one from the sampling frame. Systematic random sampling is related to simple random sampling as it also recognizes and awards each element in the population an equal chance of being selected. Two or more random starting points are selected in order to maintain a probabilistic framework. This sampling technique however offers little protection against biases as compared to simple random sampling although it is said to be convenient. Its main purpose is to simplify the process of selecting a sample as well as to ensure the dispersion of sample units.

c) Cluster sampling

Cluster sampling is a probability sampling method in which elements of the population are randomly selected in naturally occurring groups called clusters. Allison et al (2001), believes that cluster sampling involves isolating the population into groups and is generally used when the population covers an area that can be separated by regions. The sample elements are then chosen from different clusters to come up with one sample. Yount (2006), states that cluster sampling involves haphazardly selecting groups, not individuals. It is often difficult to get a rundown of individuals which make up a target population.

d) Stratified random sampling

McClave and Sincich (2013), defined stratified sampling as a sampling technique which involves the splitting the population into distinguished layers, groups or strata that are different from each other but still representatives of the entire population. Stimpson (2012) indicated that, "the method involves subdividing the population into groups and only sampling from those subgroups that are likely to be interested in the product in question". On the other hand, Alvi (2016) asserts that, three layers can be made from a population of employees in a company by splitting the employees with respect to age, gender, position or rank. Stratified sampling, is much concerned grouping element in the population according to homogeneous traits prior randomly selecting sample participants.

3.2.3 Sample size

According to Doane and Seward (2011), a sample size is the number of individuals or elements that are considered in a research as a representative of the population. Haralambos and Holbon (2008), asserts that a sample size must be more than 33% of the objective populace. In this study the researcher used disproportional stratified random sampling. The rationale for choosing this approach was that the population in the claims department can be classified into homogenous relative groups. Each strata in the claims department vary in terms of authority and the duties they perform in claims management, thus there is also a variation in the degree of information each strata possess. The researcher was seeking knowledge about the operations of the claims department at PSMAS and the causes of claims management which the participants would provide by virtue of the level of information they possess. In this study, the researcher selected those that have information on claims management at PSMAS, amongst which includes the claims manager, 2 assistant claims managers, 4 supervisors, 3 claims assessors, 3 claims adjudicators and 2 claims clerks. A sample size of 15, constituting 65% of the population has therefore been selected.

3.3 Sources of data

The researcher used both primary and secondary sources of data in carrying out the study primary data was collected from the claims department at PSMAS in carrying out the study while secondary data was collected from the internet, journals, books and newspapers. According to Churchill (2012) the sources of data that is used by the researcher can influence the findings of the research following are the sources of data used by the researcher.

3.3.1 Primary data

According to Wisdom et al (2012), primary data is data that is originated by the researcher for the purpose of a study or investigation at hand. Churchill (2012), assets that primary data is collected for the first time and therefore it is not published before it is collected thus it provides first-hand information about the research study and it is collected using various methods which includes interviews and questionnaires. Moreover, primary data was used by the researcher as it contains a high degree of accuracy and originality as it is collected directly from the population

and processed by the researcher. The researcher used primary data because it focusses on specific information thus it gives the researcher realistic view of the study.

3.3.2 Secondary data

This involves the collection of data from sources that are already available. Lancaster (2005) notes that the sources can be categorised into raw secondary and compiled secondary data. Compiled secondary data is data that would have been selected and summarized whereas raw-secondary data is that which is diminutive has been done. Secondary information contributed immensely to the research effort as the researcher consulted several sources of data available on the topic area of the study.

The university allowed the researcher to carry out her research through the accessing information on the internet. This information was accessed from scholars' work, e-books and e-journals through the internet.

The internet

The researcher was granted permission by the university to carry out her research through accessing information on the internet. This information was accessed from other scholars' works, e-books and e-journals through the internet,

Advantages

(a) The internet provides recently researched data that is not found in the library
(b) It is easy to access and it helps the researcher to screen out unnecessary data.

Disadvantages

(a) It can be difficult to retrieve information from the internet since its efficiency is dependent on the network serves which can be highly congested sometimes.
(b) It is time consuming as the researcher has to screen the data provided on the internet

Textbooks and Journals

The researcher consulted numerous professional journals and text books in this investigation. The background of claims management in medical aid societies was extracted from journals and

they assisted the researcher to have an appreciation of the researches that have been done by other scholars that are in relation to claims management.

3.4 Research instruments

Arvin (2015), refers to research instruments as a survey that is carried out, test, scale, rating or tool which is designed to measure data gathered under study, variables and characteristics. The instruments that were used for data collection were questionnaires and interviews.

3.4.1 Questionnaires

Moffat (2012) defined a questionnaire is a set of interrelated, organised questions that are directed to a specific population from which relevant and appropriate data is desired to facilitate an analysis of a research problem. O'Leary (2012) believes that questionnaires are economic research instruments which accommodates a large number of research participants. O'Leary (2012) goes on to say, questionnaires can eliminate a degree of bias from the respondents if they are structured in a way that allow follow-up questions which can be easily understood and interpreted. Gray (2015) is of the opinion that the use of the Likert Scale enhances the effectiveness of questionnaires. Kumar (2012), supports that, the use of a Likert Scale in questionnaires facilitates the researcher to collect data on the skewness of the respondents' opinions on a particular research area.

The researcher used questionnaires in this research which had structured follow-up questions so as to save time and eradicate bias from the respondents, since questionnaires facilitates respondents to simultaneously provide the required information without having to wait to analyse the responses from other research participants. In addition, the researcher also used the Likert Scale in the questionnaire to facilitate easy comparability, understanding and analysis of the data collected.

3.4.2 Likert Scale

According to Kumar (2012), a Likert Scale is a psychometric research scale that is primarily used in questionnaires in order to achieve a degree of preferences and agreements with set of statements from respondents. The researcher used the 5 point Likert Scale that ranges from Strongly Disagree to Strongly Agree. As follows: Strongly Disagree, Disagree, Neutral, Agree,

and Strongly Agree. Each level of scale was assigned a numeric number and the researcher started with 1 and incremented to 5. The researcher used the Likert scale so the results can be easily calculated as they are quantifiable and they allow the respondents to respond in a degree of agreement.

Table 3.2: Likert Scale

Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Points	5	4	3	2	1

3.4.3 Interviews

Monnet et al (1986), postulates that an interview involves an interviewer reading questions to respondents and recording their answers. According to Burns (1997), an interview is a verbal interchange, often face to face, though telephone may be used, in which an interviewer tries to elicit information, beliefs or opinions from another person. Any person-to-person interaction, either face to face or otherwise, between two or more individuals with a specific purpose in mind is called an interview.

The researcher used interviews as it is one of the most important sources of information for case studies. Khan (2014) suggest that an interview that is conducted using semi-structured criteria generate better needed results as it permits flexibility of in data collection. The researcher used open ended questions to interview respondents in order to obtain informative information by varying some questions to suit the information the researcher wanted to obtain and give room for explanation to the respondent in the case they misinterpret thus enhance clarification of ambiguity.

3.5 Validity and Reliability of data instruments

3.5.1 Reliability

Sagor (2015), asserts that reliability is connected to researcher's claims concerning the accuracy of their data. A research instrument is deemed to have served its purpose after providing correct information. The researcher carried out a pilot test on the questionnaires due to the inherent nature of the research and the results were used to improve the questionnaires. The researcher also made use of disproportionate stratified random sampling to ensure that data collected is accurate.

3.5.1 Validity

Heffer (2005) postulates that validity in data collection refers to the researcher's findings truly portraying the phenomenon that the researcher is claiming to measure. Thus, research data is valid when it really measures what it intends to measure. According to Miller and Dally (2013), validity of data collected is enhanced by comparing the research instruments to other colleagues before administering them. Assurance that the research instruments were valid and reliable was obtained from the academic supervisor who assisted and gave guidance on aligning the research instrument with the research objectives so that the required information could be obtained.

3.6 Data presentation and analysis

3.6.1 Data analysis

Nalzaro (2012), defined data analysis as the process of applying statistical or logical techniques systematically to describe and evaluate data so as to establish trends and relationship among the variables. The researcher performed data analysis so as to ascertain useful and usable information to form a basis for the findings. This was done by the use of the quantitative data that was gathered in basing the research findings.

3.6.2 Data presentation

The purpose of data presentation is to put the researcher's findings into illustrative methods. The researcher will use graphs, charts and tables as they enhance clarity and are easy to interpret collected data. (Majumder, 2014)

3.7 Summary

This chapter gives a report on the methodology that the researcher used to carry out the research. It also highlighted, the research design, sources of data and their limitations, research instruments used, population, validity and reliability of data and data presentation.

CHAPTER FOUR

DATA PRESNTATION AND ANALYSIS

4.0 Introduction

This chapter presents the findings of the research, analysis and interpretation of findings. The findings are analyzed in relation to the objectives of the study and the literature reviewed earlier. The results of the observations were presented in the form of tables, pie charts and bar graphs so as to effectively illustrate association and trends. Interpretation was done using descriptive tools such as frequencies and percentages.

