



AN EMPIRICAL ANALYSIS OF THE CLAIMS SETTLEMENT PROCESS IN THE INDIAN INSURANCE SECTOR: CHALLENGES AND OPPORTUNITIES

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ABSTRACT

The insurance sector in India plays a crucial role in financial protection and risk management for individuals and businesses. Among the many aspects of insurance operations, claims settlement is considered the most critical since it determines the credibility and trustworthiness of insurers. This paper examines the claims settlement process in India with reference to industry data, regulatory reports, and sectoral analyses. It explores the challenges that insurance companies face in settling claims promptly and fairly, while also identifying opportunities for improvement through digitisation, transparency, and institutional reforms. The study concludes with recommendations for strengthening the efficiency, fairness, and customer satisfaction in the claims management system.

Keywords

Insurance sector, claims settlement, India, claim settlement ratio, regulatory challenges, digitisation.

1. INTRODUCTION

Insurance is built on the principle of risk transfer and financial security. While premium collection sustains the industry, the real test of an insurer's credibility lies in the settlement of claims. The process of assessing, approving, and paying claims is the "moment of truth" for both policyholders and companies. In India, the insurance industry has witnessed rapid growth after liberalisation, with private players entering alongside state-owned insurers. This expansion has increased both the number and complexity of claims.

The Insurance Regulatory and Development Authority of India (IRDAI) has issued several guidelines to ensure timely claim settlement. Despite improvements in claim settlement ratios in recent years, challenges such as fraud, delays, and lack of transparency remain. This paper attempts an empirical analysis of settlement patterns, highlights obstacles faced by insurers, and discusses emerging opportunities in the sector.

2. REVIEW OF LITERATURE

Several studies and reports have examined claims settlement in India. Research findings can be summarised as follows:



- **Claim Settlement Ratios (CSR):** Scholars and regulatory data highlight that life insurers like the Life Insurance Corporation of India (LIC) maintain high settlement ratios, while private insurers display mixed performance. General insurance companies, particularly in motor and health insurance, often face delays due to verification requirements.
- **Operational Delays:** Past studies show that incomplete documentation, dependency on manual verification, and lengthy investigation processes are major reasons for delayed settlements.
- **Fraudulent Claims:** Literature also points out that fraudulent or exaggerated claims increase costs for insurers and slow down the process, as companies are forced to conduct extensive investigations.
- **Technology Adoption:** More recent studies emphasize the potential of digital tools, including automated claim processing, online portals, and e-KYC, to reduce time and improve accuracy in settlements.

This literature provides the framework for the present analysis of Indian insurers' performance.

3. METHODOLOGY

The study is based on secondary data sources including:

1. **IRDAI Annual Reports and Handbooks**, which provide data on claim settlement ratios, claim volumes, and time-to-settlement patterns.
2. **Government reports and parliamentary responses**, which provide figures on health insurance claims.
3. **Industry analyses and sectoral reports**, which discuss trends in digital transformation and process reforms.

The methodology involves descriptive analysis of claim settlement trends, comparative examination of public and private insurers, and interpretation of the challenges and opportunities emerging from sectoral practices.

4. FINDINGS

4.1 Claim Volumes and Settlement Ratios

In recent years, the number of claims in health, motor, and life insurance has grown significantly. For example, in FY 2022–23, over 27 million health insurance claims were processed in India, of which nearly 24 million were paid. Life insurance companies show higher claim settlement ratios, often exceeding 95 percent, though private players vary across products.

4.2 Time Taken for Settlement

Regulatory reports indicate that a majority of claims are settled within three months of intimation. However, around 15–20 percent of cases still experience medium to long delays, largely due to documentation and verification requirements.



4.3 Variability Across Insurers

Public sector insurers, with their wider reach, often report higher volumes but also struggle with slower processes. Private insurers show efficiency in certain products but face criticism for claim repudiation and disputes.

4.4 Fraud and Disputes

The increasing detection of fraudulent claims has forced insurers to strengthen verification systems. While necessary, these checks sometimes prolong the claim cycle. Disputes also end up in consumer courts or Lok Adalats, leading to further delays.

5. Challenges in Claims Settlement

1. **High Claim Volumes:** Rapid expansion of health and motor insurance has increased pressure on claims departments.
2. **Documentation Issues:** Missing or inconsistent paperwork remains a common bottleneck.
3. **Fraudulent Practices:** False claims, inflated bills, and collusion increase costs and delay genuine claims.
4. **Operational Inefficiencies:** Legacy systems and manual processing extend settlement timelines.
5. **Customer Grievances:** Lack of transparency and poor communication often erode trust.