4.1 Response Rate

According to Kothari (2012) a response rate is the number of respondents who completed a questionnaire divided by the total who were requested to participate. Therefore there are two variables that are involved when calculating or coming up with a response rate which is the sample size and the number of respondents. This is usually expressed as a percentage from 0% to 100%. Based on the data below, the researcher managed to get collect 12 out of 15 questionnaires administered and this shows a response rate of 80% (12/15). The unreturned questionnaire was as a result of the unavailability of the respondents as they were working from home due to the Covid-19 pandemic, however this did not affect the research as it surpassed the 30% cited by Punch to be the representative of the population.

Table 4.1 Response rate of questionnaires

Description	**Questionnaire issued**	**Questionnaire returned**	**Response Rate**
Claims manager	1	1	100%
Assistant claims manager	2	2	100%

Supervisors	2	2	100%
Claims adjudicators	4	3	75%
Claims assessors	4	3	75%
Claims clerks	2	1	50%
Total	15	12	80%

Source: primary data (2021)

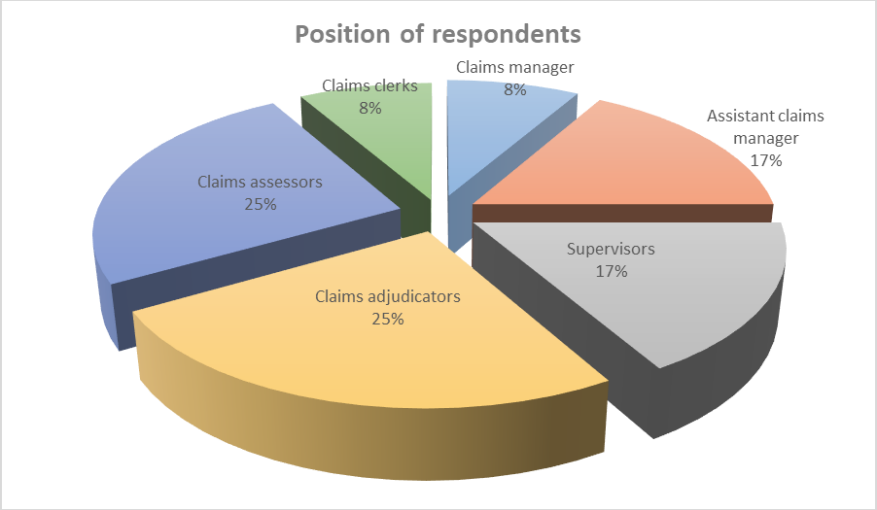
4.2 Demographic information

The demographic findings were based on the position of the respondents in the organization, the number of years in the current position as well as their departments/sections. The findings from this section is important to determine the respondent's experience, capacity and knowledge on the causes of claims mismanagement in medical aid societies and thus the ability to handle the research questions.

4.2.1 Position of the respondents

Figure 4.2.1 is an illustration of the positions held in the organization by the respondents. Majority were claims assessors (25%) and claims adjudicators (25%), the senior management that is the claims manager (8.33%) and his two assistants (16.67%) and lastly the claims clerks (16.67%). This shows that the vast majority of the respondents were in a position to handle the research questions by virtue of their designation and tasks associated with designations.

Figure 4.1: Position of respondents

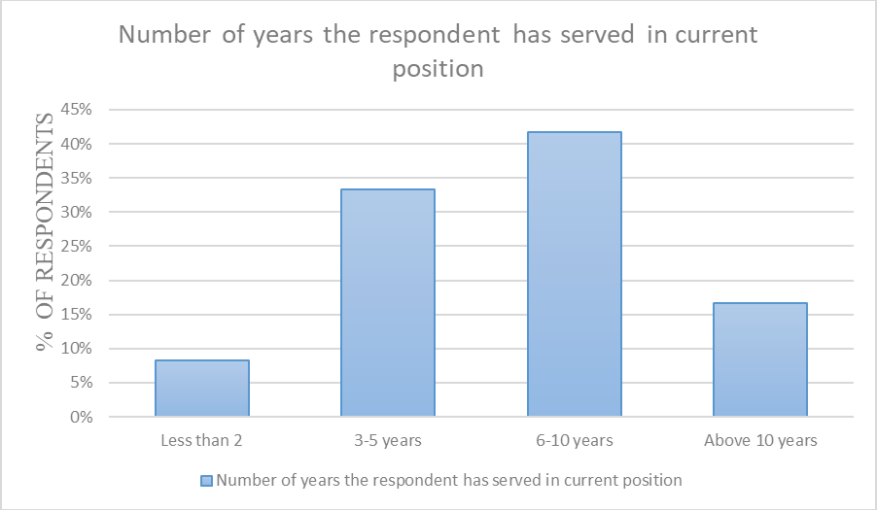


Source: primary data (2017)

4.2.2 Number of years the respondents have been in current position

From the findings, 16.7 percent of the respondents had their position for over 10 years, 41.7 percent had held their position for 6-10 years, 8.3 percent again had held their position for less than two years and 33.3 percent had held their position for 3-5 years in the claims department. The number of years the respondent had served in the claims department was crucial for this study since it is directly related to the level of experience they had in claims management and is also an indication that the respondents have been with PSMAS long enough to understand its operations and challenges emanating from their current designation.

Figure 4.2*:* Number of years, respondents has served in current position



Source: primary data (2021)

In so far as departments in which respondents worked, all respondents were in the claims department. Drawing all respondents from the claims department was purposeful and premeditated by the researcher since the study was particularly and predominantly causes of claims mismanagement in medical aid societies and thus only incumbents in the claims department could handle the research objectives.

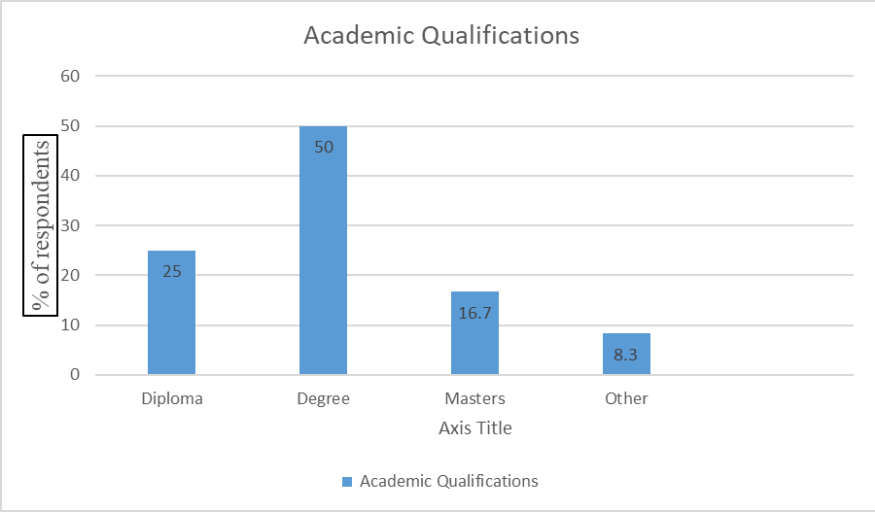
Table 4.2: Frequency

Department		
	Frequency	Percentage
Claims	12	100%

4.2.4 Academic qualification

The motive of the question was to assess the degree of accuracy and relevance of the data provided. The researcher analyzed the highest qualification of the respondents and their composition is shown in Figure 4.5. The findings revealed that, the greater proportion of the respondents are degreed constituting 50%, followed by those holding diploma qualifications constituting 25 % of the respondents, 16, 7% had master's degree according to the survey and 8.3% people had other qualifications.

Figure 4.3: Academic qualifications



Source: primary data (2017)

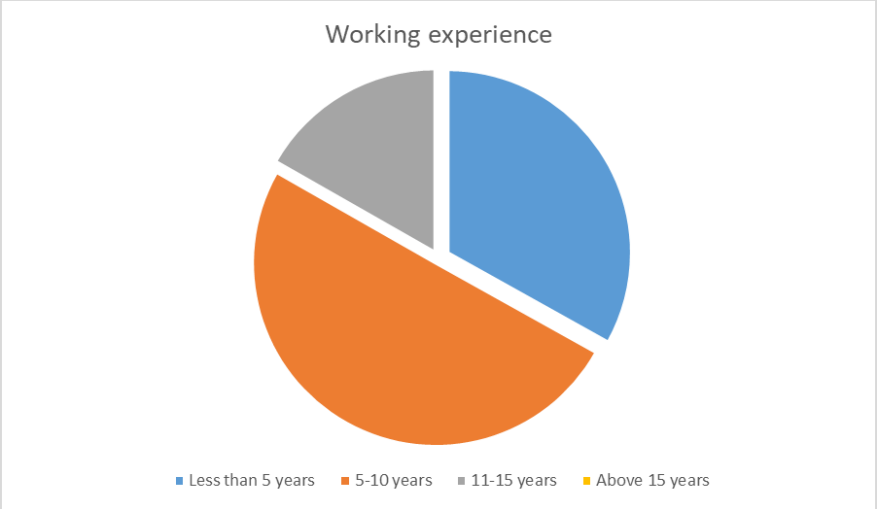
Employees in claims department are in close contact with the clients or intermediary from the time a claim is reported to its conclusion. According to Lovelock and Wirtz (2017), skills and attitude display by service employees during service encounters greatly determine the quality of service they offer a customer. Wade et al (2003) acknowledges that, the more educated a responded is, the more accurate the data is likely to be in. In support of this notion, Dey (2005) alludes that one's qualification determine whether the information given can be relied upon. The

level of education the employees have increases the probability of identifying loopholes in claims processing as well as in claims management.

4.2.5 Work experience

The objective of the question sought to know the average working experience of the employees in the claims department. The findings indicates that majority of the employees have served between 5 -10 years in claims department both at PSMAS and from other various medical aid societies and these constituted 50% of the population. 33.3% have less than 5 years' work experience in medical insurance claims function. On the other hand, 16.7% of the respondents make up the longest serving members at PSMAS who have more experience in managing claims. The researcher findings indicate that at PSMAS, the majority of the employees had served in claims department for a considerable time.

Figure 1.4: Working experience



Source: primary data (2017)

Damasio (1994) asserts that experience plays a major role in determining how much knowledge one has on certain issues. Linden (2014) supports the notion by arguing that there is a positive relationship between experience and knowledge, such that it is implied that the more experience one has the more knowledge he has on relative subject. From the aforementioned academic demagogues, it can be deduced that the length of experience in claims processing and handling, reflects how well versed the respondents were in the subject matter. On contrary, Garling (2007) states that having experience does not entirely resemble knowledge or information in the area of focus.

4.3 Data presentation and analysis

The following are the responses obtained from questionnaires

4.3.1 Factor analysis on the causes of failures in claims management.

The question aimed to determine the extent to which the respondents agreed or disagreed with factors which were identified as cause of claims mismanagement. The table below shows the causes against the responses, making use of the following abbreviations:

SA- Strongly agree, **A**-Agree**,** **N**-Neutral, **D**- Disagree**,** **SD**- Strongly disagree

Table 4.3: Causes of Claims Mismanagement

Cause	**SA**	**A**	**N**	**D**	**SD**
Cash flow constraints	33,3%	50,6%	0%	8.3%	8,3%
Medical inflation and changes in claims patterns	75%	0%	8,3%	16.7%	0%
Mismatch between contributions and associated benefits	58.3%	33.3%	0%	8.3%	0%
Loss reserve estimation errors	0%	25%	8.3%	66.7%	0%
High medical loss ratio	0%	75%	0%	25%	0%
Claims lag	66.7%	25%	0%	8.3%	0%

Source: Primary data (2021)

4.3.1.1 Cash flow constraints

From the findings above, 33, 3% strongly agreed and 50, 6% agreed that cash flow constraints can be attributed as one of the causes in which PSMAS might fail to settle claims on time. However, 8.3% strongly disagreed and 8, 3% disagreed as well that cash flow constraints had an impact on claims management. According to Tsevi (2017), the life-blood of any business can be likened to its cash flow and if the business in the course of its operations is out of cash and unable to obtain new finance, it will fail to meet its obligations when they fall due and eventually can be declared insolvent. Practically, the cash flow of the society is being suppressed by delays and non-remittance of subscriptions by its major employer organizations namely the government and the private sector. Which is one of the factors crippling the society's operations, amongst the problems is also the failure to pay service providers on time.

4.3.1.2 Medical inflation and changes in claims patterns

The researcher aimed to find out the extent to which medical inflation and changes in claims patterns qualified as a cause of claims mismanagement. 75% of the respondents strongly agreed that medical inflation and changes in claims patterns results in agitation in claims management, 8,3% were neutral, 16,7 % disagreed whilst non-of the respondents agreed or strongly disagreed. Kupuma (2020), identified medical inflation as the biggest threat which PSMAS is exposed to, he insinuated that the society import most of the drugs for millions of its members and yet membership continues to pay subscriptions in Zimdollar. The economic conditions in Zimbabwe have been in malaise characterized by devaluation of local currency, hyperinflation and high interest rates, which increased the medical cost and by extension claims cost thus contributing to failures to manage claims.

4.3.1.2 Mismatch between contributions and associated benefits

The objective of the question was to establish the relationship between the contributions charged and the associated benefits entitled to a member in the predicament of a claim. The mismatch between contributions and associated benefits was indicated by 58, 3% respondents as a contributory factor to claims mismanagement, 33, and 3% of the respondents agreed and 8, 3 % disagreed. Information from questionnaires and the interviews revealed that the contributions being charged must commensurate with the benefits attached to the specific plan in question.

When contributions are not enough to cover medical expenses it is difficult for the insurer to settle claims. Findings revealed that, with 91% of its members being civil servants, PSMAS does not have the leverage of increasing contributions as and when it deems necessary as the premiums must alienate with the prevailing salary being given to the civil servants by the government. The government contributes 80% of the total contributions payable to the society for every government employee. In this regard, there are always ongoing negotiations between the government and the society for subscription increase which are procedural and further lengthen the period in which contributions are not sufficient to cover claims.

4.3.1.4 Loss reserve estimation errors

Badounas and Pitselis (2008) denotes that loss reserves refers to the provision for insurance liabilities on a risk adjusted basis, allowing for uncertainty in cash flows that arises from the liability of the insurance contracts. From the findings, 25% indicated that claims mismanagement is as a result in loss reserve estimation errors, 8.3% were neutral and 66.7% disagree arguing that the extent to which reserves can be said to be in error is subjective to other external factors such as inflation and changes in claims patterns which cannot be accurately estimated.

4.3.1.5 High medical loss ratio

The medical loss ratio measures loss experience as a proportion of premium earned during the year. The loss ratio is a reflection on the nature of the risk underwritten and the adequacy or inadequacy of pricing risks. 75 % of the respondents agreed highly that the high medical loss ratio was contributing immensely to claims mismanagement, 40 % however disagreed. Nyamutswa (2015), postulates that when claims cost are in excess of the best practice, it implies that the various funds are not accumulating the cash reserves required for eventual payment of claims in the future. She added that, a high medical loss ratio, has implications on possible non-compliance with legislation in respect of the society's liquidity and solvency ratio, failure to pay service providers and ultimately members failing to access service.

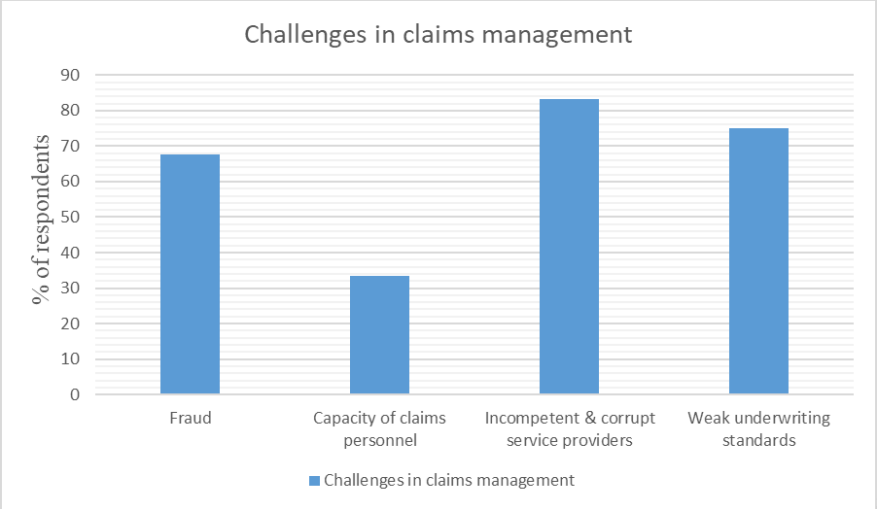
4.3.1.6 Claims lag

It is indicated by the responses from the questionnaires that 66, 7% of the respondents strongly agreed and 25% agreed that claims lag contributes to delays in settlement of claims, 8, 3% of the respondents disagree and none of the respondents strongly agreed neither strongly disagreed that claims lag can be ranked as a major factor contributing toward delays in settlement of claims. Kolbelsky (2014), opined that, segregation of duties in the claims department is a vital component of the organization's internal controls which assist the mitigation of employees committing fraudulent activities, errors and loss concealment. Findings from the study revealed that, the time in between processes lengthens the duration of claims processing but however this factor cannot be ranked amongst major causes of claims mismanagement as it is within the control of the related parties.