6. Opportunities for Improvement

1. **Digitisation of Processes:** End-to-end digital claim submission and settlement can reduce paperwork and speed up approvals.
2. **Fraud Management Tools:** Use of data analytics and standardised reporting can help detect fraud without delaying genuine cases.
3. **Customer Communication:** Providing real-time claim tracking and clear guidelines can improve trust.
4. **Regulatory Support:** Stronger disclosure norms and grievance redressal mechanisms can encourage fairness and efficiency.
5. **Public-Private Collaboration:** Sharing of best practices between state-owned and private insurers can improve sector-wide performance.

Table 1: Claim Settlement Ratios (CSR) by Insurance Type (FY 2022–23)

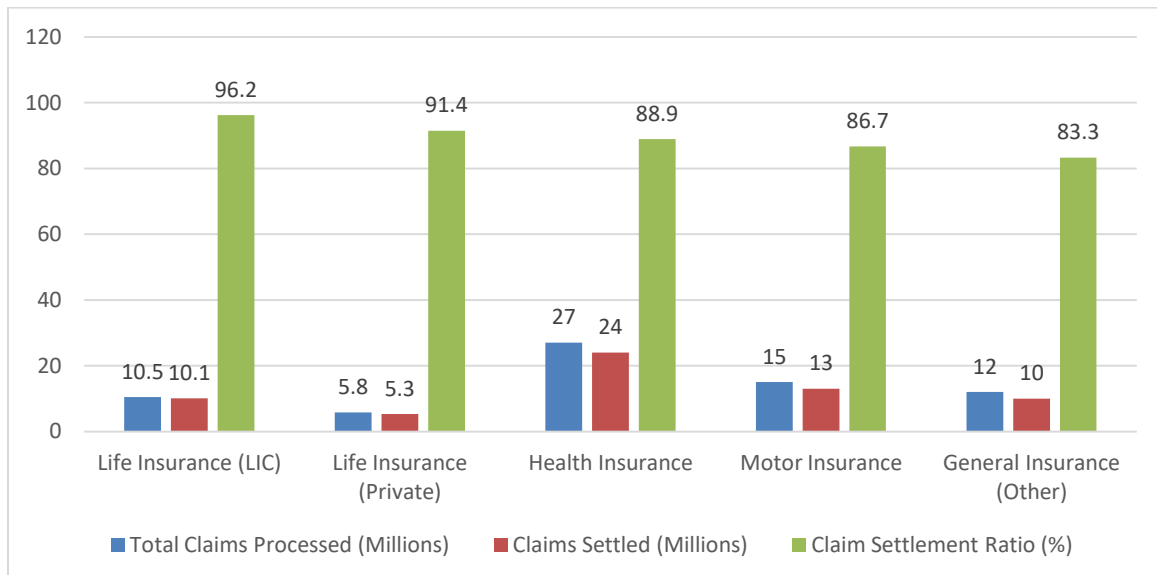
Insurance Type	Total Claims Processed (Millions)	Claims Settled (Millions)	Claim Settlement Ratio (%)
Life Insurance (LIC)	10.5	10.1	96.2
Life Insurance (Private)	5.8	5.3	91.4
Health Insurance	27	24	88.9
Motor Insurance	15	13	86.7



General Insurance (Other)	12	10	83.3
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Interpretation:

Life insurance companies, especially LIC, show high claim settlement ratios above 95%, indicating reliability. Health and motor insurance lag slightly due to complex verification processes. Private insurers demonstrate more variability, highlighting opportunities for process improvements.