4.4 Challenges in claims management

The aim of the question was to understand the challenges which are experienced in the course of processing and settlement of claims in the claims department. The challenges in claims management were ranked from the major one to the least as indicated in figure 4.8. According to the findings, weak underwriting standards and incompetent service providers were ranked as the biggest challenges with 75% and 83, 3% respectively. The least perceived challenges on the other hand were fraud and capacity of claims personnel with 33, 3% and 50% respectively

Figure 4.5: Challenges in claims management



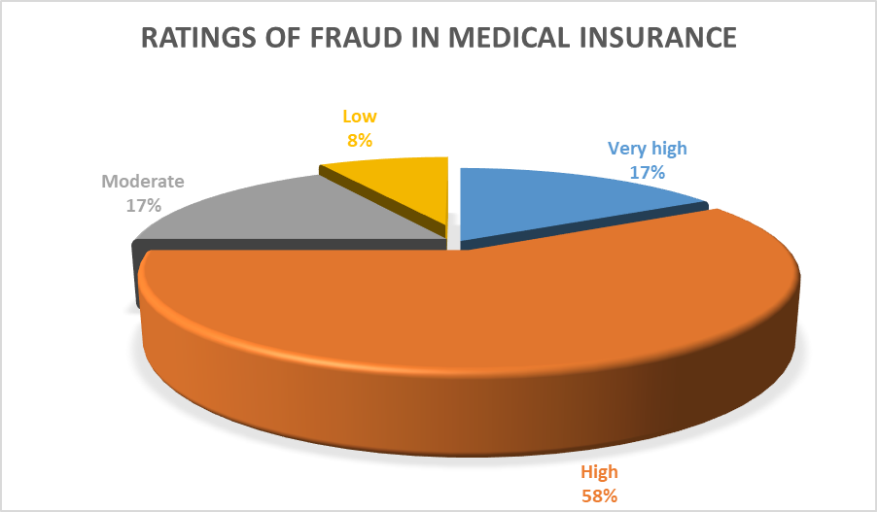
Source: Primary source (2021)

The results from the findings, indicated that the most rampant challenges in claims management includes fraud, weak underwriting standards and incompetent and corrupt service providers. According to Douglas, Houser and Arthur (1996), weak underwriting standards causes underwriters to underestimate risks, and charge premium which is less than the risk exposure. Ballesteros (2015), supports that many insider attack originates from misuse of privileges granted by the organization to their own employees, contractors and third-party service providers. Ballesteros reiterated that fundamental means of ensuring that conflict of privilege cannot occur is to segregate role allocation in order to ensure that no individual can perform a task from beginning to the end.

4.5 Rating of the level of fraud in medical aid societies

The research sought to understand how the respondents would rate the level of fraud in the Zimbabwean medical insurance sector. According to the findings, the majority 16.7% of the respondents rated it very high, 58.3% rated it high while the remaining 16.7 % percent rated it moderate and only 8.3% ranked fraud as low. Therefore the results clearly indicate the level of fraud in the Zimbabwean medical insurance sector is very high. None of the respondents indicated level of fraud as either non-existent or low.

Figure 4.6: Ratings of fraud in medical insurance



Source: primary data (2021)

The degree of fraud is perceived to be emanating from the fact the relationship between the physician and the patient is largely bi-partisan and is governed by doctor –patient confidentiality. It then follows that unless the fraud cases become repetitive and a pattern can be established, it is difficult to prove the existence of such fraud by the insurer. To a greater extent, a high degree of fraud in medical insurance can contribute immensely to the collapse of the fund. This research has shown that majority of the employees in the claims department possess adequate qualification and experience. Brown (1997) postulates that qualification and experience provides capacity to identify and curb fraud and the best defense against fraud is a well-trained claims staff. In this regard, the process of uncovering and battling fraud begins in the claims department.

4.6 Factors which influences respondent's decision to investigate a claim

The aim of this question was to get the opinion of the respondents on what triggers them to investigate a claim and the response from each factor is given below.

4.6.1 The trend of claims pattern from a service provider

The researcher wanted to find out the extent to which the trend of claims pattern from a service provider influence the respondent's decision to investigate a claim. 66, 7 % of the respondents indicated that if a service provider claims more frequently they are likely to invest his claims. However 33, 3 % of the respondents indicated that they are also moved to investigate a claim after noticing an unusual pattern of the claims experience.

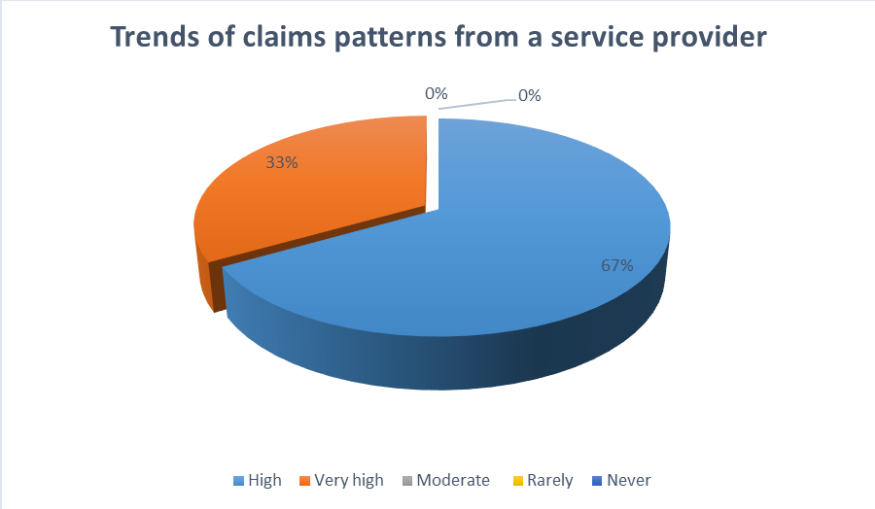
Table 4.4: Trends of claims patterns from a service provider

Number of respondents

	Very high	**High**	**Moderate**	**Rarely**	**Never**
Number of respondents	8	4	0	0	0

Source: primary data (2021)

Figure 4.7: Trends of claims patterns from a service provider



Source: primary data (2021)

Joudaki et al (2015), asserts that most physicians are suspected of abusive behavior. He asserts that healthcare claims are handled by few auditors, who are expected to review all claims and in most cases they give little attention to ach claim, focusing of special characteristics of a claim without paying attention to relationship between all variables that provides a comprehensive picture of physician behavior. Nevertheless, the claims patterns of a service provider also have direct relationship with the number of members of the society who obtains service from that particular service provider.

4.6.2 The frequency in which a member utilizes health care facility

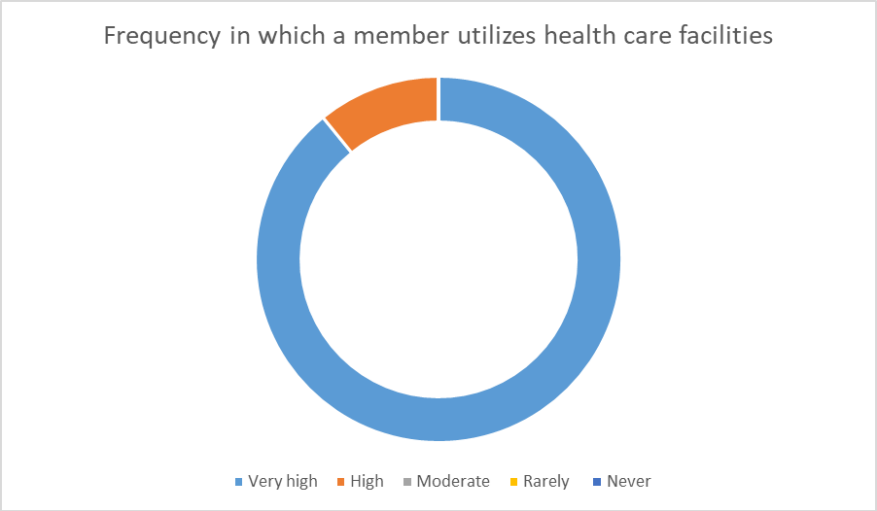
The researcher aim was to find out the extent to which frequency in which a member utilizes health care facilities influenced the decision of the respondents to investigate a claim. All of the respondents indicated that highly they would investigate claims from consistent users of medical facilities. It was found the increase in health facility utilization can be attributed to moral hazard.

Table 4.5: The frequency in which a member utilizes health care facility

Number of respondents

	Very high	High	Moderate	Rarely	Never
Number of respondents	0	12	0	0	0

Figure 4.8: Frequency in which a member utilizes health care facilities



Source: primary (2021)

Einav and Finkelstein (2017), asserts that, moral hazard refers to the responsiveness of healthcare spending to insurance coverage. In their study they revealed that health insurance increases health care utilization and spending. According to Dorfman (2008), moral hazard indicates insurance fraud. Mahito (2013) postulates that an insurance firm can choose to invest in preventing fraud and the insurance firm's investment in preventing fraud depends on whether it wants to provide an additional incentive to policyholder's efforts in exchange for realizing the possibility of insurance fraud. According to Mahito (2013), this result show that moral hazard and insurance fraud has an interlinked relationship.

4.6.3 When treatment was sought just after lapsing of the waiting period

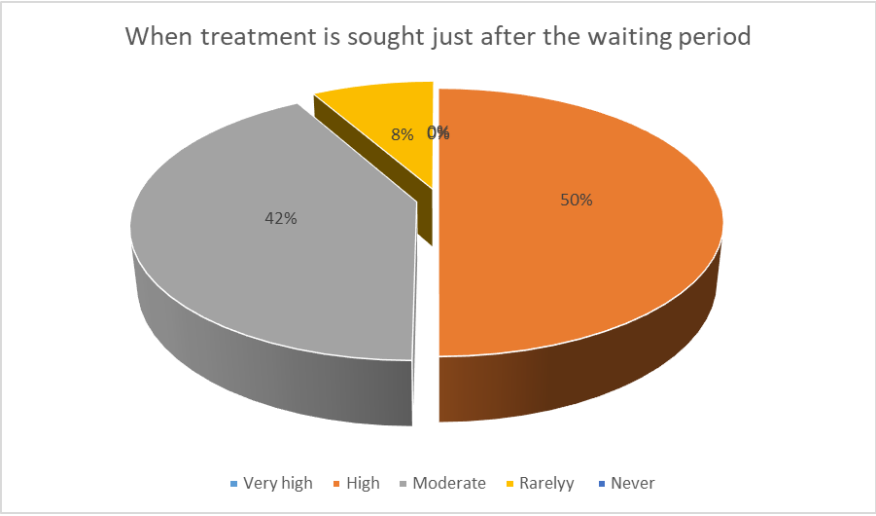
The researcher also wanted to find out how the respondents would view claims in which the member of the society would seek medical treatment just after the expiration of their waiting period. 50% of the respondents indicated that highly, 41.7% indicated that they were moderate and 8.3% indicated that rarely. From the findings, it was mixed bag as some respondents were of the notion that seeking medical treatment just after the waiting period if a red flag which raises suspicions of fraudulent acts, causing them to investigate the claim.

Table 4.6: When treatment was sought just after lapsing of the waiting period

Number of respondents

	Very high	High	Moderate	Rarely	Never
Number of respondents	0	6	5	1	0

Figure 4.10: When treatment is sought just after lapsing of the waiting period



Source: primary data (2021)

4.6.4 Circumstances of the causes of seeking treatment are not clear

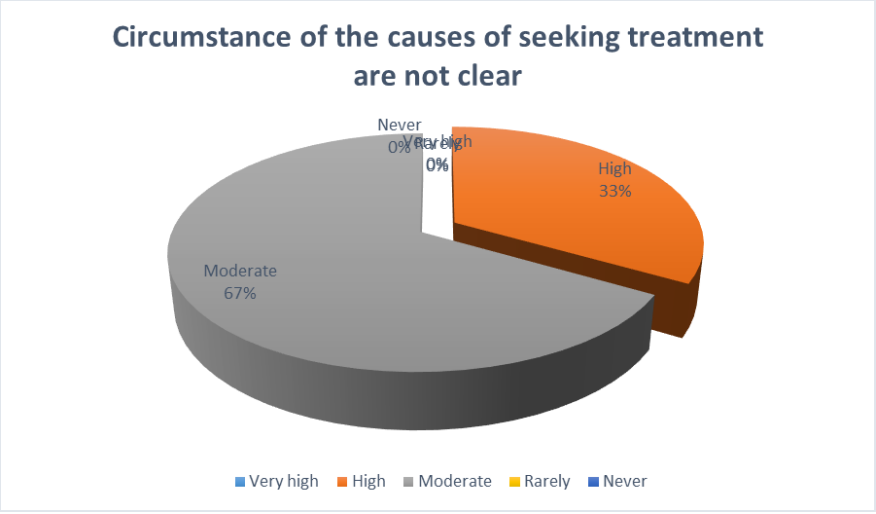
The aim of the question was to establish if in medical insurance there are cases in which an investigation of a claim is prompted due to the ambiguity of circumstances of the causes of seeking treatment. 66.7 % indicated that such circumstances are rare, and as such viewed this factor as rarely whilst the remaining 33.3% indicated that if circumstances of the causes of seeking medical treatment are not clear they were likely to investigate a claim.

Table 4.6: Circumstances of the causes in seeking treatment are not clear

Number of respondents

	Very high	**High**	**Moderate**	**Rarely**	**Never**
Number of respondents	0	4	8	0	0

Figure 4.9: Circumstances of seeking treatment are not clear

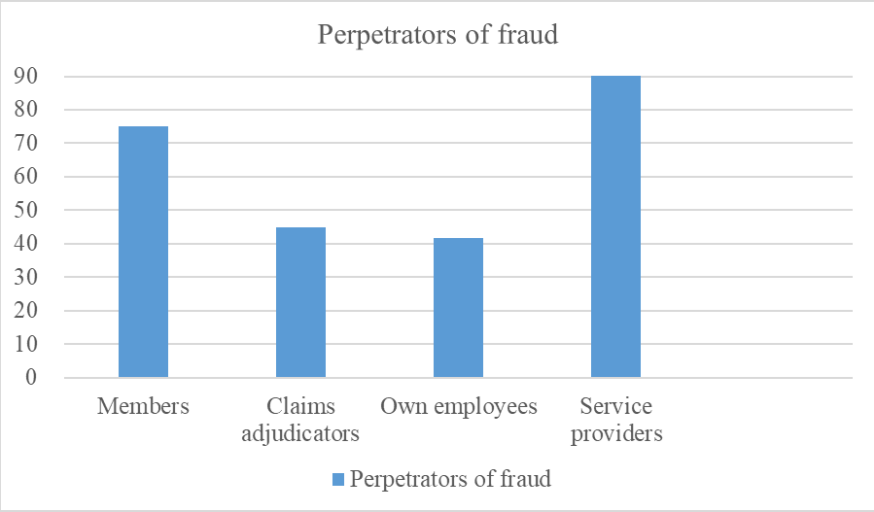


Source: primary data (2021)

4.7 Extent to which various parties are involved in perpetrating fraud

The aim of the question was to assess whom the employees considered perpetrators of fraud. The respondents were at the liberty to select from various multiple options they considers. The following graph represented the extent to which fraud perpetrators were ranked.

Figure 4.10: Perpetrators of fraud



Source of data (2021)

With reference to the above data presentation, 91.7 % of the respondents indicated that service providers are major perpetrators of fraud. This is supported by Nyemba (2017), who asserts service providers can easily manipulate data and in most cases members of the society (policyholders) participates in this act. Finding from the interviews conducted during research, pointed out various forms of fraud which is usually encountered by claims personnel amongst which includes providing false billing codes, coding fragmentation which involves the separation of one medical procedure into separate components to increase charges and up coding which involves billing a higher level of service than was rendered.

From the data gathered, 41.7% of the respondents indicated than own employees and claims adjudicators contributes significantly in perpetrating fraud. Nyemba (2017), in his article said

that employees of the insurers, especially claims examiners and claim clerks fabricate claims due to their ability to access claims and subscriber files, the scope of fraud perpetrated by the is limitless.

75% of the respondents were in tandem and indicated that members if the society cannot be left off the hook as they are also participants of medical fraud. Findings from interviews conducted by the researcher, portrays that usually members of the society engage in deceptive acts and misrepresents circumstances with intention of benefitting from what could be an impermissible benefit. Nyemba (2017) supports this and indicated that members sometimes do doctor shopping, third party fraud or alteration on prescription by inflating medical bills.

4.8 Factors contributing to delays in claims payment

The aim of the question was to determine the extent to which respondents agreed of disagreed to the factors which were pointed as contributors to delays in claims payment.

Table 4.7: Factors contributing to delays in claims payments

	Very greatly	**Greatly**	**Moderately**	**Rarely**
Funds allocated not sufficient	66.7%	25%	8.3%	0%
Staff have a high overload	25%	25%	8.3%	16.7%
Delay in submission of the adjudication form	0%	50%	33.3%	16.7%
Delay in investigation report	66.7%	0%	25%	16.7%
Delay in reporting claim	75%	0%	8.3%	16.7%
Delay in claim documentation	75%	0%	8.3%	16.7%

Source primary data (2021)

Table 4.7 analyzes results which were obtained using the likert scale. From the findings, 70% and of the respondents at PSMAS agreed very greatly, 30% agreed that delay in claims reporting

contributes significantly to delays in claim payment. All other factors constant, delay in reporting a claim results in delays in documentation of the claim which in turn results in compensation delays. 53% agreed very greatly, 17% agreed greatly and 30% were moderate that high staff overload contributes to claim payment delays. More ever, the involvement of employees from finance department further delays payment due to the various processes which they also go through before a payment is made such authorization and printing of cheque.

All respondents were in agreement that delays in submission of adjudication form and the investigation report moderately to the delays in claim payment. 70% of the respondent were of view that insufficient allocation of funds contributes to a lesser extent as a contributor to delays in claim payment, however 30% of the respondents varied from this issue.