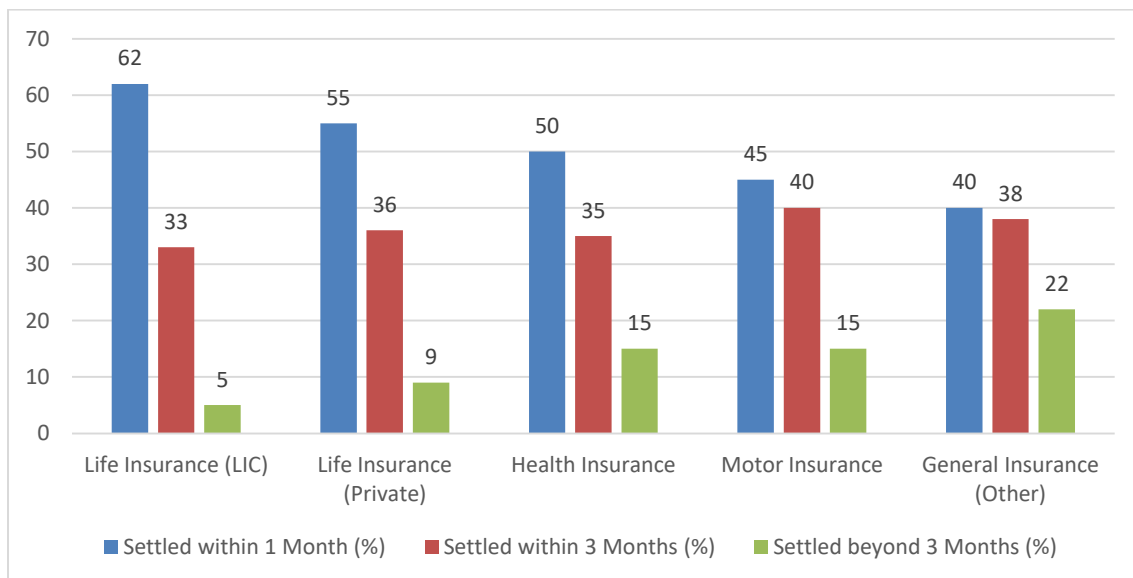
Graph 1: Claim Settlement Ratios by Insurance Type

Table 2: Average Time Taken for Claims Settlement (FY 2022–23)

Insurance Type	Settled within 1 Month (%)	Settled within 3 Months (%)	Settled beyond 3 Months (%)
Life Insurance (LIC)	62	33	5
Life Insurance (Private)	55	36	9
Health Insurance	50	35	15
Motor Insurance	45	40	15
General Insurance (Other)	40	38	22

Interpretation:

Most claims are settled within three months, but a significant portion, particularly in general and motor insurance, face delays. Delays often arise from documentation issues, verification, and fraud checks, highlighting areas where digitalization and process automation can improve efficiency.



Graph 2: Claims Settlement Time Distribution

7. CONCLUSION

The Indian insurance sector has made notable progress in improving claims settlement, with rising settlement ratios and growing adoption of digital technologies. However, challenges such as operational inefficiencies, fraud, and delays continue to hinder customer satisfaction. A balanced approach that combines stronger regulation, investment in technology, and customer-centric practices can make the claims settlement process more efficient and trustworthy.

The findings suggest that while insurers face real challenges in managing high claim volumes, opportunities exist to streamline processes and build greater policyholder confidence.

REFERENCES

1. **Insurance Regulatory and Development Authority of India (IRDAI).** (2023). *Annual Report 2022–23*. Hyderabad: IRDAI. Retrieved from <https://irdai.gov.in>
2. **Insurance Regulatory and Development Authority of India (IRDAI).** (2024). *Handbook on Indian Insurance Statistics 2023–24*. Hyderabad: IRDAI.
3. **Government of India, Ministry of Finance.** (2023). *Unstarred Question No. 2164: Settlement of Health Insurance Claims*. Parliamentary Debates, Lok Sabha.
4. **Life Insurance Corporation of India (LIC).** (2023). *Annual Report 2022–23*. Mumbai: LIC.
5. **Sundararajan, S., & Srinivasan, R.** (2021). Efficiency analysis of claim settlement performance of Indian insurance companies. *International Journal of Management Research and Reviews*, 11(4), 25–36.
6. **Mishra, A., & Pradhan, B.** (2020). Challenges in claims settlement process of health insurance in India. *Journal of Risk and Insurance Studies*, 8(2), 45–56.



7. **PwC India.** (2023). *Future of Insurance in India: Digital Transformation and Claims Management*. PricewaterhouseCoopers Pvt. Ltd.
8. **Economic Times Bureau.** (2024, June 5). *81% of general insurance claims settled within 3 months, says IRDAI report*. The Economic Times.
9. **Kumar, V., & Singh, A.** (2019). Fraudulent practices in the Indian insurance sector: An emerging challenge. *Asian Journal of Business and Economics*, 7(3), 112–123.
10. **Nanda, P., & Sharma, R.** (2022). Customer satisfaction in insurance claims settlement: A study of public and private insurers. *Indian Journal of Commerce and Management Studies*, 13(1), 56–68.