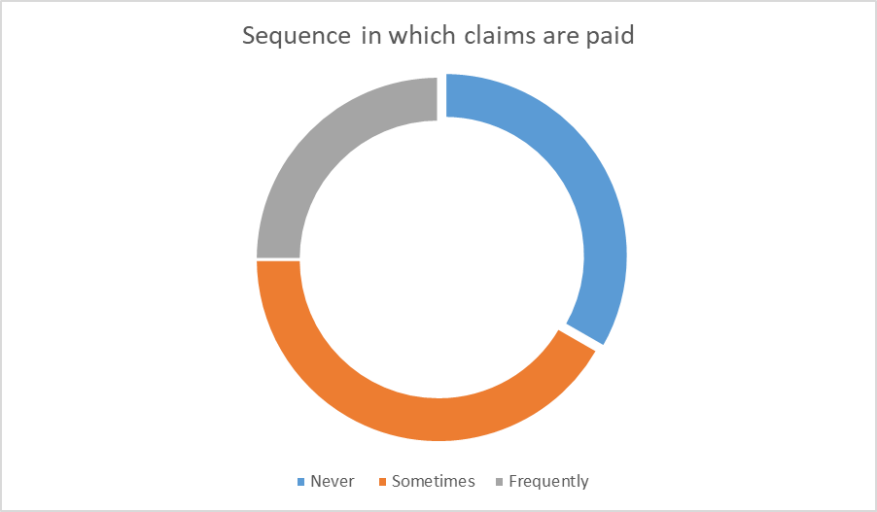
4.9 Factor analysis on challenges relating to claims payment

The research sought to know the order in which claims were paid out and the challenges which the claims department encounter in so far as claims payment is concerned.

4.9.1 Claims are paid on a first come first pay basis

In this question, the researcher wanted to ascertain if claims are paid in order of occurrence. The data collected showed that 33% of the respondents did not agree that claims are paid on a first come first pay basis. 42% of the respondents indicated that sometimes claims are paid in the order in which they were received and the remaining 25% believed that frequently claims are paid on first come first pay basis. This was a clear mark that claims were not queued in order of occurrence, or even order of documentation. Recent claims are sometimes paid before older ones. This practice creates unfair treatment of service providers and clients. When this occurs, claims personnel are not sure which claims to give priority (Kiana, 2017).

Figure 4.11: Sequence in which claims are paid

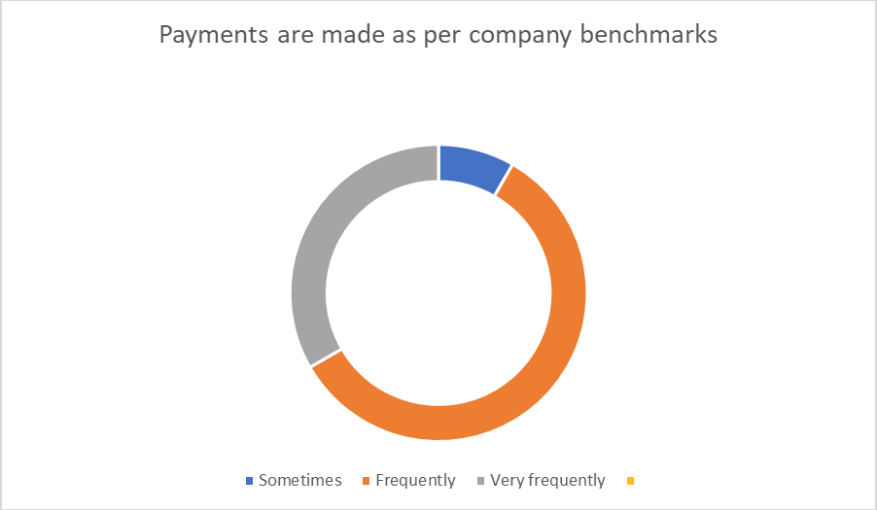


Source: primary data (2021)

4.9.2 Payments are made as per company set benchmarks

Notwithstanding the above-mentioned results, 67% of the respondents indicated that claims are rarely paid as per the company's set benchmarks, 25% indicated that sometimes and only 8% are of respondents supported that the company followed the notion that frequently company's set benchmarks are followed the pre-set company benchmarks. According to Zeithaml, Bitner and Gemler (2009), there should be no discrepancy between the services, standards and the actually service delivery. The most ideal situation is where all claims are paid expeditiously within the set benchmarks and with few variations as these variations create inconsistency in service delivery.

Fig 4.12: Payments are paid as per company benchmarks

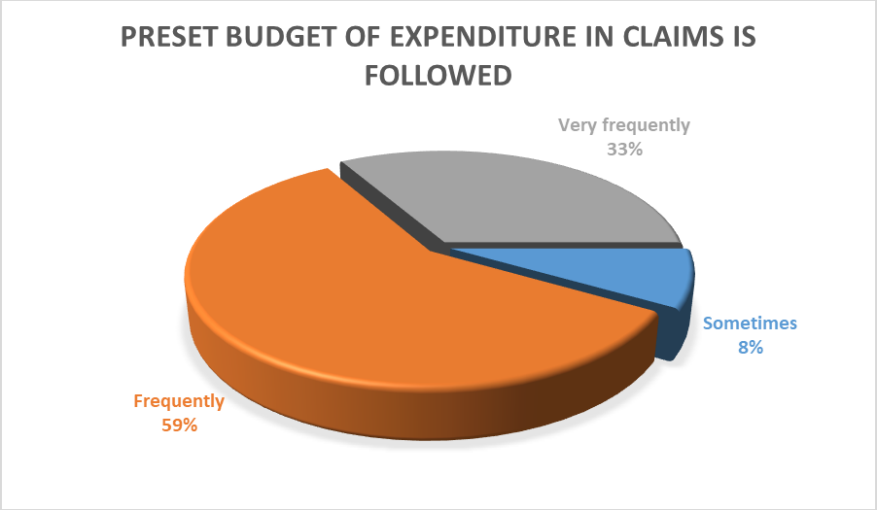


Source: primary data (2021)

4.9.3 A pre-set budget of expenditure in claims is followed

The aim of this question was to examine if the claims department is having challenges in claims payment due to the pre-set budget of expenditure in claims. 91.7% of the respondents indicated that budget on the expenditure in claims is the most prevalent challenge in relation to payment of claims. Findings from the research, insinuate that managers are allocated a fixed budget for claims payments irrespective of actual amount of claims ready for payment, it becomes a challenge when claims exceeding the preset budget are actually incurred. Wilson et al (2012), postulates that, customers have certain beliefs about the level of service that must be delivered by a service provider and in health insurance, service providers and clients expects prompt claims settlements. The situation is worse when the department is not consulted when fixing this budget. Failure to pay claims when they fall due is the major contributor to negative publicity against the medical aid society

Figure 4.13: Pre-set budget of expenditure in claims is followed

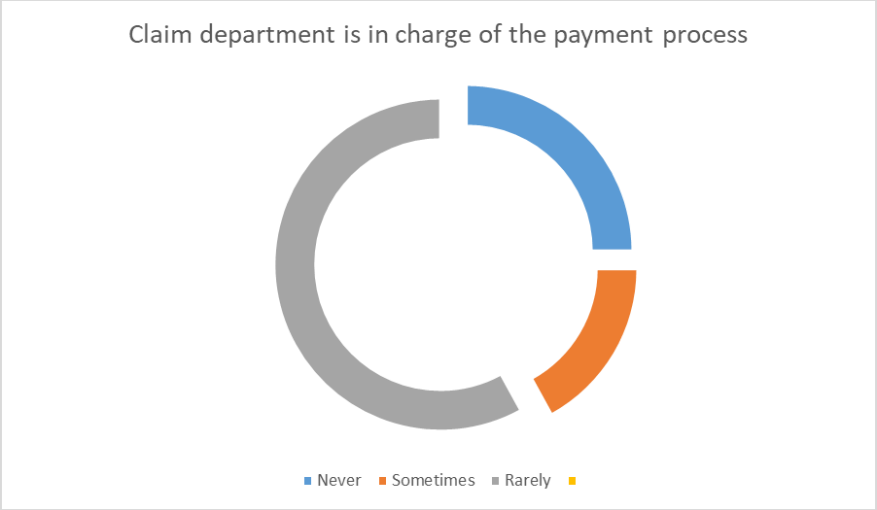


Source: primary data (2021)

4.9.4 Claims department is in charge of the payment process

From the findings the respondents showed that the claims department is not in charge with the payment process. 25% indicated never, 17% of the respondents were of the notion that sometimes and 58% of respondents said that it was rare for the claims department to be in charge of the payment process.

Figure 4.14: Claims department is in charge of the payment process



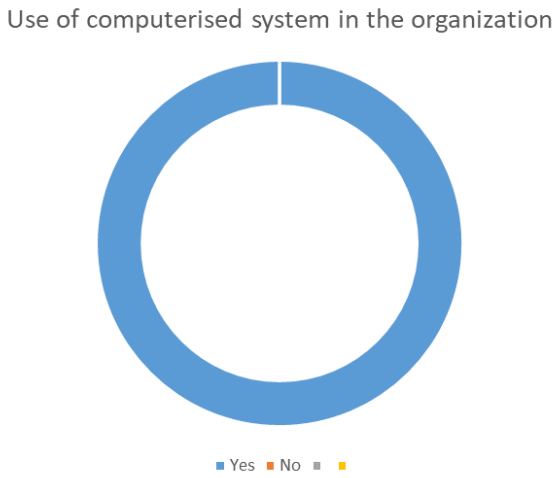
Source: primary data (2021)

Claims managers should take the lead role in deciding claims to be paid. Claims department must have a pre-agreed timeline with the finance department which must not be exceeded grom when they receive an order to pay out a claim and the actual disbursement of funds. Bakanauskas et al (2015), denotes that the integration of individual parts of the organization's activities to achieve common goal. Disruptions in the payment process reflects negatively to policyholders and claims payee in general. It poses a wrong impression to the payees, it will seem like the claims personnel are not willing to pay which is not necessarily the case.

4.10 Computerised claim processing

The researcher sought to find out if PSMAS had adopted computerised claim processing. From the data collected, all of the respondents indicated that the organization adopted a computerised system for claims processing.

Figure 4.15: Use of computerised system in the organization



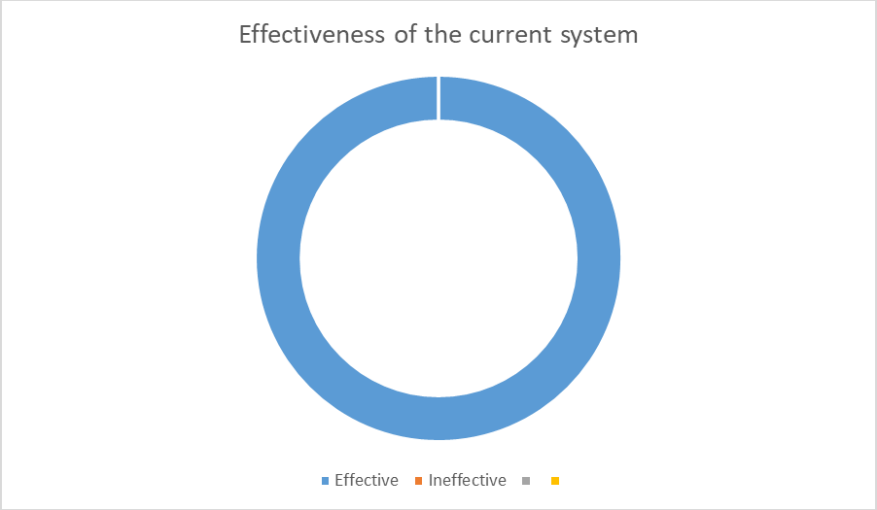
Primary source (2021)

According to Grunitty (2021), the use automation in claims processing outcompete the traditional way of handling insurance claims. Grunnity purported that the manual handling of claims was slow due to meticulousness required when checking and verifying the client's claim. However, the introduction of automated claims processing has resulted in substantial benefits to claims management as it leaves an audit trail and reduces data entry. He added that, automation eliminates the need for storage which formally emanated from the paperwork involved in manual claims processing which needed to be stored for further references by the medical insurer.

4.10.1 Effectiveness of the current system in claims processing

The researcher needed to ascertain how employees rank the current system being employed PSMAS in processing claims. All of the respondents ranked the system as very effective as shown in the diagram below.

Figure 4.16: Effectiveness of the current system



Source: primary data (2021)

From the interviews conducted by the researcher, the employees from PSMAS claims department were confident about the system been effective in claims management. Practically, PSMAS partnered with Health 263, which is offering a platform for service providers to submit claims for services rendered in real time to the society electronically, a progression from manual submissions. The Biometric system does not only speed up the submission process but also reduces errors associated with manual processing.

Additionally, the platform provides for biometric member verifications which enables enrolled members to verify their credentials electronically without necessarily presenting a membership card at the point of care. The use of the health 263 will facilitate service providers to attach prescriptions, laboratory and radiology request making claims management less cumbersome.

4.11 Knowledge on claims reserving

From the findings, the majority of respondents strongly agreed to have a good understanding of the notion behind claims reserving. This was indicated by 7 respondents representing 58.3%. Additionally, the remaining 5 respondents representing 42, 7% indicated that they had a general

appreciation of the idea of reserving. However, 70% of the population did not have an in depth knowledge of the type of reserves which are vital in medical insurance, they were not conversant with actuarial terminology in so far as forms of claims reserves is concerned. Although the respondents were not familiar with the in depth concept of claims reserving, the researcher observed on a very fundamental point that PSMAS does practise the principle of claims reserving but however its only 5% of the contributions which is allocated for reserves as a rule of thumb, the principle of the medical aid concept is still prevalent within society, that 80% of the contributions goes towards claims payment, 15 % for the administration costs and the 5% is then kept as reserves.

4.12 Summary

The study targeted a sample of 15 respondents, 12 of the total sample filled and returned the questionnaires giving a response rate of 80%. This response rate was satisfactory to make conclusions for the study, Millar (2011) supports that a response rate of 70% and above is excellent. Based on this assertion, the response rate was considered to be excellent.

The study found out that, cash flow constraints, medical inflation, mismatch between contributions and associated, high medical loss ratio and the claims lag all can be classified as causes of claims mismanagement. Effectiveness and efficiency in claims management goes a long way in ensuring survival of the business. Initiatives to increase the membership base, the brand image, growth in subscriptions and other business initiatives are attainable only if the company expeditiously settle claims on time.

This chapter has presented, interpreted and analysed the findings of the study which were obtained by the researcher. The following chapter, will discuss the summary, conclusions, recommendations from the analysis and data collected and lastly suggestion for further research.

CHAPTER FIVE

RECOMMENDATIONS AND CONCLUSIONS

5.0 Introduction

The objectives of this research was to investigate the causes of claims mismanagement in medical aid societies. This chapter focuses on outlining the summary, conclusions as well as recommendations. The recommendations based on the research findings are made to the medical aid societies in Zimbabwe with reference to Premier Service Medical Aid Society (PSMAS) on claims management strategies they can implement to improve the turnaround time and the overall timeous settlement of claims so as to remain relevant.

5.1 Summary of the research finding

The researcher sought to investigate the causes of claims mismanagement in medical aid societies with reference to Premier Service Medical Aid Society. The study also sought to find out the challenges faced by the claims department in its role of managing claims. From the practical and theoretical observations made during the study, the following findings were drawn:

a) It was established that the prevailing economic conditions in Zimbabwe characterized by meager wages and a hyperinflationary environment has diminished the purchasing power among policyholders such that the medical aid does not have the liberty to charge contributions haphazardly, to make them sufficient to meet the medical claims costs.

b) It was established that the delays in subscriptions remittances by relevant stakeholders, and the subscriptions being charged are very low to the extent that the medical aid society had to support claims with reserves in its coffers yet its only 5% of the contributions which is allocated as reserves, at the end of the day reserves were not sufficient to meet claims.

c) Findings from the interviews responses shows that medical inflation is the biggest challenge being faced by the society as most of the drugs are imports and fees being charged by healthcare providers are based in foreign currency and charge daily in line with parallel exchange rate for the US dollar. On the other hand, rates cannot be charged in line with

parallel rates as medical aid contributions come from salaries which are not being reviewed in line with the parallel rate.

d) It was observed that the size of PSMAS claims department is not proportional to the number of claims handled of close to 1 million policyholders which subscribe to its medical insurance. More so, claims workflow process is by and large mostly done manually exposing it to human error and cases of misplaced documents thus furthering the delays in settlement of claims.

e) The relationship between the physician and the patient is largely bi-partisan and is governed by doctor –patient confidentiality. It then follows that unless the fraud cases become repetitive and a pattern can be established, it is difficult to prove the existence of such fraud by the insurer.

f) It was established that the claims department is not directly in charge of the claims payment process. This should not be the case as claims department should take the leading role in determining which claims are due for payment as they are the ones who are in touch with the process.

5.2 Conclusions

The research managed to provide an insight into the causes of claims mismanagement in medical aid societies. The research revealed that successful claims management has a positive substantial effect on customer satisfaction and customer retention thus propelling efficient and successful operations of medical insurance business. Claims mismanagement remains an albatross hanging around the proverbial neck of the health insurance sector. Having said that it had always been imperative for an empirical study to be carried out as has been attempted by this research. The research sought to determine the effects of claims mismanagement on the general uptake of medical insurance and possible strategies PSMAS could implement to improve efficiency in claims settlements. While some causes have been traced back to macroeconomic fundamentals such as hyperinflation, innovative and creative ways of working around these have been recommended.

5.4 Recommendations

To address the efficacy issues on the causes of claims mismanagement at PSMAS and by extension in medical aid societies the following recommendations were made:

a) PSMAS should leverage on technological and digital platforms in managing claims workflow. It is recommended that PSMAS adopts a claims management system which can be networked across branches to improve operational efficiencies in the receipt and processing of claims. Additionally, instead of using traditional calls, Voice over internet protocols (voip) calls will be used as the main communication tool. Riding on the same internet networks links used by the claims system. This will create an efficient modern paperless office, in which no documents are lost since there are stored on a central server. Stationery demands in PSMAS will be greatly reduced.

   ILM Corp (2019), supports that digital transformation helps the organization in strengthening documents security and confidentiality as well as creating easy access to data and providing automatic data retention. Garth (2025), further alludes that investing in claims modernization creates great business value and competitive differentiation. According to Garth (2015), capitalizing in new technologies such as cloud, drone and smart analytics does not only optimize today's business but shifts the focus of claims management from a reactive response to proactive care and avoidance of losses.

b) The society must invest in establishing wholesome relationships with both service providers and claims adjudicators such that they become loyal advocates and apostles of the organization. That way it will be able to curb fraudulent endeavors which are normally infiltrated by these stakeholders. More so, management must put in place tight controls which discourage fraudulent claims such as tight monitoring of claims, sufficient documentation and monitoring claims patterns of service providers and adopting a system to increase efficiency in processing as well as detection of fraud. Wholesome relationships can be built around the adoption of Customer Relationship Management.

   Amoaka et al (2011), postulates that the concept of Customer Relationship Management identifies customer needs thus understanding and influencing customer behavior through ongoing communications strategies and an effort to acquire, retain and satisfy customer. Amoaka et al (2011) further asserts that CRM is more than just simply managing customer and monitoring behavior or attitude. It has the potential to change a customer's relationship with a company and increase revenues in the bargain

c) Effort should be directed towards robust consumer education on the wellness dimension which has been introduced as a precautionary approach to lower claims. The wellness

programs and facilities should be within the proximate of all associated members and the benefits must be clearly articulated to encourage members to utilize this dimension efficiently that way the medical loss ratio can be maintained within the acceptable threshold. Sanyanga (2014), assets that Funders must consider designing packages which pro-actively promote prevention and wellness, products which subsidize health purchases from supermarkets in order to improve quality and control costs. Sanyanga (2014), further alludes that the need to educate consumers is imperative so that consumers are informed and can actively make informed decisions pertaining their health.

d) PSMAS must ensure that the claims department has adequate number of employees who have the requisite skills to handle claims in order to improve speed in claims payment. According to Engton (2017), insufficient personnel in an organization brings about an increase in workload and less supervision. Studies in this area revealed that there is a negative relationship between stress and job performance. It was found that, if there is increase in motivation over the work environment and an increase in supervision support, there will be an increase in performance respectively. Goga and Hoel (2003), opined that work overload puts organization's reputation is at stake and can potentially result in loss of employees, this situation calls for immediate concern from organizational management to employ stress management practice to handle the case by increasing employees so as to increase organization's performance.

e) In addition, the company must allocate funds to pay claims as they fall due. This can be attained through Asset Liability Management which is a fundamental element of health insurer strategy and operations. According to Gilbert (2016), the importance of ALM to insurers' results from insurance being primarily a liability driven business with assets purchased to match, in a risk efficient manner the obligation cash flows which may be uncertain for various reasons such as policyholders' options. Meyers (2017), postulates that insurance companies must periodically analyze the financial condition of the company, a process which aim to ascertain the ability of the entity's capital and surplus to adequately support future operations through a currently unknown environment.

f) The society must encourage the purchase of medical insurance using foreign currency by availing discounts on contributions paid in foreign currency. Of late local currency depreciation has been worsening the plights of the society. Policyholders therefore should be

made to prioritize maintaining their schemes in foreign currency which is more stable than the Zimbabwean dollars.

Mpofu 2015, postulates that the Zimbabwean economy has been characterized by several monetary and fiscal changes among them being hyperinflation, liquidity constraints and high interest rates. Statutory Instrument 280 of 2020 gazette insurance companies to transact in foreign currency so as to preserve reasonable policyholder expectations and provide fair value to customers.

5.5 Suggested area of further study

In this study focus was on exploring the causes of claims mismanagement in medical aid societies. The researcher suggest that further research must be exerted on the following subjects:

a) Evaluations on current strategies being implemented by medical aid societies to reduce claims costs.
b) Assessing the impact of current regulation on medical aid societies in enabling efficient claims management.
c) An investigation of the public's opinion on claims processing and payment in medical aid societies.

5.6 Summary

The objective of the research was to investigate the causes of claims mismanagement in medical aid society. PSMAS was used as the case study to the subject under research. Chapter one introduced the background of the study and presented the intentions of the researcher in the statement of the problem. The opinions of other authors that anchored the research topic were outlined in chapter two. The chapter looked at the claims management process, causes of claims mismanagement, challenges faced in claims management, the risks which emanates from claims mismanagement, the benefits and strategies to enhance efficient claims management.

Chapter three was a review various research instruments and data collection techniques to adopt in collecting relevant data sufficient to validate the objectives of the research. According to Howell (2013) research designs are the pillar of every research as they support researchers at every stage. The chapter presents methods used by the researcher in data collection, population, sampling techniques, sample size, validity and reliability of data gathered. In chapter four, the

researcher did an analysis and presentation of research findings. The data was obtained mostly from questionnaires, interviews, newspapers and various forms secondary data. The findings were processed into understandable and meaningful information by the use of tables, graphs and pie charts. After have had obtained all the information in mentioned chapters, summary, conclusion and recommendations for the research was drawn.

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APPENDIX A: QUESTIONAIRE
SECTION A: Personal information

1. Name (optional) ……

2. Company (optional)……..

3. Position……..

4. Number of years' experience in the current position (whether in current organization or from another organization ……..

5. Section/Department…….

SECTION B

1. What do you think are the main causes of failures in claims management? Rank them by ticking the appropriate box. Please note that you can tick as many as possible.

Claims mismanagement is caused by?	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
Cashflow Constraints					
Medical inflation and changes in claims patterns					
Mismatch between contributions and associated benefits					
Loss reserve estimation errors					
High Medical Loss Ratio					
Claims lag					
Any other (Specify)					

2). Indicate the extent to which you experience the following, as main challenges in claim management.

Factor	**Very highly**	**Highly**	**Moderate**	**Rarely**	**Never**
Fraud					
Capacity of claims personnel					
Incompetent and corrupt service providers					
Weak underwriting standards					
Any other (Specify)					

3) On a scale of 1 – 5, how would you rate the level of fraud in medical aid societies in Zimbabwe?

(1) Non- existent ☐ (2) Low ☐ (3) Moderate ☐ (4) High ☐

(5) Very high ☐

3) Indicate the extent to which the following factors influence your decision to Investigate a claim?

Factor	Very High (5)	High (4)	Moderate (3)	Rarely (2)	Never (1)
The trend of claim patterns from a service provider					
The frequency in which a member utilizes healthcare facilities					
When the disease condition was not declared before commencement of cover					
When treatment was sort just after the lapsing of a waiting period.					
Circumstances of the causes in seeking treatment are not clear					
Any other (Specify below)					

4) Indicate the extent to which each of the following is involved in perpetrating fraud?

	Very highly (5)	Highly (4)	Moderate (3)	Low (2)	I don't know (1)
Members of the society					
Claims adjudicators					
Own employees					
Service providers					
Any other? (Specify)					

5) Indicate the extent to which the following factors contribute to delay in claim Payment?

	Very greatly (5)	Greatly (4)	Moderately (3)	Rarely (2)	Never (1)
Funds allocated not sufficient					
Staff have a high overload					
Delay in submission of the adjudication form					
Delay in investigation report					
Delay in reporting claim					
Delay in claim documentation					
Any other (Specify)					

6) Is there a computer system in your organization for claims processing? Yes ☐

No ☐

7) How would you rank the system, in terms of claims processing?

(1) Highly ineffective ☐ (2) Ineffective ☐ (3) I don't know ☐ (4) Effective ☐

(5) Highly effective ☐

8) How would you rank the system, in terms of generation of required claims reports?

(1) Highly ineffective ☐ (2) Ineffective ☐ (3) I don't know ☐ (4) Effective ☐

(5) Highly effective ☐

9a) In your view, what do you understand by claims reserving and which claims reserves does your organization maintain……

……...

……

9b) In your view, does claims reserving improves claims management……

……..

……

10) Indicate the extent to which the following apply, in relation to payment of claims in your organization?

	Very frequently	Frequently	Sometimes	Rarely	Never
Claims are paid on a first come first pay basis					
A pre-set budget of expenditure in claims is followed					

Claims department is in charge of the payment process					
Payments are made as per company set benchmarks					

11) How large is your Claims Department? .....employees (number)

12) What is their average working experience?

(a) Less than 5 years …… (b) 5 – 10 years ……. (c) 11 – 15 years …… (d) Over 15 years ……..

13) How many employees in Claims Department have the following as the highest qualifications?

(a) Secondary school …… (b) Diploma holder ……. (c) University graduate …….

14) What recommendations can be made to solve claims management challenges faced by Medical Aid Societies in Zimbabwe?

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……

……

Thank you for your patience and cooperation in filling out this questionnaire.

APPENDIX B: INTERVIEW GUIDE

The following questions were generally used to direct flow of discussions during interviews, although many follow-up questions were used depending on how respondents gave answers:

1. What do you think are the main causes of claims mismanagement?
2. What are the challenges that the organization has faced in managing claims?
3. How has your company been affected by narrow card acceptance from service providers?
4. How has your organization been affected by fraudulent claims and what measures are in place to mitigate the risk of fraud?
5. Which current strategies are you implementing to ensure sound claims management?